Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 25 September 2014 at 2.00 pm

Showroom Workstation, Paternoster Row, Sheffield S1 2BX

The Press and Public are Welcome to Attend

Membership

Councillor Julie Dore	Leader of the Council
Dr Tim Moorhead	Chair of the Clinical Commissioning Group
Richard Armstrong	Interim Director of Commissioning, NHS England
Ian Atkinson	Accountable Officer, Clinical Commissioning Group
Dr Nikki Bates	Governing Body Member, Clinical Commissioning Group
Councillor Jackie Drayton	Cabinet Member for Children, Young People and Families
Professor Pam Enderby	Chair, Healthwatch Sheffield
Councillor Mazher Iqbal	Cabinet Member for Communities and Public Health
Councillor Mary Lea	Cabinet Member for Health Care and Independent Living
Jayne Ludlam	Executive Director, Children, Young People & Families
Laraine Manley	Executive Director, Communities
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group
John Mothersole	Chief Executive, Sheffield City Council
Dr Ted Turner	Governing Body Member, Clinical Commissioning Group
Dr Jeremy Wight	Director of Public Health

Sheffield City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

Sheffield's Health and Wellbeing Board started to meet in shadow form in January 2012 and became a statutory group in April 2013. The Health and Social Care Act 2012 states that every local authority needs a Health and Wellbeing Board. It is a group of local GPs, local councillors, a representative of Sheffield citizens, and senior managers in the NHS and the local authority, all of whom seek to make local government and local health services better for local people. Its terms of reference sets out how it will operate.

Sheffield's Health and Wellbeing Board has a formal public meeting every three months as well as a range of public events held at least once a quarter.

Sheffield's Health and Wellbeing Board has a website which tells you more about what we do. www.sheffield.gov.uk/healthwellbeingboard

PUBLIC ACCESS TO THE MEETING

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Meetings are normally open to the public but sometimes the Board may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last.

If you require any further information please contact Jason Dietsch on 0114 273 4117 or email jason.dietsch@sheffield.gov.uk

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

25 SEPTEMBER 2014

Order of Business

1. Apologies for Absence

2. Exclusion of Public and Press
To identify items where resolutions may be moved to exclude the public and press

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

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

5. Update on the Joint Health and Wellbeing Strategy: Outcome 1 - Sheffield is a healthy and successful city (Pages 5 - 22)
Report of the Co-Chairs of the Health and Wellbeing Board.

6. Mental Health in Sheffield: a Snapshot (Pages 23 - 100)
A report of Healthwatch Sheffield on Sheffield Health and Wellbeing Board's Engagement event on Mental Health, 24 July 2014.

7. Report on Health and Wellbeing Board Engagement April-September 2014 (Pages 101 - 106)
Report of the Co-Chairs of the Health and Wellbeing Board.

8. The Integration of Health and Social Care
To receive a presentation.

9. Due North: Report of the Inquiry on Health Equity for the North (Pages 107 - 210)
Report of the Director of Public Health.

10. Funding Transfer from NHS England to Social Care (Pages 211 - 214)

Report of the Director of Commissioning, Sheffield City Council

11. Better Care Fund
The Programme Director, Better Care Fund, to report.

12. Minutes of the Previous Meeting (Pages 215 - 224)

To approve the minutes of the meeting of the Board held on 26 June 2014.

NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 11 December 2014 at 2.00 pm

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

Further advice can be obtained from Gillian Duckworth, Interim Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

This page is intentionally left blank

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Councillor Julie Dore and Dr Tim Moorhead, Co-Chairs of the Health and Wellbeing Board
Date:	25 September 2014
Subject:	Update on the Joint Health and Wellbeing Strategy: Outcome 1 – Sheffield is a healthy and successful city
Author of Report:	Louisa Willoughby, 0114 205 7143 *and other authors as stated*

Summary:

The Joint Health and Wellbeing Strategy is the Health and Wellbeing Board's strategy for Sheffield and as such is Sheffield's overarching city strategy in all matters relating to health and wellbeing. Outcome 1 of the Strategy is about the wider determinants of health, namely employment, housing and poverty. The outcome has nine key actions and is supported by eight indicators.

This report sets out:

- What has happened under each action over the past year and any issues and opportunities for the action in the year to come.
- Areas where the Health and Wellbeing Board can make a difference.

Recommendations:

Health and Wellbeing Board members are invited to:

- Actively support the recommendations made under each action in the report.
- Discuss in depth and pay particular attention to the following areas:
  - **Living Wage.** Board members are asked to consider the need for evidence on how the Living Wage is being taken up across Sheffield; consider the implications of introducing the Living Wage to the health and care sector by 2019; consider a proposition to Government around sharing the costs.
  - **Fuel poverty.** Board members are invited to sense the opportunity to be more ambitious in this area, for example to create a partnership across a number of sectors, potentially as an 'invest to save' initiative linked to affordable credit and private sector housing work.
  - **Worklessness.** Board members are encouraged to consider the numbers of people receiving long-term Employment Support Allowance and to pursue taking a whole-city

approach with the Department for Work and Pensions and the Cabinet Office to manage this in a different way.

- Support the ongoing programme of needs assessment and request a needs assessment to be submitted to a future Board meeting on tackling air quality.
- Request another update on this outcome in September 2015.

Background Papers:

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

Sheffield Health and Wellbeing Board
Update on the Joint Health and Wellbeing Strategy
Outcome 1 – Sheffield is a healthy and successful city
September 2014

1. What is this outcome 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.

The outcome is split into four main themes:

- City-wide influence.
- Housing.
- Health and employment.
- Poverty.

It is supported by eight outcome indicators which are set out in more detail in the Appendix.

2. How are we performing? – Indicators for outcome 1

Section completed by Louise Brewins, Head of Public Health Intelligence, Sheffield City Council

Sheffield generally compares well with the average for England and the Core Cities for this outcome area with the exception of long term unemployment and average income, both of which are significantly worse than the national average; and the gap is widening. When this is considered alongside the relatively static position on the proportion of Sheffield children living in poverty (around 1 in 4), clearly income and employment must remain the top priorities for this outcome area and therefore for the Strategy as a whole.

In addition however, although there is a positive local trend and comparative position on the proportion of deaths attributable to air quality, it should be noted that the current estimated figure of 4.7% is equivalent to approximately 500 deaths in people over the age of 30 years every year. This is clearly too many. This year's Director of Public Health report will be based on climate change and there has recently been a Green Commission held. The City also has an air quality action plan. Nevertheless the Board will want to be assured that it is doing everything it can in this regard and it is therefore recommended that more detailed information on this issue be provided to a future Board meeting.

Further information about the indicators for Outcome 1 can be found in the Appendix.

3. What do we need to know? – Developing the evidence base for outcome 1

Section completed by Louise Brewins, Head of Public Health Intelligence, Sheffield City Council

There are a number of agreed analyses and assessments being undertaken that will help to address the gaps in and/or enhance the evidence base identified in the Joint Strategic Needs Assessment relating to this outcome. These include:

- **Poverty** - the current child and household poverty strategy is due to run out at the end of 2014. A new strategy has been drafted, following detailed needs assessment, and is currently out to consultation.
- **Welfare reform** – Sheffield Hallam University has been commissioned to provide detailed estimates of the impact of the benefit reforms across Sheffield's households. The report is due in the autumn and will be used to strengthen our monitoring and evaluation of the overall impact of welfare reform on the City.
- **Food poverty** – as part of the evaluation of the new food strategy, mapping of food poverty across the City (using MOSAIC groups) is being undertaken to provide local insight to support targeted and appropriate action.
- **Environment** – this year's Director of Public Health report will focus on climate change. Evidence will be gathered that considers the impacts for the City and to generate recommendations for preventing/adapting to climate change. The report is due to be published in December 2014.
- **Community Wellbeing** – a new programme is being commissioned to support community resilience and development of social capital. As part of this, data are being gathered to support monitoring and evaluation of the service specification as well as wider research to support measuring wellbeing outcomes.

4. Examining the outcome, action by action

Theme: City-wide influence

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

Action 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

Section completed by Councillor Julie Dore and Dr Tim Moorhead, Co-Chairs of the Health and Wellbeing Board

1. **What progress has been made with this action over the past year?**

The Health and Wellbeing Board has a clear focus on engaging and communicating with a wide range of partners across the city, and with Sheffield people. More can be read about the Health and Wellbeing Board's engagement in the update presented to the Board at its September 2014 meeting. In addition, the Health Needs Assessments which are carried out over the course of the year focus not just on traditional areas concerning health and care but branch out more widely, assisting the Health and Wellbeing Board to have a wider approach to health and wellbeing.

Board members are also working to continually develop their approaches to influencing partners and organisations across the city to make health and wellbeing a part of what they do. Much of this is done organically by building relationships with partners.

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

There is more that the Health and Wellbeing Board can do to influence partners and organisations across Sheffield. There is a lot of opportunity to do so, and partner relationships in Sheffield are strong. However, it is also the case that partners and organisations have their own priorities and there are limits to how much they are able to change in this current financial climate. We also acknowledge the breadth of this action – in a city the size of Sheffield, there are hundreds of organisations we could work with, and therefore have to recognise that the influencing role will be carried out incrementally over a number of years.

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

- Support the development of Health Impact Assessments across partner organisations.
- Work with the Sheffield Executive Board and its partners to consider how we can develop this influencing role further over the next year.

Housing

Housing across the city to be of a good quality, well-insulated with affordable bills and healthy and safe facilities

Action 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

Section filled out by Michelle Slater, Private Sector Housing Service Manager, Sheffield City Council.

1. **What progress has been made with this action over the past year?**

- A plan to improve poorer quality private sector housing has been agreed.
- A selective licensing scheme has begun in Page Hall to improve the quality of homes in that area. Work is also ongoing to reduce the waste and fly tipping which leads to pest infestation and infectious diseases. This links to the Board's Strategy action 3.6 to improve the experience of new arrivals to the city.

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

Over the next year the following opportunities are available to:

- Seek out and tackle more unsafe homes by reducing hazards in homes including eliminating or reducing damp and mould, addressing trip and fall hazards and increasing the levels of fire protection and detection.
- Focus more attention on areas where there are large concentrations of European migrants as cultural differences can lead to health hazards through poor sanitation and build ups of waste and litter.
- Take a hard line on landlords that refuse to meet their responsibilities – both in disrepair and tenancy management with the aim of improving health and safety in all private rented homes.
- Improve neighbourhoods affected by problematic empty homes and the crime and nuisance associated with them.
- Work positively with committed landlords to provide and promote quality student homes.
- Improve the health and wellbeing of tenants in private rented homes by working with GPs and health professionals about the potential for improving health and wellbeing through housing interventions.

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

- Encourage GP practices to case-find tenants living in poor quality private rented homes, and make referrals to the Private housing standards team so that an inspection and potential repairs carried out to improve the occupant's health.
- Incorporate work to improve the information and advice offered to tenants and landlords with other information and advice offered around health and wellbeing.

Health and employment

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

Action 1.3: 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.

Section completed by Tony Tweedy, Director of Lifelong Learning, Skills and Communities, Sheffield City Council and Antony Hughes, Children's Commissioner, Sheffield City Council

1. **What progress has been made with this action over the past year?**

- Outcomes at all key stages have improved strongly in the last five years. *Early indications* are that this trend continues this year.
- Sheffield's City Wide Learning Body has led work to transform practice in a number of key areas including: governance, parental engagement in learning, school admissions, RE and in partnership with the Children's Health and Wellbeing Partnership Board PSHE and emotional health and wellbeing.
- Education-business links have been strengthened through the extended *Made in Sheffield* programme. A Skills Passport, endorsed by local employers, allows school students to articulate and reflect on the skills, experiences and achievements relevant to the world of work that they have acquired through their involvement in *Made in Sheffield*.
- *Make:Learn:Share*, a pilot programme, saw Young Ambassadors teaching coding, robotics, 3D printing and app design in feeder primary schools.
- The Local Economic Partnership committed to *Learn to Work*, the city-region's schools' challenge designed to drive up performance in subject areas critical to economic growth.
- DfE approval and funding granted to create the city's second University Technical College specialising in Human Sciences and Digital Technologies.
- The work of the multi-agency Community Youth Teams has been embedded and through this reduced NEETs to an historic low for the city.
- Attainment at 19 has improved at a faster rate than nationally for the last three years, although parity with the English average remains to be achieved; and reduced the inequality gap (attainment of students previously eligible for free school meals compared to those who weren't eligible) to a level lower than the national average.

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

The following areas need to be worked on over the next year:

- Reading outcomes at all key stages remain too low.
- Outcomes for certain groups (those receiving a free school meal, newly arrived children, looked after children) are too long.
- The proportion of children attending a good or better school is below national overages.
- Embed *Made in Sheffield* in the business sectors and schools.
- Identify those talented teachers and cutting edge departments capable of leading the SCR Schools Challenge thereby driving up performance and post-16 participation in key subjects.

- Work with employers to develop the city's second University Technical College as a gateway to careers in the health, sports science and digital industries.
- Win DWP approval and secure the external investment needed to trial a Social Impact Bond as a sustainable means of reducing the disproportionate number of vulnerable teenagers represented in the NEETs cohort.
- Work with colleges and training providers to drive up Level 2 and 3 achievement in vocational subjects at 19.

As opportunities:

- The quality of partnership and collaboration between schools is good and this partnership work is driving improvement in outcomes for children.
- Reviews are already underway of early intervention and prevention around schools, PSHE and a pilot of emotional health and wellbeing support – offers great opportunities for joint work between the education and health communities.
- Change (policy and financial) in the schools sector.

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

- Consider, in the light of the local authority's new responsibilities under the Raising of the Participation Age legislation, a greater focus on performance and outcomes at 19 as well as 16.
- Identify ways in which members of the Board and those in their networks and partnerships can better support the development of the Made in Sheffield curriculum, work experience and Skills Passport in sectors such as Health and Care.
- Identify ways in which members of the Board and those in their networks and partnerships can support the curriculum design, development and launch of the UTC for Human Sciences and Digital Technologies.
- Identify key actions that Board members and their partners and networks can take forward in supporting the vulnerable groups of 16-19 year olds identified above to remain in, or to reengage in education, employment or training, such as the development of 0-25 service for vulnerable young people and improved provision of Children's and Adolescent Mental Health Services for disengaged teenagers.
- Support the recommendations of the reviews of early intervention and prevention around schools, PSHE and emotional health and wellbeing support – and use these and joint work on the implementation of the Children and Families Act as a springboard into discussions about how the strength and depth of partnership and collaboration can be improved between the education and health communities, and to consider potential areas for collective action and pooled budgets.

Action 1.4: Work with employers to create employment pathways for young people, and emphasise the role of health and wellbeing amongst all employers in the city.

Section completed by Tony Tweedy, Director of Lifelong Learning, Skills and Communities, Sheffield City Council

1. **What progress has been made with this action over the past year?**

The City Council and its partners have through the Learning for Work Partnership actively pursued the seven key actions agreed by the city's Youth Employment Task Group and set out in the Jobs for Youth Action Plan, including:

- Preventing disengagement from compulsory education and training.
- Raising aspirations and improving career choices.
- Intervening early with work-focused programmes.
- Developing appropriate solutions so that no one is left behind.
- Placing employers at the centre of the design and delivery of programmes such as apprenticeships.
- Developing an Employer Charter and good Employer Code of Practice' to encourage and recognise employers who seek to improve the health and wellbeing of their staff.

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

Issues:

- The number of young adults claiming JSA has reduced more quickly than amongst the working age population as a whole. There were almost a third (-32.3%) fewer young claimants in July 2014 than there were in July 2013 whilst the number of claimants aged 25+ reduced by 23.7% over the same period. However, for those young adults who remain unemployed, the threat of long-term unemployment (over 12 months) continues to be a real concern.

Opportunities:

- A key element in both addressing long-term unemployment and in improving the longer-term life chances of those young people who have previously been without work is the promotion of the Skills Escalator. The escalator is being designed by Opportunity Sheffield to both equip those most in need with the employability skills and the work history needed to secure sustained employment and to encourage employers to invest in the training of the existing workforce thereby creating career pathways, greater earning power and improved job security. The £100m Skills Bank and the £23.8m Progress to Work programme, negotiated as part of the city-region's Growth Deal with government, are both designed to support the Skills Escalator, to pilot a new way of creating sustained employment for those at greatest risk and to offer a model to an incoming government in 2015 as to how a localised Work Programme can deliver bigger and better impact.
- As the economic recovery picks up and unemployment for all groups falls, the focus needs to be increasingly on those claimants on work-related benefits other than JSA. This means tackling the issue of those 24,000 or more Sheffield residents in receipt of Incapacity Benefit/Employment Support Allowance, a majority of whom have been workless for more than two years and many for more than five years. This group mainly comprises individuals determined to be unfit for work because of a range of mental and physical health conditions and it is the repository of the most vulnerable adults where agencies have had least success in creating suitable employment pathways including those with learning difficulties and disabilities.

- The ground is fertile for a proposition to government that sets out how this problem can be better addressed by a coalition of willing and determined local partners that adopt a 'whole person' approach to employability for workless individuals, such as that to be trialled in the CCG/JCP ESA Pilot.

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

- Continue to focus on the long-term effects of youth unemployment and ensure measures are being taken to address this, particularly for vulnerable groups including care leavers, teenage parents, young offenders and those with learning difficulties and disabilities (LDD).
- Consider how a 0-25 LDD service might be developed to better plan successful and sustainable learning and employment outcomes for this group
- Commit to supporting and monitoring closely the work of the CCG/JCP funded ESA pilot with a view to working up a proposition to government of new and better ways of delivering local solutions to long-term worklessness, particularly for the most vulnerable
- Require SCC's employability programme (*Sheffield's Working*) and the Sheffield 100 Apprentices programme to be closely aligned to the needs of the most vulnerable young people and adults in support of the above
- Consider how the model for a 0-25 LDD service could be extended to older adults with a view to improving life chances and employment outcomes.
- Clearly set out how it wishes partners to take forward the commitment "to emphasise the role of health and wellbeing amongst all employers in the city."

Action 1.5: 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.

Section completed by Sharon Squires, Director of the Sheffield First Partnership

1. **What progress has been made with this action over the past year?**

Organisations across Sheffield continue to adopt the Living Wage as requested by the Fairness Commission report. The most recent large organisation to do so is the University of Sheffield. Work is underway in partnership with the Sheffield Chamber of Commerce to discuss the Living Wage with private employers across the city and city region, and encourage greater commitment to paying the Living Wage. We are also working with the Chamber on developing a Fair Employer code for Sheffield, recognising that employers can be fair even if they are unable to pay the living wage. These are significant developments.

The Sheffield Fair City Campaign will be launched in the autumn. This is being developed in partnership with Diva, a local social marketing company, and will focus on increasing understanding of and commitment to Fairness. We are will focus on the Living Wage as part of that campaign.

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

Many small private and voluntary sector organisations state that they simply cannot afford to pay the Living Wage. Issues such as the continuing impact of the recession, cuts to grants and budgets and the need to increase productivity remain fundamental challenges to these employers. However there remain some larger organisations and businesses which need to be persuaded on the benefits of paying the Living Wage and this will be done as part of the Fair City Campaign.

In terms of opportunities the living wage is a critical part of reducing poverty in Sheffield and improving health. In-work poverty is increasing across the city, and low wages, combined with unfair contracts of employment, has created the situation where too many citizens are leading increasing stressful lives, working excessive hours, with poor conditions (e.g no holiday or sickness pay) and still unable to afford basic goods such as energy and food.

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

- Actively support the Fair City Campaign once it is launched in the autumn.
- Review commissioning practices across the Council/CCG and other key stakeholders to ensure they align with the aspiration that all employees should be paid a living wage by 2023.
- Support the development of a one-off project to collate more detailed information on who is paying the living wage in the city, and barriers to wider adoption by employers.

Action 1.6 Support the Health, Disability and Work Plan and further work to understand and evaluate the costs of poor health to employment.

Section completed by Chris Shaw, Head of Health Improvement, Sheffield City Council

1. **What progress has been made with this action over the past year?**

A specification for a pilot programme seeking to reduce health barriers to employment in specific areas of Sheffield is being drafted with collaboration from the GPs in the areas involved and funded by Public Health and Job Centre Plus. The aim is to commence in October.

A Good Employer award is now being offered to employers in the City, developed with Public Health England as part of the Government's Workplace Health Responsibility deal. The aim is to launch it in September/October.

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

- The pilot (see above) will reduce health barriers to employment. The City should use the learning to work more closely with employers and the Local Economic Partnership to develop the City's proposals in terms of replacements to the Work Programme. One of the reasons the existing DWP Return to Work (the Work Programme) has failed a substantial (and vulnerable) section of the community is the lack of connectivity between employment and health systems at both national and local level. This project seeks to develop these linkages, either to assist the existing programme, or to add value to its replacement, which could be a more locally oriented system.
- A review into the funding providing employment opportunities for people with health conditions or disabilities suggests current investment isn't coordinated. Individual Placement Support (IPS) and Place then Train model are recognised as good practice.
- The City's performance in terms of employment for those on a Care Programme for mental health conditions or with learning disabilities is unsatisfactory and contributing to health inequalities in the City. We can do better.

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

- Continue to contribute to the delivery and development of the pilot programme seeking to reduce health barriers to employment (CCG).
- Support the Good Employer award now being offered to employers in the City.
- Following on from the review of supported employment funding, ensure investment by partners into providing employment opportunities for people with health conditions or disabilities is coordinated across agencies and follows best practice.
- Meet with the Local Employment Partnership to encourage participation in the Good Employer Aware, encourage their engagement, and investigate the potential for co-funding solutions to these issues
- Contribute to a Health, Disability and Employment summit early in 2015.

Action 1.7 Pursue the development of broader approaches to health and the economy both with the Core Cities and in Sheffield City Region.

Section filled out by Jeremy Wight, Director of Public Health, Sheffield City Council

1. **What progress has been made with this action over the past year?**

The Core Cities group is still meeting and both Sheffield and Manchester have developed pilot programmes to remove health barriers to employment. However continuity of representation (there have been a lot of changes in Public Health leadership across the Core Cities) and this being a 'non-traditional' public health area have resulted in slow progress from the other Cities. Sheffield and Manchester will present proposals at the next Core Cities Employment and health Group to accelerate progress.

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

The Core Cities Group has established a Cabinet and are looking to develop proposals to Government for improving / replacing the (DWP) Work Programme. Health barriers are a key 'weakness' in the current programme and the Core Cities Group has a key role in advising the Core Cities Cabinet as to system and product improvements to address this.

Within the Sheffield City Region there is a will to deliver a City Region wide 'Good Employer' award. This is being developed across public health teams.

Any interventions involving Job Centre Plus will need to be considered at a City Region Level as JCP boundaries are not the same as local government's.

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

- Hold a roundtable with the Local Enterprise Partnership Members to establish areas of common interest and mutual benefit within the context of the Core Cities' proposals.
- Explore joint funding opportunities to improve employment opportunities for vulnerable residents, especially when these have a potential to reduce longer term health and care costs across the City.

Poverty

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.

Action 1.8 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.

Section completed by Tony Tweedy, Director of Lifelong Learning, Skills and Communities, Sheffield City Council

1. **What progress has been made with this action over the past year?**

- The current Child and Household Poverty Strategy comes to an end in 2014. 79% of all targets are on-track or achieved.
- A number of Fairness Commission objectives have been achieved. For example:
    - The city has progressed a number of important initiatives designed to stimulate economic activity and increase employment, such as Skills Made Easy, RISE, support for businesses to grow through export; the creation of infrastructure funds to facilitate physical development and extensive support for the City Region Local Enterprise Partnership; a £1.3m Sheffield Employability programme aimed at helping those facing the greatest barriers to access work.
    - A city-region programme to trial new ways of tackling youth unemployment including work trials and links to City Deal apprenticeships has received government funding.
    - The Council is signed up to the Mindful Employer, Stonewall and the Two Ticks scheme and are currently in the top ten 100 Stonewall employers list. It is the first local authority to sign up to the Hidden Impairment group. The recommendation to have a voluntary 'Fair Employer' code of practice is not currently being led by any organisation in the city.
    - A Living Wage has been implemented by the Council for the staff it directly employs. Work is on-going with contractors.

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

There is an opportunity in the refreshing of the strategy to improve our impact in this area. The key issues are the impact of welfare reform; organisations facing decreasing resources and increasing demand; and there is no local data to show who in Sheffield is in work and living below the poverty line and so our ability to target any activity is hampered.

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

- Contribute to the consultation and development of the new Tackling Poverty Strategy and commit to taking action as part of the new Strategy.
- Continue to work towards full implementation of the Fairness Commission recommendations.

Action 1.9 Support the creation and implementation of a city-wide fuel poverty strategy.

Section completed by Chris Shaw, Head of Health Improvement, Sheffield City Council

1. **What progress has been made with this action over the past year?**

- A Knowledge Group was formed with contributions from the universities, NHS, VCF sector, private sector and SCC.
- The CCG were engaged on the issue of Excess Winter Deaths.
- Work underway with SCC Sustainable Development Service to address shortcomings of existing Government 'Home Insulation Schemes' and increase their impact on the health of the City
- Funding from Public Health secured to provide support for those experiencing Fuel Poverty and at risk of Cold related illness this winter.

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

- The National Warm Homes Programmes (Green Deal and Eco) have significant shortcomings and funding locally for such programmes is limited.
- Need to ensure when the health system becomes aware of individuals in fuel poverty, or at risk of cold related illness they are referred to the appropriate agencies across the City who can assist, including SCC, and the VCF sector.
- The VCF sector and health and Care sector have the knowledge and capability to be the 'case finders' and the 'advisors' for residents in fuel poverty. However the funding to deliver this intervention is only for 1 year.

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

- Participate in the development of the Fuel Poverty Strategy.
- Once the Strategy is produced encourage the Health sector to participate in case finding and advising residents in fuel poverty and/ or at risk of cold home related illness.
- Ensure resources are targeted at coordinating the multiple agencies and teams with a role in reducing fuel poverty.

5. Appendix – More information about the outcome indicators

1. **Indicator:** Children in poverty

Definition: Percentage of children < 16 years living in families in receipt of out of work benefits or tax credits where their reported income is < 60% median income.

	2009	2010	2011
Sheffield	25%	24.8%	24.4%
England	21.9%	21.1%	20.6%
Core City Rank (1 is best)	2	2	2

2. **Indicator:** Foundation stage profile attainment

Definition: Percentage of children achieving 78+ points, including at least 6 points in both 'Personal, Social & Emotional Development' and 'Communication, Language & Literacy'.

	2010	2011	2012
Sheffield	52.1%	59%	63%
England	56%	59%	64%
Core City Rank (1 is best)	6	2	1

3. **Indicator**: GCSE attainment

Definition: Percentage of people achieving 5 GCSEs A* to C including in English and Maths.

	2011	2012	2013
Sheffield	49.5%	55.6%	57.3%
England	58.9%	59.4%	60.8%
Core City Rank (1 is best)	7	4	2

4. **Indicator**: Young people not in education, employment or training

Definition: Percentage of 16-18 year olds not in employment, education or training.

	2011	2012	2013
Sheffield	8.2%	7.7%	6.6%
England	6.1%	5.8%	5.3%
Core City Rank (1 is best)	4	5	3

5. **Indicator**: Homelessness acceptances

Definition: Households found to be eligible for assistance, unintentionally homeless and falling within a priority need group. The main duty is to secure settled accommodation. Expressed as a rate per 1,000 households.

	2011-12	2012-13	2013-14
Sheffield	6.0	5.0	3.4
England	2.3	2.4	2.9
Core City Rank (1 is best)	7	7	6

6. **Indicator**: Deaths attributable to air pollution

Definition: Fraction of mortality in people aged 30 years or more attributable to particulate (anthropogenic PM 2.5) air pollution.

	2010	2011	2012
Sheffield	5.5%	5.1%	4.7%
England	5.6%	5.4%	5.1%
Core City Rank (1 is best)	3	3	3

7. **Indicator**: Long term unemployment

Definition: Rate of long term unemployment in 16-64 year olds. Crude rate per 1,000 population.

	2011	2012	2013
Sheffield	7.9	13.5	14.7
England	5.7	9.5	9.9
Core City Rank (1 is best)	4	4	4

8. **Indicator**: Average income

Definition: Gross median annual pay (all employees and jobs). Data are based on place of residence.

	2011	2012	2013
Sheffield	£19,751	£19,844	£19,521
England	£21,454	£21,813	£22,204
Core City Rank (1 is best)	6	5	7

This page is intentionally left blank

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Pam Enderby, Chair of Healthwatch Sheffield
Date:	25 September 2014
Subject:	Report on the Health and Wellbeing Board's and Healthwatch Sheffield's July 2014 Engagement Event on Mental Health
Author of Report:	Vicky Cooper, 0114 253 6688

Summary:

The report details the Health and Wellbeing Board's Engagement Event of the 24th July 2014, facilitated by Healthwatch Sheffield. The report contains a write up of findings, recommendations, methodology and a full set of responses.

Questions for the Health and Wellbeing Board:

How will the Health and Wellbeing Board ensure that the information captured by this and all Health and Wellbeing Board engagement events is proven to influence service change for the people of Sheffield?

Recommendations:

- Sheffield Health and Wellbeing Board note the points of this report and work proactively to translate people's views into action, and that all actions are communicated back to the people who attended this event.
- All future engagement events should include a service user quota to ensure sufficient representation from members of the public.
- This report becomes the basis of future work on the 10 topics discussed at the event with a view to repeating this exercise in 12 months time and assessing the distance travelled.
- To work with Healthwatch Sheffield to ensure that people remain involved and their views and experiences are used to help shape and improve services in the City.

Background Papers:

Full engagement event report and appendices

This page is intentionally left blank

Mental Health in Sheffield: A Snapshot

A report on Sheffield Health and Welllbeing Board's Engagement event on Mental Health, July 24th, 2014

Healthwatch Sheffield

(September 2014)

Contents

Contact us

Healthwatch Sheffield
The Circle
33 Rockingham Lane
Sheffield
S1 4FW

Tel: (0114) 253 6688
Email: info@healthwatchsheffield.co.uk

www.healthwatchsheffield.co.uk

Key Issues – A One Page Summary

What did most people say would most improve Mental Health in Sheffield?

- Joining up services and Information sharing between agencies
- Support for paid and unpaid carers
- Improved information and communications
- Training for staff and volunteers
- Person Centred Care

What did they feel are the current barriers to this?

- Not getting access to services, or getting the right service
- Waiting too long for a service, or not getting help early enough
- Limited resources – staff, time, money, facilities, services
- Having physical and mental needs treated separately
- Lack of integration and communication between services

Recommendations and Next Steps

- Sheffield Health and Wellbeing Board note the points of this report and work proactively to translate people's views into action, and that all actions are communicated back to the people who attended this event
- All future engagement events should include a service user quota to ensure sufficient representation from members of the public
- This report becomes the basis of future work on the 10 topics discussed at the event with a view to repeating this exercise in 12 months time and assessing the distance travelled
- To work with Healthwatch Sheffield to ensure that people remain involved and their views and experiences are used to help shape and improve services in the City

Background

Sheffield's Health and Wellbeing Board asked Healthwatch Sheffield if they would be interested in running one of their engagement events taking place in July 2014. Healthwatch agreed and was able to select the topic of mental health.

Why?

We did this because we felt Mental Health was a difficult topic to collect views on, but a very important one. The findings at the event could also be used to make recommendations to a number of ongoing consultations including the Sheffield Mental Health Strategy refresh and the Healthwatch England special enquiry into discharge from services.

Who?

We were very clear from the start that we wanted to actively encourage service users to come along and have their say, making sure that the people who know the most about the condition were the priority. With this in mind, we ring fenced a number of tickets specifically for service users, and encouraged all service providers taking a ticket to also select a service user to attend with them. On the day, we estimate (based on the Eventbrite ticket list) that 60% of the 80 people attending were service users. For those who were unable to be in the room at the time, we hosted a live webchat (using Google Hangout) and also promoted a Twitter hashtag (#mhsheff2014).

Both the webchat and live Twitter feed were visible on large screens in the hall on the day. We received 86 tweets, all of which can be read in appendix 1.

How did we do it?

We gathered views in a variety of ways and since the event was taking place in the summer we loosely based the event on a summer fete theme.

To encourage people to talk about mental health as part of the day, a DVD was shown of the Sheffield MIND Let's Get Talking project. It showed service users from Somali and Pakistani backgrounds talking about their mental health problems and the stigma and discrimination people face.

Participants then had the opportunity to visit the summer fete, an informal session which gave people a chance to get refreshments, take part in our Hook-a-Duck consultation put up their Mental Health Bunting and view the Young Healthwatch stall.

All views from this session can be found in the 'Mental Health Bunting' section later in this document.

People were then asked to sit at tables to discuss 10 topics:-

1) Discharge from Hospital
2) Acute Care – Including secure units
3) Integration – bringing health and social care together
4) Barriers to accessing services
5) Information – how do you find things out?
6) Early support and intervention
7) Primary Care – GPs, dentists, opticians, pharmacists
8) How do you stay well?
9) Emergency care and support
10) Dementia

Rather than ask people to move around, the facilitators rotated around the room as if on a carousel. People had five minutes to add their views on post-it notes to each topic before the melodeon player signified it was time for the facilitator (and their topic) to move on. This allowed everyone to contribute to a large number of topics in a short period of time.

An artist was also present to capture the discussion in a visual form. Participants were invited to view the artwork and mental health bunting throughout the event.

What did people tell us?

We received a large amount of feedback from all the activities. Every comment we received can be viewed in Appendix 2. A summary of the main themes arising from the activities and the table discussions follows.

Table Topics

Acute Care

Key Points:

- Both patients and staff would like staff to have more time.
- Sometimes it is difficult to access services or get the right one for you.
- Families/carers need more support at points of transition (e.g. when someone is admitted, or discharged from acute care).

Emerging Themes

A&E

Several people mentioned A&E, and of these most people didn't feel it was the right place to be in a crisis. Response times and waiting times were also felt to be too long.

Staff

Staff in acute settings were described as having heavy workloads, or having lost their empathy. A service user commented that staff "not got the time for 1:1 work. They can't provide an individual service."

A staff provider echoed this: "Find that hands are tied to be able to do 1:1, an individual / bespoke service. Things have to fit the process, not the individual."

Families / Carers

Preparing the family or carer for discharge was mentioned, as was identifying clear routes out of acute care. "Families with acute care needs need help to access ongoing services" reflects most of the comments on this area. "The trauma of acute admission on family members is not always acknowledged."

Inpatient Settings

People who had identified themselves as having been an inpatient all disliked the experience. They described the environment as frightening, not enough having enough therapeutic activity and feeling neglected.

Access and Choice

Several people described not being able to get what they needed, when they needed it most in Acute Care. "Office hours are not helpful", "I need easier

access", "I need help to access the right service", "I don't always need specialist help, but I need good signposting."

Barriers to Accessing Services

Key Points:

- The stigma surrounding mental health remains the biggest issue in accessing services.
- More tailored training for staff is needed.
- Accessing primary care can be a challenge for some people.

Emerging Themes

Access and Waiting Times

People have very different experiences of waiting times and access to services. Geography and cultural differences were mentioned as factors that affected this. Service users spoke of thresholds for services being too high, waiting times for both primary and secondary care being too long, and not enough counselling available.

GPs

Several people said that they didn't think their GP had a good understanding of their condition. One person felt that there was a lack of encouragement by the GP to discuss mental health at an early stage. Poor referral letters and uncaring receptionists were also mentioned.

Information

Better information around self help would improve access to services for several people. Often people may not know what's available, or how to use it. "Accessing websites may be difficult for some people."

Training and Education

Awareness training for GPs, reception staff and employers were all mentioned.

Stigma

There remains a huge stigma around mental health, even though there is an acknowledgement of slow change.

"Women with anxiety are seen as marginalised"

"There are cultural barriers"

"Stigma, misconceptions, fear, personal shame."

A common theme was also that people either don't realise that they are ill or refuse to accept that they may need support or help.

Discharge from Hospital

Key Points:

- There is a perception that after discharge there is not enough support in place, and many patients feel there is a gap in service immediately after discharge.
- Transitions need to look more seamless to the service user, and need to take place only when everyone is informed and ready to do so.

Emerging Themes

Are you ok?

Several people would like to see more checking on people post-discharge.

"No checking of are you ok – are you well?"

"Discharge from acute services does not mean that someone has recovered!"

"Patients need to be eased back into coping on their own rather than just left. Often they don't see people for weeks."

"Do not 'send' people home unless there is someone to receive them."

Support after discharge

The majority of comments on discharge were about support.

"The discharge process is a revolving door."

"Not having appropriate support in place for after discharge is a major concern."

"Do not discharge until ALL care issues are fully arranged and resourced."

Housing was frequently mentioned as a service which needed to be involved earlier (i.e. "Let the housing know!").

Transitions

Universally, everyone wanted to see true integrated working when it came to transitions.

"Services working together e.g. health, council, individual's housing."

Discharge from Hospital (continued)

Transitions

“Stop the practice of playing pass the parcel with people and just treating them as money packages.”

“There is a lack of communication between mental health and physical health.”

“Limited support at discharge could cause people going back in.”

Most people mentioned better joining up of services and resources, and ensuring that everyone involved in the transition including the service user and their family and/or carer were informed and ready before the transition began.

Early Support and Intervention

Key Points:

- Much of the early support and intervention is carried out by the voluntary/ third sector. People are happy with this.
- Cuts and waiting times remain a concern for younger people and their families accessing services.
- People would like to see lower thresholds for access to services.

Emerging Themes

Voluntary/Third Sector Support

Many of the contributions to this discussion noted the valuable role of the voluntary /third sector.

“The voluntary sector is well placed to provide early intervention as people are often more willing to interact with them than other providers.”

“People become wary of primary health because of stigma. People therefore more ready to go to a non-statutory group.”

“The third sector offers flexibility, variety and is user friendly.”

Children

People mentioned the Youth Parliament and school nurses as important, but questioned the usefulness of CAHMS given a perception of long waiting times leading to more acute health issues.

“What support is there for 16-18 year olds?”

“Cuts to young people’s services e.g. Sure Start can lead to language development not being supported which can add to behavioural difficulties.”

“If young people are given help to adjust, then they find it easier to join groups and to be able to mix with others which helps their confidence.”

Thresholds

Thresholds for treatment were felt to be too high.

“You have to be in crisis before you are seen” and “Only crisis merits support.”

“People need to access services quickly. There is more money spent on late intervention”. “Services need to be available early and quickly.”

Emergency Care

Key Points:

- Emergency care has several areas of good practice.
- The tension between treating the physical and mental issue in an emergency situation remains critical.
- Individuals may have a large range of external factors that will affect their treatment.

Emerging Themes

Good Practice

Several people had points of good practice in emergency care.

“24hr Rethink helpline and crisis accommodation is impressive.”

“The response to the crisis in terms of saving my life was effective.”

“Crisis house – good but only if you can jump through the hoops.”

“Paramedics have been very good in crisis/suicide – non-judgemental and kind.”

A&E

A&E was not considered a good place to receive mental health treatment.

“A&E is focused on medical not mental health concerns.”

“A&E need for better training for mental health issues when someone presents with multiple issues.”

“Emergency A&E too focussed on ‘customer satisfaction’. Rarely have I seen surveys so poorly and inappropriately used.”

Mental versus Physical Health

Most people who had received emergency care noted the tension between treating their physical and mental health needs.

“I was taken to A&E because of an overdose. I was treated as someone with physical symptoms. The mental health ‘input’ did not begin until transfer to a psychiatric ward.”

Emergency Care (continued)

Mental versus Physical Health (continued)

"What is the priority? The mental or physical issue?"

"A&E need better training for mental health issues when someone presents with multiple issues."

Treating the Individual

"We need to be aware that even in an emergency there may be important things on service users' minds e.g. childcare."

"Services need to listen to carers who know the patient best."

"Non-attendance is not always a choice. Physical / stamina issues as well as mental stamina can be interpreted as disinterest."

How do you stay well?

Key Points:

- There is no 'one-size-fits-all' solution to keeping well. Individuals find things that work for them.
- Having a network of people to speak to, either online, through family or friends, is the single most important thing that helps people.
- Children need strong support both at home and at school.

Emerging Themes

Promoting wellbeing

People told us of a variety of things that helped them such as; mindfulness, exercise, eating well, cycling, sleep, Yoga, counselling, drinking less and laughing. Others talked about learning to prioritise their mental health: "I put my wellbeing and mental health before work deadlines."

Families, Groups and Networks

Having others around you to support you also works for many.

"Need to keep contact with family."

"Volunteer and interact with others with similar interests."

"Talk and keep in contact with your neighbours."

"Social media (especially Twitter) is great for connecting with others with mental health issues."

Children

Many people recognised the importance of promoting good mental health in children. They noted the importance of strong support at school:

"Schools having a holistic focus on wellbeing as well as attainment", as well as at home "give families and kids the tools to tackle cyber bullying", and elsewhere "organise activities for children and teenagers."

Befriending

Several people recommended assistance to help people to widen their social circle. “Help people to find interesting networking things to do and support them in the early stages of their recovery.” “Extended families – adopt a granny or granddad” and “befriending services.”

Information

Key Points:

- People don’t believe that there is a central resource for information on mental health.
- Sometimes people can’t find the information they need, but do know what needs to change to make it easier for them to find.
- Information that is as relevant as possible to the individual and delivered in the right format for them is the most effective.

Emerging Themes

Where you access information is key

Many people spoke of a particular place (online or physical) where they would go to find information, and where it was missing when they needed it.

“No info on mental health wards to signpost to alternative services.”

“Employers need to have information available.”

“Information is of no value if you cannot get it from where it is, to where it needs to be.”

One central point

Most comments in this section were about the need for one centrally held resource which was well advertised, clear, easy to use and up to date.

“I need one place to find out where all mental health services are located.”

“There is no central hub giving information.”

“A single point of access, needs to be up to date.”

Missing information

Often, people noted that they couldn’t get the information they needed.

“How would I get the information if I’m not on the system?”

“Information could be better.”

“Still a lot of missing information and lack of information about personal budgets.”

Information (continued)

Personalised information

Several people mentioned that a positive avenue is to receive information that is tailored to them, or delivered in person.

“Practice champions in GP practices offering help and advice.”

“Websites are not always the best for people with a mental problem.”

“Avoid the word ‘Mental Health’ for older people where stigma is strongest – ‘emotional health’ instead.”

Integration of Services

Key Points:

- More training for front line staff is needed.
- Putting the person first is key to integration.
- Time, money and staff remain a barrier.

Emerging Themes

Training and Education

There were many comments in this section about the need for training for people who work with people with a mental health condition.
“Mental health training for all front line support workers (i.e. police, care workers and GPs).”

“Raise awareness generally.”

“All staff need all necessary skills otherwise harm is done.”

“Up skilling of practitioners across the sector to work more effectively.”

Integration of Services (continued)

Person-centred care

People who had experience of a mental health condition spoke of the need to put the person first.

“If all services were integrated the pathways would be clearer.”

“We need to do ‘whole family work’, not individual.”

“People don’t want a whole lot of professionals in their lives.”

“It is important to avoid people having to tell their story lots of different times. Integration will help with this. We need to bust myths e.g. children being taken away if social services find out.”

“Organisations need to be quicker and more efficient about working with each other e.g. Sheffield Homes and the Council. Need to focus on the person and prioritising what they need.”

Resources

Time, money and staff were all quoted as things that remained barriers to integrated working.

“Sharing resources is needed, not working in silos.”

“Organisations need to be given time to reflect and plan integration.”

“Money! Stop playing power games, empire building and put the cash in.”

Standards

The issue of different criteria and standards between services was also seen to be a barrier.

“Difference in needs assessment between referrer and referring organisation (different criteria at the moment, raising expectations unfairly).”

“Accessibility on the same criteria (health universal, social care less widely available).”

Dementia

Key Points:

- More support for carers
- Training and awareness raising is particularly important with dementia as it is felt there is a lack of understanding / empathy
- Keeping people in their community and supporting that community to support them is important

Emerging Themes

Supporting Carers

The overwhelming majority of people felt that more support for carers was needed.

“More support for carers is needed.”

“Respite care for people with dementia so carers can carry on coping.”

“More support services for carers.”

Training

Specific dementia training was seen as essential to improving understanding of the condition.

“More training to be given to carers in dementia care.”

“Education for professions that do not work with dementia at all/that often.”

“Staff development in care homes.”

Raising awareness

“Access to awareness / training sessions.”

“Lots of education – raise the profile.”

“Information for children – Why can’t gran remember?”

Dementia (continued)

Community

The role of community, and the importance both of remaining in the community, and of the community in accepting dementia, were both seen as important.

“Access – keeping well in their community.”

“Dementia friendly safe places in every community.”

“Communities should be more tolerant of differences.”

“More dementia friendly officers especially in schools, shops and communities.”

Mental Health Bunting Feedback

To gather a wide range of views from those in the room, we invited people to take some coloured paper triangles, and to write their views down.

Pink triangles were for people to tell us what was good about mental health services in Sheffield, and Blue triangles were for what could be improved.

Although a timed exercise, those present were encouraged to add as many triangles to the line as they felt they wanted to. This produced our ‘mental health bunting’ which can be seen here.

In total, there were 68 ‘pink’ responses and 180 ‘blue’. These were then grouped into topics as follows on the next pages.

PINK Bunting Responses – What is good about services

Specific Services
Any triangle where someone mentioned a specific service, therapy or person. The most commonly mentioned of these was Improving Access to Psychological Therapies (IAPT).

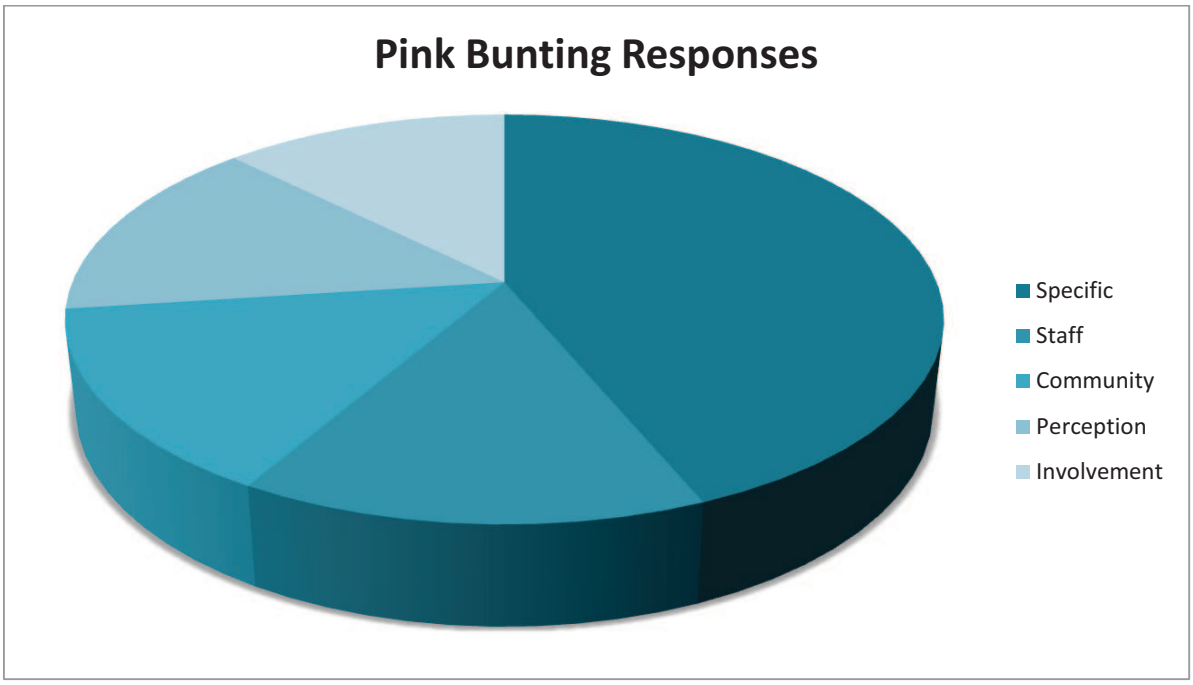
Staff
Includes staff attitudes, well trained staff, supportive and empathetic staff.

Community
Any community based resource or reference to the wider community.

Perceptions
Covers changes in the way someone's condition is viewed, changes in treatment, changes in how open people feel they can be on the topic.

Involvement
Any triangle mentioning attempts to ask service users their views, to be involved in commissioning or service design, anything user-led.

The most popular category was specific named services (21 responses), followed by staff, community and perceptions (7 responses).



BLUE Bunting Responses - What can be improved

Access
Includes all comments where a service does not exist, is not open at the time when it is needed, or where people find it difficult to get to use a service.

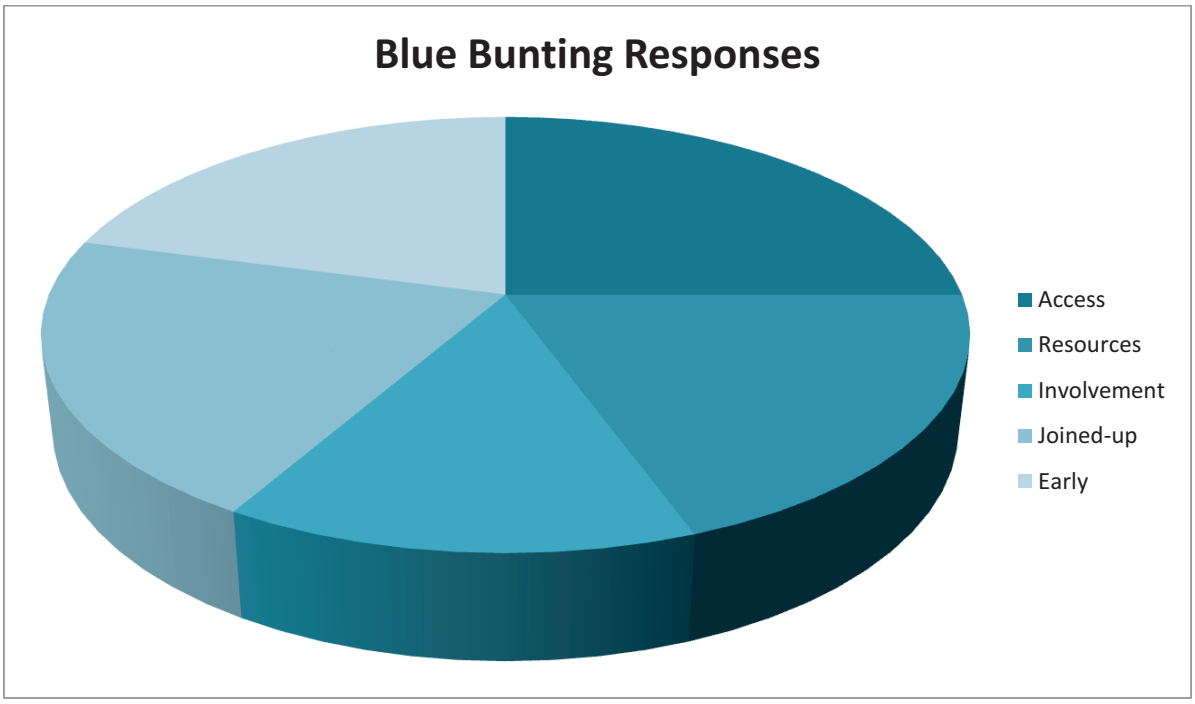
Resources
Includes all comments about lack of money, time, premises and other resources.

Involvement
All comments relating to people feeling they would like to be more involved in their care, and services needing to consult people more.

Joined-up
All comments about integrating care, needing to work more closely together and transitions.

Early
All comments about thresholds being set too high, waiting times leading to worsening in conditions, and needing to access services earlier.

Other
All other comments about specific improvements to specific services. No particular service was mentioned several times, so because of the large number of responses in this category, this will not be included on the chart below.



Thinking inside the box...

On every table was a box into which people were encouraged to place comments which may be something they didn't want to say in front of others, something they'd forgotten to say earlier, or something they didn't get time to say.

The full list of these can be found in Appendix 3.

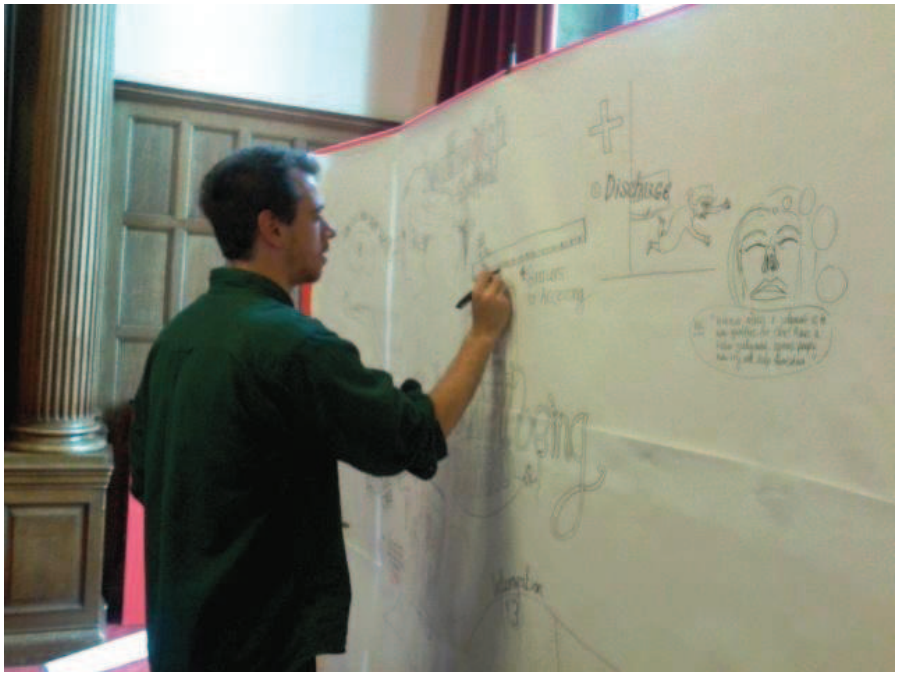
This section also includes notes made during the webchat by the chat host. A sample of these comments is recorded below.

- There is an empathy deficit in some aspects of care.
- Depression and other illnesses e.g. nervousness and anxiety must not be dismissed.
- Patient Participation Groups in every GP practice would help to support people locally around accessing alternative support for mental ill health.
- Nothing has been said about how to improve service user involvement to enable improvement of mental health services.
- Information is of no value if it cannot get from where it is to where it needs to be.

Event Feedback

Feedback from the event was very positive, with 89% of respondents scoring a 4 or 5. (1 being poor, 5 being excellent.)

The most common theme received in the feedback was the need to translate the discussion into action.



Thanks

We would like to thank the artist Paul Harrison (pictured above) for ‘storifying’ the event for us.

We’d also like to thank the Health and Wellbeing Board for offering us the opportunity to hold this event, Louisa Willoughby for helping to plan it, and our table facilitators; Marge Wiltshire, Sue White, Nighat Khan, Andy Wallace, Myrtle O’Connor, Steven Todd, Anne-Marie Hutchinson, Tania Taylor, Bethan Plant and Sarah Burt.

We’d like to thank our chair, Pam Enderby for opening the event and the joint chair of the Health and Wellbeing Board, Julie Dore, for closing it.

But most importantly we’d like to thank everyone who gave their time to attend, either physically or on the internet.

Your views matter - thank you.

This page is intentionally left blank

Appendix 1: Twitter Feed

 **Vicky Cooper** @minicooper73
We are talking mental health tomorrow 2-4, join our conversation using #mhsheff2014

HealthwatchSheffield @hwsheffield
We are talking mental health tomorrow 2-4, join our conversation using #mhsheff2014

 **SheffHealthWellbeing** @sheffieldhwb
Excited for our engagement event tomorrow on #mentalhealth! Join the chat at #mhsheff2014

HealthwatchSheffield @hwsheffield
We are talking mental health tomorrow with @SheffieldHWB 2-4, join our conversation using #mhsheff2014

HealthwatchSheffield @hwsheffield
Have your say about mental health services in Sheffield. Join us for a Twitter chat 2-4pm today using#mhsheff2014

 **Juice** @juicesheffield
Looking forward to attending this afternoons Mental Health Engagement Event @SheffieldHWB @HWSheffield#mhsheff2014

 **SheffHealthWellbeing** @sheffieldhwb
Goodie bags for our event today with @HWSheffield in the lovely Sheffield town hall @TownHallEvents#mhsheff2014 pic.twitter.com/dX7hTkH8Py

 **Beth Longstaff** @beth_longstaff
@SheffieldHWB @HWSheffield @TownHallEvents GOODYBAG!!! I knew I was wise to register for this#mhsheff2014

 **SheffHealthWellbeing** @sheffieldhwb
Lots of great activities planned for today's event - thanks to @HWSheffield #mhsheff2014pic.twitter.com/HyK72rFtts

 **Deborah Woodhouse** @deborahwoodhou1
@DeborahWoodhou1 I have a child with Mental Health problems as he is coming up to 16 not sure what service he will receive #mhsheff2014

 **Beth Longstaff** @beth_longstaff
RT @HWSheffield: Have your say about mental health services in Sheffield. Join us for a Twitter chat 2-4pm today using #mhsheff2014

Juice @juicesheffield
Looking forward to attending this afternoons Mental Health Engagement Event @SheffieldHWB @HWSheffield#mhsheff2014

E&D at Sheffield Uni @shefunieandd
RT @JuiceSheffield: Looking forward to attending this afternoons Mental Health Engagement Event@SheffieldHWB @HWSheffield #mhsheff2014

SheffHealthWellbeing @sheffieldhwb
RT @JuiceSheffield: Looking forward to attending this afternoons Mental Health Engagement Event@SheffieldHWB @HWSheffield #mhsheff2014

NHS Sheffield CCG @nhssheffieldccg
RT @SheffieldHWB: Goodie bags for our event today with @HWSheffield in the lovely Sheffield town hall @TownHallEvents #mhsheff2014 http://t…

Town Hall Events @townhallevents
RT @SheffieldHWB: Goodie bags for our event today with @HWSheffield in the lovely Sheffield town hall@TownHallEvents #mhsheff2014 http://t…

SheffHealthWellbeing @sheffieldhwb
Great to have @ph_harrison illustrating the event! #mhsheff2014

SheffHealthWellbeing @sheffieldhwb
Lots of great activities planned for today's event - thanks to @HWSheffield #mhsheff2014 pic.twitter.com/HyK72rFtts

 **Town Hall Events** @townhallevents
RT @SheffieldHWB: Goodie bags for our event today with @HWSheffield in the lovely Sheffield town hall@TownHallEvents #mhsheff2014 http://t…

 **SheffHealthWellbeing** @sheffieldhwb
Great to have @ph_harrison illustrating the event! #mhsheff2014

 **Deborah Woodhouse** @deborahwoodhou1
A question for #mhsheff2014 debate. What is happening for teenagers 16+. Inappropriate to be in adult services but no specialised service.

 **SheffHealthWellbeing** @sheffieldhwb
Great to have @Chilypep here too #mhsheff2014 pic.twitter.com/3QYDFhgzrm

SheffHealthWellbeing @sheffieldhwb
Pam Enderby @HWSheffield chair and @SheffieldHWB member is introducing the event #mhsheff2014

STAMP Sheffield @stampsheffield
RT @SheffieldHWB: Great to have @Chilypep here too #mhsheff2014 pic.twitter.com/3QYDFhgzrm

VOYCE PG @wearevoyce
RT @SheffieldHWB: Great to have @Chilypep here too #mhsheff2014 pic.twitter.com/3QYDFhgzrm

SheffHealthWellbeing @sheffieldhwb
Pam Enderby @HWSheffield chair and @SheffieldHWB member is introducing the event #mhsheff2014

SheffHealthWellbeing @sheffieldhwb
Great video by @SheffieldMind to kick off the event #mhsheff2014

SheffHealthWellbeing @sheffieldhwb
Bunting which talks about mental health services in Sheffield #mhsheff2014 pic.twitter.com/arYBAijA1v

Deborah Woodhouse @deborahwoodhou1
@SheffieldHWB Thank you. Transition to adult services doesn't seem to be working either. Not for us anyway#mhsheff2014

ShefParentCarerForum @shefparentforum
Pleased about #sheffield #mentalhealth debate. many of our #ParentCarers struggle. @HWSheffield#mhsheff2014

STAMP Sheffield @stampsheffield
@SheffieldHWB @HWSheffield check out our manifesto at chilypep.org.uk for young people's views re mental health! #mhsheff2014

ShefParentCarerForum @shefparentforum
Pleased about #sheffield #mentalhealth debate. many of our #ParentCarers struggle. @HWSheffield#mhsheff2014

STAMP Sheffield @stampsheffield
@SheffieldHWB @HWSheffield check out our manifesto at chilypep.org.uk for young people's views re mental health! #mhsheff2014

SheffHealthWellbeing @sheffieldhwb
RT @ShefParentForum: Pleased about #sheffield #mentalhealth debate. many of our #ParentCarers struggle.@HWSheffield #mhsheff2014

Fi Biggs @laughingf1f1
RT @SheffieldHWB: Bunting which talks about mental health services in Sheffield #mhsheff2014pic.twitter.com/arYBAijA1v

Acctsheffield @acctsheffield
Do you know around 70% of young people & adults with autism struggle with mental health problems at some time in their life? #mhsheff2014

Acctsheffield @acctsheffield
RT @SheffieldHWB: Great to have @Chilypep here too #mhsheff2014 pic.twitter.com/3QYDFhgzrm

Acctsheffield @acctsheffield
RT @STAMPSheffield: @SheffieldHWB @HWSheffield check out our manifesto at chilypep.org.uk for young people's views re mental health!…

Chilypep @chilypep
RT @STAMPSheffield: @SheffieldHWB @HWSheffield check out our manifesto at chilypep.org.uk for young people's views re mental health!…


SheffHealthWellbeing @sheffieldhwb
Round table discussions have begun - these'll be on a number of crucial themes #mhsheff2014


Deborah Woodhouse @deborahwoodhou1
On a positive note the support my boy has received from #Sheffield #CAMHS has been fantastic. @HWSheffield#mhsheff2014

Acctsheffield @acctsheffield
RT @STAMPSheffield: @SheffieldHWB @HWSheffield check out our manifesto at chilypep.org.uk for young people's views re mental health!…

 **SheffHealthWellbeing** @sheffieldhwb
Round table discussions have begun - these'll be on a number of crucial themes #mhsheff2014

 **Deborah Woodhouse** @deborahwoodhou1
On a positive note the support my boy has received from #Sheffield #CAMHS has been fantastic. @HWSheffield#mhsheff2014

NSUN mental health @nsunnews
At brilliant @hwsheffield #mhsheff2014 event - summer fair themed with bunting

 **Deborah Woodhouse** @deborahwoodhou1
Home & Hospital Service have done a great job in keeping my son's interest & education going. Service superb but very stretched #mhsheff2014

 **SheffHealthWellbeing** @sheffieldhwb
RT @NSUNnews: At brilliant @hwsheffield #mhsheff2014 event - summer fair themed with bunting

 **Jo Hemmingfield** @johemmingfield
Fab interactive Healthwatch event at Sheffield Town Hall #mhsheff2014

 **SheffHealthWellbeing** @sheffieldhwb
RT @JoHemmingfield: Fab interactive Healthwatch event at Sheffield Town Hall #mhsheff2014

 **Fi Biggs** @laughingf1f1
@SYorksHA fab heated discussion on identifying gaps in services- I am sitting with customers who are giving their views #mhsheff2014

 **SheffHealthWellbeing** @sheffieldhwb
RT @JoHemmingfield: Fab interactive Healthwatch event at Sheffield Town Hall #mhsheff2014

 **Fi Biggs** @laughingf1f1
@SYorksHA fab heated discussion on identifying gaps in services- I am sitting with customers who are giving their views #mhsheff2014

 **John Culver** @jcsuperstar54
We need to embed the principles and practice of recovery across the whole system #mhsheff2014

 **Tony Blackbourn** @deejaysnr
@HWSheffield#mhsheff2014 put them in a care home and forget them is no longer the answer more information on media sites.

 **SheffHealthWellbeing** @sheffieldhwb
Great that so many have come including people not here tweeting and skyping #mhsheff2014 pic.twitter.com/OqQHbv8622

Acctsheffield @acctsheffield
A significant minority of children & young people we support have problems accessing schools ; mental health compromised #mhsheff2014

Acctsheffield @acctsheffield
We hope #sheffield addresses this gap. no child should be unable to access an education appropriate to their needs @HWSheffield #mhsheff2014

John Culver @jcsuperstar54
#Mental health first aid training needed for healthcare professionals #mhsheff2014

NSUN mental health @nsunnews
@hwsheffield #mhsheff2014 great conversations with nearly 100 people on integration, acute care, primary care and a whole lot more

John Culver @jcsuperstar54
Be aware of the Timebuilders Project @timebuilders as an effective way of promoting mental health recovery#mhsheff2014

NSUN mental health @nsunnews
@hwsheffield #mhsheff2014 great conversations with nearly 100 people on integration, acute care, primary care and a whole lot more

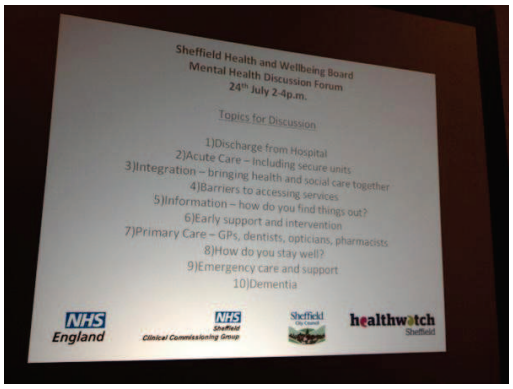
John Culver @jcsuperstar54
Be aware of the Timebuilders Project @timebuilders as an effective way of promoting mental health recovery#mhsheff2014

Acctsheffield @acctsheffield
RT @SheffieldHWB: Great that so many have come including people not here tweeting and skyping#mhsheff2014 pic.twitter.com/OqQHbv8622

Tony Blackbourn @deejaysnr
@sheffieldhw #mhsheff2014 just one of the people on the webcast pic.twitter.com/a4G4uAOPxS

Fi Biggs @laughingf1f1
@SYorksHA did you know there is a higher suicidal rate when discharged from hospital for those with mental health? #mhsheff2014

SheffHealthWellbeing @sheffieldhwb
The topics we're discussing #mhsheff2014 pic.twitter.com/uZf9tX8dJ7



Jo Hemmingfield @johemmingfield
RT @laughingF1f1: @SYorksHA did you know there is a higher suicidal rate when discharged from hospital for those with mental health? #mhshe…

HealthwatchSheffield @hwsheffield
RT @NSUNnews: @hwsheffield #mhsheff2014 great conversations with nearly 100 people on integration, acute care, primary care and a whole lot…

Fi Biggs @laughingf1f1
@SheffieldHWB it's great to hear feedback which I hope will change things for the better #mhsheff2014

Tony Blackbourn @deejaysnr
@HWSheffield #mhsheff2014 it's the music player keeping everything moving. pic.twitter.com/95Gl0iISJI

SheffHealthWellbeing @sheffieldhwb
Now for the summing up - we've got a huge amount of information and feedback #mhsheff2014

 **Tony Blackbourn** @deejaysnr
@HWSheffield#mhsheff2014 busking on Fargate from 5pm more likely. Been a brilliant meeting and carousel well done The Team

 **SheffHealthWellbeing** @sheffieldhwb
Thanks to all the lovely facilitators -
from @SheffCouncil @NHSSheffieldCCG @vasnews @HWSheffield#mhsheff2014

 **HealthwatchSheffield** @hwsheffield
RT @deejaysnr: @HWSheffield #mhsheff2014 it's the music player keeping everything moving.pic.twitter.com/95Gl0iISJI

 **NSUN mental health** @nsunnews
10, yes 10, facilitated #mentalhealth discussions in a row in 1 hour! @hwsheffield #mhsheff2014 #ambitious

 **SheffHealthWellbeing** @sheffieldhwb
RT @NSUNnews: 10, yes 10, facilitated #mentalhealth discussions in a row in 1 hour! @hwsheffield#mhsheff2014 #ambitious

 **Jo Hemmingfield** @johemmingfield
Really listening to people who use services and drugs not being only answer as key factors in adult inpatient services #mhsheff2014

 **Jo Hemmingfield** @johemmingfield
RT @SheffieldHWB: Great to have @Chilypep here too #mhsheff2014 pic.twitter.com/3QYDFhgzrm

 **SheffHealthWellbeing** @sheffieldhwb
RT @JoHemmingfield: Really listening to people who use services and drugs not being only answer as key factors in adult inpatient services …

 **Juice** @juicesheffield
RT @NSUNnews: 10, yes 10, facilitated #mentalhealth discussions in a row in 1 hour! @hwsheffield#mhsheff2014 #ambitious

 **SheffHealthWellbeing** @sheffieldhwb
Julie Dore, co-chair of @SheffieldHWB and leader of @SheffCouncil is summing up #mhsheff2014

 **SheffHealthWellbeing** @sheffieldhwb
Thanks to @HWSheffield for organising such a brilliant event with us with such good discussions getting down to the real issues #mhsheff2014

 **Jo Hemmingfield** @johemmingfield
Councillor Julie Dore highlighting shocking and unacceptable suicide rates in men #mhsheff2014 @SheffCouncil

 **Tony Blackbourn** @deejaysnr
@HWSheffield #mhsheff2014 Mental health has been shoved under the carpet 4 2 long like cancer needs bringing out into the public on media.

 **HealthwatchSheffield** @hwsheffield
RT @JoHemmingfield: Really listening to people who use services and drugs not being only answer as key factors in adult inpatient services …

Fi Biggs @laughingf1f1
"@JoHemmingfield: Councillor Julie Dore highlighting shocking and unacceptable suicide rates in men#mhsheff2014 @SheffCouncil" @SYorksHA

yani salycov @ydagestan
RT @NSUNnews: 10, yes 10, facilitated #mentalhealth discussions in a row in 1 hour! @hwsheffield#mhsheff2014 #ambitious

SheffHealthWellbeing @sheffieldhwb
#**mhsheff2014** thanks to @ph_harrison for great artwork at the event pic.twitter.com/gGf9Ayjie2

Deborah Woodhouse @deborahwoodhou1
RT @laughingF1f1: "@JoHemmingfield: Councillor Julie Dore highlighting shocking and unacceptable suicide rates in men #mhsheff2014 @SheffCo…

HealthwatchSheffield @hwsheffield
24 July mental health event - Lets keep the conversation going on mental health services in sheffield using#mhsheff2014 Send us your views

Appendix 2: Table Discussions (Comments in full)

Acute Care - comments and thoughts from 24th July Mental Health Event

- Police should be used as last resort
- Not a therapeutic environment – very frightening place
- Continuity – different person rings/visits every time from home treatment/crisis care only from A point of view (who works with Mental Health) finds that hands are tied to be able to do 1:1, individual and bespoke service. Has to fit the process not the individual
- Not enough therapeutic activity – people on wards need someone to talk to and things to do, but staff are totally burnt out(get volunteers if necessary)
- Waiting days for right response. Need right thing at right time
- Office hours service not helpful
- Need ability to self referrer
- Opportunity for all service users to feed back
- Is there a clear route out of acute care, after crisis? How can acute care move forwards?
- Lack of information to family re discharge preparation
- Need specialist to help with medication management
- A&E need better response
- Appropriate service for personality disorder
- Acute Care – including secure unit. Preparing the family/carer for the patients discharge should be a high priority
- People need an assessment
- Professionals using eligibility
- Treating person as a whole – giving people enough time
- Get rid of the doors in office – in patient units
- Give medication than talking therapies
- Key role of GP to recognise care required
- Feel like they are not connected to real life
- Accessing out of hours – especially A&E – waited 8 hours for care team
- Problem with Acute Care – goes through the police they don't know it's a health issue
- Help to access the right health service
- Access should be easier
- Need information for people to know about alternative support
- Staff not got the time for 1:1 work. They can't provide an individual service
- Preparing people for discharge
- Acute care centres need more supervision and visits by CQC
- Difficulty with language and cultural beliefs

- Acute administration could acknowledge concerns from carer/family, to be acted on earlier
- Acute wards sometimes not best place for person who is seriously ill e.g. eating disorder
- Basic skills compassion – how would you like to be cared for?
- Culling acute beds
- What exists for people with ongoing conditions?
- Families with acute care needs but need help to ongoing accessible services
- Care in secure units – neglected / no empathy – especially elderly patients
- Not always need specialist help but need good sign posting
- Better attitude of staff – lost their empathy
- Need to see specialist – mental health person when needs too
- A&E is often not the right place to be in Mental Health crisis
- Care co-ordinators have heavy case loads
- The need to find out the patients choice
- Trauma of acute admission on family members not always acknowledged
- From a GP perspective the 'crisis team' response is good
- Need integrated service – planning discharge

Barriers to Accessing Services - comments and thoughts from 24th July Mental Health Event

- Clients feeling - Stigma/guilt/unworthy and they have to 'jump through hoops'
- Lack of understanding from various GP's
- Fear of being sectioned or not being understood
- Waiting times to access secondary care – very poor
- Lack of sign posting to services and VCF providers especially by GP' and CMH teams
- Need to be sensitive towards different cultures
- Different geographic areas have better services
- There should be alternative routes into help not just through GP
- There are cultural barriers
- Put money and resources into proactive removal of barriers
- Barriers for accessing services – long waiting time to see GP
- Women with anxiety are marginalised and seen as problems not treated
- Compartmentalised by too many services for patients – don't treat the whole person
- Need to ensure each person gets 1)self help 2) right support building 3) appropriate treatment
- Reduce stigma in society would reduce barriers to services
- Better GP referrals
- Having the support and confidence of accessing services. Awareness of where to go
- Barriers – stigma/PR/misconceptions/fear/personal shame / lack of info/ miss information
- Self refer as well as professional
- Lack of encouragement by GP to go down teh road of discussing mental health at early stage
- A realisation is needed that mental health issues are not limited to those deemed to be of low intelligence
- Hospital and home education service
- People don't realise they are ill
- Caring approach from receptionists – training needed with front desk staff
- Services need to be able to work with people who are disorganised/chaotic when ill
- Thresholds for accessing services being set too high, so people can't get help until they are really ill
- Information – people don't know what's available
- Patients have a fear of accessing services

- Acceptance that the patient has a need.
- Physically getting to the service if ill
- Accessing some websites may be difficult for some people
- Some doctors seem to think that chemical intervention is a cure, escalated to physical restraint. Doctors to have the awareness training and resources to arrange holistic treatments.
- We are now at a stage where we can say mental disorders have a physical cause, so why arbitrarily make a distinction? i.e. inform the public = cultural change.
- Remove barriers – people need empathy. The vol com sector is trusted and should have named people in the local areas. Have a hub where people can go and feel safe. Educate the public.
- Children's services improving by working together with others.
- Waiting lists are too long – clients only being seen at crisis
- Don't trust services to be helpful
- One service doesn't take lead (holistic care)
- Getting professionals to take you seriously
- Nature of the illness, people don't admit they need help
- Lack of employers understanding implications around Equality Act 2010
- Attitudes – need for better MH awareness training for front line staff
- Persons 'Illness' to be taken seriously
- Accessibility for working people
- GP's need to be more understanding
- Increase in cultural awareness amongst services could reduce barriers
- Not recognising symptoms – self care
- Too much responsibility falls on volunteers – less people out there
- Dual diagnosis – treat the person! Especially a challenge when drugs/alcohol abuse and mental health
- No follow up. Client not looked at as a whole body
- GP's who don't understand the impact of mental health on engagement – leading to poor referral letters
- Getting your hands on an appropriate service is impossible
- Not knowing about the service – lack of information sharing
- Stereotyping – afraid to approach the person
- Lack of services! Not enough counselling available – 6 sessions is rarely enough
- Mum doesn't want to admit to having mental health issues (depression)
- Since mum who has clinical depression, she has no care – she feels she has been ''forgotten''
- Should be acknowledged more in education

- Afraid of telephones – this is my barrier
- More sensitive diagnosis (person centred rather than medical etc)
- Complex needs – system rather than individual (not the person with complex needs; More to do with the complexity of services and how they are divided up eg lots of referrals rather than all dealt with in one place.
- Psychology and OT and community nursing are great if you get them.
- If you held something different subsequently you have to start all over again! Suggested GP put a script on the screen in the surgery, so it could be accessed by all health and care professionals. For out of hours – GP has sent hard copy to them – need to be much more joined up across all services

Dementia - Comments and thoughts from 24th July Mental Health Event

- Education for professionals that do not work with dementia at all/that often
- More training to be given to carers in dementia care
- Access – Keeping people well in their community agenda
- Care homes should be better supported and recognised for positive contributions as well as negative to Dementia Care
- Employers could do a lot more (to support carers etc)
- What does it mean to be 'dementia friendly'
- Important to find support
- Good feedback from caring and coping causes and dementia cases
- Adversity
- Financial
- Need to have on TV regularly
- Care home staffing ratios
- Shared care approach for people in care homes is really important
- Learning disability problems often hard to mention re mental health
- Carers issues
- Hear the voices of those with dementia – what is it like for them
- Paradox of less help for people who 'cope' best
- Communities should be more tolerant of differences
- Social isolation for carers
- Information for children – Why gran can't remember.....?
- Early diagnosis
- For dementia awareness- what about community education sessions with vol com sector at their premises?
- Better links with activity Sheffield and increase well being and physical activity
- More dementia friendly officers especially in schools, shops, communities
- More public awareness about stigma
- Dementia friendly safe places in every community
- Bruckwood View Nursing Home being the primary service for people with dementia and learning disabilities – more needed
- Meet the need of the client not the needs of the service
- Lost Chord is Brilliant
- Staff development in care homes
- Services in general need to be dementia friendly
- Lost Chord – spice of life - please introduce music
- Levels of staffing in care homes
- Care homes – should be for one area, not mixed, then you wouldn't have the problem with people not looked after
- Understanding implications of early diagnosis – how might they feel?

- Help to raise public awareness – early diagnosis
- Hospitals leaving patients to fill out forms with dementia – no help from staffing
- Access to awareness / training sessions
- Respite care for people with dementia so carers can carry on coping
- Group for learning disabilities with dementia
- More resources needed (compared with cancer)
- Make things meaning full
- Don't forget the under 65's with dementia
- Clearer guidelines for diagnoses that may ''fit'' into different services mental health/neological /dementia
- People with dementia have physical health problem to (90+%) – perfect area for physical and mental health integration
- Need good planning in case of carer breakdown e.g. emergency respite
- Make physical activity as easy as possible – research shows it can delay on set of dementia
- Isolation sometimes not understanding the symptoms
- Missing signs of dementia and not being aware of help available
- Recognition of dementia for people with learning disabilities with communication problems
- Concerns about dementia service for people with Downs Syndrome
- Dementia and learning disabilities service sometimes do not help
- Dementia service for people with Downs Syndrome carers are isolated because of lack of understanding
- Careers of people with learning disabilities may not be able to understand
- Needs to be more support explanation of the stages of dementia and what it means for the carer as well as the person with dementia
- Professionals and service providers must treat people holistically and not by the criteria of their service
- A whole person approach needs to be about clinical and social and welfare joining up
- Carers support crucial – as much as possible
- Not enough joined up strategies for people with dementia who have other conditions – need a whole person approach
- As much music therapy as possible
- Dementia needs to be seen as a mental health condition- and treated as such by GP's
- Some work to be done around dementia /risk of malnutrition?
- Healthy activities to be part of work time – no enough time to prevent health problems (including dementia when young)
- Prevent / delay dementia through mindfulness courses offered to everyone and particularly senior citizens

- Rapid diagnosis when acute dementia occurs
- Respite care – is there enough?
- Early identification of issues
- Accessing help early
- Lack of info in the community
- Care homes have a residents association
- Real checks so not given notice in advance (provider checks)
- Dementia – we need evidence that things are improving!(otherwise we don't believe that anything is happening)
- Impact of change from familiar home environment to hospitals (strange and frightening) was huge – her decline accelerated hugely
- Social isolation recognising when women is lonely an frightened
- Better testing for on-set dementia and adequate preparation
- Lots of education – raise profile
- More support services for carers
- Sheffield has a dementia friendly policy
- Look at different achieves
- Resources catching up with research
- Become a dementia champion – have a drop in
- Waiting times for diagnosis are still long
- The nursing home staff were wonderful, very expert and lovely
- How can we reduce the stigma associated with dementia?
- More support for carers is needed

Discharge from Hospitals - comments and thoughts from 24th July Mental Health Event

- There needs to be more community support (initially)
- Limited support at discharge which could cause people going back in
- Revolving door – discharge process
- After discharge there is no-one who checks in with you to see how you're doing
- It's a defect of mental health condition
- Transition is key
- It needs joint approach not just medical intervention
- Tends to be reactive rather than proactive
- Clear pathway and communication from hospital to community support
- Can the increase of physical activity help and reduce the chance of going back in ?
- Communication problems don't seem to merge – are there numbers of people that allow this to be done?
- No checking of things are ok – are you/were you well?
- Cuts to facilities make it difficult to provide services
- Services are being stretched because we are talking about it more
- Facilities are varied dependent on mental health illness. Serious mental health issues in personal experience has been poor due to lack of communication between teams
- More resources are needed following discharge
- Good information to primary care – a phone call might be better than a letter 1 week later
- Some benefits of having separate agencies – choice for individuals
- Not working with other services to make sure smooth discharge
- Lack of co-ordination and communication between mental health and physical health
- Staff don't get the support they do a great job – difficult job
- Don't have training and skills to help with others
- Discharge from acute services does not mean someone has recovered!! They need support to maintain and develop recovery level achieved in acute care
- Maybe a ''stepped'' approach needs to occur sometimes
  Hospital --> Recovery
  Facility – >community
- I just wanted to do anything to be taken off section and discharged
- Are there data practice guidance in mental health service as with other services
- Whole family support – seeing whole picture of discharge
- Organised before you come out of hospital – everything should be in place

- Care planning - use of single point of contact /Use care pathways /Responsibility taken by professionals
- Not having appropriate support in place for after discharge is a major concern
- Attitudes can have impact- only hear a bit of the stories
- There is an arbitrary and unnecessary budget distinction between hospital discharge duty and social care – sort it !
- Level of support when patients leave acute service
- Care plan needs updating – things change
- Let the housing know! Present abandoned – investigation and aid – reintegration
- Make sure there is more consistency about discharge assessments – in my specialism – people with similar needs on discharge have a variety of different support packages – eg. some have a CPN on discharge – others don't
- Different experience and needs depend on what community social support they have
- Don't know diagnosis – how do you get help ?
- Care planning GP practice nurse may be the best resource for this if propley trained and judged
- Preparation for discharge to be better planned
- Need to clear date/ti,e for next contact and stick to it
- Have already designed a full discharge plan
- Not co-ordinating discharge can make a bad situation worse
- Really good communication needs to occur between Dr's /nurses/the patient / families – involve in the process
- Housing waiting list can effect discharge time
- Services working together e.g health/council/individuals housing
- Only discharge individuals who have transport and care provided. Communication between services so there can be provided
- Depends why you have been admitted
- Can be good opportunity to ensure appropriate community support, accommodation etc is in place
- Social life ? – help to find a social life?
- All things take time – should contact social workers – community teams over worked
- Good support plans needed – significant others included in the process
- Housing/ equipment/physical health needs/social care / community support – all integrated
- Support needed for relatives
- Don't know patients properly so how can they sort out discharge
- Discharge can take a while and be frustrating

- Care in place ‘before’ discharge
- Making sure different specialist work together
- No discharge until ALL care issues are fully arranged and resourced
- More automatically follow up by community services
- Patients need easing back into coping being on their own rather than just left. Often they don’t see people for weeks.
- Refer to community activities ‘social prescription’
- Social prescriptions – do they exist? Not just pills
- CPN service very good in Sheffield – need more
- When discharged patient usually left to their own accord. No move on support.
- Do not ‘send’ patients home unless they have someone at home to receive them
- One electronic record and access to it – will aid discharge
- Ensure facilities are available in the community at home level
- Discharge too early – revolving door
- Should standardise discharge process which make sure they are spoken to and full picture is in place before discharge can happen
- Lack of housing for patients on psychiatric wards – cost ?
- How do we find out what services are like and how they perform?
- Effects whole family – treat individual not family
- Discharge from hospital – people who are about to be discharged need to know who to expect coming to see them when they are back at home
- Discharge planned from day one
- Discharge from hospital – too early then no proper ‘home’ assessment – mobility/stairs/ other needs?
- Not everyone has care at home
- Upon discharge from hospital, information to include Vol Com groups to the service user and their carers
- Ongoing long term support is needed – for individuals and carers
- Loss of trust of services can make the process harder
- Care in the community is not a equal playing field – need a safety net for all
- Person centred – what does this person need?
- Attitudes are getting better – talk about recovery – it’s a personal experience
- Level of care in the community doesn’t match the care the patient gets in teh hospital. Acute services are not always the best
- Careful planning for individuals – one thing doesn’t fit all
- Discharge service should help people get well not be readmitted
- Reduction in CPN may cause problems – you can’t hurry what they do
- No follow up – feel isolated
- Preparation for discharge to be better planned

- Care planning GP practice nurse may be the best resource for this if properly trained and funded
- Stop the practice of playing pass the parcel with people and just treating them as money packages
- Needs lots of support after discharge – need to be able to choose what support would suit them
- Storify
- Important to re-integrate people into normal life – more partnership working with families needed in advance of discharge. Sometime pressure to discharge rapidly.

Early Support and Intervention – comments and thoughts from 24th July Mental Health Event

- Volunteering underestimated
- Knowledge of who to sign post
- Waiting times for initial support prevents quality intervention
- Tips and early warning signs for employers of Sheffield City Council
- This would be lovely – just a pipe dream
- Better trained/ universal prevision
- Where intervention is indicated, it is often not recognised, so a crisis becomes a disaster for all Vol Com awareness training is needed
- What support is there for 16-18 year olds?
- Thresholds for services to high – only crisis merits support
- Awareness in school and parents. Need to act early for support and confidence
- Third sector offer flexibility, variety and are user friendly
- Earliest support is telling someone that you feel unwell. If professionals are not available, why not visit the local Com Centre?
- Responsibility of employers in supporting people with mental health issues
- Train people in mental health first aid i.e. at work, in Schools, everywhere
- Publicity campaign about what mental health is and how it effects people
- Voluntary sector is well placed to provide early intervention as people are often more willing to interact with 3rd sector than other providers
- Need to put the service where people go e.g. job centres , youth centres , GP's surgeries
- Awareness of services out there
- There is still a stigma in having a mental health problem
- Exclusion – websites – people can't always access
- Youth Parliament
- Have to be in crisis before you are seen
- GP may give immediate medication but it may be inappropriate
- Mental Health awareness sessions for students at college and university
- Value of 3rd sector – people become wary of primary health because of stigma. People therefore more ready to go to a non statutory group
- Mind are useful to provide tools to help employers support employees
- Cost effective. Better value for money
- Intervention should be on a more individual assessment
- Difficulty in deferring mental health as to do, you need early intervention
- Early diagnosis from GP's that there is a problem that needs addressing
- Earlier people and young people are given help to adjust, they then find it easier to join groups and to be able to mix with others help with confidence
- 10 minute doctor's appointments doesn't always bring the problem out properly

- People unaware where to contact for help – Discharged from temporary sections without relevant support
- 24/7 self referral help line/support available within the workplace
- The role of the school nurse?
- People don't access intervention early because of the nature of illness
- Services need to be available quickly – not being told there is a 2 year waiting list for psychologist appoint or psychotherapy
- Access services quickly – more money spent on late intervention
- Support for carers who are supporting people in the early intervention sages is poor and difficult to access
- Proper preventative services for YP at risk of developing MH problems (large % show signs before 14 yrs (Maggie has presentation)
- Access to an adult they can trust outside of the family unit; continuous support and not being let down.
- Waiting list for YP and children's specialist services (bottleneck; funnel assessment service – referrals made to them before you reach OAMHS
- Impact of cuts to YP&C services eg Surestart (interface between physical and mental wellbeing; language development not supported can add to behavioural difficulties
- Get people involved in support groups early on

Emergency Care – comments and thoughts from 24th July Mental Health Event

- What is emergency care? What is an emergency?
- Discharge from acute wards not always in full coordination with relatives/carers
- A&E focused on medical not mental health concerns
- A&E not a pleasant environment during a mental health crisis
- Young children – no emergency care. Parents don't understand – taking exams
- Need to be aware even in emergency – there may be important things on service users mind eg child care
- If is important to consider allowing someone to contact their employer
- Lack of understanding to individual needs
- The response to the crisis in terms of saving my life was effective
- 111 or perhaps 999 call centre staff need to be aware of public with communication difficulties
- The counselling by consultants (medical) seemed on a set formula – eg are you remorseful? Will you do it again?
- Emergency transport - adapting policies to an individuals
- Good links/ communications – out of hours and community teams
- 24 hour Rethink helpline and crisis accommodation are impressive
- Lack of information re what is available through emergency services
- Training is not given enough priority for equality not medical attitudes
- I was taken to A&E because of overdose. I was treated as someone with physical symptoms. The mental health 'input' did not begin until transfer to psychiatric ward
- A&E need for better training for mental health issues when someone presents with multiple issues
- Emergency workers want to listen to the patient or next of kin. No respect for the PA's – knowledge of the situation
- Priority – physical or Mental Health issue
- Mental Health counselling needed 24/7 as well as treating physical conditions.
- Emergency care 111 for ambulance , 999 emergency suicide trauma police involvement
- When they don't recognise the person presenting has multiple issues and someone is being 'awkward' they are more likely to call the police then the mental health team
- Emergency home treatment teams work in secret – no one knows about them
- Taking advice from family (who know more about the person)
- Services need to listen to carers who know the patient best

- Emergency A&E are too focused on 'customer satisfaction'. Rarely I have seen surveys so poorly and inappropriately used
- Police often first response in a crisis – helping people before it gets to crisis point is essential
- Education required for professionals who don't work in mental health. Lead to desperate need for holistic treatment.
- Service users to know about local vol com groups to call visit
- Vol com volunteers to receive sign posting training and specialised emergency numbers
- Emergency care and support – does the public know which number to ring/which agency to contact? More information please!
- Holistic approach to someone's mental health not solely the issues, which has caused the emergency
- Paramedics have been very good in crisis/suicide - non judgemental and kind
- Making information and resources available to A&E staff to enable them to point service users to the right area/services for their needs. Preventing the need for A&E in the future
- Nobody who knows the person is available at 2am
- Issues/less support out of hours
- Crisis house – good but only if you can jump through the hoops (no self referral)
- A&E is not the best place to be in a Mental Health Crisis
- My daughter is over 18 and so I was not allowed to accompany her
- Possibly developing a walk in mental health emergency service
- Crisis care is only accessed by people with dangerous / behaviour / criminal issues
- Long term (adult) conditions who develop cognitive issues – (Mental health and wellbeing of people with physical long-term conditions. Increase in (eg IAPT) self-management/referral difficult for cog impairment (could be a barriers).
- Cuts to social workers – less people will be picked up as needing help or have someone refer them.
- Non-attendance is not always a choice; physical/stamina issues as well as mental stamina issues can be interpreted as dis-interest

How do you stay well? - Comments and thoughts from 24th July Mental Health Event

- Need to keep contact with family
- Help to eliminate loneliness by encouraging both users and vol com groups to interact
- Information to be able to join group activities to maintain good mental health, friendship and total well being
- Need to be able to engage with support from those people with and without EWBMH issues. Integrated back into wellbeing
- Quicker access to counselling – not acceptable for people to wait 6 months for counsellor at their GP
- Physical exercise – go for a run
- More groups for people to access
- Create a community & Vol com scheme for alerts of absences to prevent isolation
- Having a choice
- Making people aware of how to welcome people
- Mindfulness and meditation
- Eating well
- What if after 14 months you are not well?
- Sleep
- Accessible exercise opportunities
- Workforce/ work place wellbeing
- Befriending service
- I put my well being and mental health before work deadlines (since having mental health crisis a few years ago)
- Communication about what is available
- I am very lucky that I can pay for counselling when I need some extra help – but most people can't do that ☹
- Opportunities to do more in Sheffield
- Free drop in's - more consistency
- I love Pedal Ready – they taught me to ride a bike – which had a fantastic positive effect on my mental health
- Pedal Ready - got me to cycle – positive impact on health and wellbeing
- Look at lots of different activities not just sport e.g meditation, yoga, gardening
- Advice and information - health – particularly whilst the weather is hot and warm
- NHS advice needed
- Radio programmes
- Advice and information
- Tackle cyber bullying – raise awareness – give families/kids/schools tools

- Laughing – having fun and being positive
- Have more free events – Tramlines not free anymore
- Have free exercise opportunities
- Encourage children and young people to play
- Mindfulness practice
- Having interesting networking things to do and support to do them in the early stages of recovery
- Free membership of gyms for all senior citizens
- Children should have cooking lessons at school – to help parents with their diets
- Mental dexterity
- Difficult to stay well when elderly and social isolation/physical disability
- Lights – to reduce SAD
- Community groups – walking/relaxation
- Relationships
- Faith community
- Extended families – adopt a granny/granddad
- Social media/ chat can help people connect and make friends – particularly communities and interest
- Social media (especially twitter) great for connecting to others with mental health issues
- Involving carers/families
- Reduce time CTYP spend on computers/social media
- Volunteer
- Support groups are important
- Eat well
- Get involved with Timebuilders Project
- Learning how to manage negative emotions – useful for everybody
- Expend your network of friends and contacts
- Positive coping strategies – exercise/join group therapy sessions/partake in hobbies and interests
- Having access and support to engage in activities
- A befriending programme
- Talk and keep in contact with your neighbours
- Schools dealing with issues like bullying in a positive manner
- Improving pupils and teacher relationships
- Schools having an holistic focus on well being as well as attainment
- Art and creativity
- Day centres need to be open longer hours
- Lunch clubs etc
- Get people connected to reduce isolation
- Mindful courses available to all

- Reducing transport costs
- Promoting communication
- Yoga/tai chi/qigong/Pilates
- Focus on working with GYP at an early age
- Focus on maternal mental health
- Individual health visitors
- Make service meet the needs of the client. E.g. afternoon groups and appointments would be better for homeless people who suffer with mental health
- Organise activities for children/teenagers
- How do you stay well? GP's need to know more about the type of activity is available in the areas so that they can prescribe appropriate exercise, diet etc rather than more pills
- Drink less/stay sober
- Being active in the community
- Volunteering and interacting with others with similar interests
- Overcoming the fear of social isolation
- Friendly, familiar places

Information – Comments and thoughts from 24th July Mental Health Event

- There seems to be no joined up thinking – Social Care /NHS
- Need to use all ways to communicate – don't just rely on digital ways
- No overall care
- Is there a care partnership specifically for Sheffield Services? This can offer a point of access no matter what
- Be clear about the use of advance statements
- Advertising services
- No info on mental health wards to signpost to alternative services
- Ex- service users are often out of the loop information wise
- More physical activity within a care home setting
- Make every contact count! about mental health issues
- Mixture of services – community workers knowing
- Practice champions in GP practices offering help and advice
- GP's district nurses, carers etc need to disseminate info
- Still a lot of miss information and lack of info about personal budgets – accessing and general info
- No central hub giving information (pop up?)
- Why is there no procedure when accessing services?
- Sheffield mind needs to get out to the public more. Everyone knows about cancer
- Information is patchy
- Services lack the skills to offer advice
- How many service users do not speak English?
- Go to your local city counsellors surgery
- Employers need to have information available
- Booklet from Heart Foundation re Stress
- Booklet to be picked up from supermarkets
- Information in GP services using posters, video, service users etc
- Information needs to be presented in a very clear straight forward way to help people find their way through quite a complex system
- Go to GP for initial meetings who should be able to refer the patient to the appropriate service
- Join Sheffield 50+ and Sheffield U3A
- CCG should commission a mental health service at walk in centre 24/7 ASAP!
- Support literature from charitable organisations
- Health navigators (community support workers) Signposters
- Websites not always the best way for people with a mental problem
- Information could be better
- Your Voice (good for getting info about where to go, what to do)

- One point of access
- Mental health champions
- Disseminate info about staying well e.g. 5 ways to wellbeing
- Guidance and advice for employers
- Sheffield Help Yourself Directory – too difficult to use
- Every GP practice should have copies of Your Voice available for patients
- More mental health advocates
- Need to help people get the information that they need- perhaps better use of drop down menus/info
- Information – how do you find out things? Start off by using plain English so people know what 'professionals' are talking about
- Drip feeding constantly / consistency
- Information for friends and family who are worried
- Information is of no value if you cannot get it from where it is, to where it needs to be. Therefore liaise with community engagement to disseminate information to the Volcom sector groups
- Campaign on Mental Health
- There is no provision in Sheffield to support parents with mental health problems in the education system
- Lack of effective information sharing in communities
- Hard to get information especially if not on line or if you have only basic computer skills
- Mental health directory too difficult to use
- Advertise using social media or posters
- Engage Educate Empower
- Need accurate info from SCC/NHS
- How would I get the information, if I'm not on the system?
- Sheffield Mental Health Guide needs updating and to be accessible
- Information needs to be hard copy as well as on line as not everyone has access to the internet
- Un-joined up, no coordination – across all sectors including GP's
- Limited access to get information only from GP
- General public know less about how to access Mental Health services, should they need it in the future
- Avoid the word 'Mental Health' for older people where stigma strongest - 'emotional health' instead ?
- Older people don't want to admit to having a mental illness – feel no one will care
- Don't know what services that are on offer - go round to care homes giving info ?
- Not enough information for the younger end at present and no guidance as to diagnosis for mental health problems

- Everyone is an individual
- Need more lunch clubs/services for older people
- Elderly people in care home seem to be forgotten! (and their families)
- Transport – as this is key to stopping isolation (stuck at home)
- Where can I find out about more dementia friendly services?
- Online resources are good but constitute to digital exclusion
- Difficulty with adults that have no family – where can I find help?
- One place to find out where all mental health services are located
- Information re support for carers so they can understand what their loved one is going through – what help is available
- Where there is a volunteering service
- Sharing information between services
- Mental health is not in the news/media/Facebook – it wants more information
- Information just from GP's. It needs to get to the youngsters eg. In schools/social media
- Put a public question to the CCG – who have the money to commission mental health services
- Community knows what's there is but they had to look. It needs more advertising
- Use your local library
- People have to tell their stories too many times – then information not used
- Have a better understanding and a way to get to the young is Facebook, but they have to be 'in your face' with it
- Educating people everywhere about well being
- A single point of access – web based needs to be up to date

Integration of Services - comments and thoughts from 24th July Mental Health Event

- Mental health training for all front line support workers :- i.e. police/ care workers & GP's
- Information exchange between Mental Health services
- Teams around the family working well in children's services but it lacks engagement with adult services
- Collaborative working and mutual understanding of Police working with Ambulance staff working with social services
- Alcohol /drug services mixed with crisis care in Nether Edge important
- Money! Stop! – playing power games, empire building and put the cash in
- Raising awareness generally amongst front line workers
- Awareness of Deaf/autism/ADHD by police and all services
- Sharing resources is needed not working in silos
- Good will of staff in the sector
- SYEDA – does programme in school re eating disorder
- Oiling the wheels professionals to take responsibility
- Lack of communication – better information needed
- One electronic system
- Service users need skills to ask for what they need
- Reducing distinction between mental health and physical health would help underpin integration
- If all services were integrated the path ways would be clearer
- Adult services need greater involvement with children's services – culture needs to change – we need to do 'whole family' work not individual
- Organisations given time to reflect and plan integration
- A&E is often not a place of safety for Mental Health crisis
- Adult mental health workers based in children's service = good
- All staff need all necessary skills otherwise harm is done!
- GP surgeries with ore specialist Mental Health services to support and sign post
- Multiple points of contact 'repeat service assessors'' do have a need to be helped – not just a drain on resources
- Better co-ordination between agencies
- DVD of their journey to tell their story and keep it to pass on
- Barrier – concern about confidentiality
- Links with housing – listen and work with front line housing staff and work together and include in partnership working
- To a large extent because of the lack of education people with mental health issues are stigmatised and invisible
- Bring police force into discussions re strategy
- All providers agencies and vol com sector to Engage, Educate, Empower

- More CPN's on call day and night
- Better communication needed
- Choice between different important too
- Is it a form of abuse not to provide an integrated service
- A facility to be able to show more mapping
- Practical on the job awareness training for all front line workers so they have an over view
- Every front line worker should get Mental Health awareness training
- Barrier – professional – I know about mental health – you don't
- Up skilling of practitioners across the sector to work effectively
- Networking is key – building contacts help
- Education should help people /children have mental health resilience
- Trial - Better Care Fund – a little of NHS and social care budgets combined. Shared records.
- Accessibility on same criteria (health universal; social care less widely available – tighter criteria)
- Difference in needs assessment between referrer and referring organisation (different criteria at the moment, raising expectations unfairly; clarity)
- Often a lesser intervention will work – people will come when they need, not demanding access to everything.
- Service providers need to be more trusting of service users
- People don't want a whole lot of professionals in their lives
- Important to avoid people having to tell their story lots of different times – integration will help with this. Need to bust myths about, eg children being taken away if social services find out. Being clear about confidentiality.
- Organisations need to be quicker and more efficient about working with each other eg Sheffield Homes & the Council. Need to focus on the person and prioritising what they need.

Appendix 3: Bunting comments in full

FEEDBACK ON BUNTING

Attendees were asked to provide:

a) What they felt was good about MH services in Sheffield **(PINK BUNTING)**
b) What/how MH services in Sheffield could be improved **(BLUE BUNTING)**

PINK – What is good about Mental Health Services in Sheffield

- People are not longer locked away like physically or mentally. No more institutions! Any community now has the professional and personal helpers
- Embedding the principles and practice of recovery consistently across the system – tertiary, secondary, primary
- Social cafes
- Targetted mental health (TAMHS) service in schools & interchange Sheffield Counselling Service – both aiming to support (+ YP who are vulnerable and providing capacity building and training in schools
- Consultation and engagement work which has been completed involving young people 'inspecting' and reviewing the services which CAMHS offer.
- The young commissioners – involved in commissioning services
- The fact that this mental health discussion forum is set up and they are listening to the people that need this help
- Fantastic/non-judgement staff who are willing to listen and give as much time as is needed
- CBT & IAPS services being available from the GP
- Variety of therapies available through IAPT; self-help; meditation
- Recognition of mental health conditions by the general practice that should be able to ensure there is help and care in the local community. Building up social capital, networking with local groups
- Within the community there are many voluntary groups that could open their doors provided there is adequate awareness training for the volunteers
- Affected people to be told of community groups in their area – concerns, coffee and chat, initial help ie signposting will; will be made welcome
- Staff show they really care – don't lose that!
- No institutions anymore; people with mental health can live freely in the community; majority of people are aware of mental health and are more accepting
- Darnall dementia group (day centre: person-centred care)

- The Crisis House – mindfulness courses
- Society beginning to be more accepting and understanding of mental health issues.
- More preventative wellbeing offers/physical activity
- Diverse eg BME, YP, women only services. Very strong voluntary sector
- Partnership working with other organisations. Champion workers
- Patient care & support; accessibility to services; provision of therapy eg BBT, mindfulness, relaxation
- Numerous third sector organisations that are visible and well-publicised eg MIND, SYEDA, Halfway
- Alpha Hospital staff – My shared pathway – patient involvement and recovery plans
- The range and variety of services which reflect the diversity of mental illness ie SYEDA. Many services are user –led or informed and empower users to become more involved. All based upon recovery agenda
- People within the organisation caring about the illness and supporting people with mental health issues.
- Support for carers of people with serious mental illness
- Services are trying to improve by talking to local people
- Opportunities to discuss needs, improvement and problems with services through partnership boards and various specialist groups; wide range of specialist services for various mental health problems – but not always sufficient for those people suffering
- Skilled nurses
- There are some! Catering for all levels of need
- Making it 'acceptable' to say you have a mental health issue
- Lots of local neighbourhood group – which must be identified
- Adult service at Love St; Allowing access to psychology community nurse and occupational therapist for autistic adult who is unable to access mainstream services. Thanks to Katherine Hildyard, Ruth McFall and Lizzy Schofield. (but this is now being restructured)
- Increasing mental health awareness training within workplace through health promotion
- Mental health issues losing their stigma – further to go, more VolCom awareness training
- When the services are accessible, the staff know how a problematic situation can be solved with awareness of other services in the community.
- Recognition that "talking therapies" can make a difference
- Access to Liaison Psychiatry for people with a mental health problem caused by a neuro-degenerative condition (ie Huntingdon's Disease). (However, communication could always be improved.). Professional advice to help navigate neurological conditions through MH services – PCHAMPS/Consultants with special interest in neuro/CPN's with

understanding. There are not enough of them but the one's that exist are excellent.

- Services which have a holistic model of health & wellbeing, which support individuals to access community initiatives. These initiatives include: health training, health champions, physical activity sessions – walking groups
- Research beginning to focus on mental health within emergency care services
- More support for independent service-users (and carer) groups based on the wishes of the group.
- Educational psychology service has excellent resources to support bereavement and loss
- Some really dedicated staff trying to do a good job eg support workers on Maple Ward and the housekeepers on acute wards can be wonderful, a friendly hello and a smile
- Mental health services do seem to have become better at linking u with other services eg for people with alcohol and drug problems. IAPT generally a positive development – talking therapies/giving people tools they can use themselves, rather than just medication. MIND provides excellent services (should be properly supported/funded)
- Partnership working with services users and carers. Really listening, taking seriously, and implementing changes.
- Health trainers
- IAPT services
- Lots of services available
- SHINDIG (Sheffield Dementia Involvement Group); improvements in care re older adults MH in STH; Dementia friendly communities/Sheffield Dementia Action Alliance; Focus on prevention and recovery (though needs to be greater); Joint working between health and social care (where it happens); CCG commissioning leadership; Dementiacarer.net; voluntary sector offer (though more resources/greater coverage required)
- Support for carers; good occupational health provision
- Positive engaging services and the people involved in delivering those services (staff & volunteers)
- FNP service – providing evidence based input to help develop babies brains and positive attachment; good foundation for children's mental health
- More peer support on wards!
- First appointment with psychiatrist for mum seemed to go well – will it continue?
- The people who care
- My friends really helped me
- Clare!
- GP referrals
- I got the help I needed at the right time for me!

- MAAT probe NAVIGO/respect training
- IAPT for depression (no drugs)
- Dedicated knowledgeable staff; many excellent projects changing lives for the better
- Living in a tolerant city; services and residents that are caring; partnership working within the city
- There is a 24 hour telephone helpline – but not everyone knows this
- Approachable
- Lots of dedicated staff; mental health first aid (though could be more available)
- Networking. Your Voice magazine. Do you know about - funded by Council – run by users, carers

BLUE - What/how could MH services in Sheffield be improved?

- Having a recovery education programme – having a clear referral pathway
- Easy access to any service – joined up thinking on making sure when access is required eg to GP Out of Hours service that the service user's basic condition does not need explaining. Currently no details are available to such a doctor digitally. It's all still on paper.
- Resources – More counselling (capacity problems)
- Medical check in early stage. Could have prevented before things got worse.
- Capacity – waiting lists can be long. If someone is in crisis they can't always wait.
- Staff offices on in-patient wards have doors. There should always be a designated member of staff "on reception" at all times.
- Teach people leaving services to 'self care'/stay well strategies
- Early on in human life a problem should be seen and dealt with before it gets so big that it takes the person in to a dark world.
- Mental health needs to be a leading action in all communities.
- Bad experience of talking to people about depression "pull your socks up"
- Too long to get counselling/CBT.
- Don't know who to turn to when on the cusp on depression ie dealing with ongoing unemployment.
- Access to acute services is often difficult. Who starts the process? Are GP's and health workers able to diagnose possible mental health problems? More training.
- Discrimination about mental health. People not understanding it is an illness.

- Some vulnerable people with mental health issues do not feel fearful when they are being harassed, so the Police are unable to assist – education needed!
- Community voluntary groups to proactively welcome affected people through their doors, advertise, promote then signpost, refer etc.
- Communication
- Better information for carers when a crisis occurs
- Reduction in waiting time for counselling services.
- Lack of a defined ownership of a co-ordinated, holistic, person-centred care plan
- Some of the premises from which MH services are delivered are awful. Very scare and intimidating.
- Need timely access to psychological therapy for complex MH problems (ie not IAPT!)
- Better access to services. More joined up working. Improve with the benchmarking of a mental illness. As it is a fine line. As to whether you can access the service or not.
- MH Services – many episodes occur at weekends when service is not available.
- Training for all NHS workers to be knowledgeable of mental health.
- Access to NHS psychiatric professionals for people with enduring mental health conditions (especially those who try to help themselves)
- Day services need to be improved. More funds – no more cuts!
- Improve – difficulty accessing – more clear guidelines
- Sharing information in communities about services and activities that are available for members of the community.
- More planned step downs to avoid 'falling off the cliff'. More resources for early intervention and prevention. More work around awareness raising and anti-stigma campaigns. Better training on mental health for GPs.
- Maternal mental health service
- Staffing on some hospital wards (acute and intensive) support for people with serious mental illness after leaving hospital.
- Communication for the younger ones
- (Alpha Hospital Sheffield) – Transfer process between hospitals – lack of communication.
- General hospital care and treatment of people with mental health issues
- People need to know where to go to get help especially early intervention.
- Need to put ideas and plans into action for the benefit of sufferers and their carers
- Difficult to access treatment at early stages of an illness – often severe symptoms/signs have to be manifest before treatment is available – even then delays occur

- Need for greater co-ordination between physical and mental health needs and treatment.
- Greater awareness amongst public
- (Alpha Hospital, Sheffield) – Carer involvement. More information & support for family members eg involvement groups, coffee mornings. Help families gain understanding
- I would like them to be more obvious and accessible.
- Where to go other than your GP when you just want to talk what provision is available?
- More information available in public areas
- Providing a consistent and equitable tier 1 / 2 emotional wellbeing and mental health service for children, young people & families.
- Partnerships ie housing, mental health services, VCF, neighbours resources, GP's, getting access
- APT – for those people who have complex conditions/multi pathologies. They find it difficult to engage/attend – they need more direction and support
- Long-term intervention – people with complex conditions as well as a mental health diagnosis need on multi-disciplinary approach over the course of a long time.
- Communication between mental health and physical health teams
- GP understanding of mental health if not primary cause for concern
- Acute MH wards are terrifying environments – staff are overstretched and burnt out and patients often overlooked. Not therapeutic places - no one to talk to.
- Transition from children's services to adult services. Don't engage with children in their environment or adolescents.
- Social and mental health care should be part of the same personal wellbeing plan
- Support the carers. Having the feeling of being on your own. Need of direction. Help to cut waiting time for help
- Need to ensure access to treatment for all.
- Need to ensure a person-centred holistic treatment in therapeutic environments eg the rooms in health centres can be dreadful if you are in a distressed state eg no access to water
- Need to improve joined up partnership working across services, providers, VCF and self help groups. Access to signposting and info sharing
- There are too many groups in the service for people to fall through and no one taking responsibility to ensure access to treatment
- Need 24 hr liaison psychiatry service! (lengthy waits in A & E bad)
- The eligibility threshold for services seems to be set very high, so that people with moderate anxiety/depression find it hard to access support.

- Not sure how much MH services are able to do to support people into recovery, which can take some time.
- Need to acknowledge that mental and physical health are closely related – need a holistic approach
- Need 24/7 cover for HM in OOH services, 111, 999, A & E, walk in centre
- Join up and develop greater links with community projects which improve wellbeing.
- Empower individual and communities to improved health
- Embed '5 ways to well being' message throughout service provision
- Lack of communication between departments (families not always encouraged to be involved in recovery process)
- Services (or lack thereof) for people with borderline personality disorder. Separate service needed
- We need to talk about challenge and change in our ordinary lives
- Bring the VolCom sector on-board, with engagement, education, empowerment
- Early intervention for elderly patients with signs of dementia. GP's should recognise signs before it is too late for effective treatment
- Need to ensure meaningful service user involvement – across all services not just SHSC & T
- Use values based commissioning to lead to co-produced service delivery and design
- Fund NSJN leadership training for service users
- It takes too long to be seen by secondary care; waiting lists; no targets.
- Actively promote the signposting of non-commissioned services to patients engage with the keeping people well in their communities agenda
- In my experience there is very little support or access to treatment for women with young children. We are often marginalised as being anxious and a problem with no access to meaningful treatment
- Organisational & individual – lack of understanding regard the impact of mental health issues within working environment
- Better joining up of services and knowledge. More resources for advocacy services
- Difficulty in being taken on be mental health service for person with a learning disability
- Culturally needs to be accessible – understanding of cultural competence international perspectives.
- Pathways and opportunities to physical activity
- Staff training regarding various types of mental illness
- Mindfulness courses for all
- The systems that don't care

- From Chesterfield – now Sheffield. We have been told services here are much worse than Chesterfield – great!
- Money grabbing, untrained, unqualified, unskilled "homecare" agencies
- There was no help until I hit crisis
- Confusion about where to go with issues
- Lack of continuity
- I would love a bit more support with my care – I feel a bit lost
- Links between/across services poor – creates gaps and missed opportunities
- Services for people in crisis – particularly out of hours; offer to carers; management of MHS – medically unexplained symptoms
- Health inequalities for people with mental ill health/LD – life expectancy gap
- Overall poor service user engagement – particularly adult MH
- Too much resource on beds - not enough on community support/prevention
- MH public health – need more
- Get fines for people not turning up for appointments without cancellations. Doctor's surgeries, dentists, foot clinics etc. We can find ways to find and fund NHS if we claimed all free healthcare from people who have paid nothing into system
- Peer Support
- MH funding has been decimated and agencies that are trying to support clients are being forced out of business in consequence
- The main improvement is by the powers that be. To give more cash to that section. More trainers in the voluntary and primary care
- More "linked up" network with different organisations to have a faster response to impact on improving a situation
- Resources – increased better co-ordination; prevention – address the causes of MH; Research into treatments that work; Co-ordination of services – 'one stop shops' etc; Greater awareness of help available
- Insufficient out of hours services (and A&E not appropriate for mental health emergencies)
- Shortage of counselling services. Lack of resources to fully support and involve carers (eg through assessment of carers needs)
- Networking: carers – look at action group, something to do
- Waiting times; lack signposting. Info not joined up; early intervention – school nurse? People don't know where to go
- Please don't let our mental health services go or services to blind and deaf and disabled. We know much is needed but we must look into avenues of help elsewhere eg wills & gifts to; ? for pads(incontinence) etc and some treatment
- Revolving door – no one to check on you; Need integration; physical health neglected; Integration – stop power games (£)/ mental health resilience training £4 for every £1 spent

- More support for service –users and ex-users who want to work
- Retain local responsibility with local health practice
- Mental health in Sheffield is one of the illnesses that is mainly forgotten and only recently come to the fore. It can be long term situation. Let's hope.

Appendix 4: Thinking inside the box & webchat comment in full

- Stigma; waiting times
- Diet Exercise
- Family friends stops isolations
- Don't stay alone in your house
- Sense of humour – have fun. Keep things in perspective
- Socialise – visit older relatives, talk
- Police to be made aware that making fun of people with mental health is a criminal offence contrary to section 1b of Protection from Harassment
- Lack of actual work completed (pass the buck and start again)
- Why do city councillors get you thinking that changes are going to happen then zilch
- There is an empathy deficit in some aspects of care
- Early support and intervention – yes, prevention is usually better than cure. Start with education in schools about MH issues.
- Non-judgemental listening; not being labelled
- Telephone anxiety/phobia – need access to services by email or text
- Summary: information is of no value if it cannot get from where it is to where it needs to be
- Friendship. Social needs and exercise; reducing stigma
- Education – don't make kids not good at exams feel inferior
- Helping yourself – GP sees you as "well" so not needing help
- GP's need to be aware of carers needs. Appointments at same time as dementia sufferer
- Keep prices of pools etc down
- People think only way to get help is to be alcoholic or drug addict
- Access to OPN or psychiatrist on A&E
- Walk-in NHS mental health centre
- RRT won't come out if patient has CPN
- What emergency care?
- People with enduring conditions, who try to help themselves "don't meet criteria" however ill
- Places for people to go with mental health – having for example as they want to feel safe
- After care and support for people getting better – ongoing support
- Greater links with community projects to improve mental health. Empowering individuals

- Nothing has been said about how to improve service user involvement to enable improvement of mental health services. I would like to see commissioners fund NSUN leadership. Training for Sheffield people with experience of mental ill health. Values based commissioning
- GP's - I forgot to put that patient participation groups in every GP practice would help to support people locally around accessing alternative support for mental ill health
- If all professionals share knowledge and responsibility would this only over a system where cuts are already having an effect? Eg young people with drug and alcohol issues also tend to have MH issues. If the drug and alcohol worker shares with the mental health teams – would we have the capacity to ensure a good outcome?
- I would like to say (yet again!) that it is an absolute scandal that (some?) home care agencies are allowed to send untrained, unqualified, unskilled people into people's own homes then (highly detrimentally) try to take over their lives, then take the 'beneficiary' of this 'service' to the gates of the court to extract their 40 years of life savings from them.
- Doctors should recognise mental health, depression and other issues need separate requirements. The person with mental health problems should be sent to be schooled for values and confidence within themselves.
- Educate, engage and empower, listen, learn and love
- Mental health must be granted their fair share. Depression and other illnesses eg nervous and anxiety must not be dismissed.
- Healthcare means all aspects of health, so it is incredible that distinctions were made between physical and mental challenges, and that distinctions were created arbitrarily between the service providers.
- Charities are having to "mop up" people who can't get a service from the NHS – GP's and others are telling patients to go to such and such charity for counselling etc but the charities don't have any money either.
- What are we doing about suicide levels in the city? These people must have hidden extremes of poor mental health that are getting missed. How do we become more aware of what to do as services and individuals?

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Councillor Julie Dore and Dr Tim Moorhead, Co-Chairs of the Health and Wellbeing Board
Date:	25 September 2014
Subject:	Report on Health and Wellbeing Board Engagement April-September 2014
Author of Report:	Louisa Willoughby, 0114 205 7143

Summary:

Health and Wellbeing Boards have a responsibility, as system leaders, to ensure that the work they carry out is transparent and appropriately involves members of the public, providers and practitioners. Sheffield's Health and Wellbeing Board has been acknowledged in the past as developing best practice in relation to engagement, and the Board recognises the importance of being a system leader.

This report is intended to provide the Health and Wellbeing Board with a snapshot of its engagement from the last six months. It focusses on *Health and Wellbeing Board-specific* engagement, and therefore does not cover the engagement carried out by the organisations that are represented on the Board. It also provides some suggestions for how that engagement can be improved.

Recommendations:

It is recommended that the Health and Wellbeing Board focus its engagement from October 2014-March 2015 on a range of areas specified in the report.

Reasons for Recommendations:

It is important that the Health and Wellbeing Board continues to be transparent and accessible in its decision-making.

REPORT ON HEALTH AND WELLBEING BOARD ENGAGEMENT APRIL-SEPTEMBER 2014

1.0 SUMMARY

1.1 Health and Wellbeing Boards have a responsibility, as system leaders, to ensure that the work they carry out is transparent and appropriately involves members of the public, providers and practitioners.

1.2 Sheffield's Health and Wellbeing Board has been acknowledged in the past as developing best practice in relation to engagement.[1] The Board recognises the importance of being a system leader in action 1.1 of the Board's Joint Health and Wellbeing Strategy, which states sets out a desire to:

> *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.*

1.3 This report is intended to provide the Health and Wellbeing Board with a snapshot of its engagement from the last six months. It also provides some suggestions for how that engagement can be improved.

1.4 The report is the first of its kind, and we intend for the next update to be presented to the Board at its public meeting in March 2015. The report does not consider the engagement the Board carried out from April 2013-March 2014, although information about this and reports from events held are available on the Board's website.[2] Furthermore, the report focusses on *Health and Wellbeing Board-specific* engagement, and therefore does not cover the engagement carried out by the organisations that are represented on the Board.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 It is important that the decisions of decision-makers are accessible and transparent, enabling local people to be informed and, where they wish to be, involved in the decisions made.

2.2 Sheffield's Health and Wellbeing Board has from the start sought to:

- Communicate what the Board is doing and when its meetings are happening, and ensure these meetings take place in a space that is appropriate and large enough for members of the public to attend.
- Publicise and publish its papers and presentations, and report back on what was discussed, including in real time through a Twitter feed.
- Involve people in the making of key strategic city-wide decisions through engagement events and consultations, and through the opportunity to ask a question publicly at more formal meetings.

[1] See, for example, *Stronger Together: How Health and Wellbeing Boards can work effectively with local providers* and *Good Practice in Joint Health and Wellbeing Strategies*, both online at http://www.nhsconfed.org/resources/2014/08/resources-for-health-and-wellbeing-boards.
[2] See http://www.sheffield.gov.uk/healthwellbeingboard.

- Advertise more specific consultation efforts of the organisations that make up the Health and Wellbeing Board: Sheffield City Council, NHS Sheffield Clinical Commissioning Group, NHS England and Healthwatch Sheffield.

2.3 As well as focussing on Sheffield people as citizens, service users and patients, the Board has also sought to provide opportunity for health and wellbeing providers, practitioners, interest groups and others to provide comment.

2.4 This report demonstrates the Board's efforts to reach a wide audience of people, and make suggestions for how the Board's approach could be developed over the next six months, to enable Sheffield people to be even more involved in the process.

3.0 HEALTH AND WELLBEING BOARD ENGAGEMENT APRIL-SEPTEMBER 2014

This report will cover the Board's engagement from April-September 2014 focussing on four main areas:

- Meetings.
- Communication.
- Consultation.
- Local, regional and national connections.

3.1 Meetings

- Over the period April-September 2014, the Board held one **formal public meeting** in June, with another being held in September and which will receive this paper.
    - Around 25 individuals attended to observe the meeting in June, which is perhaps slightly less than usual.
    - Attendees to observe included representatives from housing associations, voluntary sector organisations, South Yorkshire Police, the city's two universities, students, trades unions, NHS providers and pharmaceutical companies, as well as individual service users.
    - A number of public questions were asked – if responses are not given on the day, they are provided in writing after the meeting and published in the minutes.
    - Presentations from the meeting were published online and then advertised in the Board's next enewsletter.

- Over the period April-September 2014, the Board held two **engagement events**, one in May on tackling health inequalities, and one in July on mental health.
    - Both events were very popular, with around 100 attendees at each. The event on mental health focussed particularly on encouraging service users to attend. The events were advertised to the Board's main network as well as through other organisations including Healthwatch Sheffield.
    - Healthwatch Sheffield organised a follow-up event in early June on the topic of tackling health inequalities, and helped to organise the mental health event in July.
    - There was live tweeting throughout both events and presentations/reports from the events were published online and then advertised in the Board's next enewsletter. British Sign Language interpreters are available on request.
    - Each event attracted new individuals who had not previously attended Health and Wellbeing Board events before. In May, 69 individuals were added to our email list, and in July, 19 were.

- The events make a difference to decision-making: for example, the report from the event on health inequalities was then taken to June's formal public meeting, and the report from the event on mental health is being taken to September's.

- From time-to-time, the Health and Wellbeing Board holds other meetings. For example, in July several **Board members met with business leaders** who work in healthcare technologies.

3.2 Communication

- The Board's most comprehensive vehicle for communication is its **enewsletter** which it sends out monthly except for combined July/August and December/January editions.[3]
  - The number of people receiving the enewsletter has steadily increased, and there are currently just over 1,700 people on the distribution list. Some of these are providers and practitioners, and some are service users, patients and citizens.
  - The enewsletter provides regular updates on the Board's meetings and activities. Each month has a spotlight on one of the Board's five work programmes and links to recent presentations, event reports and other social media.
  - Enewsletters are printed and posted to individuals on request.

- The Board has a **website** which has recently been refreshed to be clearer and simpler.[4] In total, in March-August 2014 the website's pages have received nearly 7,000 unique views – some to the main homepage; others directly to specific pages from links in enewsletters.
  - The top five pages in terms of unique hits are:
    - Joint Health and Wellbeing Strategy – 970 unique hits.
    - Integration of health and social care – 756 unique hits.
    - Joint Strategic Needs Assessment – 560 unique hits.
    - About the Health and Wellbeing Board – 527 unique hits.
  - Visitors spend quite a long time on the pages, which is a sign that they have found the information they are looking for and are reading it. The bounce rate of the 'homepage' is low, meaning that people are staying on the site to explore further.
  - There are spikes in visitor numbers when the enewsletter is sent out.

- The Board also uses a number of **other online resources** to publicise its work and ensure information is readily available. For example:
  - Regular updates and opportunities to engage are posted on Twitter.[5] At the time of writing, the Board has 814 followers.
  - All presentations are posted on Slideshare.[6] The most popular presentations over the last six months at the time of writing have been:
    - Presentation on the Care Act – 216 views.
    - Update on the integration of health and social care – 202 views.
    - Presentation on the Children and Families Act – 144 views.
  - The Board has started to use Storify to create accounts about its events and meetings.[7] The report of June's formal public meeting had been viewed by 103 people at the time of writing.

[3] See http://us6.campaign-archive1.com/home/?u=4c519d652065c050d46e2444e&id=d680dbeecd.
[4] See https://www.sheffield.gov.uk/healthwellbeingboard.
[5] See https://twitter.com/sheffieldhwb.
[6] See https://www.slideshare.net/sheffieldhwb.
[7] See http://www.storify.com/sheffieldhwb.

- From time-to-time, videos about the Board's work or interviews of Board members are posted onto YouTube.[8] A recent introduction to one of the Board's projects had been viewed by 62 people at the time of writing. Transcripts are available on request.

- The Board has also ensured it communicates clearly about potentially complex matters through creating **summary documents**. For example, a one-page summary of the feedback from the tackling health inequalities engagement event was published, and a six-page summary of the 50-page Better Care Fund submission was made widely available. Furthermore, printed summary copies of the Joint Health and Wellbeing Strategy have been distributed widely.

3.3 Consultations

- From April-September 2014 the Board's primary means of consultation has been through its **engagement events**, and then vicariously through the individual engagement of the Board's member organisations, some of whose activities were advertised in the Board's enewsletter.

- However, in April the Board did conclude an opportunity via. **SurveyMonkey** for individuals to express an interest in being involved with the integration of health and social are work. 234 individuals responded to this. Individual projects as part of the integration work have then consulted as appropriate for their particular schemes.

3.4 Local, regional and national connections

- As the representative of Sheffield people, **Healthwatch Sheffield** has an important role to play in engaging with Sheffield people on the Board's behalf and on feeding this information back into the Board.
    - In the period April-September 2014, Healthwatch Sheffield used its experience and feedback to plan the mental health engagement event, and provide introductions for the Board into the transition between services and information and advice.
    - Healthwatch Sheffield have also been invited to comment on the review of outcome 1 of the Joint Health and Wellbeing Strategy.

- In addition, the **Board's member organisations, and health and social care providers across Sheffield**, also all do engagement themselves. For example, in the past few months consultations and engagement have been carried out around the Care Act, changes to musculoskeletal services, the mental health strategy, and the Right First Time Programme. The Health and Wellbeing Board seeks to feed into these other engagement mechanisms where appropriate and is only part of the wider engagement picture in Sheffield.

- Over the period April-September 2014, the Board has been clarifying its relationship with a range of **partnership boards** which existed under the old health and wellbeing partnership (before the statutory Health and Wellbeing Board was created). While the Board recognises the important relationship these groups have, it does not have a

[8] See https://www.youtube.com/user/SheffHWB.

formal relationship with any of them, and instead invites them to engage with the Board through the mechanisms listed above.

- Board members have engaged **regionally** with other Health and Wellbeing Boards as appropriate to share best practice and learning.

- Officers supporting the Board have recently been involved in creating **national guidance** for the use of social media by Health and Wellbeing Boards.

4 RECOMMENDATIONS FOR THE HEALTH AND WELLBEING BOARD

It is recommended that the Health and Wellbeing Board focus its engagement from October 2014-March 2015 on the following areas:

4.1 Engaging with citizens, service users and patients

It is recommended that:

- An engagement event be held in October 2014 focusing on children and young people.
- Places for engagement events be restricted for providers and practitioners to ensure the voice of citizens, service users and patients is heard.
- One or more Board members put themselves forward to be videoed about their vision for the Health and Wellbeing Board.
- Places such as The Circle, Town Hall and local libraries are replenished with summary copies of the Joint Health and Wellbeing Strategy.
- NHS England's representative on the Board clarifies NHS England's approach to public engagement and assures the Board that it will involve the Board in its engagement.
- Healthwatch Sheffield informs the Board's review of outcomes 2, 4 and 5 of the Joint Health and Wellbeing Strategy.

4.2 Engaging with providers and businesses

It is recommended that:

- The Health and Wellbeing Board considers how it can follow up the July meeting it had with businesses that work in healthcare technologies.
- The Health and Wellbeing Board holds an engagement event with the growing Provider Assembly in January 2015.

4.3 General

It is recommended that:

- The Board receives a similar summary to this in March 2015.

5 REASONS FOR THE RECOMMENDATIONS

It is important that the Health and Wellbeing Board continues to be transparent and accessible in its decision-making.

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Dr Jeremy Wight, Director of Public Health
Date:	25 September 2014
Subject:	Due North: Report of the Inquiry on Health Equity for the North
Author of Report:	Jeremy Wight, 0114 205 7462

Summary:
The attached report: *Due North, Report of the Inquiry on Health Equity for the North* was commissioned by Public Health England from the Centre for Local Economic Strategies (CLES) at the University of Liverpool, and written by a panel led by Professor Margaret Whitehead. The brief was to examine health inequalities in the North of England – both within the North and between the North and the rest of the country, to 'provide fresh insight into policy and actions...'.
The report makes a very clear link with the need for economic development in the North, and the need to invest in the development of people and places. Equally, the need for devolution and democratic renewal (to give local people more power over the conditions in which they live), is emphasised. There are recommendations for actions in the areas of tackling poverty, actions in early childhood, democratic renewal and strengthening the role of the health sector.
Many, but not all, of the recommendations are already being implemented in Sheffield, and are included in our *Health Inequalities Action Plan*.

Recommendations:

- The Health and Wellbeing Board should consider the report and determine whether there are additional actions, following the report's recommendations, that should be included in the *Health Inequalities Action Plan.*
- That in light of the emphasis in the report on the importance of the local economy in addressing health inequalities, that the Health and Wellbeing Board should refer it to the Sheffield Executive Board and the Local Enterprise Partnership.

Background Papers: Due North, Report of the Inquiry on Health Equity for the North

This page is intentionally left blank

DUE NORTH

Report of the Inquiry on Health Equity for the North

Due North: The report of the Inquiry on Health Equity for the North

Inquiry Chair: Margaret Whitehead

Report prepared by the Inquiry Panel on Health Equity for the North of England

First published in Great Britain in September 2014 by University of Liverpool and Centre for Local Economic Strategies

ISBN: 1 870053 76 1

Aknowledgements

We thank the many people who contributed to the Inquiry's work. This Inquiry was carried out by a panel chaired by Margaret Whitehead and supported by a secretariat from the Centre for Local Economic Strategies (CLES). The review was informed by 18 policy makers and practitioners, with expertise in the relevant policy fields (see appendix 1) and four discussion papers prepared by Ben Barr, David Taylor-Robinson, James Higgerson, Elspeth Anwar, Ivan Gee (University of Liverpool), Clare Bambra and Kayleigh Garthwaite (Durham University) and Adrian Nolan and Neil McInroy (CLES). This report was prepared by the Inquiry Panel supported by CLES (Neil McInroy, Adrian Nolan and Laura Symonds) and the WHO Collaborating Centre for Policy Research on Social Determinants of Health (Ben Barr). Public Health England provided financial support for the conduct of the Inquiry and the gathering of evidence but played no part in the decisions or conclusions of the Inquiry Panel.

CONTENTS PAGE

PREFACE

Life is not grim up North, but, on average, people here get less time to enjoy it. Because of poorer health, many people in the North have shorter lifetimes and longer periods of ill-health than in other parts of the country. That health inequalities exist and persist across the north of England is not news, but that does not mean that they are inevitable.

While the focus of the Inquiry is on the North, it will be of interest to every area and the country as a whole.

This has been an independent inquiry commissioned by Public Health England. We particularly wanted and welcome fresh insights into policy and actions to tackle health inequalities within the North of England and with the rest of the country, in the context of the new public health responsibilities locally and nationally, and the increasingly live debate about greater economic balance.

I would like to thank Professor Whitehead, her panel, witnesses to the Inquiry and the Centre for Local Economic Strategies for the time, energy and commitment that has resulted in this report

PHE's own interim response to the issues and recommendations from this inquiry is published alongside this report and we will produce a fuller response at a later date, when we have had time to explore and consider the issues in greater depth. We look forward to contributing to stimulating discussion and debate with partners over the coming months.

Paul Johnstone
Public Health England
August 2014

FOREWORD

We have lived with a North-South health divide in England for a long time, illustrated by the shocking statistic that a baby girl in Manchester can expect to live 15 fewer years in good health than a baby girl in Richmond. This gap is not static but has continued to widen over recent decades. This regional health divide masks inequalities in health between different socio-economic groups within every region in England which are just as marked: health declines with increasing disadvantage of socio-economic groups wherever they live in the country.

By and large, the causes of these health inequalities are the same across the country – and are to do with differences between socioeconomic groups in poverty, power and resources needed for health; exposure to health damaging environments; and differences in opportunities to enjoy positive health factors and protective conditions, for example, to give children the best start in life. It is, however, the severity of these causes that is greater in the North, contributing to the observed regional pattern in health. It also marks out the North as a good place to start when inquiring into what can be done about social inequalities in health in this country. There may be lessons to be learnt for the whole country.

There are more pressing reasons, however, for setting up this Inquiry on Health Equity for the North at this point in time. The austerity measures introduced as a response to the 2008 recession have fallen more heavily on the North and on disadvantaged areas more than affluent areas, making the situation even worse. Reforms to the welfare system are potentially increasing inequalities and demand for services. At the same time, there are increasing calls for greater devolution to city and county regions within England. There is a growing sense that now is the time to influence how the process of devolution happens, so that budgets and powers are decentralised and used in ways that reduce economic and health inequalities.

It is against this background that the Inquiry Panel developed its' recommendations – recommendations that are based on an analysis of the root causes of the observed health inequalities. A guiding principle has been to build on the assets and agency of the North. There are plenty of ideas, therefore, about what agencies in the North could and should do, made stronger by working together, to tackle the causes of health inequalities. These are centred around the twin aims of the prevention of poverty in the long term and the promotion of prosperity, by boosting the prospects of people and places. They are also about how Northern agencies could make best use of devolved powers to do things more effectively and equitably.

The Panel is keen to stress, however, that there are some actions that only central government can take. Government policy is both the cause and the solution to some of the problems analysed by the Inquiry. The report therefore sets out what central government needs to do, both to support action at the regional level and to re-orientate national policies to reduce economic and health inequalities. There is an important role too for national health agencies, including the NHS and Public Health England. The aim of this report is to bring a Northern perspective to the debate on what should be done about a nationwide problem. We are optimistic that something can be done to make a difference and that this is the right time to try.

Margaret Whitehead
Chair, Inquiry on Health Equity for the North
August 2014

EXECUTIVE SUMMARY

Why have an inquiry into health inequalities and the North?

The North of England has persistently had poorer health than the rest of England and the gap has continued to widen over four decades and under five governments. Since 1965, this equates to 1.5 million excess premature deaths in the North compared with the rest of the country. The latest figures indicate that a baby boy born in Manchester can expect to live for 17 fewer years in good health than a boy born in Richmond in London. Similarly, a baby girl born in Manchester can expect to live for 15 fewer years in good health, if current rates of illness and mortality persist.

The so called 'North-South Divide' gives only a partial picture. There is a gradient in health across different social groups in every part of England: on average, poor health increases with increasing socio-economic disadvantage, resulting in the large inequalities in health between social groups that are observed today. There are several reasons why the North of England is particularly adversely affected by the drivers of poor health. Firstly, poverty is not spread evenly across the country but is concentrated in particular regions, and the North is disproportionately affected. Whilst the North represents 30% of the population of England it includes 50% of the poorest neighbourhoods. Secondly, poor neighbourhoods in the North tend to have worse health even than places with similar levels of poverty in the rest of England. Thirdly, there is a steeper social gradient in health within the North than in the rest of England meaning that there is an even greater gap in health between disadvantaged and prosperous socio-economic groups in the North than in the rest of the country. It is against this background that this Inquiry was set up.

Aims of the inquiry

In February 2014, Public Health England (PHE) commissioned an inquiry to examine Health Inequalities affecting the North of England. This inquiry has been led by an independent Review Panel of leading academics, policy makers and practitioners from the North of England. This is part of 'Health Equity North' - a programme of research, debate and collaboration, set up by PHE, to explore and address health inequalities. This programme was launched in early 2014, with its first action to set up this independent inquiry.

The aim of this inquiry is to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England.

The Inquiry Panel

The Inquiry Panel was recruited to bring together different expertise and perspectives, reflecting the fact that reducing health inequalities involves influencing a mix of social, health, economic and place-based factors. The panel consisted of representatives from across the North of England in public health, local government, economic development and the voluntary and community sector. The members of the Inquiry Panel were:

- Professor Margaret Whitehead (Chair), W.H. Duncan Chair of Public Health, Department of Public Health and Policy, University of Liverpool;
- Professor Clare Bambra, Professor of Public Health Geography, Department of Geography, Durham University;
- Ben Barr, Senior Lecturer, Department of Public Health and Policy, University of Liverpool;
- Jessica Bowles, Head of Policy, Manchester City Council;
- Richard Caulfield, Chief Executive, Voluntary Sector North West;
- Professor Tim Doran, Professor of Health Policy, Department of Health Sciences, University of York;
- Dominic Harrison, Director of Public Health, Blackburn with Darwen Council;
- Anna Lynch, Director of Public Health, Durham County Council;
- Neil McInroy, Chief Executive, Centre for Local Economic Strategies;
- Steven Pleasant, Chief Executive, Tameside Metropolitan Borough Council;
- Julia Weldon, Director of Public Health, Hull City Council.

The process

Recommendations were developed through 3 focused policy sessions and 3 further deliberative meetings of the panel over the period February to July 2014. The policy sessions involved the submission of written discussion papers commissioned by the panel, as well as a wider group of experts and practitioners, with expertise in the relevant policy fields, who were invited to these sessions (see Appendix 1 for a list of participants). During the three further deliberative sessions held by the Inquiry the panel refined the recommendations, drawing on the discussions and written evidence from the policy sessions, and the experience and knowledge of the panel members.

This report sets out a series of strategic and practical policy recommendations that are supported by evidence and analysis and are targeted at policy makers and practitioners working in the North of England. These recommendations acknowledge that the Panel's area of expertise is within agencies in the North, while at the same time highlighting the clear need for actions that can only be taken by central government. We, therefore, give two types of recommendations for each high-level recommendation:

- What can agencies in the North do to help reduce health inequalities within the North and between the North and the rest of England?
- What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

What causes the observed health inequalities?

The Inquiry's overarching assessment of the main causes of the observed problem of health inequalities within and between North and South, are:

- Differences in poverty, power and resources needed for health;
- Differences in exposure to health damaging environments, such as poorer living and working conditions and unemployment;
- Differences in the chronic disease and disability left by the historical legacy of heavy industry and its decline;
- Differences in opportunities to enjoy positive health factors and protective conditions that help maintain health, such as good quality early years education; economic and food security, control over decisions that affect your life; social support and feeling part of the society in which you live.

Not only are there strong step-wise gradients in these root causes, but austerity measures in recent years have been making the situation worse – the burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South; on disadvantaged than more affluent areas; and on the more vulnerable population groups in society, such as children. These measures are leading to reductions in the services that support health and well-being in the very places and groups where need is the greatest.

Policy drivers of inequalities and solutions

1. Economic development and living conditions

The difference in health between the North and the rest of England is largely explained by socioeconomic differences, including the uneven economic development and poverty. One of the consequences of the uneven economic development in the UK has been higher unemployment, lower incomes, adverse working conditions, poorer housing, and higher unsecured debts in the North, all of which have an adverse impact on health and increase health inequalities.

The adverse impact of unemployment on health is well established. Studies have consistently shown that unemployment increases the chances of poor health. Empirical studies from the recessions of the 1980s and 1990s have shown that unemployment is associated with an increased likelihood of morbidity and mortality, with the recent recession leading to an additional 1,000 suicides in England. The negative health experiences of unemployment are not limited to the unemployed but also extend to their families and the wider community. Youth unemployment is thought to have particularly adverse long term consequences for mental and physical health across the life course.

The burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South;

The high levels of chronic illness in the North also contribute to lower levels of employment. Disability and poor health are the primary reasons why people in the North are out of work, as demonstrated by the high levels of people on incapacity benefits. Strategies to reduce inequalities need to prevent

people leaving work due to poor health, enable people with health problems to return to work and provide an adequate standard of living for those that cannot work.

A great deal of evidence has demonstrated an inverse relationship between income and poor health, with falls in income and increases in poverty associated with increased risk of mental and physical health problems. Poor psychosocial conditions at work increase risk of health problems, in particular cardiovascular conditions and mental health problems. More precarious forms of employment, including temporary contracts, are also increasing and these have been associated with increased health risks.

Poor housing has been shown to have numerous detrimental effects on physical and mental health. Living in fuel poverty or cold housing can adversely affect the mental and physical health of children and adults. It is estimated that this costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes. For infants, after taking other factors into account, living in fuel poor homes is associated with a 30% greater risk of admission to hospital or attendance at primary care facilities.

This calls for a strategy that not only ameliorates the impact of poverty but also seeks to prevent poverty in the future

People in debt are three times more likely to have a mental health problem than those not in debt, the more severe the debt more severe the health difficulties. In terms of physical health, debt has been linked to a poorer self-rated physical health, long term illness or disability, chronic fatigue, back pain, higher levels of obesity and worse health and health related quality of life.

What could be done differently?

The evidence reviewed by the panel has outlined a number of actions that have the potential to address the economic and employment causes of health inequalities. This calls for a strategy that not only ameliorates the impact of poverty but also seeks to prevent poverty in the future, not least by investing in people (improving skills and health and hence employment prospects), as well as investing in places. This strategy links public service reform to economic development in the North, to refocus services on preventing poverty and promoting prosperity.

2. Early childhood as a critical period

The UK has some of the worst indicators for child health and well-being of any high-income country. In 2007 a UNICEF study found that the UK had the worst levels of child well-being of any developed country and a recent study found that it had the second worst child mortality rate in Western Europe. Within England, the health of children is generally worse in the North, reflecting the higher levels of child poverty.

There is a large body of evidence demonstrating that early disadvantage tracks forward, to influence health and development trajectories in later life, and that children who start behind tend to stay behind. For example, children living in poverty and experiencing disadvantage in the UK are more likely to: die in the first year of life; be born small; be bottle fed; breathe second-hand smoke; become overweight; perform poorly at school; die in an accident; become a young parent; and as adults they are more likely to die earlier, be out of work, living in poor housing, receive inadequate wages, and report poor health.

Whilst the higher levels of child poverty and disadvantage in the North of England are potentially storing up problems for the future, none of this is inevitable. Numerous reviews of evidence have repeatedly shown that providing better support early in children's lives is the most effective approach to significantly reduce inequalities in life chances. In the North of England, where large proportions of children are growing up in poverty, it is critical that action to improve early child development takes place on a scale that is proportionate to need.

In the North of England, where large proportions of children are growing up in poverty, it is critical that action to improve early child development takes place on a scale that is proportionate to need.

Some progress has been made over the past decade; however these gains are now under threat. The UK was the first European country to systematically implement a strategy to reduce health inequalities. In particular, the Government set targets to reduce inequalities in infant mortality and to cut and eventually 'eradicate' child poverty. To address these targets, a raft of well-funded policies were implemented including changes to the tax and benefits system that led to a reduction in child poverty and the establishment of Sure Start centres, which aimed to reduce child poverty through the targeted provision of pre-school education. Child poverty did reduce dramatically and inequalities in infant mortality also fell during this period. Unfortunately, we are now seeing signs that these achievements are being undone. For the first time in more than 17 years, child poverty in the United Kingdom increased in absolute terms in 2011 and the reduction in inequalities in infant mortality ceased with the onset of the financial crisis in 2008. The Social Mobility and Child Poverty Commission has estimated that by 2020 3.5 million children will be in absolute poverty, about 5 times the number needed to meet the Government's legal obligation to end child poverty.

What could be done differently?

Children are often not in a position to speak out for themselves and for this reason are offered special protection under the UN charter on human rights. The arguments are not just about the evidence, but also that investing in children is morally and legally the right thing to do. A rights-based approach to addressing inequalities in the health and well-being of children has the potential to engender a new commitment to investment in the early years.

The evidence indicates that two strands of action are required to significantly reduce child health inequalities at a population level. Firstly, a universal system of welfare support is needed that prioritises children, in order to eliminate child poverty. Well-developed social protection systems result in better outcomes for children and protect them against shocks such as economic crises. Those countries in Europe that do have more adequate social protection experience better child health outcomes. The recent analysis of the Social Mobility and Child Poverty Commission has shown that the Government's current strategy for reducing child poverty is not credible. They conclude that 'hitting the relative poverty target through improved parental employment outcomes alone is impossible' and recommend that increases in parental employment and wages are supplemented by additional financial support for families.

Secondly, a system of high quality universal early years child care and education support is also necessary. In Nordic countries, a child's life chances are not so dependent on how privileged their

parents were than they are in other developed countries. One reason for this is the provision of universal and high-quality early years intervention and support, which can have a powerful equalising effect.

There is a great deal of agreement that providing good quality universal early years education and childcare proportionately across society would effectively reduce inequalities. Providing any education is not enough, though, since it is the quality of preschool learning that appears to be critical for longer-term beneficial effects. This needs to be supported by routine support to families through parenting programmes, key workers, and children's centres with integrated health and care services and outreach into communities. The evidence base for these early interventions is strong.

3. Devolution: having the power to make a difference at the right spatial scale

The evidence suggests that there are three ways through which levels of community control and democratic engagement have an impact on health. Firstly, those who have less influence are less able to affect the use of public resources to improve their health and well-being. The Northern regions, for example, have had limited collective influence over how resources and assets are used in the North of England and this has hindered action on health inequalities. Secondly the process of getting involved, together with others, in influencing decisions, builds social capital that leads to health benefits. Thirdly, where people feel they can influence and control their living environment, this in itself is likely to have psychological benefits and reduce the adverse health effects of stress.

Northern regions have had limited collective influence over how resources and assets are used and this has hindered action on health inequalities.

There is a growing body of evidence indicating that greater community control leads to better health. Low levels of control are associated with poor mental and physical health. A number of studies have found that the strength of democracy in a country is associated with better population health and lower inequalities. Countries with long-term social-democratic governments tend to have more developed preventive health services. US states with higher political participation amongst the poor have more adequate social welfare programmes, lower mortality rates and less disability. There is evidence indicating that the democratic participation of women is particularly important for the health of the whole population.

When community members act together to achieve common goals there are indirect benefits resulting from improved social support and supportive networks which can reduce social isolation and nurture a sense of community, trust and community competence. Research indicates that community empowerment initiatives can produce positive outcomes for the individuals directly involved including: improved health, self-efficacy, self-esteem, social networks, community cohesion and improved access to education leading to increased skills and paid employment. Evidence from the 65 most deprived local authorities in England shows that, as the proportion of the population reporting that they can influence decisions in their local area increases, the average level of premature mortality and prevalence of mental illness in the area declines.

A constraint on the capacity of local government to make a difference is the highly centralised nature of the political system in England. England has one of the most centralised political systems in Europe, both political and economic power are concentrated in London and the surrounding area and this has contributed to the large inequalities between regions. The disproportionate cuts to local government budgets currently being implemented are exacerbating the problem. Successful regions will have control over the prerequisites of growth, such as skills, transport and planning.

What could be done differently?

Increasingly, the new combined authorities and core cities are demanding greater devolution of powers and resources to cities and local government. There is also a growing consensus across political parties that this is needed to drive economic growth and reduce regional inequalities in England. Simply devolving power to city regions and combined authorities, however, will not, on its own, address inequalities. Giving local areas greater control over investment for economic development will only reduce health and economic inequalities if local strategies for economic growth have clear social objectives to promote health and well-being and reduce inequalities, backed by locally integrated public services aimed at supporting people into employment. The public health leadership of local authorities will need to play a central role if devolution to cities and regions is going to reverse the trend of rising inequalities. Devolution of power and resources to local administrations needs to be accompanied by greater public participation in local decision-making. Decisions in Whitehall may seem distant and unaccountable to people living in the North, but decisions made by combined authorities or local economic partnerships will seem no more democratic unless there is greater transparency and participation.

There is the potential for devolution within England to herald a new approach to health inequalities

There is the potential for devolution within England to herald a new approach to health inequalities that is based on fundamentally shifting power from central government to regions, local authorities and communities. But only if there is real devolution, rather than just rhetoric, and local powers are used to improve health and reduce inequalities – allowing them to do the right things at the right spatial scale.

None of this, however, should reduce the responsibilities of national government. The role of national government in addressing health inequalities remains of the utmost importance. Robust national policy is essential to ensure that there are sufficient public resources available and that these are distributed and used fairly to improve the life chances of the poorest fastest. National legislation remains an important mechanism for protecting people from the adverse consequences of uncontrolled commercial markets. Where services are delivered through national agencies, they need to work flexibly as part of a set of local organisations that can integrate services so that they address local needs.

4. The vital role of the health sector

We did not consider that the observed health inequalities between the North and the rest of England and within the North are caused by poorer access or quality of NHS services. Although there are still inequalities in access to healthcare by deprivation, these could not account for the size

and nature of the differences in health status that we observe. On the contrary, access to NHS care when ill has helped to reduce health inequalities. The NHS helps to ameliorate the health damage caused by wider determinants outside the health sector. To do this, NHS services in deprived areas need to be adequately resourced to enable them to reduce inequalities and the principle of the NHS as free at the point of need must be maintained.

The NHS can influence health inequalities through 3 main areas of activity. Firstly by providing equitable high quality health care, secondly by directly influencing the social determinants of health through procurement and as an employer, and thirdly as a champion and facilitator that influences other sectors to take action to reduce inequalities in health.

What could be done differently?

The most pressing concern for the NHS is to maintain its core principle of equitable access to high quality health care, free at the point of need. This will involve addressing those inequalities in health care that do exist, avoiding introducing policies that will increase health inequalities and ensuring that health care provision across the country is planned and resourced so that it reduces heath inequalities. Specifically the panel identified the following priority areas through which the health sector can play an important role in reducing health inequalities.

Firstly the NHS needs to allocate resources so that they reduce health inequalities within the North and between the North and the rest of England. There is evidence to indicate that the policy to increase the proportion of NHS resources going to deprived areas did lead to a narrowing of inequalities in mortality from some causes. This highlights the importance of having resource allocation policies with an explicit goal to reduce inequalities in outcomes.

Secondly, local health service planning needs to ensure that the resources available to the NHS within each area are used to reduce inequalities. This means targeting resources to those most in need and investing in interventions and services that are most effective in the most disadvantaged groups. The current focus of CCGs on demand management has tended to mean increased investment in services for the elderly. Whilst this is important, it should not be at the expense of investment earlier in the life course, which is a vital component of all health inequalities strategies.

Access to NHS care when ill has helped to reduce health inequalities, amelioratating the health damage caused by wider determinants outside the health sector.

Thirdly a more community-orientated model of primary care needs to be encouraged that fully integrates support across the determinants of health. This includes enabling people seeking help through the primary care system to get the support they need for the full range of problems that are driving them to seek help in the first place. These are often the wider determinants of their health, such as financial problems, unsuitable housing, hopelessness and generally feeling out of control of their lives.

Fourthly a large-scale strategy for the North of England is needed to maximize the impact of the NHS on health inequalities through its procurement and its role as an employer. There are also promising examples indicating how local NHS organisations are using their commissioning and procurement of services to improve the economic, social, and environmental well-being of their area. If the commissioning and procurement of all the NHS organisations in the North of England focused on maximizing social value for the North, this could make a significant difference.

Finally the health sector needs to be a strong advocate, facilitating and influencing all sectors to take action to reduce inequalities in health. With Directors of Public Health transferring from the NHS to local authorities there are fewer voices in the NHS speaking out on issues relating to the public's health and health inequalities. Public Health England was established to be an independent advocate for action across all sectors on health inequalities. The actions that are required to address health inequalities involve radical social change. They are therefore often controversial. Public Health England needs to be supporting and challenging all government departments to tackle health inequalities.

Recommendations

Tackling these root causes leads to a set of 4 high-level recommendations and supporting actions that build on the assets of the North to target inequalities both within the North and between the North and the rest of England. These recommendations are explained in detail in Section 4. These recommendations are formulated from a Northern perspective and address the core question: what can the North do to tackle the health equity issues revealed in this report? This perspective does not mean that we discount national actions – far from it – we give two types of recommendations for each high-level recommendation:

1) What can agencies in the North, do to help reduce the health inequalities within the North and between the North and the rest of England?
2) What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

We believe that the recommended actions would benefit the whole country, not just the North.

Recommendation 1: Tackle poverty and economic inequality within the North and between the North and the rest of England.

Agencies in the North should work together to:

- Draw up health equity strategies that include measures to ameliorate and prevent poverty among the residents in each agency's patch;
- Focus public service reform on the prevention of poverty in the future and promoting the prosperity of the region by re-orientating services to boost the prospects of people and place. This includes establishing integrated support across

the public sector to improve the employment prospects of those out of work or entering the labour market.

- Adopt a common progressive procurement approach to promote health and to support people back into work;
- Ensure that reducing economic and health inequalities are central objectives of local economic development strategy and delivery;
- Implement and regulate the Living Wage at the local authority level;
- Increase the availability of high quality affordable housing through stronger regulation of the private rented sector, where quality is poor, and through investment in new housing.
- Assess the impact in the North of changes in national economic and welfare policies;

Central government needs to:

- Invest in the delivery of locally commissioned and integrated programmes encompassing welfare reform, skills and employment programmes to support people into work;
- Extend the national measurement of the well-being programme to better monitor progress and influence policy on inequalities;
- Develop a national industrial strategy that reduces inequalities between the regions;
- Assess the impact of changes in national policies on health inequalities in general and regional inequalities in particular;
- Expand the role of Credit Unions and take measures to end the poverty premium;
- Develop policy to enable local authorities to tackle the issue of poor condition of the housing stock at the bottom end of the private rental market;
- End in-work poverty by implementing and regulating a Living Wage;
- Ensure that welfare systems provide a Minimum Income for Healthy Living (MIHL);
- Grant City and County regions greater control over the commissioning and use of the skills budget and the Work Programme to make them more equitable and responsive to differing local labour markets;
- Develop a new deal between local partners and national government that allocates the total public resources for local populations to reduce inequalities in life chances between areas.

Recommendation 2: Promote healthy development in early childhood.

Agencies in the North should work together to:

- Monitor and incrementally increase the proportion of overall expenditure allocated to giving every child the best possible start in life, and ensure that the level of expenditure on early years development reflects levels of need;
- Ensure access to good quality universal early years education and childcare with greater emphasis on those with the greatest needs, so that all children achieve an acceptable level of school readiness;
- Maintain and protect universal integrated neighbourhood support for early child development, with a central role for health visitors and children's centres that clearly articulates the proportionate universalism approach;
- Collect better data on children in the early years across organisations so that we can track changes over time;
- Develop and sign up to a charter to protect the rights of children to the best possible health.

Central government needs to:

- Embed a rights based approach to children's health across government;
- Reduce child poverty through the measures advocated by the Child Poverty Commission which includes investment in action on the social determinants of all parents' ability to properly care for children, such as paid parental leave, flexible work schedules, Living Wages, secure and promising educational futures for young women, and affordable high quality child care;
- Reverse recent falls in the living standards of less advantaged families;
- Commit to carrying out a cumulative impact assessment of any future welfare changes to ensure a better understanding of their impacts on poverty and to allow negative impacts to be more effectively mitigated;
- Invest in raising the qualifications of staff working in early years childcare and education;
- Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused according to need;
- Increase investment in universal support to families through parenting programmes, children's centres and key workers, delivered to meet social needs.
- Make provision for universal, good quality early years education and childcare proportionately according to need across the country.

Recommendation 3: Share power over resources and increase the influence that the public has on how resources are used to improve the determinants of health.

Agencies in the North should work together to:

- Establish deep collaboration between combined authorities in the North to develop a Pan-Northern approach to economic development and health inequalities;
- Take the opportunity offered by greater devolved powers and resources to develop, at scale, locally integrated programmes of economic growth and public services reform to support people into employment;
- Re-vitalise Health and Well-being Boards to become stronger advocates for health both locally and nationally.
- Develop community led systems for health equity monitoring and accountability;
- Expand the involvement of citizens in shaping how local budgets are used;
- Assess opportunities for setting up publicly owned mutual organisations for providing public services where appropriate, and invest in and support their development;
- Help develop the capacity of communities to participate in local decision-making and developing solutions which inform policies and investments at local and national levels;

Central government needs to:

- Grant local government a greater role in deciding how public resources are used to improve the health and well-being of the communities they serve;

- Revise national policy to give greater flexibility to local government to raise funds for investment and use assets to improve the health and well-being of their communities;
- Invest in and expand the role of Healthwatch as an independent community-led advocate that can hold government and public services to account for action and progress on health inequalities;
- Invite local government to co-design and co-invest in national programmes, including the Work Programme, to tailor them more effectively to the needs of the local population.

Recommendation 4: Strengthen the role of the health sector in promoting health equity.

Public Health England should:

- Conduct a cumulative assessment of the impact of welfare reform and cuts to local and national public services;
- Support local authorities to produce a Health Inequalities Risk Mitigation Strategy;
- Help to establish a cross-departmental system of health impact assessment;
- Support the involvement of Health and Well-being Boards and public health teams in the governance of Local Enterprise Partnerships and combined authorities;
- Contribute to a review of current systems for the central allocation of public resources to local areas;
- Support the development a network of Health and Well-being Boards across the North of England with a special focus on health equity;
- Collaborate on the development of a charter to protect the rights of children;
- Work with Healthwatch and Health and Well-being Boards across the North of England to develop community-led systems for health equity monitoring and accountability.

Clinical Commissioning Groups and other NHS agencies in the North should work together to:

- Lead the way in using the Social Value Act to ensure that procurement and commissioning maximises opportunities for high quality local employment, high quality care, and reductions in economic and health inequalities;
- Pool resources with other partners to ensure that universal integrated neighbourhood support for early child development is developed and maintained;
- Work with local authorities, the Department for Work and Pensions (DWP) and other agencies to develop 'Health First' type employment support programmes for people with chronic health conditions;
- Work more effectively with local authority Directors of Public Health and PHE to address the risk conditions (social and economic determinants of health) that drive health and social care system demand;
- Support Health and Well-being Boards to integrate budgets and jointly direct health and well-being spending plans for the NHS and local authorities;
- Provide leadership to support health services and clinical teams to reduce children's exposure to poverty and its consequences;
- Encourage the provision of services in primary care to reduce poverty among people with chronic illness, including, for example, debt and housing advice and support to access to disability-related benefits.

1 PRINCIPLES AND PROCESSES OF THE INQUIRY

The aim of this inquiry has been to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England.

1.1 Introduction: the aims of the inquiry

In February 2014 Public Health England (PHE) commissioned an inquiry to examine Health Inequalities affecting the North of England. This inquiry has been led by an independent Inquiry Panel of leading academics, policy makers and practitioners from the North of England. This is part of 'Health Equity North', a programme of research, debate and collaboration, set up by PHE, to explore and address health inequalities. This public health call for action was launched in early 2014, with its first action to set up this independent inquiry.

The aim of this inquiry has been to develop recommendations for policies that can address the social inequalities in health within the North and between the North and the rest of England.

In particular the panel has sought to develop recommendations that:

- Build on the assets and resilience of the North, rather than presenting the North as a victim. This includes identifying policy that enhances the capacity of communities, organisations and enterprises in the North to build on their assets and develop their collective capacity to influence inequalities in health.
- Enable a platform for local authorities, city and county regions, Health and Well-being Boards and the other collaboratives across the North to act on the national stage in lobbying for policies that reduce inequalities and the health divide between the North and the rest of England.
- Make the most of the new public health responsibilities of local government for the health and well-being of their local populations and the reduction of health inequalities.
- Address the root causes of health inequalities - the conditions in which people grow, live, work and age – within the North as well as between the North and the rest of England.
- Are supported by what is known about the mechanisms that generate health inequalities and effective policy approaches, building on previous reviews of health inequalities.

Although commissioned by PHE, the evidence presented in this report and its recommendations have been independently developed by the Inquiry Panel.

1.2 The Inquiry Panel

The Inquiry Panel was recruited to bring together different expertise and perspectives, reflecting the fact that reducing health inequalities involves influencing a mix of social, health, economic and place based factors. The panel consisted of representatives from across the North of England in public health, local government, economic development and the voluntary and community sector. It was chaired by Professor Margaret Whitehead, W H Duncan Chair of Public Health at the University of Liverpool and Head of the World Health Organisation (WHO) Collaborating Centre for Policy Research on the Social Determinants of Health. The members of the Inquiry Panel were:

- Professor Margaret Whitehead (Chair), W.H. Duncan Chair of Public Health, Department of Public Health and Policy, University of Liverpool;
- Professor Clare Bambra, Professor of Public Health Geography, Department of Geography, Durham University;
- Ben Barr, Senior Lecturer, Department of Public Health and Policy, University of Liverpool;
- Jessica Bowles, Head of Policy, Manchester City Council;
- Richard Caulfield, Chief Executive, Voluntary Sector North West;
- Professor Tim Doran, Professor of Health Policy, Department of Health Sciences, University of York;
- Dominic Harrison, Director of Public Health, Blackburn with Darwen Council;
- Anna Lynch, Director of Public Health, Durham County Council;
- Neil McInroy, Chief Executive, Centre for Local Economic Strategies;
- Steven Pleasant, Chief Executive, Tameside Metropolitan Borough Council;
- Julia Weldon, Director of Public Health, Hull City Council.

1.3 The process

Recommendations were developed through 3 focused policy sessions and 3 further deliberative meetings of the panel over the period January to July 2014. The policy sessions involved the submission of written evidence papers commissioned by the panel, as well as a wider group of experts and practitioners, with expertise in the relevant policy fields, who were invited to these sessions (see Appendix 1 for a list of participants and the accompanying Appendices document for the submitted evidence papers). The Inquiry Panel discussed the evidence and policy implications with this wider group of experts and practitioners, at each of these policy sessions. The policy sessions focused on 3 priority areas that had been identified as having particular relevance for addressing health inequalities affecting the North of England.

- Healthy economic development and ensuring an adequate standard of living;
- Promoting healthy development in early childhood; and
- Devolution and democratic renewal.

During the three further deliberative sessions held by the Inquiry, the panel refined the recommendations, drawing on the discussions and written evidence from the policy sessions, and the experience and knowledge of the panel members.

The report sets out a series of strategic and practical policy recommendations that are supported by evidence and analysis and are targeted at policy makers and practitioners working in the North of England. These recommendations, acknowledge that the Panel's area of expertise is within agencies in the North, while at the same time highlighting the clear need for actions that can only be taken by central government. We, therefore, give two types of recommendations for each high-level recommendation:

- What can agencies in the North do to help reduce health inequalities within the North and between the North and the rest of England?
- What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

1.4 Principles of the inquiry

The inquiry uses the term health inequalities to describe the systematic differences in health between social groups that are avoidable by organised action and are considered unfair and unjust.[1] Three general principles run through the review and inform its analysis and recommendations.

- Firstly that reducing health inequalities is a matter of social justice, as the WHO Commission on Social Determinants of Health concluded, it is a 'social injustice that is killing on a grand scale.'[2]
- Secondly that inequality in health arises because of inequalities in power and influence. Reducing health inequalities 'can be thought of as increasing the freedom and power among people with the most limited possibilities of controlling and influencing their own life and society.'[3]
- Thirdly that these inequalities in power result in inequalities in the resources needed for health including material and psychosocial working and living conditions, education opportunities, built environments and opportunities for social participation.

These inequalities in power and resources produce a social gradient in health: people and communities have progressively better health the better their socioeconomic conditions. Therefore effective approaches to decrease health inequalities need to reduce inequalities in resources across the whole gradient and not just amongst the people at the bottom. However a shift in the resources for health across the social gradient will only be sustained if it is accompanied by an increase in the power and influence people have over those resources.

There have been a series of reviews of health inequalities in the UK, Europe and globally, and the purpose of this inquiry is not to repeat the work of these reviews, but to learn from and move beyond them in developing action on health inequalities for a specific region – the North of England (the NHS areas of Yorkshire and the Humber, North West and North East). The evidence from previous reviews is clear. The highest priority for action should be to ensure a good start to life for every child and to maintain an adequate standard of living across the life course that enables everyone to participate in society and maintain good health. However health inequalities have proved themselves to be highly persistent. Economic and social inequalities are perpetuated within places and over generations. The 2013 WHO Europe review of Determinants and the Health Divide recognized that reducing health inequalities involves the 'whole-of-government' and 'whole-of-society'.[4] The challenge is how to bring about this change. Achieving and sustaining action will involve a step change in how the public, particularly the most disadvantaged groups, are engaged in and influence policy, a shift in the model of economic development and a strategy that prevents the perpetuation of health risks from one generation to the next. This led the Inquiry to focus on the 3 priority areas outlined in 1.3, in developing its recommendations:

The Inquiry has sought to bring a fresh perspective to the issue of health inequalities that focuses on preventing inequalities occurring in the future as well as ameliorating the impact of current inequalities.

The concepts of 'place', 'governance' and 'assets', have been important to the Inquiry's approach. Firstly, by emphasizing the geographical distribution of health inequalities in England as well as differences between socioeconomic groups within the North, this inquiry highlights the importance of 'place' in both the generation of health inequalities and the policies that address them. The social, economic and political processes that influence health inequalities intersect in the places where people live and work. It is here that we need to start in order to bring about this change in the 'whole-of-government' and 'whole-of-society'. Secondly, it is important to recognise that previous approaches to tackle health inequalities in England and beyond have, in the main, fallen short of their objectives. The WHO European review of the health divide has analysed the reasons for this lack of progress.[4] It concludes that they result from a failure in governance and accountability, which has meant that policies have not sufficiently addressed the root causes of health inequalities, in particular the inequalities in power and resources needed for health. Reducing inequalities in health requires coherence of action across a range of stakeholders working in the interests of the public. The Inquiry has therefore sought to develop approaches that enable new systems of governance and accountability for health equity, in particular accountability to the public, which support coordinated action that influences the places in which people live, work and flourish. Thirdly, the inquiry has sought to develop policy options that build on the assets of the North, enabling everyone – from communities to organisations and enterprises - to develop their collective capacity to influence inequalities in health.

1.5 The role of evidence in developing the recommendations

The Inquiry has sought to develop recommendations that are supported by a robust analysis of the causes of health inequalities within the North of England and between the North and the rest of England. It is widely agreed that social policies working at the population, rather than individual, level have the greatest potential to reduce health inequalities by addressing the social conditions and economic and political systems that contribute to and sustain them. However these types of 'upstream' policies present the greatest challenges for researchers trying to evaluate health and other impacts. This results in the 'inverse evidence law' whereby the availability of evidence tends to vary inversely with the potential impact of the intervention.[5] The recommendations have therefore been informed by a broad range of evidence including the experience of the panel members of what is feasible and what is likely to have the greatest impact.

2 CURRENT POLICY CONTEXT

The inquiry comes at a time when there are some specific threats and opportunities for action on health inequalities in general and the North-South health divide in particular.

The inquiry comes at a time when there are some specific threats and opportunities for action on health inequalities in general and the North-South health divide in particular. In 2013 public health responsibilities that had been part of the NHS since 1974 were transferred back to local government. However this happened at a particularly challenging time for councils. The programme of austerity measures that continues to be pursued by the UK government is hitting local government particularly hard and reforms to welfare are potentially increasing inequalities and demand for services.[6] Increasingly, the new combined authorities and core cities are demanding greater devolution of powers and resources to cities and local government. There is also a growing consensus across political parties that this is needed to drive economic growth and reduce regional inequalities in England.[7,8] The recommendations of the Inquiry need to been seen in the context of these developments in national policy as outlined in more detail below. The Inquiry Panel has sought to develop recommendations that make the most of these developments whilst minimising the risks for health inequalities.

2.1 The opportunities offered by public health in local government

The transfer of public health from the NHS to local government has been welcomed. It is local government services, such as housing, economic development, culture, leisure and environmental health, that have the most potential to improve public health outcomes. Situating public health departments within local authorities clearly enhances the opportunities for them to influence these determinants of health.

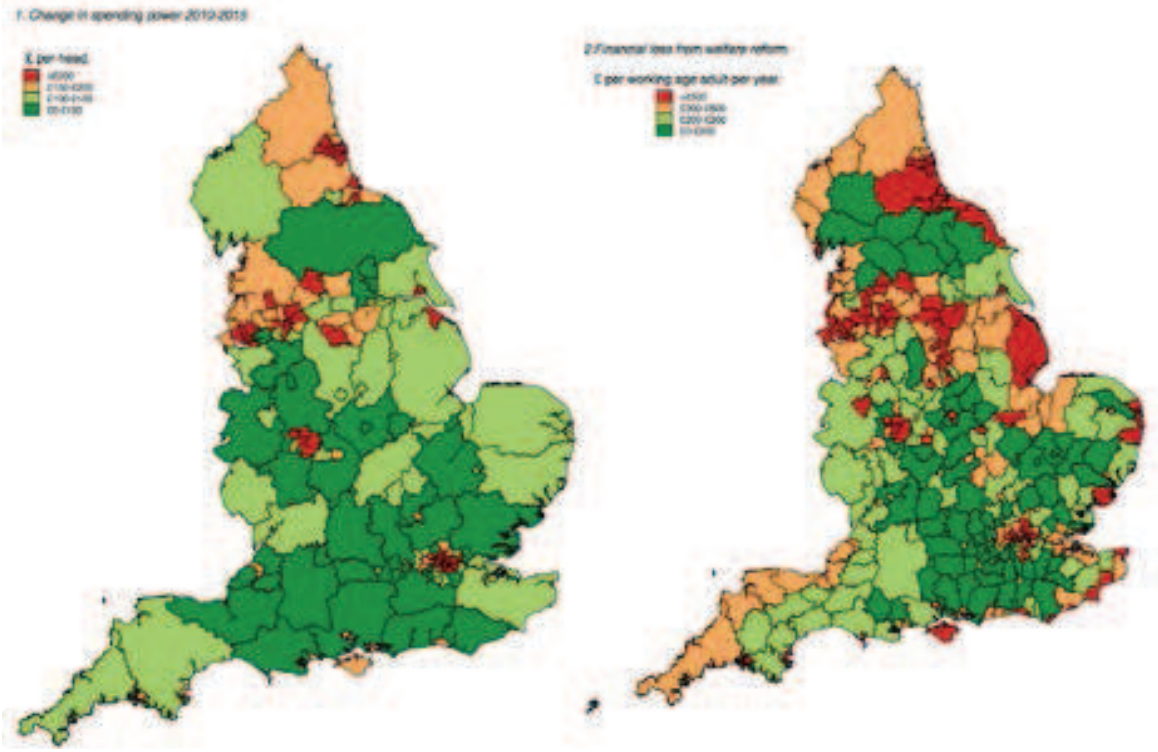
An important function of local government is also to 'shape places' by representing, engaging and leading the citizens and communities in a place to collectively develop local identity and promote well-being.[9] The implications of this role for improving the health of the people living in a place, even in the face of adverse national and global trends, has not yet been fully recognized or fully realised. The new public health role for local government provides an opportunity to develop this further. The transition of Directors of Public Health and their teams from PCTs to local authorities was not just a transition between organisations, it was a transition from an organisation whose primary responsibility was the commissioning of services to another organisation whose primary responsibility is democratic governance. This is an opportunity to fully integrate health goals into all sectors by incorporating health and equity considerations as a standard part of decision-making across sectors and policy areas.

2.2 Action on health inequalities in an age of austerity

The capacity for local government to influence the health and well-being of the places they represent is limited by a programme of austerity that is hitting councils hardest in some of the poorest parts of the North. In 2013 the Government allocated a ring-fenced public health budget to local authorities. The Secretary of State for Health at the time said this should be used to tackle 'poverty-related health need'.[10] This 'public health grant' represents approximately 3% of local government expenditure and only 1% of the combined local expenditure of the NHS and local government in an area.[11,12] This in itself would be inadequate to address the health effects of poverty, but given that this grant was transferred to councils at a time when their core budgets are being cut by nearly 30%, it is difficult to see how, in these circumstances, local government can have an impact on health inequalities. In fact these cuts are likely to make health inequalities worse because they are disproportionately hitting the poorest areas with the worst health outcomes hardest (see Figures 1 and 2). On top of these cuts to local authority budgets, more deprived areas are experiencing large financial losses due to welfare reform with the three regions of northern England loosing an estimated £5.2bn a year.[13] This has an impact not just on the individuals and families facing reduced incomes from welfare benefits, but also represents a large loss to the local economy (see Figure 1).

Figure 1: Map of change in local authority spending power and financial losses from welfare reform for each council in England.

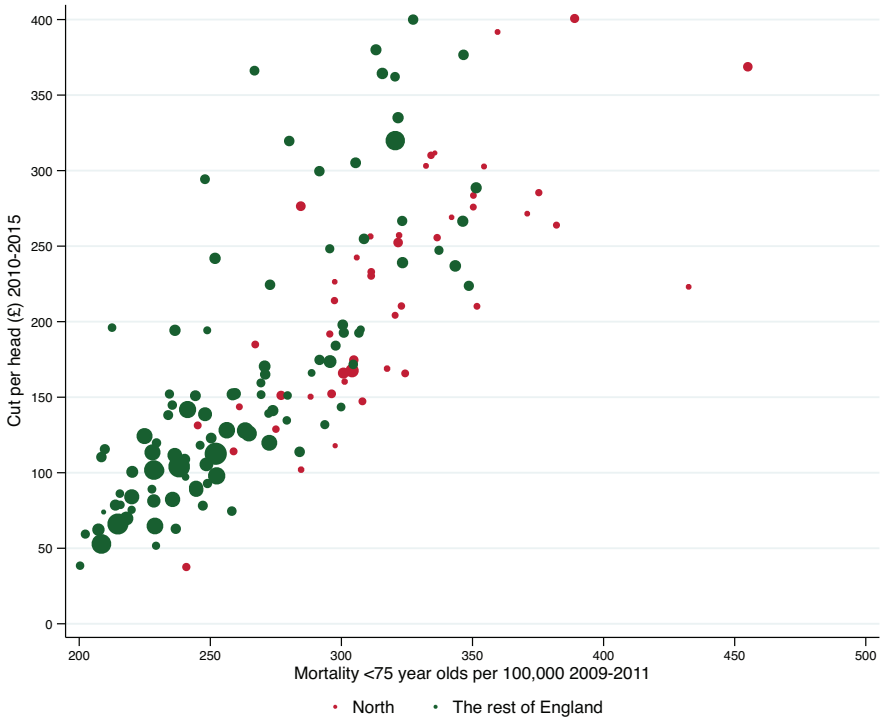
Map shows that cuts in council funding and financial losses from welfare reform are greatest in the North



Sources: 1. DCLG - Local government financial settlement, 2.Beatty and Fothergill 2014

Figure 2: Council cuts per head correlated against premature mortality rates

Cuts in council budgets are greatest in areas in the North of England, with the worst health



Sources: 1. DCLG - Local government financial settlement, 2. Public Health England - Longer Lives

Whilst the health effects of these policies may not be felt immediately the international evidence from previous periods of welfare expansion and contraction indicate that inequalities in both mortality and morbidity increase when welfare services are cut.[14–17] There is a pressing need to ensure that sufficient resources are available to address inequalities and where a reduction in government spending is unavoidable it needs to be carried out in a way that does not exacerbate existing inequalities.

2.3 Devolution: having the power to make a difference

A further constraint on the capacity of local government to make a difference is the highly centralised nature of the political system in England. England has one of the most centralised political systems in Europe with central government controlling a higher proportion of public spending than any other OECD country in Europe (see section 3.5). The concentration of political and economic power in London and the surrounding area has contributed to the large inequalities between regions.[18] The present Coalition Government has committed to greater decentralisation, as did the previous government. However the UK continues to become more centralised with local government controlling a declining proportion of public expenditure (see section 3.5). The disproportionate cuts to local government budgets currently being implemented are exacerbating this.

Increasingly the new combined authorities and core cities in England are demanding greater devolution of powers and resources to cities and local government. There is also a growing consensus across political parties this is needed to drive economic growth and reduce regional inequalities in England.[7,8] The focus has so far been on enabling greater local control over investment in infrastructure and skills. The review of economic growth commissioned from Lord Heseltine by the Prime Minister recommended devolving £49bn of central government funding to Local Economic Partnerships. The Coalition Government have begun a process of devolving limited responsibilities and funding to cities and their surrounding areas through a programme of 'City Deals' and 'Growth Deals'. The growth review by Lord Adonis for the Labour party proposes making combined authorities (for both Cities and County Regions) the foundation for future devolution with £30bn being transferred from central to local government for skills, infrastructure and economic development. However it remains to be seen whether proposals from the current government or the opposition translate into a real commitment to the devolution of powers. In England the 'history of the last 30 years is marked by a series of well-intentioned devolution initiatives, which have often evolved into subtle instruments of control.'[9]

The concentration of political and economic power in London and the surrounding area has contributed to the large inequalities between regions

Devolution could support effective action on health inequalities, but only if three conditions are met. Firstly, local economic growth needs to promote health and reduce inequalities. Giving local areas greater control over investment for economic development, will only reduce health and economic inequalities if local strategies for economic growth have clear social objectives to promote health and well-being and reduce inequalities. Devolution must be about securing a fairer share of the proceeds of growth. The public health leadership of local authorities will need to play a central role if devolution to cities and regions is going to reverse the trend of rising inequalities. How the devolved resources for skills, infrastructure, employment and business are used will have major implications for health inequalities.

Secondly, devolution needs to address the inequalities in power that underlie inequalities in health. It needs to increase the power and influence that local communities have over public policy and the use of public resources. This means greater public participation in local decision-making. Decisions in Whitehall may seem distant and unaccountable to people living in the North, but decisions made by combined authorities or Local Economic Partnerships will seem no more democratic unless there is greater transparency and participation. Key decisions are better made if they can be influenced, or even made, by those most affected, and local decision-making and control can enable solutions to be developed that build on the assets of citizens rather than being imposed on them.

Thirdly, devolution needs to enable public services to be developed and improved so that they prevent future poverty and inequalities as well as ameliorating the effect of current inequalities. This means integrating, coordinating and sequencing all public services so that they reflect how people live their lives, rather than reflecting the organisational boundaries of public services. Importantly, with greater local control and flexibility about how resources are used, integrated public services can be developed to enable all young children to get the best start in life, to be ready for and successful at school, support transitions from school into training and employment, prevent illness and the consequences of illness throughout life and help people who are out of work to get back into employment.

There is the potential for devolution within England to herald a new approach to the challenges faced by the regions, based on fundamentally shifting power from central government to regions, local authorities and communities. This will only happen if there is real devolution, rather than just rhetoric, and local powers are used to improve health and reduce inequalities.

None of this however should reduce the responsibilities of national government. The role of national government in addressing health inequalities remains of the utmost importance. Robust national policy is essential to ensure that there are sufficient public resources available and that these are distributed and used fairly to improve the life chances of the poorest fastest. National legislation remains an important mechanism for protecting people from the adverse consequences of uncontrolled commercial markets. Where services are delivered through national agencies, they need to work flexibly as part of a set of local organisations that can integrate services so that they address local needs.

The role of national government in addressing health inequalities remains of the utmost importance.

3 EVIDENCE

This section outlines the evidence and analysis underlying the recommendations made by the panel.

This section outlines the evidence and analysis underlying the recommendations made by the panel. Firstly we outline the current situation of health inequalities affecting the North of England and trends in those inequalities over the past decade. Next we outline the evidence for action across the three priority areas identified in the introduction:

- Economic development and the standard of living;
- Early childhood;
- Devolution and democratic renewal;

Finally we outline the role of the health sector in reducing health inequalities.

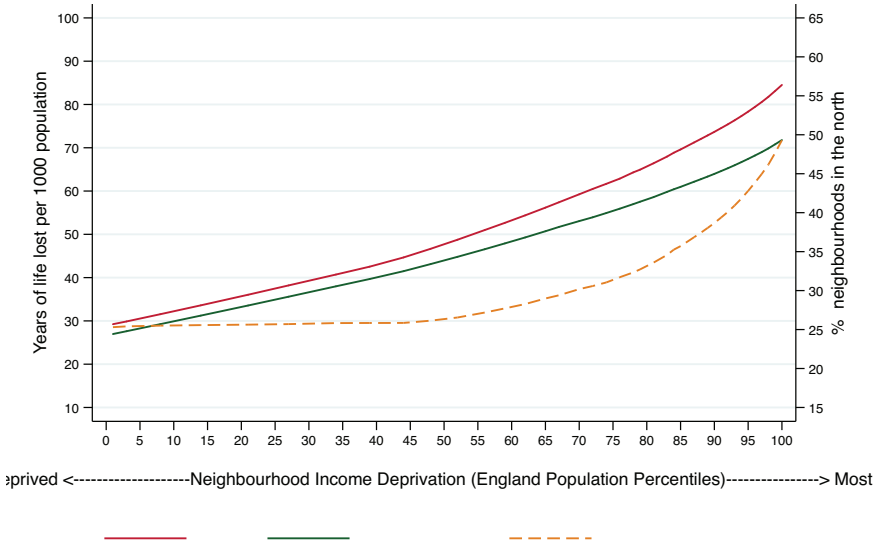
3.1 Health inequalities and the North of England

The North of England has persistently had poorer health than the rest of England and the gap has continued to widen over four decades and under five governments[19] Since 1965, this equates to 1.5 million excess premature deaths in the North compared with the rest of the country.[20] The latest figures indicate that a baby boy born in Manchester can expect to live for 17 fewer years in good health, than a boy born in Richmond in London. Similarly a baby girl born in Manchester can expect to live for 15 fewer years in good health, if current rates of illness and mortality persist.

The so called 'North-South Divide' gives only a partial picture. There is a gradient in health across different social groups in every part of England: on average, poor health increases with increasing socio-economic disadvantage, resulting in the large inequalities in health between social groups that are observed today. There are several reasons why the North of England is particularly adversely affected by the drivers of poor health. Firstly, poverty is not spread evenly across the country but is concentrated in particular regions, and the North is disproportionately affected. Whilst the North represents 30% of the population of England it includes 50% of the poorest neighbourhoods. Secondly, poor neighbourhoods in the North tend to have worse health even than places with similar levels of poverty in the rest of England. Thirdly, there is a steeper social gradient in health within the North than in the rest of England meaning that there is an even greater gap in health between disadvantaged and privileged socio-economic groups in the North than in the rest of the country (see Figure 3). The historical growth and decline of industry in the North has resulted in concentrations of poverty that have persisted in areas for generations. This exacerbates health inequalities and has left a legacy of high levels of chronic disease and disability. It is the combination of these factors: adverse socioeconomic conditions that disproportionately affect the North and a steeper social gradient in health that results in the North-South health divide shown in Figure 4.

Figure 3: Years of Life Lost by neighbourhood income level, the North and the rest of England, and the % of neighbourhoods at each income level that are in the North

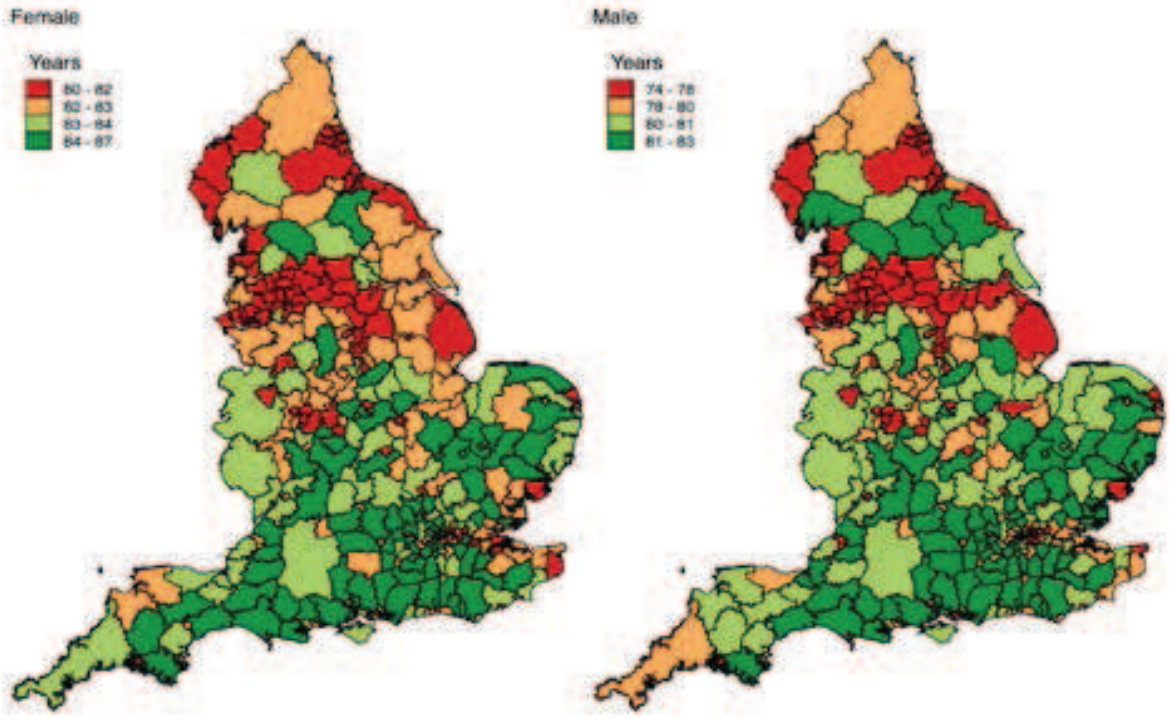
Graph shows poorer health across all neighbourhood income levels in the North, a steeper 'social gradient in health in the North, and a higher concentration of poor neighbourhoods



Years of Life lost (YLL), from deaths under the age of 75, 2008-2012 , lowess smoothed lines. Source: PHE and DCLG.

Figure 4: Life Expectancy amongst males and females by LA, 2009-2012

Map shows lower life expectancy in the North

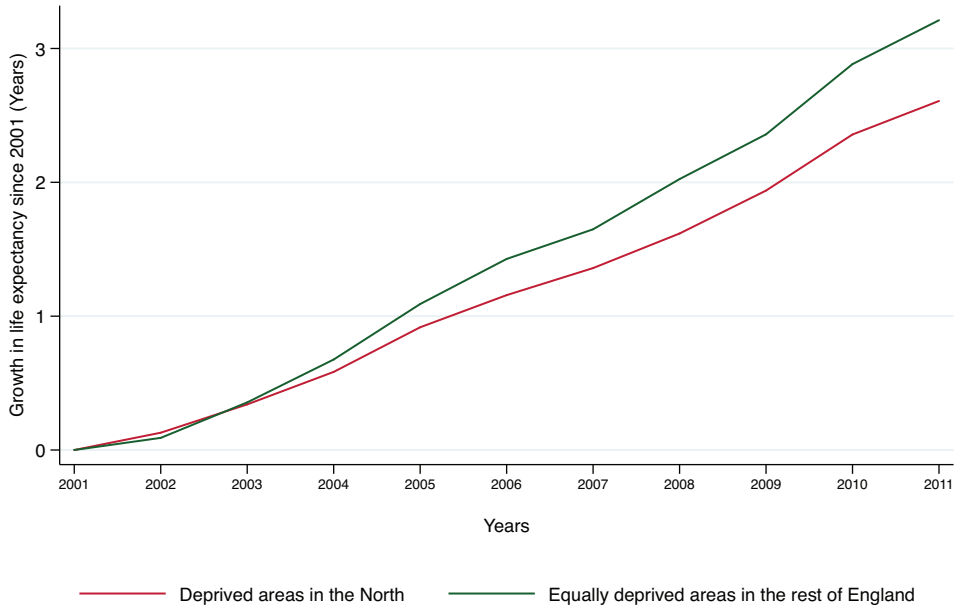


Source: HSCIC.

Between 1999 and 2010 the government pursued a systematic strategy to reduce inequalities in health in England. Although this strategy fell short of fully achieving its objectives, there are indications of some progress.[21] The gap in mortality amenable to healthcare, infant mortality, and male life expectancy, between the most and least deprived areas all reduced during this time.[22,23] Falls in inequalities in infant mortality occurred alongside large falls in child poverty (see section 3.4). A policy of allocating an increasing proportion of NHS resources to poor areas was associated with declining inequalities in mortality amenable to healthcare[23] (see section 3.6). Reductions in inequalities in male life expectancy between areas were in part explained by the large fall in unemployment in deprived areas that occurred prior to the recent economic crisis.[24] However, on average, deprived areas in the North have experienced smaller increases in life expectancy than areas with similar levels of deprivation in the rest of England (see Figure 5). In particular deprived boroughs in London experienced large increases in life expectancy over the last decade. This suggests that for some reason it has been harder to gain the same level of health improvement in deprived areas in the North as compared to deprived areas in the South. This could reflect different levels of investment or that determinants of poor health in the North are more intractable and require different approaches.

Figure 5: Trend in life expectancy in deprived areas in the North and in the rest of England

Graph shows how life expectancy has increased less for people living in deprived areas in the North compared to people living in areas with a similar level of deprivation in the rest of England.

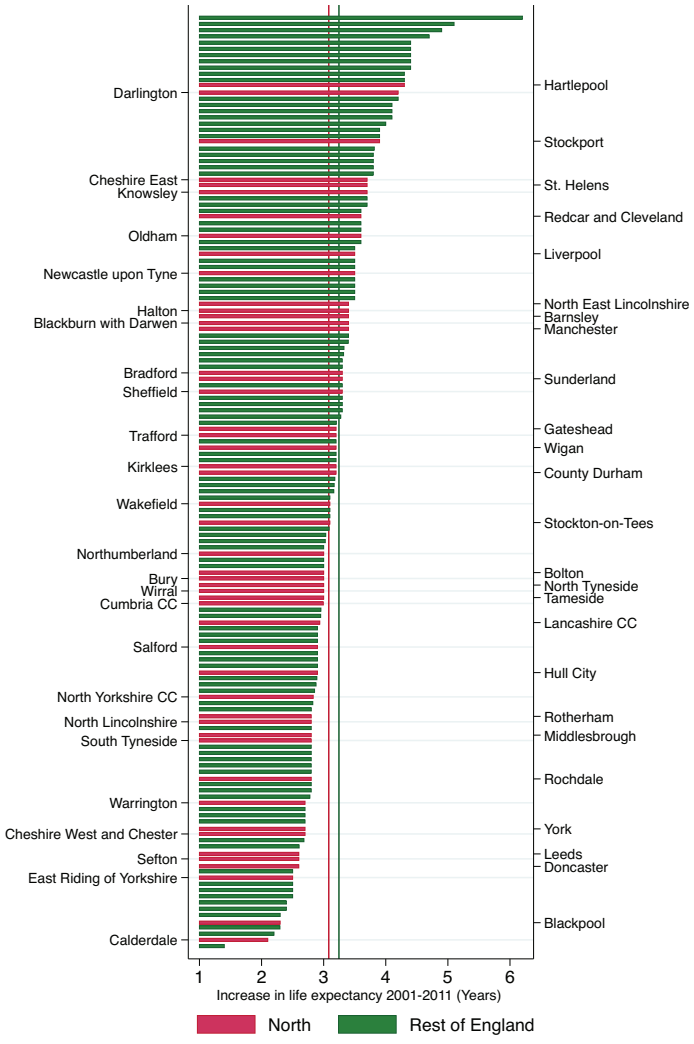


Deprived areas defined as being the 20% most deprived local authorities in England. Life expectancy calculated as weighted average for groups of local authorities. Source: HSCIC

Whilst local authorities in the North have on average experienced smaller improvements in health, these averages hide a number of exceptions to this pattern. Some of the most deprived local authorities in the North have bucked this trend (see Figure 6). Blackburn with Darwen, Halton, Hartlepool, Knowsley, Liverpool and Oldham all had some of the lowest levels of life expectancy in 2001[1] and since then they have all experienced greater improvements in life expectancy than the national average. An important question, which remains largely unanswered, is – what has enabled some areas to improve health outcomes in the face of adverse circumstances, whilst other places have struggled?

Figure 6: Increase in life expectancy between 2001 and 2011, Local Authorities in England

Graph shows how much life expectancy increased over the past decade for people living in each local authority in England.



Life expectancy calculated as average of male and female life expectancy. Source: HSCIC.

3.2 Economic development and living conditions

Disturbing trends

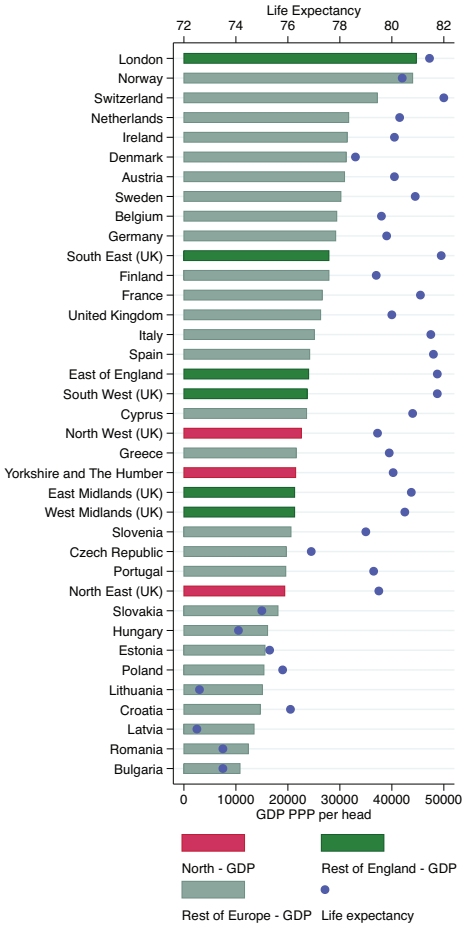
The pattern of economic growth

The difference in health between the North and the rest of England is largely explained by socio-economic differences.[20] Whilst the historical growth and subsequent decline of heavy industry in the North has had long-term adverse consequences for both the economy and for health, more recent economic policy has exacerbated this situation. Over the last decade the model of economic growth pursued in the UK has been predicated upon the accumulation of debt, low wages in many sectors, and a disproportionately large financial sector.[25] The North of England has found itself on the wrong side of policies that have privileged the accumulation of financial assets ahead of the creation of sustainable work. Economic growth in England has led to an increase in economic inequalities both between individuals and between regions, with the UK now having the largest difference in economic output between regions of any country in Europe.[25] In recent years many regional administrative structures have been dismantled, including Government Offices for the Regions, Regional Development Agencies, posts of 'Minister for the Regions' and Strategic Health Authorities. This has potentially limited the capacity of government to address English regional imbalances.[26] The economic gap between regions has widened to such an extent that they could be different countries, whilst the GDP of London is comparable to Norway, the GDP of the North East is similar to Portugal (see figure 7). Patterns of health largely mirror these economic differences. The 2008 recession, disproportionately hit areas of the North of England, particularly the North East, further widening inequalities,[27] and the economic recovery does not appear to be addressing these issues, with jobs growth concentrated in London and the South East.[28] Without a radical change in strategy the recovery is likely to repeat the mistakes of the past and further exacerbate the North-South Divide.

Without a radical change in strategy the recovery is likely to repeat the mistakes of the past and further exacerbate the North-South Divide.

Figure 7: GDP per head and life expectancy levels across the regions of England and European countries

Graph shows how GDP and life expectancy for each of the regions of England compares to countries in Europe.



Source: EUROSTAT 2010.

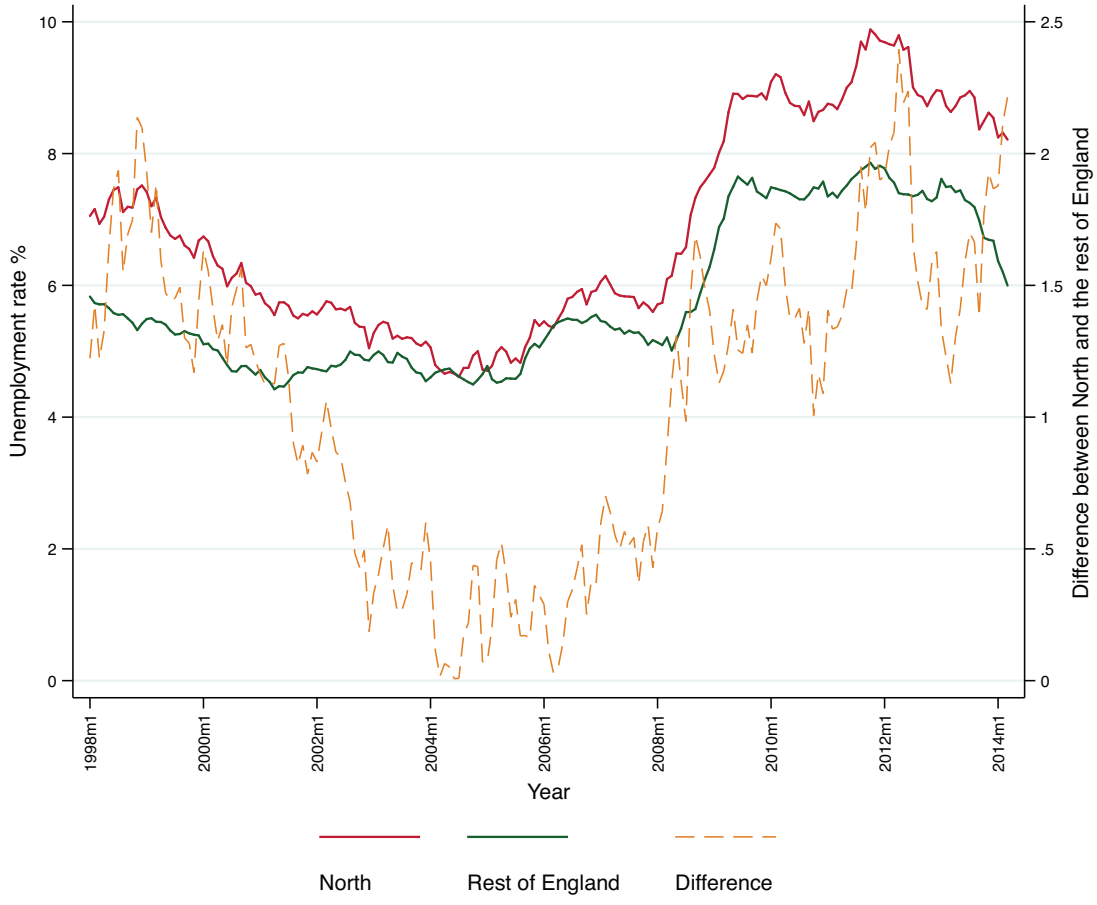
The unemployment gap between the North and the rest of England

The difference in economic growth between the North and the rest of England has had major implications for people's chances of employment. Over the past 20 years the North has consistently had lower employment rates than the South for both men and women.[29] This is associated with the lasting effects of de-industrialisation.[30] In the latter part of the 20th century, there were regionally concentrated falls in the demand for labour (most notably in the North East and North West), particularly affecting those with less education.[31] The current unemployment rate is markedly higher in the North at 9% as compared to 7% in the rest of England and a higher proportion of the working age population are not in the labour market at all (24%). This 'economic inactivity' in the North is partly caused by high levels of disability with 9% of the working age population claiming disability benefits.[32]

However some progress was made at narrowing this unemployment gap during the period of economic growth that followed the 1990's recession. The gap in the unemployment rate between the North and the rest of England was almost eliminated by 2006, with the North East experiencing the largest fall in unemployment of any region outside London. There is evidence that this helped narrow health inequalities in some areas.[24] However the onset of the economic crisis in 2008 has reversed this situation and the gap in unemployment is once again as large as it was in the 1990's (see Figure 8). One of the limitations of economic growth that is based on unsecure forms of employment is that when the inevitable financial crisis arrives, these gains rapidly disappear.

Figure 8: Unemployment rate from 1998 to 2014 in the North and the rest of England

Graph shows how the gap in unemployment between the North and the rest of England" had narrowed until the 2008 recession, when it widened again.

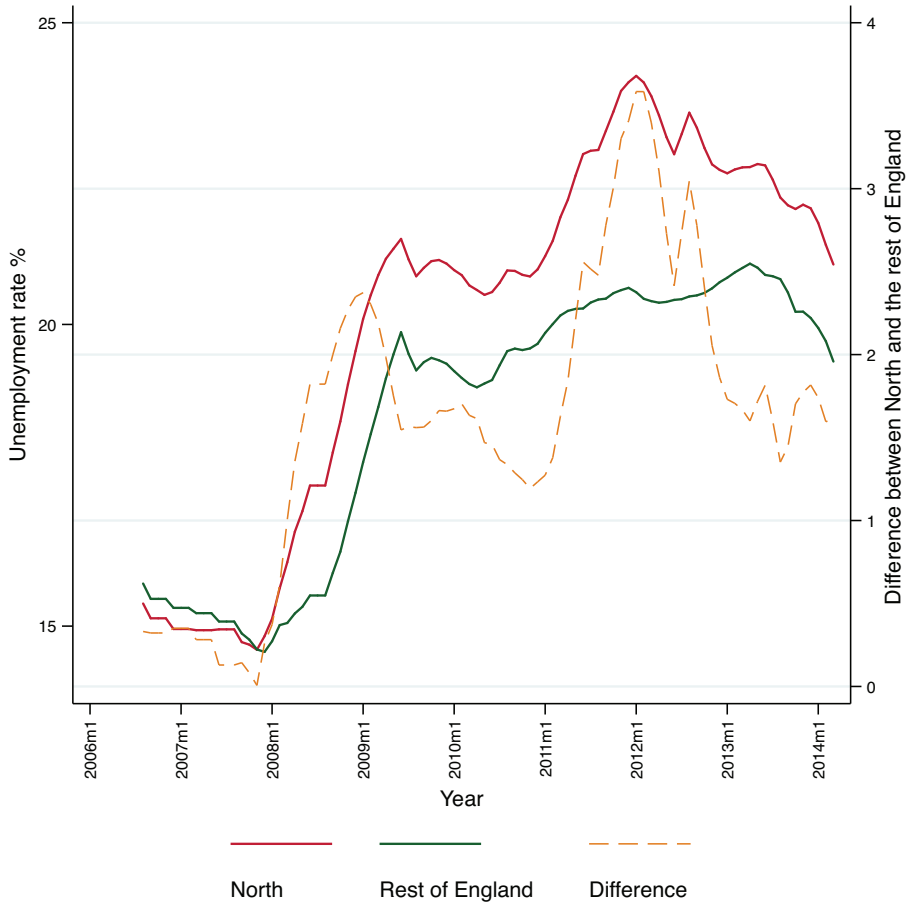


Source: ONS.

Of particular concern are the high levels of unemployment amongst young people. With the onset of the recession in 2008 youth unemployment increased rapidly. By 2011, 1 in 5 young people were out of work. The rise in youth unemployment was more severe in the North (see Figure 9). Whilst the level of unemployment amongst young people has started to fall, it is still markedly higher than its pre-recession level and the gap between the North and the rest of England remains. The current high level of youth unemployment has serious consequences and has been described as a 'Public Health Time Bomb' [33] due to the long term scarring effects it can have on health and future employment prospects.

Figure 9: Youth unemployment rate from 2007 to 2014

Graph shows how the gap in youth unemployment, between the North and the rest of England has widened since the 2008 recession.



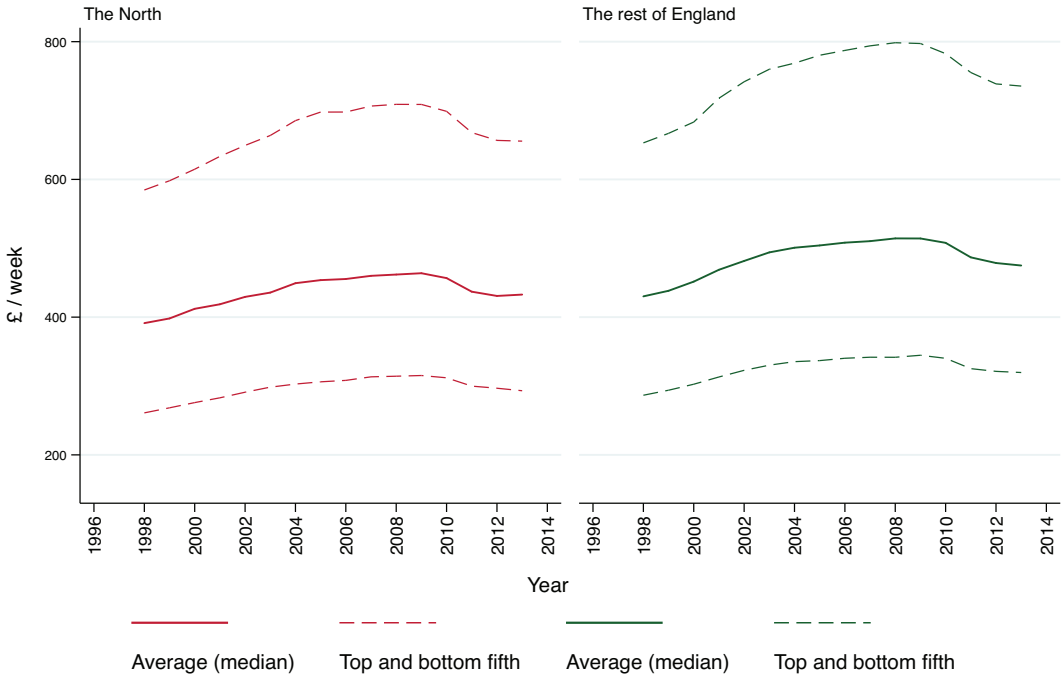
Source: ONS - 12 month moving average.

Falling wages, increasing wage inequality

For those in employment in the North wages are markedly lower and the gap between the North and South has widened. However this does not mean that families on low incomes in London and the South East have necessarily experienced greater improvements in living standards. Inequalities within all regions have increased. Figure 10 shows the trend in average wages and the wages of the top and bottom fifths in the North and in the rest of England. There has been little real terms growth in wages for people on low incomes regardless of where they live. This growth in wage inequality during a time of economic growth has been followed by a consistent fall in real wages since 2009, the longest period of declining wages for at least 50 years.

Figure 10: Growth in median weekly earnings and top and bottom fifth percentiles, 1996 to 2012

Graph shows how wages are lower in the North, inequalities have increased across the country and wages have fallen for all groups since 2009.



Source: ASHE, gross weekly wages, full time workers - adjusted for inflation using CPI. Percentiles estimated as weighted average of regional values.

The impacts of welfare reform

A number of current reforms to the welfare system have the potential to widen the gaps in prosperity between the North and the rest of England and exacerbate inequalities within the North. The biggest financial impacts are on people with disabilities - it is estimated that individuals adversely affected by the incapacity benefit reforms can expect to lose an average of £3,500 a year, and those losing out as a result of the changeover from Disability Living Allowance to Personal Independence Payments by an average of £3,000 a year.[13] Given that the number of people on these benefits in the North of England is much higher than in the rest of England, it is clear that these reforms will disproportionately affect the North. The higher reliance on benefits and tax credits in deprived areas in the North of England means that the failure to up-rate with inflation and the reductions to tax credits will also have a greater impact here.[13] The under-occupation charge or 'bedroom tax' cuts an average of £14 a week from a household with one spare room. The higher numbers of people relying on housing benefit in the North will mean that more people are affected. One survey has found that two-thirds of households affected by the bedroom tax have fallen into rent arrears since the policy was introduced in April, while one in seven families have received eviction letters and face losing their homes.[34]

Increasing poverty gap

Lower wages, higher levels of unemployment, disability and economic inactivity in the North all result in higher levels of poverty. 18% of individuals in the North East, 17% in the North West and 19% in Yorkshire and Humber are in poverty as compared to 12% in the South East.[35] Rates of poverty are higher in the North for both people in and out of work. Of particular concern for the North-South divide is that the gap in levels of poverty between the North and the rest of England is increasing, with rates of in-work poverty rising particularly rapidly in the North (see Figure 11). The rise of in-work poverty has become a major national concern, for the first time the majority of households in poverty in Britain have at least one person working. For many, work is no longer the route out of poverty, that it once was.[36] The high levels of poverty amongst those in work mean that the Government's poverty reduction strategy is unlikely to be effective, as it relies largely on people being lifted out of poverty by entering employment.[37]

The rise of in-work poverty has become a major national concern, for the first time the majority of households in poverty in Britain have at least one person working.

Figure 11: % of working age people (16-64) in out of work and in work poverty

Graph shows how the gap in poverty between the North and the rest of England is widening.

Source: HBAI. Poverty calculated as % below 60% of 2010 median income. Poverty rates are 3 year moving average - 16-64 year olds.

It is not just low incomes that contribute to poverty, low income households also have to pay the highest charges for basic utilities such as gas and electricity (the 'poverty premium'). Save the Children has calculated that this annual 'poverty premium' can amount to more than £1,280 for a typical low-income family. The poverty premium for families on a low income has increased significantly since 2007 and the cost of gas and electricity is still a major contributor to this inequity.

Food poverty is becoming an growing issue in the UK.[38] A recent report commissioned by the Government on household food security[39] concluded that organisations providing food-aid are consistently reporting increases in demand, and there was no evidence that this was the result of increased provision of food aid as had been suggested by the Work and Pensions Minister.[40] One major food bank provider has reported a 170% rise in activity in the last 12 months.[32] The primary reasons reported for this rise in use of food-aid are benefits sanctions, delays in welfare payments, crises in household income due to low wages, rising food costs and increasing household debt.[32]

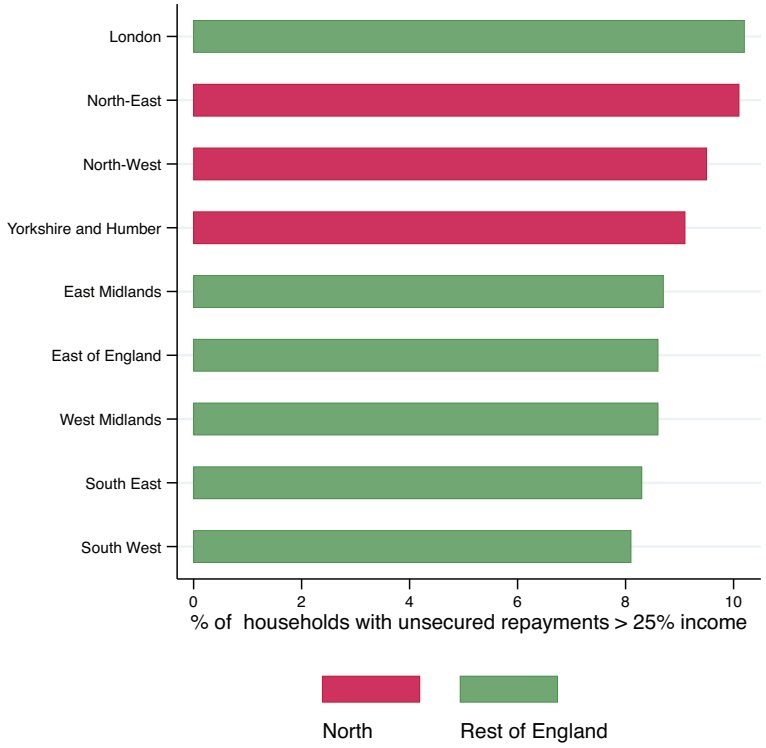
The burden of debt

The economic growth of the past decade has been fuelled by a massive growth in personal debt. Indeed it was the high risk lending to households unable to repay their debts that brought the financial system to a standstill. The level of personal debt has nearly doubled in the past decade. People in the UK now owe £1.43 trillion, an average of £54,000 per household, up from £29,000 a decade ago. Unsecured consumer debt has trebled since 1993, reaching £158 billion in 2013.[41] These debts are increasingly a problem for households on low incomes, with those on incomes of £13,500 or less having total debts worth 6 times their income.[42] Falling wages, rising food and energy costs, coupled with reductions in welfare benefits are contributing to increased financial exclusion and unsustainable debts.[43] Outside of London the Northern regions have the highest proportion of households who are spending more than 25% of their income on unsecured debts[44] (see Figure 12).

Debts are more likely to become a problem for people on low income, not just because of their inadequate income levels, but also because of the high cost of the credit services open to them such as: rent-to-own stores, doorstep lenders (home credit companies), pawnbrokers, catalogues and payday loans.

Figure 12: Percentage of households across English regions with unsecured repayments that are above 25% of their income

Graph shows how people in the northern regions have high levels of unsecured debts.



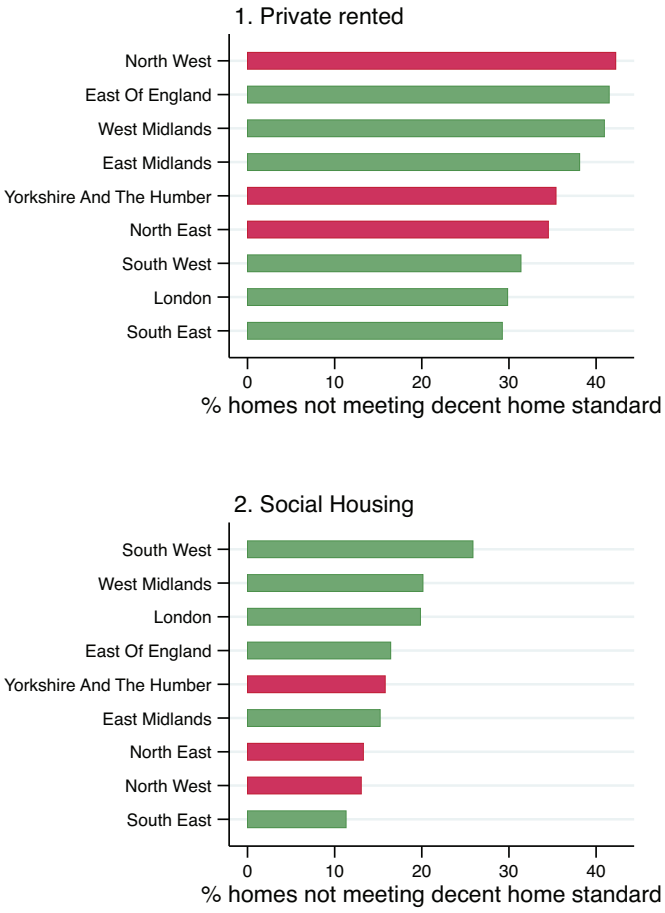
Source: Bryan, M et al. 2010 Over-Indebtedness in Great Britain.

The condition of housing and fuel poverty

Housing and neighbourhood conditions are important social determinants of health inequalities, with 26% of houses in the most deprived areas failing to meet the decent home standard, compared to 17% in the most affluent areas. There have been considerable improvements in the quality of social housing in recent years, with the North having a higher proportion of social housing that meets the decent homes standard than the rest of the country. However there remains a major issue with parts of the private rented sector particularly in poor areas. Of all tenure types it is the private rented sector which has the highest proportion of homes which do not meet the decent homes standard.[45] This is particularly an issue in the North West where over 40% of houses in the private rented sector did not meet this standard in 2011 (see Figure 13).

Figure 13: Graph showing the percentage of households not meeting decent homes standard, by region and tenure, 2012

Graph shows high levels of poor housing in the private rented sector.

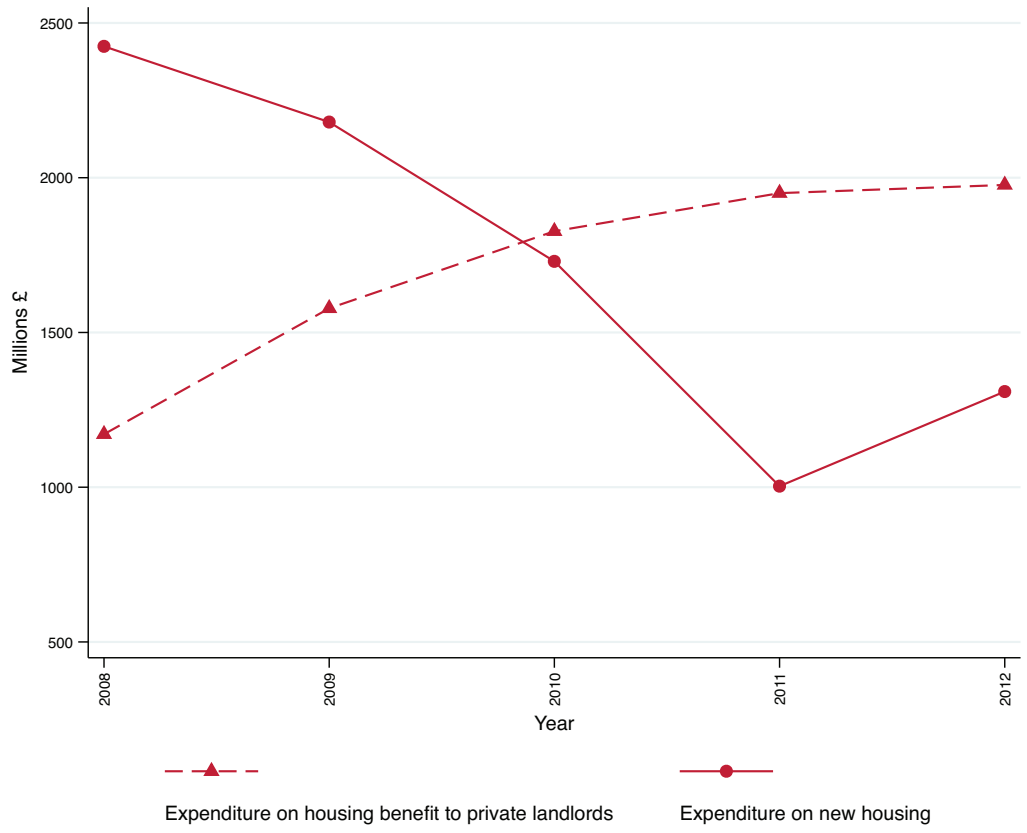


Source: English housing survey 2010

The private rented sector is also growing rapidly, increasing by 88% between 2001 and 2011.[46] This has contributed to a large increase in expenditure on housing benefits.[47] The housing benefit bill in the North of England has nearly doubled in the past 10 years from £3 billion in 2002 to £5.5 billion in 2012. The proportion of this going to private landlords increased from 10% to 15% during this time.[48] Since 2010 expenditure on housing benefits to private landlords in the North of England is now higher than the total public expenditure on building new homes (see Figure 14). It is recognised that this shift in public spending from investment in high quality affordable homes to subsidising rents in poor quality housing is not an efficient use of public resources and is not helping to address the housing problems in the North.[47] As families on low incomes increasingly have to rely on private rented accommodation, strategies to reduce health inequalities will need to implement policies that improve the quality of housing at the lower end of this sector as well as developing affordable alternatives.

Figure 14: Public expenditure on new homes and housing benefit to private landlords in the North of England 2008- 2012

Graph shows that more public funds in the North are spent on housing benefits to private landlords than on new housing.

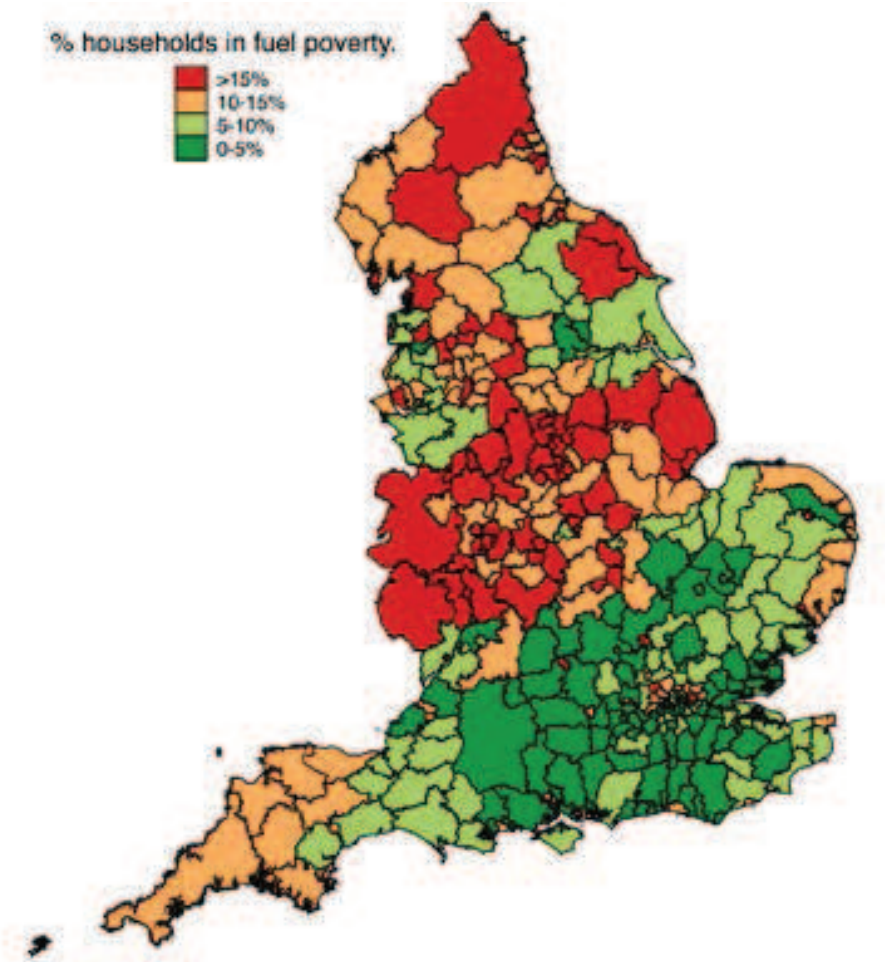


Sources: PESA and DWP.

Poor housing along with high energy bills and low incomes, all contribute to fuel poverty. In 2011, the number of fuel poor households in England was estimated at around 2.4 million, representing approximately 11 per cent of all English households.[32] The poorest tenth of households spent more than a fifth of their budget on fuel and the number of UK children living in fuel poverty has risen to 1.6 million - 130,000 more than in 2010.[32] The West Midlands, North East and North West have some of the highest levels of fuel poverty in England, whilst London and the South East have the lowest (Figure 15).

Figure 15: % of households in fuel poverty, 2012

Graph shows higher levels of fuel poverty in the North of England



Source: Department for Energy and Climate Change. Low Income High Costs (LIHC) definition of fuel poverty.

How unequal economic development and poorer living conditions contribute to health inequalities

One of the consequences of the uneven economic development in the UK has been higher unemployment, lower incomes, adverse working conditions, poorer housing, and higher debts in the North, all of which adversely impact health and increase health inequalities.

The adverse impact of unemployment on health is well established. Studies have consistently shown that unemployment increases the chances of poor health.[49] Empirical studies from the recessions of the 1980s and 1990s have shown that unemployment is associated with an increased likelihood of morbidity and mortality, with the recent recession leading to an additional 1,000 suicides in England. [50,51] The negative health experiences of unemployment are not limited to the unemployed but also extend to their families and the wider community.[52] Youth unemployment is thought to have particularly adverse long term consequences for mental and physical health across the life course. [53,54]

The high levels of chronic illness in the North also contribute to lower levels of employment. Disability and poor health are the primary reasons why people in the North are out of work, as demonstrated by the high levels of people on incapacity benefits. Strategies to reduce inequalities need to prevent people leaving work due to poor health, enable people with health problems to return to work and provide an adequate standard of living for those that cannot work.

A great deal of evidence has demonstrated an inverse relationship between income and poor health, with falls in income and increases in poverty associated with increased risk of mental and physical health problems.[55] A number of studies have shown that psychosocial conditions at work increase the risk of health problems, in particular cardiovascular conditions and mental health problems. This has been found to explain a large proportion of inequalities in health between social groups.[56–58] More precarious forms of employment including temporary contracts are also increasing and these have been associated with increased health risks.[59]

Poor housing has been shown to have numerous detrimental effects on physical and mental health. Living in fuel poverty or cold housing can adversely affect the mental and physical health of children and adults. It is estimated that this costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes [60] For infants, after taking other factors into account, living in fuel poor homes is associated with a 30% greater risk of admission to hospital or attendance at primary care facilities.[61]

People in debt are three times more likely to have a mental health problem than those not in debt, the more severe the debt more severe the health difficulties.[62] In terms of physical health, debt has been linked to a poorer self-rated physical health,[63] long term illness or disability,[62] chronic fatigue,[64] back pain,[65] higher levels of obesity and worse health and health related quality of life.[66]

What could be done differently?

A new approach is needed to prevent the causes of economic inequalities and poverty in the North of England. This needs to involve a long-term plan to transform how the £136 billion of public money that is spent in the North each year is used to promote the well-being and capabilities of people in the North. At present 40% of this money is spent on mitigating the effects of poverty and inequality through the provision of welfare benefits. Clearly the

provision of adequate welfare benefits for people who are unable to work due to unemployment, disability or old age is of central importance for reducing poverty. But over the long term, investing public resources in the development of people (e.g. in their education, skills and health) and places (e.g. in good housing and infrastructure) will be a more effective and efficient use of resources, promoting prosperity and reducing inequalities in the future. Prevention is better than treatment. Public service reform and economic development are therefore interlinked. Better public services that focus on developing people and places and preventing poverty result in a healthier, more skilled population which in turn helps to make the region prosperous, increasing the public resources available through taxation that can be invested in public services.

Investing public resources in the development of people and places will be a more effective and efficient use of resources, promoting prosperity and reducing inequalities in the future

The evidence reviewed by the panel has outlined a number of actions that have the potential to address these causes of economic inequalities and poverty that underlie health inequalities, whilst ensuring adequate social protection for those who need it. Firstly, there are actions related to national and regional economic strategy and investment. Secondly, there are approaches that could improve employment prospects. Thirdly there are actions to raise the standard of living of those people in and out of work; fourthly proposals to reduce problem debts, and finally actions to improve housing conditions. Evidence and analysis supporting actions in each of these areas is outlined below.

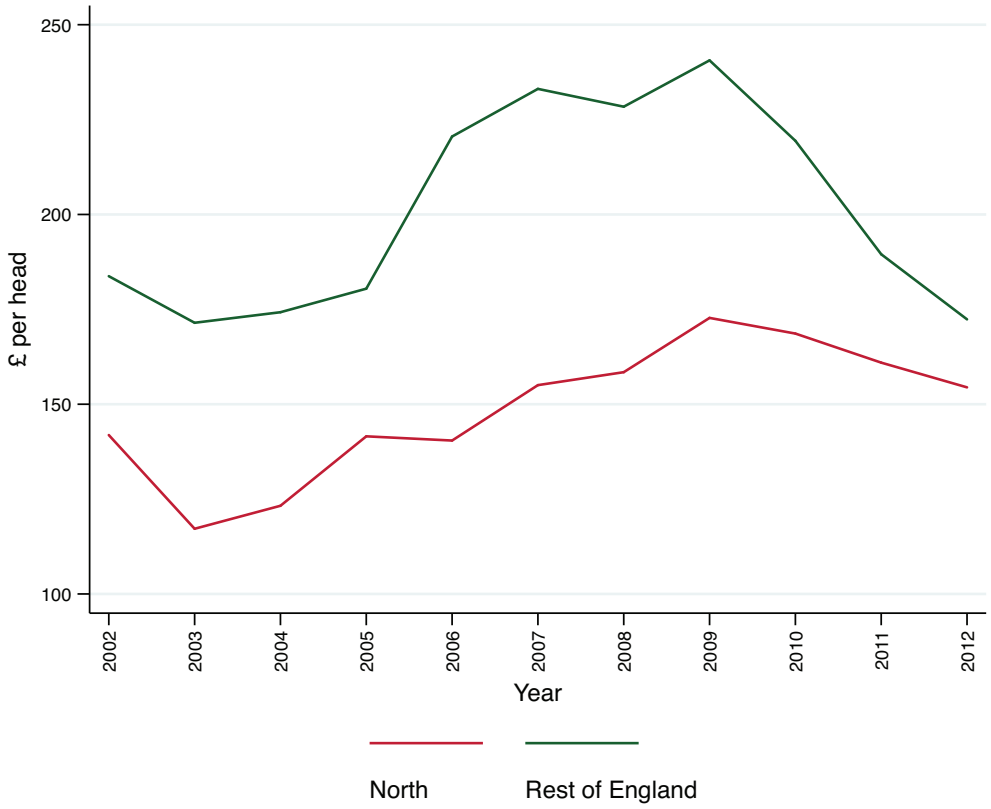
Economic strategy and investment

To address the regional imbalances in the economy of England and the inequalities within the North, the economy of the North will need to grow at a faster rate than the rest of the country, whilst ensuring the proceeds of growth are shared more equitably within the North. Growth in the North needs to be based on retaining and developing the assets of the North. This means people, skills, talent, culture, arts and the environment and not just industry. The Adonis and Heseltine reviews propose similar solutions to the regional imbalance in Britain's economy. These include greater investment in infrastructure, developing skills, investment in research, increasing investment in small to medium sized enterprises (SMEs) and crucially devolving power and resources to cities and regions. This is echoed by the early thinking of the RSA's City Growth Commission.[67] It is recognized that decisions about infrastructure, skills and investment are best made locally if they are to reflect local contexts and have a better chance of bringing a local growth dividend, reducing regional inequalities.

The UK's infrastructure is lagging behind other developed countries and this has been cited as a major barrier to economic growth in the North.[28] The North currently loses out in public investment in infrastructure, which is focused on London and the South East. For example public spending on transport per head of population is markedly lower in the North compared to the rest of England (see figure 16). The imbalances in public investment exacerbate regional economic inequalities and the North will need to secure greater public and private investment in infrastructure in order to reduce these inequalities.

Figure 16: Government capital expenditure on transport per head of population in the North and the rest of England from 2002 to 2012

Graph shows lower levels of investment in transport infrastructure in the North of England.



Adjusted for inflation using GDP deflator, Source: PESA.

Increasing investment and devolving additional resources to cities and regions so that they can invest in infrastructure, skills and business will not in itself reduce economic or health inequalities. Economic growth in the major cities in the North has tended to be characterised by increasing inequalities as it has the rest of England. To reduce economic and health inequalities these need to be embedded as a core objective of economic strategies.[25] Some industries will be better placed than others to achieve these objectives and this should guide where local and central governments intervene to promote growth.[68] Economic models that integrate social objectives are possible and increasingly being pursued through strong local leadership.

Governments are increasingly realizing that economic growth needs to be about more than just increased economic output. A number of governments, following the work of Joseph Stiglitz,[69] have begun to develop indicators of well-being, sustainability and equity as measures of economic progress, that can be used alongside more traditional measures such as GDP. However for these programmes to be effective, they must be aligned to policy-making and address inequalities as well as just monitoring average improvements in well-being.

Promoting good employment

It is crucial that economic growth generates good employment for all. An important mechanism to achieve this is to ensure that the money spent by the public sector on services in the North of England is used to achieve social benefits including a skilled and strong labour market. Procurement processes can be used for this purpose and the Social Value Act provides some mechanisms to support this.

With higher youth unemployment in the North of England, action to develop the skills and employment opportunities of young people is essential to address inequalities. Ineffective school-to-work transitions for those young people that do not go to university has been identified as a problem that is increasing youth unemployment.[28] This has led to calls for an increase in technical apprenticeships to develop the skills that are needed by employers.[28] Whilst there has been a large increase in apprenticeships in recent years, there has not been sufficient growth in the technical subjects needed by employers. The public sector has been criticized for being significantly underrepresented in apprenticeships, despite having the requisite roles.[28] The public sector remains a large employer in the North of England and should be leading the way in expanding the number of apprenticeships available in the required technical fields.

Return-to-work programmes can mitigate the health effects of unemployment as well as improve employment prospects

There is potential to build a far more integrated system locally, that joins up schools, vocational training, apprenticeships and employment support to ensure that young people are given the best chance to develop the skills they need to get a good job, particularly those young people who don't go to university. This would involve giving local areas greater control over resources administered by the Skills Funding Agency, so that they can shape further education and training provision and apprenticeships to support local economic priorities and sectors now and in the future. Public sector partners along with private sector employers can then maximise the opportunities for training through apprenticeships. Better integrating vocational training into employment support programmes such as the Work Programme would further improve employment prospects for those out of the labour market.

Current welfare reforms have been justified on the basis that they will improve financial work incentives and this will encourage more people into work. However the evidence base indicates that reducing adequacy and access to benefits is not an effective approach to help people into employment, particularly for people with disabilities, the main cause of economic inactivity in the North.[70,71] The evidence is stronger for active labour market policies such as return-to-work programmes. Research has shown that return-to-work programmes can mitigate the health effects of unemployment as well as improve employment prospects, particularly those that involve training and increased social contact and support.[72] However there is also evidence that some return to work programmes can be more harmful than unemployment on its own.[73] The evidence indicates that effective approaches use integrated case management to combine vocational training, rehabilitation and involve employers in return-to-work planning. They provide long-term, sustained and staged support for those furthest from the labour market and address underlying health issues alongside other barriers to employment.[74–77]

The Government's flagship active labour market policy, the Work Programme, has been criticized for poor performance and in particular failing people with disabilities. Only around 2-4% of the clients on disability benefits referred the programme have found work after a year, a figure that is worse than the programme it replaced.[78,79] The payment by results model of the Work Programme exacerbates inequalities, as it means that the service is more profitable for providers working in the areas with the best labour markets.[78] Several organisations have called for a localisation of return-to-work programmes[80] such as the Work Programme, which are currently centrally commissioned by the DWP. This would enable these programmes to better link with skills and training, local employers and integrated support across the public sector including the NHS: a model that better reflects the evidence base for effective approaches. An example of how such localisation might work is Greater Manchester's 'Working Well' programme, which was launched in March 2014 and will run for 5 years. It will support 5,000 Employment and Support allowance (ESA) claimants across Greater Manchester to overcome their barriers to work. Under the scheme, individuals will receive integrated and intensive support from key workers, who will coordinate public services to ensure issues which are holding claimants back from work are tackled at the right time and right order. Central government is providing 80% of the funding for the pilot, with the remaining 20% made up by the ten Greater Manchester local authorities.

Raising living standards

The evidence presented to the panel outlined a number of promising approaches to raising the standard of living of those people in and out of work on low incomes. Firstly there are approaches to extend the Living Wage. Since 2010, several local authorities, including Blackpool, Islington, Liverpool, Newcastle, Sheffield, Newport, Plymouth, Southampton, Leicester, Tower Hamlets and York have established 'Fairness Commissions' to investigate and implement ways of reducing inequality in their areas and have recommended implementing and campaigning for the payment of a Living Wage.[81] The recent report of the Living Wage Commission has concluded that bringing an additional 1 million workers up to the Living Wage is achievable by 2020. They outline a roadmap of recommendations to achieve this, including, ensuring that all directly employed public sector employees are paid a Living Wage and that the public sector considers whether contractors pay a Living Wage when procuring services.[82]

To reduce health inequalities benefits need to be set at a level that ensures health is not adversely affected.

A Living Wage even if widely implemented is however only part of the solution. Being out of work continues to carry a much higher risk of poverty than being in low-paid work. Current changes to the level of welfare benefits are being justified on the basis that they will improve financial work incentives. However to reduce health inequalities benefits need to be set at a level that ensures health is not adversely affected. The evidence-base for a Minimum Income for Healthy Living (MIHL) has established a benchmark for the level of income that enables consumption of a healthy diet, expenses related to exercise costs, as well as costs related to social integration and support networks.[55] The MIHL provides a systematic approach to setting welfare benefit levels, so that they effectively counteract poverty, improve living standards and reduce health inequalities. This led the Marmot review of health inequalities to recommend that standards for minimum income for healthy living were developed and implemented.

Reducing debt

There is a growing recognition that credit unions can have a positive influence on the financial capability and hence the well-being of their members, particularly in low-income areas.[83] They have the potential to provide more secure access to credit for people on low incomes by addressing the power imbalances between creditor and debtor that characterize the current pay-day lending market. As democratic organisations credit unions are more likely to work in the interests of their members particularly those that have poor financial capability. However a study by the DWP found that the credit union sector would need to overcome a number of weaknesses to fully realise its potential.[42] A recent report by the IPPR has proposed a strategy for overcoming these weaknesses and expanding local not-for profit institutions such as credit unions. They propose establishing an Affordable Credit Trust (ACT) – a statutory body that would expand access to affordable short-term credit provided by non-profit-making, member-owned and democratically run institutions. This would be achieved by the ACT issuing 'charters' to these institutions based on a set of minimum conditions, providing them with capital, enabling risk sharing between institutions, and monitoring and supporting their work.[42]

The case for the introduction of a cap on the cost of credit in the UK was previously explored by the Office of Fair Trading (OFT) in its review of high cost credit.[32] There is a need to limit the cost of credit to low income households through properly enforcing current legislation and potentially developing new legislation to cap either the interest rate or total cost of credit (the total amount paid, including interest and other charges such as compulsory insurance). Whilst there is concern that this would reduce credit opportunities for low income customers, who potentially would turn to illegal money lenders, research has shown that a cap on interest rates can protect low income consumers without negative impacts.[84]

Improving housing

Improving housing conditions, making homes warmer, affordable and reducing fuel poverty in the North of England would reduce health inequalities.[60] As noted above, there have been large improvements in the condition of social housing. Between 2000 and 2010 the Decent Homes Programme improved the housing condition of over a million households in social housing. Registered Social Landlords (housing associations, trusts and cooperatives) were particular effective, reducing the percentage of their non-decent homes from 21% to 8%. The majority of these homes were improved at no direct cost to the taxpayer.[85]

Between 2003 and 2011 the government implemented a Housing Market Renewal (HMR) programme to tackle problems of poor housing in areas of intense deprivation, largely in northern inner cities and towns. £2.2 billion was invested directly through the programme, and more than £1 billion additional investment came from other partners. The National Audit Office concluded that the achievements of this investment were considerable, improving the quality of the housing stock, reducing crime as well as increasing jobs and training opportunities in the implementation areas.[86] Others have criticised the HMR programme for insufficiently engaging with local communities.[47] The cessation of the HMR programme in 2011 has led a number of local authorities to look for new approaches to address underlying problems in the housing market.

Public expenditure on housing has fallen considerably since the recession and it is unlikely that this trend will reverse in the near future.[80]

Therefore new sources of finance are needed to improve housing conditions in the North of England. In Scotland Alex Salmond has called for pension fund investment in a major house building programme, and local authorities in England have begun to consider similar schemes.[87] For example in Greater Manchester the Housing Investment Board is developing new approaches to promote investment in affordable housing including using public sector land and investment from local authority pension funds.[88] There is a need for local areas to shift from 'benefits to bricks', in other words to be able to build more affordable high quality homes which would save money over the long term by reducing local housing benefit spending. This has led some to call for councils to be allowed to retain and reinvest a share of any savings achieved by local action to reduce housing benefit levels.[80] Others have highlighted that housing policy is overly centralised indicating that decentralizing funding to regional funds could enable public resources to more efficiently meet housing needs.[47]

As well as increasing the amount of affordable housing in the North there is a need to improve the condition of the private rented housing particularly at the low end of the market. This has led to a third of councils in England considering proposals for the compulsory licensing of private landlords in some areas to improve housing conditions.[89]

3.3 Development in early childhood

Disturbing trends

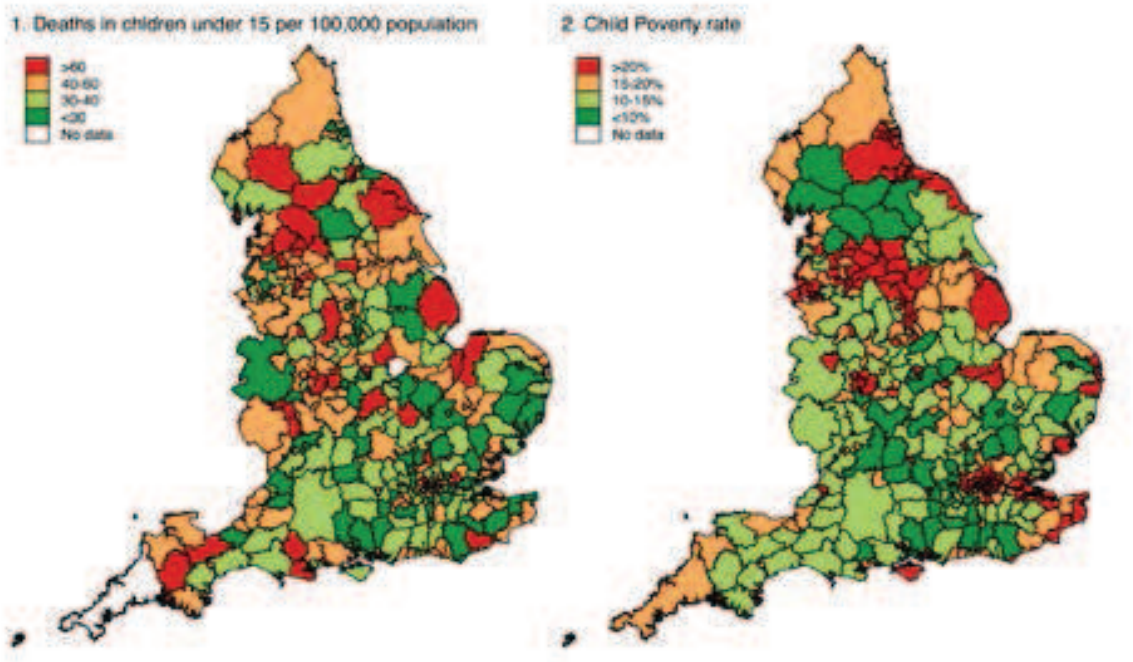
The UK has some of the worst indicators for child health and well-being of any high-income country. In 2007 a UNICEF study found that the UK had the worst levels of child well-being of any developed country and a recent study found that it had the second worst child mortality rate in Western Europe.[90,91] Within the UK the health of children is generally worse in the North, reflecting higher levels of child poverty (see Figure 17).

There is a large body of evidence demonstrating that early disadvantage tracks forward, to influence health and development trajectories in later life, and that children who start behind tend to stay behind. For example, children living in poverty and experiencing disadvantage in the UK are more likely to: die in the first year of life; be born small; be bottle fed; breathe second-hand smoke; become overweight; perform poorly at school; die in an accident; become a young parent; and as adults they are more likely to die earlier, be out of work, living in poor housing, receive inadequate wages, and report poor health.[92]

Whilst the higher levels of child poverty and disadvantage in the North of England are potentially storing up problems for the future, none of this is inevitable. Numerous reviews of evidence have

Figure 17: Child poverty rate and under 15 year old mortality per 100,000 population by local authority area in England

Map shows higher levels of child poverty and mortality in the North of England.



Sources: 1. HSCIC. 2. HMRC - Children in families receiving WTC and CTC, and income <60% median.

repeatedly shown that providing better support early in children's lives is one of the most effective approaches to reduce inequalities in life chances. As the Marmot review of health inequalities in England concluded:

'Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.'

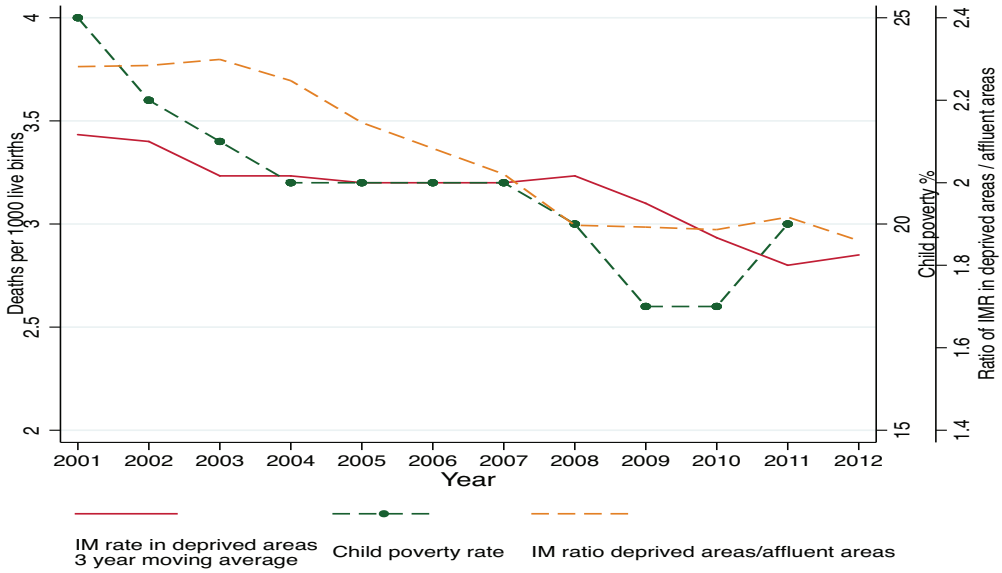
In the North of England, where large proportions of children are growing up in poverty, it is critical that action to improve early child development takes place on a scale that is proportionate to need.

Some progress has been made over the past decade; however these gains are now under threat. The UK was the first European country to systematically implement a strategy to reduce health inequalities.[93] In particular, the Government set targets to reduce inequalities in infant mortality and to cut and eventually 'eradicate' child poverty.[94] In order to address these targets a raft of well-funded policies were implemented including changes to the tax and benefits system that led to a reduction in child poverty and the establishment of Sure Start centres, which aimed to reduce child poverty through the targeted provision of pre-school education. Child poverty did reduce dramatically and inequalities in infant mortality also fell during this time (see Figure 18). However we are now seeing signs that these achievements are being undone.[95] For the first time in more than 17 years, child poverty in the United Kingdom increased in absolute terms in 2011 and the reduction in inequalities in infant mortality ceased with the onset of the financial crisis in 2008. The Social Mobility and Child Poverty Commission has estimated that by 2020 3.5 million children will be in absolute poverty, about 5 times the number needed to meet the Government's legal obligation to end child poverty.[96]

For the first time in more than 17 years, child poverty in the United Kingdom increased in absolute terms in 2011

Figure 18: Reduction in inequalities in Infant Mortality (IM) and child poverty from 2001 to 2008, and trends following recession to 2012

Graph shows reduction in inequalities in infant mortality and child poverty



Source: 1. HSCIC. 2. HBAI, poverty rate defined as 60% of 2010 median income.

Recent analyses of austerity policies in the UK suggest that children are amongst the groups being hit hardest.[97] A number of the changes to the welfare and benefits system have been detrimental to children, including the abolition of the education maintenance allowance, health in pregnancy grants and child trust funds, the freezing of child benefit, the removal of working tax credit from couples working 16–24 hours, and the failure to uprate child tax credit with inflation.[79] Spending on children's centres has fallen by 28%, 580 children's centres have closed and local government spending on early childhood development programmes has fallen by £28 per person.[98] The largest cuts to children's services are however yet to come, with a number of councils in the North of England announcing further drastic cuts to children's centres, following the 2015/16 local government finance settlement. For instance Liverpool City Council announced proposals to cut the children's centre budget by 70%, reducing the number of centres from 27 down to 3. Sheffield's 36 Children's Centres are being re-organised into 17 hub centres and Rotherham Council has proposed to close 13 of its 22 Children's Centres.[98] This level of disinvestment from support for early years interventions is likely to increase health inequalities and the gap in health outcomes between the North and the rest of England.

How insufficient investment in early child development contributes to health inequalities

The benefits of investing in the early years are well demonstrated. Investing in improving the life chances of children in the North of England will reduce inequalities in the North and between the North and the rest of England. Disinvesting in children will increase these inequalities. The repercussions of not providing high quality support early in children's lives are severe, not just for the health of children, but also for the sustainability of public services in the future. Tackling many of life's inequalities at the earliest age yields improvements across the life-course, which in turn can result in large financial savings.[99] The Nobel Prize-winning economist James Heckman has set out a compelling economic case that shows that the rate of economic return on early year's investment is significantly higher than for any other stage in the education system. Heckman states that investment in the early years is 'a rare public policy initiative that promotes fairness and social justice and at the same time promotes productivity in the economy and in society at large'[100] Shifting resources significantly to support the early years of life has the potential to not only impact on the health divide but also could help reduce the economic divide as well.

What could be done differently?

Children are often not in a position to speak out for themselves and for this reason are offered special protection under the UN charter on human rights. The arguments are not just about the evidence, but also that investing in children is morally and legally the right thing to do. A rights-based approach to addressing inequalities in the health and well-being of children has the potential to engender a new commitment to investment in the early years.

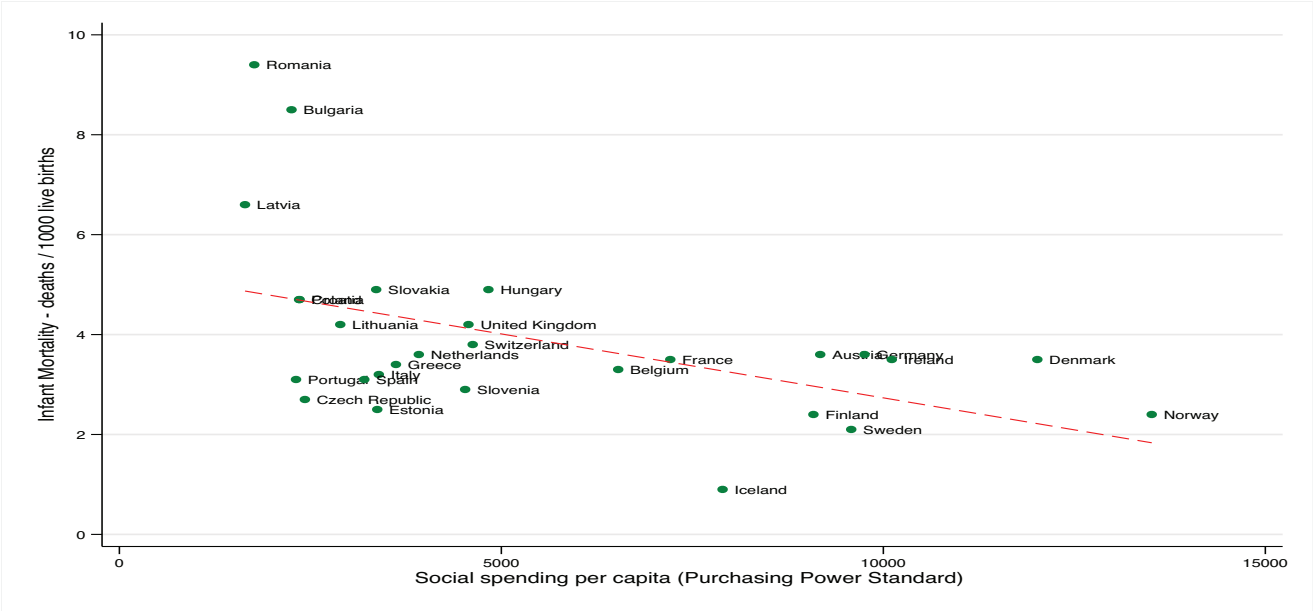
Actions to promote healthy development in early childhood need to address the immediate issue of children living in poverty today, whilst investing in the early years to prevent poverty in the future. This requires two strands of action. Firstly, a universal system of welfare support is needed that prioritises children, in order to eliminate child poverty. Secondly, universal early years education, childcare and integrated neighbourhood support for early child development is needed to break the link between parental poverty and a child's life chances.

Well-developed social protection systems result in better outcomes for children and protect them against shocks such as economic crises.

Well-developed social protection systems result in better outcomes for children and protect them against shocks such as economic crises.[101,102] Those countries in Europe that do have more adequate social protection experience better child health outcomes (see Figure 19). The recent analysis of the Social Mobility and Child Poverty Commission has shown that the Government's current strategy for reducing child poverty is not credible. They conclude that 'hitting the relative poverty target through improved parental employment outcomes alone is impossible' and recommend that increases in parental employment and wages are supplemented by additional financial support for families.

Figure 19: Social welfare spending on families and children and infant mortality in 27 EU countries - 2011

Graph shows how greater levels of social spending are associated with improved child health.



Source: EUROSTAT.

Income transfers alone, however, are not a sustainable approach to reduce poverty and inequalities in child health.[103] A system of high quality universal early years child care and education support is also necessary. In Nordic countries the links between a child's life chances and that of their parents are weaker than in other developed countries. One reason for this is the provision of universal and high-quality early years intervention and support, which can have a powerful equalising effect.[104]

There is a great deal of agreement that providing good quality universal early years education and childcare proportionately across the gradient would effectively reduce inequalities. Providing any education is not enough, since it is the quality of preschool learning that appears to be critical for longer-term beneficial effects.[105]

Considerable progress has been made over the past 2 decades at increasing the level of public investment in early years childcare and education. Current levels of free entitlement benefit almost all families with young children and the evidence indicates that this is making the most difference to children from disadvantaged backgrounds.[106] Families are currently entitled to 15 hours of pre-school childcare for 3-4 years old, 38 weeks a year. The current Coalition Government has extended this to 2 year olds for the most deprived 20% of families and this will be widened to the most deprived 40% of families from September 2014. However this offer is restricted and will still limit parent's employment opportunities. A universal entitlement ensures that all families have a stake in childcare provision, this engenders popular support for childcare and promotes sustainability. Analysis indicates that extending the universal free entitlement of early years child care and education to 15 hours a week for 48 weeks per year, for all children from the age of

two until they enter school, and guaranteeing an additional 20 hours of subsidised childcare a week for working parents, would increase maternal employment and improve child development.[106] Analysis by IPPR indicates that with government subsidising 95% of the costs of these additional hours for families on Universal Credit and 30% for other families, this extension of early years provision could be affordable through changes to the marriage tax allowance, child benefit and tax relief on pensions.[106]

This needs to be supported by routine support to families through parenting programmes, key workers, and children's centres with integrated health and care services and outreach into communities.[107] The evidence base for these early interventions is strong, and has been extensively reviewed elsewhere.[108,109] It is vital that these interventions are sustained over the long term and supported by sufficient investment. As the review of child poverty by Frank Field has recommended government should be gradually moving funding to the early years and this should be weighted to the most disadvantaged areas.[103]

3.4 Devolution and democratic renewal

Disturbing trends

Amatya Sen, the Nobel prize winning economist has concluded that a fundamental cause of inequalities in health is the relative lack of control and powerlessness of less privileged groups.[110] According to the Marmot review of health inequalities in England[55], strategies to reduce health inequalities should 'create the conditions for people to take control over their lives...the review puts empowerment of individuals and communities at the centre of actions to reduce health inequalities.'

People need to have resources in order to have control over the environment in which they live and the decisions that affect them. So the proposals outlined to tackle poverty and economic inequality, fairly distribute resources and invest in early child development are all essential to promote greater control. Ensuring that all people have adequate resources to participate in society is good for society as a whole not just those who are disadvantaged. More equal societies work better for everyone, whatever their social position.[111]

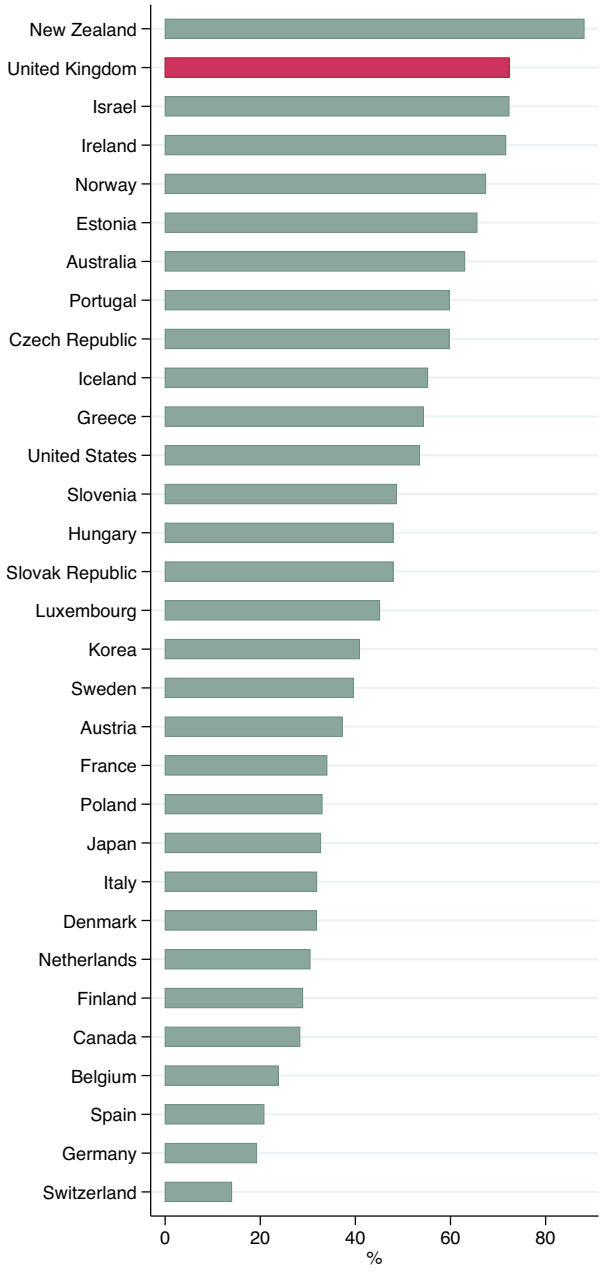
How resources are used, and how fairly they are distributed depends in part on the control and influence of different social groups. Those societies that have stronger democratic institutions, where disadvantaged groups have more control and influence tend to have fairer distribution of resources. Addressing the inequalities in power and resources that underlie health inequalities involves influencing those who have the power to make a difference and increasing the power of those who are powerless.

Devolution and democratic renewal are therefore central for addressing health inequalities within the North and between the North and the rest of England. Devolution means regions in the North retaining more power and resources to collectively develop solutions that build on the assets and resilience of the North. Democratic renewal means people in the North having greater influence over how resources are used and the decisions that affect their lives. Democracy is not just about voting. Although representation is important, increasing the influence people have also requires greater participation (direct mechanisms through which citizens can influence decision making) and deliberation (developing decisions through public debate and reasoning of the alternatives and their consequences).

The UK has one of the most centralised political systems in the OECD.[112] Figure 20 shows the proportion of government expenditure in each OCED country that is controlled by central government, rather than sub-national levels of government. In more centralised countries political institutions may appear unrepresentative and distant. European countries that have stronger local government tend to have higher turnout in elections,[113] potentially reflecting that government is more in touch with the day-to-day problems that people face.[114]

Figure 20: Proportion of total government expenditure controlled by central government, OECD countries, in 2009

Graph shows how the UK has one of the most centralised governments in the OECD.



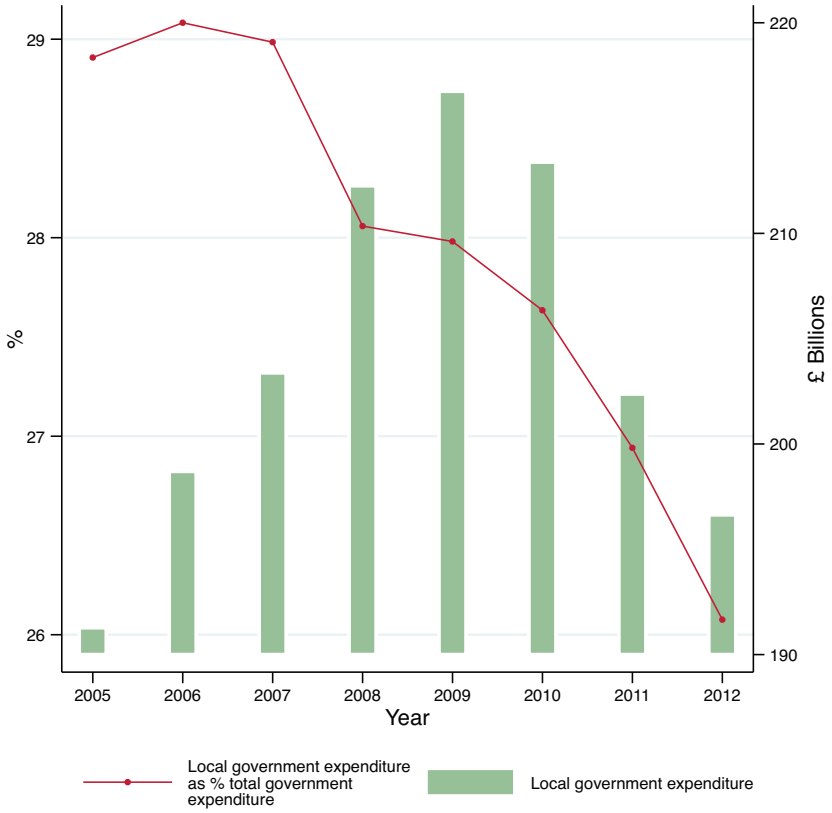
Source: OECD-Government at a Glance 2011.

Whilst both the current and previous governments have promoted localism, the rhetoric of public policy is often different from the reality. Government in the UK continues to become more centralized. Local government expenditure as a proportion of total public expenditure has been declining for a number of years and recent austerity measures are exacerbating this (see Figure 21).[115] Since 2010 local government has received some of the largest cuts to their budgets an average reduction of around 33%, compared to a 12% reduction in other government departments.[116] (see Figure 21).

The centralised nature of government in the UK limits the capacity for local governments and regions in the North to take action to really make a difference to people's life chances. For example, of the £22bn public funds spent in Greater Manchester each year, central government controls how £16bn is spent and has significant influence on the rest. Localism and democratic engagement are therefore closely related; where power and resources are actually devolved to local areas, this has the potential to enhance the influence people have over the way their communities are run. But this will only be the case if devolution of power and resources to local administrations is accompanied by greater public participation in local decision-making.

Figure 21: Local government expenditure in England from 2005 to 2012, and local government expenditure as a % of total government expenditure

Graph shows the decline in public resources controlled by Local Government since 2005 and how this is exacerbated by cuts in council budgets.



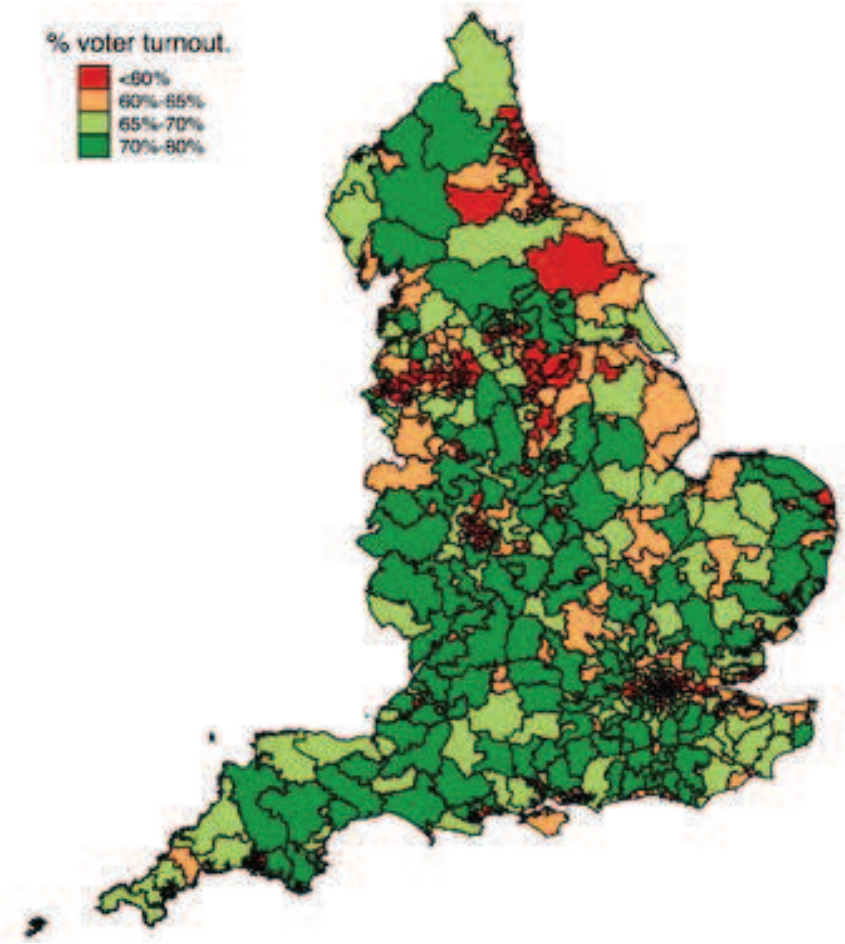
Source: OECD Fiscal decentralistaion database, adjusted to 2012 prices using GDP deflator

It is well recognized that democratic engagement in the UK, as in many other 'wealthy' countries has declined in recent years. But this decline is not being experienced equally across all social groups. The decline in political engagement is occurring at a faster rate in more disadvantaged groups. Political inequality and economic inequality are interrelated and the declining influence of disadvantaged groups on public policy exacerbates inequalities. For example a recent report has shown that it is those who are most disengaged from the democratic process (and do not vote) who are being hit hardest through current changes to welfare policy in the UK.[117]

The pattern of voter turnout in England closely mirrors patterns of poverty and poor health (see Figure 22). Whilst this is only a sign of democratic disengagement it means that people living in disadvantaged places lack influence over whether and how public resources and community assets are used to improve their health.

Figure 22: Voter turnout by parliamentary constituency in the 2010 General Election

The North South Democratic Divide. Map shows the lower levels of voter turnout in poorer areas in the North of England.

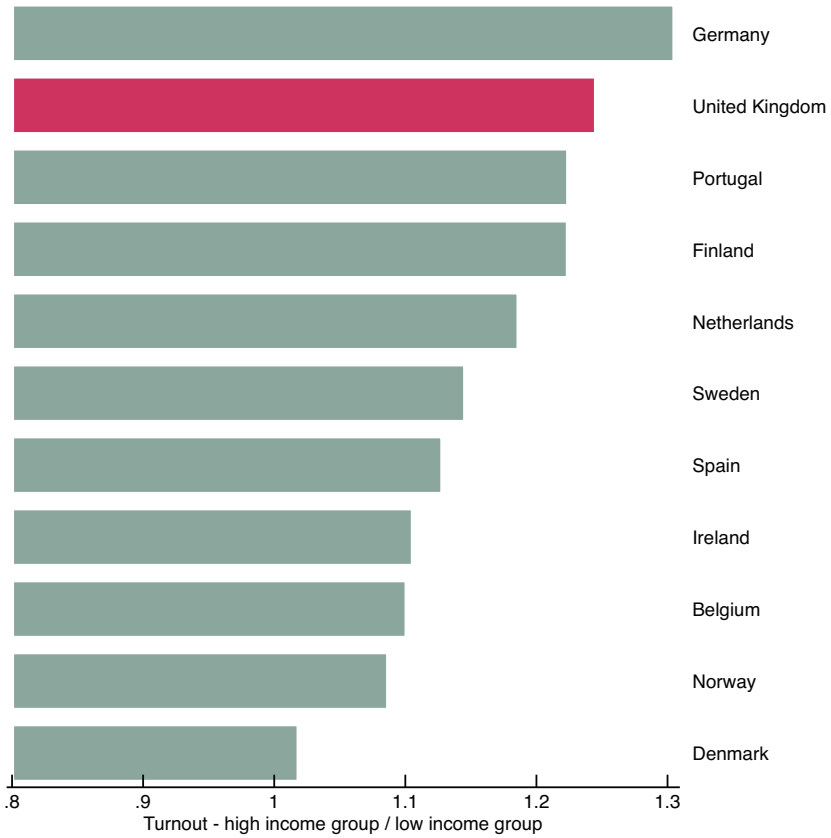


Source: Electoral Commission.

Inequalities in democratic participation are greater in the UK than many other European countries (Figure 23). A number of other measures of democratic engagement (signing a petition, discussing politics, expressing views to an elected representative, attending political meetings) are also lower in more disadvantaged groups and people living in deprived areas are less likely to report that they can influence decisions affecting their local area.[117,118]

Figure 23: Voter turnout in high income groups relative to low income group in selected European countries – most recent election before 2012

Graph shows high inequalities in voter turnout in the UK. Ratio of the voter turnout in high income group relative to low income group.



Source: European Social Survey, 2012 – Wave 6. Includes all EU15 countries participating in the Survey. Low income - bottom quintile, high income - top quintile. Question: 'Did you vote at the last national election?'" "Does not include those who were ineligible to vote at last election.

How the lack of influence and democratic engagement contributes to health inequalities

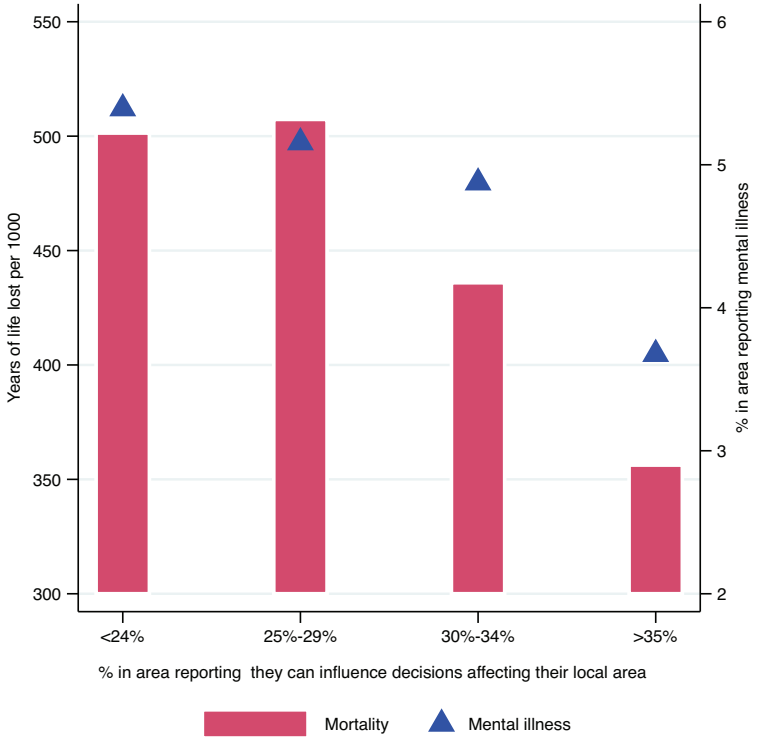
There are three ways through which levels of community control and democratic engagement have an impact on health. Firstly those who have less influence are less able to affect the use of public resources to improve their health and well-being. For example the Northern regions have had limited collective influence over how resources and assets are used in the North of England and this has potentially hindered action on health inequalities. Secondly the process of getting involved, together with others, in influencing decisions, builds social capital that leads to health benefits. Thirdly, where people feel they can influence and control their living environment, this in itself is likely to have psychological benefits and reduce the adverse health effects of stress.[118]

There is a growing body of evidence indicating that greater community control leads to better health. Low levels of control are associated with poor mental and physical health.[57,119–122] A number of studies have found that the strength of democracy in a country is associated with better population health and lower inequalities.[118,123–126] Countries with long-term social-democratic governments tend to have more developed preventive health services.[127] US states with higher political participation amongst the poor have more adequate social welfare programmes, lower mortality rates and less disability.[128,129] There is evidence indicating that the democratic participation of women is particularly important for the health of the whole population.[130–135]

When community members act together to achieve common goals there are indirect benefits resulting from improved social support and supportive networks which can reduce social isolation and nurture a sense of community, trust and community competence.[136] Research indicates that community empowerment initiatives can produce positive outcomes for the individuals directly involved including: improved health, self-efficacy, self-esteem, social networks, community cohesion and improved access to education leading to increased skills and paid employment.[136] Figure 24 shows the level of mortality and mental illness amongst the 65 most deprived local authorities in England divided into 4 groups based on the proportion of the population reporting that they can influence decisions in their local area. As the level of influence increases, the average level of premature mortality and prevalence of mental illness in the area declines.

Figure 24: Average levels of mortality and mental illness split amongst four graded groups of deprived local authority areas

Graph shows that health is better in poor areas where people have more control.



20% most deprived local authorities. Sources: 1. Place Survey (2008). 2.Annual population survey (2007-2009) 3.HSCIC (2007-2009)

Concerns have been raised that devolving power to local areas, particularly where they are given greater freedom to raise funds through taxation and develop divergent systems of welfare (in health, education, housing and social protection for example), could disadvantage economically under-developed areas and result in differences between areas in the level of welfare provision. However there is limited empirical evidence to support these concerns. Regional devolution in some countries has resulted in a decline rather than an increase in inequalities between regions.[137] However this has tended to occur in countries where there are strong popular movements demanding devolution, and devolution has occurred alongside greater democratic accountability at the regional level. It has been suggested that the greater dispersal of power in more devolved systems has actually helped prevent some of the reductions in welfare provision that are being experienced in many countries.[138]

The evidence presented to the panel therefore supports the conclusions of the Marmot review of health inequalities in England that the empowerment of individuals and communities should be at the centre of actions to reduce health inequalities. Policies that enhance the democratic engagement and collective influence of the North as a whole and of the communities within the North will contribute to reducing health inequalities.

What could be done differently?

England's eight largest cities outside London, five of which are in the North, recently launched a major national campaign demanding more power over how they spend their money.[139] Northern local authorities are strengthening their ability to work together and are lobbying government for greater devolution of powers and responsibilities. The Greater Manchester Combined Authority is looking for a deal with the Government that would give it greater control over significant blocks of funding, enabling it to implement a programme of economic development and public service reform that aims to eliminate, by 2020, the current gap between spending on public services in Greater Manchester and the tax generated in the area.[140] The referendum on Scottish Independence is adding momentum to these demands for greater devolution for the North of England[141] and the economic development strategies of both the Government and the opposition are also strongly focused on devolving power and resources to city and county regions (see section 4.3).

In the past, a barrier to effective action on health inequalities has been that centrally imposed constraints on services and the use of different budgets has prevented joint working across the determinants of health inequalities (e.g. education, training, employment, health, social care, and housing). For local communities and organisations to effectively shape services in an area, sufficient resources need to be controlled locally and there needs to be greater flexibility for all public service organisations to be able to co-design services, share budgets, systems of management and governance. The previous Government's 'Total Place' programme, which has been taken forward in the coalition's 'Community Budget' programme, is an approach to address this issue. This could be extended further with budgets allocated over longer time scales to enable organisations to work with local communities and develop sustainable new approaches for integrated public services. This approach to public service reform that provides the right support at the right time, reflecting how people live their lives, rather than the organisational boundaries of public services, is needed to prevent poverty and inequalities. When people develop chronic illness, for example, integrated support across agencies to keep people in employment and maintain financial security can help prevent a downward spiral of poverty and poor health that exacerbates inequalities.

Present strategies for devolution and integration, however, say very little about how they will address inequalities or enhance democratic accountability. The international evidence[137] indicates that devolution can lead to greater public investment in welfare systems, but only if it occurs alongside greater democratic accountability at the regional level. Proposals for devolution need to develop democratic mechanisms that enhance the capacity for communities, organisations and enterprises across the North to work collectively to address inequalities. Strategies to enhance community control need to start with the issues that people face on a day-to-day basis and the services they use. The decentralisation of budgets and services could significantly enhance local democratic engagement as long as this happens alongside an expansion of the influence that local communities have over how these resources are used.

Participatory Budgeting (PB) provides a promising approach that could support this. Whilst there have been a number of small PB projects in the UK, this would need to be carried out on a large scale involving a significant proportion of public resources if it is to be effective. It needs to involve the widespread participation of residents in the deliberation and agreement of local budgets. In

Latin American Countries, PB is now used as a mainstream mechanism to allocate a significant proportion of the budget of over 1,000 local authorities, with 43% of the population in Brazil now living in municipalities with Participatory Budgets.[142,143] The evaluation of the 5 PB pilots in the UK found that the introduction of PB increased turnout in elections, improved social cohesion, attracted additional funds into deprived areas, and improved the self-confidence of individuals and organisations.[144] International evidence shows that PB can produce more equitable public spending.[145] Although a National Strategy for PB was published in 2008 with the stated aim that PB should be used in every local authority area by 2012, there has been little progress in expanding the use of PB in recent years.[146]

Approaches to enhance the power and control that people have over the institutions that affect their lives have tended to focus on the people themselves. However it is often the institutions that are limiting the influence that people have. The institutions (for example government, councils and providers of services) need to change to enable people to participate in, negotiate with, influence, control, and hold them to account. There is evidence indicating that where the public are involved in and have some control over services this improves their uptake and effectiveness. Community-owned social housing for example has been found to perform better than local-authority managed housing in terms of both the quality of services and community cohesion.[136] A number of national policies have been introduced in recent years that aim to enable communities to take over public services and assets. These will only enhance community control and reduce inequalities, however, if resources are invested to enable disadvantaged communities to take on this role and if these assets are transferred to truly democratic organisations. Mutuals, cooperatives and similar types of organisations, where people using the services have a voice in their operation, have the potential to increase genuine participation of disadvantaged groups in the provision of services.[147]

Whilst it is perhaps more important that public institutions change to enable greater participation, people do also need the skills and resources to be able to engage and influence public services. There is evidence indicating the important components of effective community engagement. Guidance issued by the National Institute of Health and Clinical excellence highlights a number of elements that should be included in approaches that seek to increase levels of engagement. These include building on established networks to recruit individuals from the local community and investing in a process of training and action to engage them with community members to influence the planning and delivery of services. It is also important to ensure that mechanisms are in place to adequately reward people for participating.[148]

3.5 The role of the health sector

Promising and disturbing trends

Whilst the focus of this inquiry has been to develop policies that have an impact on the social determinants of health inequalities, health care systems also have an important role to play. In most international comparisons the NHS is rated favourably compared to other countries, particularly in terms of equity of access and strength of primary care[149] Whilst socioeconomic inequalities in access to healthcare do exist in England, the assessment of the Panel was that these were unlikely to account for the size and nature of the differences in health status that exist between the North and the rest of England. International evidence suggests that health services have made a valuable, if modest, contribution to recent declines in mortality in England and other countries. Estimates indicate that improvements in health care account for between 15% to 25% of these declines in mortality, the rest being explained by factors outside the health service.[150]

Timely appropriate access to high quality care is more effective at preventing deaths from some health conditions (for example heart disease), than others (such as accidents). Mortality that could be preventable through action by the health service is referred to as 'mortality amenable to health care'. The risk of dying from these conditions is increased by factors outside the health service, such as the circumstances in which people live and work, but this risk can be ameliorated through high quality health care. Figure 25 shows the pattern of mortality from these 'amenable' causes across England in 2012.

The North continues to experience higher rates of mortality amenable to health care than the rest of England, with the deprived areas within the North of England experiencing some of the highest levels in the country.

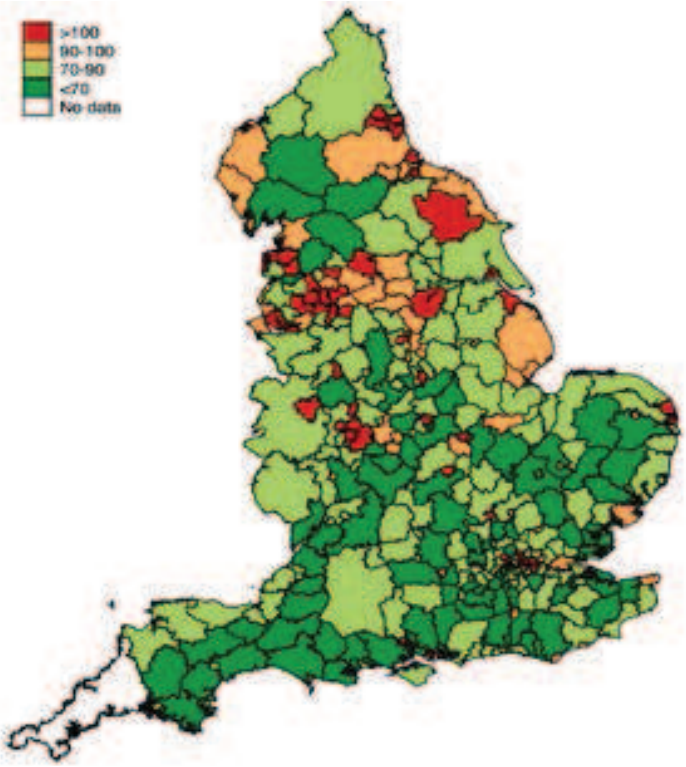
Mortality amenable to health care has been falling dramatically in recent years. This is explained by a number of different factors. These include reductions in risk factors such as smoking, increased investment in health care, and improvements in treatment. The NHS has implemented a wide range of quality improvement initiatives since the 1990s, including the establishment of the National Institute for Health and Care Excellence (NICE), the introduction of more robust clinical governance arrangements, expanding use of information technology, issuing national service frameworks for chronic conditions, and pioneering financial and reputational incentives for providers. These have contributed to rapid improvements in quality of care, particularly in primary care.[151]

The NHS is rated favourably compared to other countries, particularly in terms of equity of access and strength of primary care.

In England, these improvements in amenable mortality have been greatest in the more deprived parts of the country,[23] as a result of which the mortality gap between local authorities in the North and those in the rest of England has narrowed slightly over the past decade, particularly for men (see figure 26). A number of countries have experienced similar declines in absolute inequalities in mortality amenable to health care. This led Mackenbach (2003) to conclude that 'The introduction of effective medical care, aided by perhaps not a perfect but a nonetheless very considerable degree of access to health care for the lower socio-economic groups, has caused mortality differences to narrow, at least in absolute terms'[152]

Figure 25: The pattern of mortality amenable to health care across England in 2012

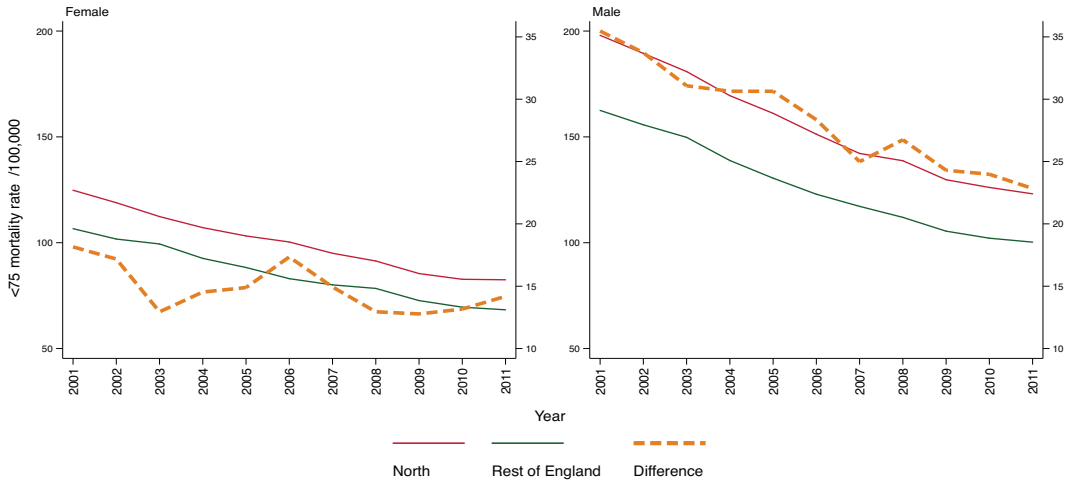
Map shows higher levels of mortality amenable to healthcare in the North.



Source: HSCIC.

Figure 26: Trend in mortality amenable to healthcare in the North and the rest of England

Graph shows how the mortality gap from causes amenable to health care between the North and rest of England has reduced.



Source: HSCIC. Population weighted averages of local authority rates

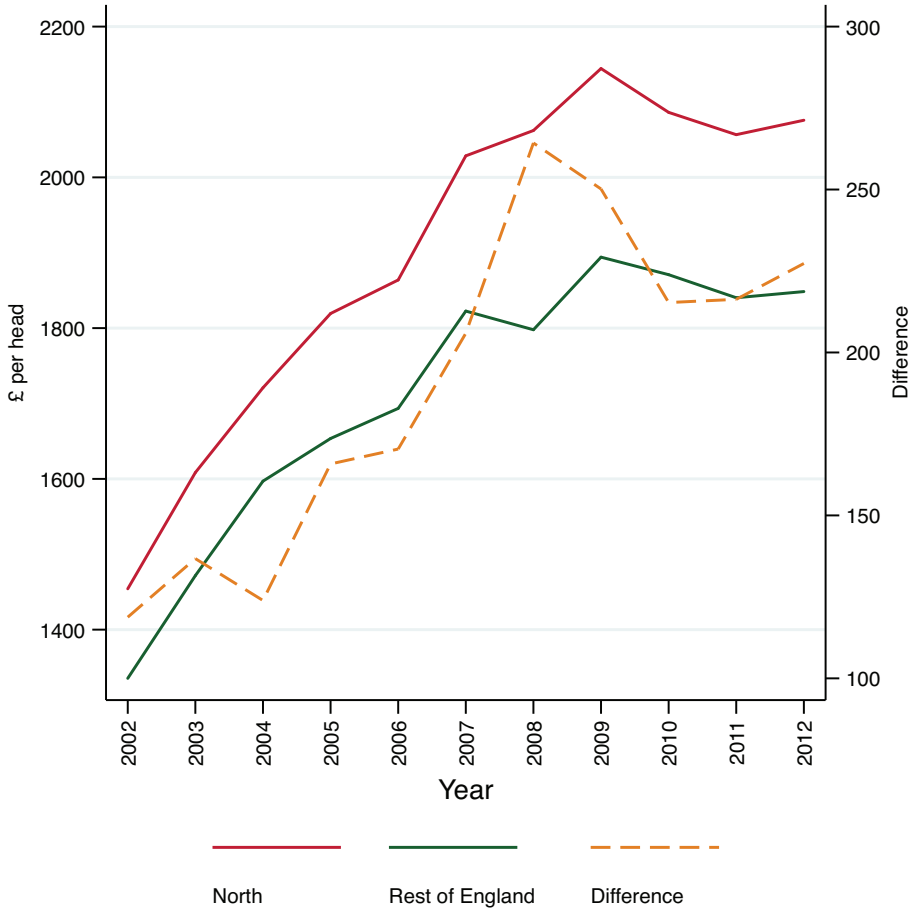
How the NHS has contributed to action on health inequalities

The NHS can influence health inequalities through three main areas of activity. Firstly by providing equitable high quality health care, secondly by directly influencing the social determinants of health through procurement and as an employer, and thirdly as a champion and facilitator that influences other sectors to take action to reduce inequalities in health.

One way the NHS promotes equitable health care is to allocate resources to local areas based on levels of need. The NHS has used various formulae since the 1970's to achieve this aim. Between 1999 and 2011 the UK Government added an additional objective for the allocation of resources in the NHS in England: 'to contribute to the reduction in avoidable health inequalities'.[153] As a consequence, increases in allocations during that time tended to favour more deprived areas with the North gaining a greater increase in resources than the rest of England (see Figure 27).

Figure 27: Expenditure on healthcare in the North and the rest of England

Graph shows how health care expenditure increased more in the North than in the rest of England.



Source: PESA.

Recent research in England has shown that the policy of allocating an increasing proportion of NHS resources to deprived areas led to a decline in inequalities in mortality from causes amenable to healthcare. This has contributed to a decline in the gap in mortality between the North and the rest of England.[23] However a large gap still remains indicating that there is substantial scope for health services to further reduce inequalities in amenable mortality in England. There is still evidence indicating that for some health services there is an 'inverse care law' whereby 'the availability of good medical care tends to vary inversely with the need for it in the population served.'[154] Systematic reviews have concluded that whilst in the UK there is evidence of reasonably equitable access to primary health care by different socioeconomic groups, there is also evidence of the over-use of specialist hospital services by more affluent groups.[155,156]

Although the NHS has clearly prevented some health inequalities, some of the principles that made this possible are now under threat. Expenditure on the NHS as a whole has increased each year since its establishment. This trend accelerated between 1999 and 2009.[157] Since then, as a result of the Government's austerity policy, for the first time in its history, the amount of money available to the NHS per head of population has declined (see figure 27). This coupled with rising demand largely due to an ageing population, is putting the NHS under huge strain. It is compromising its capacity to provide a comprehensive health service free at the point of use. Changes to the way NHS resources are allocated, including the abolition of the previous 'health inequalities' policy, mean that cuts in funding are hitting the poorest areas hardest.[158]

These constraints on funding have prompted some commentators to suggest that user-charges should be introduced for some core services such as seeing a GP, but to date the British Medical Association has opposed this change to funding.[159] There is strong evidence that such developments would increase health inequalities. For example, The Wanless Report presented evidence that charges can not only discourage people from seeking treatment, but can also direct people to other parts of the healthcare system that do not make charges or cause them to delay until treatment is more urgent and expensive.[160] There is also no evidence that changing the mix of funding for health care increases productivity or reduces overall expenditure, and it is likely that increasing the routes of funding from households to providers will limit the potential for cost containment and actually be inflationary.[161]

Changes to the way NHS resources are allocated, including the abolition of the previous 'health inequalities' policy, mean that cuts in funding are hitting the poorest areas hardest

The Government has also introduced a major reorganisation of the NHS that has continued and accelerated a process started by the previous Government to expand the role of competition, private sector provision and markets in the delivery of health care. International evidence indicates that these policies have a negative impact on equity in health care.[162] The combination of funding constraints and the expansion of market reforms are jeopardising the capacity of the NHS to take effective action on health inequalities.

Following the transfer of some public health responsibilities from the NHS to Local Authorities, the role of the NHS in reducing health inequalities has been downplayed.[10] The health system has a key role in acting as a champion and facilitator to

influence other sectors to take action to reduce inequalities in health. Whilst Primary Care Trusts had a clear role in leading local partnerships to address the determinants of health in their resident populations, the evidence reviewed by the panel indicates that Clinical Commissioning Groups (CCGs) are not yet fulfilling this role to the same extent. The focus of the work of CCGs so far has been on developing the quality of health services and their primary goal has been to reduce demand for health services. Their engagement with local authorities has focused on the integration of health and social care services, rather than advocating for action on the social determinants of health. Whilst a great deal of effort is being put into managing high users of services in order to reduce demand, there is a danger that the NHS has lost its focus and influence on the social factors that are giving rise to these high levels of demand in the first place.

The NHS has yet to take full advantage of the positive impact it can have on health and local economies through its employment and procurement processes.

It is not only through the delivery of health care that the NHS has an impact on health. The NHS spends £30 billion pounds each year in the North of England and employs around 350,000 people. How these funds are spent and the working conditions of its staff, will have a major impact on health inequalities and the economy in the North of England. The NHS has been criticised for its poor track record of workplace health, and has some of the highest levels of sickness absence of any employer.[163] The Social Value Act enables public service commissioning to factor in social value when procuring services. The NHS has yet to take full advantage of the positive impact it can have on health and local economies through its employment and procurement processes. The NHS also provides opportunities for training, however its involvement in providing apprenticeships has been limited.[164] There is clearly more the NHS can do as an employer and an economic force to influence the social determinants of health inequalities.

What could be done differently?

The most pressing concern for the NHS is to maintain its core principle of equitable access to high quality health care, free at the point of need. This will involve addressing those inequalities in health care that do exist, avoiding introducing policies that will increase health inequalities and ensuring that health care provision across the country is planned and resourced so that it reduces heath inequalities. Specifically the panel identified the following priority areas through which the health sector can play an important role in reducing health inequalities.

Firstly, the NHS needs to allocate resources so that they reduce health inequalities within the North and between the North and the rest of England. As outlined above there is evidence to indicate that the policy to increase the proportion of NHS resources going to deprived areas did lead to a narrowing of inequalities in mortality from some causes.[23] This highlights the importance of having resource allocation policies with an explicit goal to reduce inequalities in outcomes. The health inequalities objective for NHS resource allocation policy has been discontinued and needs to be re-instated. To reduce inequalities the policy should be to distribute resources based on population health outcomes with an explicit objective to reduce the gap in those outcomes between the most deprived and most affluent areas.

Secondly, local health service planning needs to ensure that the resources available to the NHS within each area are used to reduce inequalities. This means targeting resources to those most in need and investing in interventions and services that are most effective in the most disadvantaged groups. The current focus of CCGs on demand management has tended to mean increased investment in services for the elderly. Whilst this is important, it shouldn't be at the expense of investment earlier in the life course, which is given a high priority in all health inequalities strategies.[92] The recent reorganisation of the NHS has had a detrimental impact on its capacity to plan health services. Roles and responsibilities are now split between multiple organisations each working on a different geographical footprint and responsible for different populations. Regional bodies for planning services over wider areas have been dismantled. Mechanisms for the local planning of health service investment need to be strengthened and more focused on effective approaches to reduce health inequalities, rather than solely focusing on short-term strategies to reduce demand. This would be helped by re-establishing the principle of having one NHS organisation, which is responsible for all of the health care for people living in an area. Action to address inequalities requires joint action across public services, this means that local NHS organisations need to plan services, integrate budgets and co-design provision in partnership with local authorities and other local agencies.

Thirdly, a more community-orientated model of primary care needs to be developed that fully integrates support across the determinants of health. Primary care is the jewel in the crown of the NHS. It is recognized as one of the strongest primary care systems in the world.[165] Nearly 300 million consultations take place in general practice each year, 90% of all health-care encounters in the NHS.[150] Several cross-country comparative studies have demonstrated the importance of good access to primary care for improving health and reducing health inequalities.[150] The primary care system, however, is experiencing an unprecedented increase in workload with the RCGP and the BMA reporting that it is close to breaking point.[166,167] A number of factors are coming together to exacerbate this. Demand across the NHS is growing, primarily because the average age of the population is increasing. But on top of this primary care is being seen as the solution to the NHS funding gap, with improved community care preventing people requiring expensive hospital care. This is shifting activity from hospitals into primary care. GPs are also reporting increases in workload as a direct result of the Government's reforms to the welfare system.[6]

The Government has responded to these issues with a plan to ensure that the top 1% of the population with complex health and care needs have a personalised care plan, a named GP and same-day telephone consultations.[168] Focusing on managing the conditions of the 1% of the population with the highest levels of health care utilisation will not solve these problems. The top 1% of people using primary care only account for a small proportion of the 300 million consultations in primary care each year. In addition, high health care utilisation in one year does not necessarily predict high utilisation in the following year, so such interventions frequently miss the most demanding patients. A better approach may be to enable people seeking help through the primary care system to get the support they need for the full range of problems that are driving them to seek help in the first place. These are often the wider determinants of their health, such as financial problems, unsuitable housing, hopelessness and generally feeling out of control of their lives.[169]

The Marmot review[55] (and an associated report with the BMA recommended that to address health inequalities GPs should take a more holistic approach in considering the patient as a whole person within the context of his/her family, community and workplace. There has been a long history of some GP practices using primary care as a focus to integrate support across the social determinants of health together with community groups, local authorities and other organisations.[170–172] This is linked to a wider theory of community oriented primary health care long advocated by the WHO.[173] A recent report by a group of GPs working in deprived areas of Scotland, has recommended that to develop this model GPs should be supported by a new lay worker role. They would link practices with a wide range of sectors in the locality, including social services, the police, education, housing, work and employability, welfare rights and advocacy, culture and leisure, using the strong relationships with that exist with patients in general practice to develop it as a natural community hub.[169] Practices also need to be supported with sufficient resources to allow additional time for consultations with patients with complex needs and to support the development of long-term relationships.[174]

Fourthly, a large-scale strategy for the North of England is needed to maximize the impact of the NHS on health inequalities through its procurement and its role as an employer. There are also promising examples indicating how local NHS organisations are using their commissioning and procurement of services to improve the economic, social, and environmental well-being of their area.[175,176] However there is no national or regional strategy setting out how the Social Value Act should be interpreted by the health and social care system making the most of economies of scale. This is something that benefits from being coordinated on a larger scale. If the commissioning and procurement of all the NHS organisations in the North of England focused on maximizing social value for the North, this could make a significant difference.[177]

Finally, the health sector needs to be a strong advocate, facilitating and influencing all sectors to take action to reduce inequalities in health. With Directors of Public Health transferring from the NHS to local authorities there are fewer voices in the NHS speaking out on issues relating to the public's health and health inequalities. Public Health England was established to be an independent advocate for action across all sectors on health inequalities. The actions that are required to address health inequalities involve radical social change. They are therefore often controversial. The House of Commons Health Committee recently expressed concern that Public Health England was not sufficiently independent of government and that it might avoid speaking out on important public health issues that are seen as 'too controversial.'

Public Health England needs to be supporting and challenging all government departments to tackle health inequalities.

Public Health England needs to be supporting and challenging all government departments to tackle health inequalities. Its expertise in Health Impact Assessment needs to be used to ensure that decisions from across government take into account their impact on health inequalities.[177]

Whilst the new public health responsibilities of local government have the potential to strengthen joint action on the social determinants of health inequalities, effective action across central

government departments is crucial. With national targets for health inequalities no longer in place and the abolition of the cross-government public health structures in Whitehall,[178] the cross-government focus on health inequalities has been lost. This needs to be re-established, and Public Health England needs to be at the centre of leading a cross cross-government programme coordinating action on health inequalities.

4 RECOMMENDATIONS

This section presents the key recommendations from the Inquiry into Health Equity in the North explaining why each recommendation is needed, with more detail on possible actions under each one.

What causes the observed health inequalities?

The Inquiry's overarching assessment of the main causes of the observed problem of health inequalities within and between North and South, are:

- Differences in poverty, power, and resources needed for health;
- Differences in exposure to health damaging environments, such as poorer living and working conditions and unemployment;
- Differences in the chronic disease and disability left by the historical legacy of heavy industry and its decline;
- Differences in opportunities to enjoy positive health factors and protective conditions that help maintain health, such as good quality early years education; economic and food security, control over decisions that affect your life; social support and feeling part of the society in which you live.

Not only are there strong step-wise gradients in these root causes, but austerity measures in recent years have been making the situation worse – the burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South; on disadvantaged than more affluent areas; and on the more vulnerable population groups in society, such as children. These measures are leading to reductions in the services that support health and well-being in the very places and groups where need is the greatest.

We did not consider that the observed health inequalities between the North and the rest of England and within the North are caused by poorer access or quality of NHS services. Although there are still inequalities in access to healthcare by deprivation, they could not account for the size and nature of the differences in health status that we observe. On the contrary, access to NHS care when ill has helped to reduce health inequalities. The NHS helps to ameliorate the health damage caused by wider determinants outside the health sector. To do this NHS services in deprived areas need to be adequately resourced to enable them to reduce inequalities and the principle of the NHS as free at the point of need, must be maintained.

The Inquiry has sought to bring a fresh perspective to the issue of health inequalities that focuses on preventing inequalities occurring in the future as well as ameliorating the impact of current inequalities. Tackling the root causes of health inequalities leads to a set of 4 high-level recommendations and supporting actions that build on the assets of the North to target inequalities both within the North and between the North and the rest of England. These recommendations, acknowledge that most of the Panel's area of expertise is within agencies in the North, while at the same time highlighting the clear need for actions that can only be taken by central government. We, therefore, give two types of recommendations for each high-level recommendation:

- What can agencies in the North do to help reduce health inequalities within the North and between the North and the rest of England?
- What does central government need to do to reduce these inequalities – recognising that there are some actions that only central government can take?

4.1 Recommendation 1: Tackle poverty and economic inequality within the North and between the North and the rest of England

Why is this needed?

Levels of economic inequality have risen rapidly in the UK and other western countries since the 1970's. These levels of inequality have been shown to be associated with adverse health and social outcomes. This has resulted in persistent social and economic differences between the North and the South that underlie the health inequalities observed.

Economic strategy in the UK is primarily based around economic growth and creating more jobs. These economic objectives are not anchored in wider social objectives, such as reducing the large economic differences between regions in the UK, reducing inequalities or promoting health and well-being. There needs to be a shift in economic development activity to promote healthier economic policies and social inclusion. This means an approach to economic development that maximizes the social value from economic activity, promotes economic democracy, reduces inequality and provides employment that is good for health and is a route out of poverty.

Poverty, unemployment and poor housing are all markedly higher in the North. A low wage economy means that having a job does not necessarily protect against poverty in the way that it once did. The lack of growth in wages that has particularly affected the North has led to an accumulation of unsecured personal debt, which is also linked to poor health. Those on low incomes are also adversely effected by having to pay higher prices than better-off families for basic necessities like gas, electricity and banking. For those who cannot work due to unemployment, disability or age, the value of welfare benefits in the UK is low compared to other European countries. There is good evidence linking low incomes to poor health over the course of people's lives and this has led to calls for a minimum income for healthy living (MIHL) for those on benefits. Additionally, reforms to the welfare system are adversely affecting the most vulnerable groups, particularly children and people with disabilities. To improve the health of poorer people, there is a need to ensure the welfare system provides an adequate standard of living for those who can't work. In addition, whilst there have been large improvements in the quality of social housing, families on low income are increasingly relying on poor quality private rented accommodation that is in inadequate condition, and this is especially affecting families with children.

Public services, as currently configured, have concentrated on ameliorating the impact of poverty – treating the consequences - rather than engaging in the prevention of poverty in the longer-term, which could have a major impact on health inequalities. Public service reform could help to prevent poverty and promote economic prosperity if it were focused on investing in people and places: for example, helping people to get back into work, gain better quality work and remain in work, through local integrated systems for skills and employment support; using public sector procurement to promote local high quality employment, good working conditions and training; raising living standards through action to increase wages and reduce the burden of debt; investing in affordable quality housing; and finally developing seamless universal and targeted support to families through early years education, childcare and parenting programmes.

The way public resources are allocated to local areas does not ensure sufficient resources are distributed to areas with the greatest needs or that the total public sector investment in places is used effectively to reduce health inequalities.

The Government's policy of reducing public expenditure is adversely affecting populations with the worst health outcomes and falling more heavily on the North than the South. This is potentially increasing health inequalities. Additionally the current system for allocating central government funds to local areas through separate departmental silos is a barrier to joint work on health inequalities. It involves numerous complex separate formulae for different services and often comes with significant strings attached that make co-ordinated delivery, co-design and joint investment challenging. Whilst these formulae do seek to take into account differences in need as well as other factors, their objectives are often unclear and their development is not coordinated.[179] The level of resources allocated to local areas from across sectors should be focused on reducing inequalities in outcomes. How resources are allocated does appear to make a difference. The health inequalities objective for resource allocation in the NHS, that was in place between 2000 and 2011, for example, led to a reduction in health inequalities between LAs in disadvantaged areas and the average for England as a whole.

Agencies in the North should work together to:

— ***Draw up health equity strategies that include measures to ameliorate and prevent poverty among residents in each agency's patch.***

These measures could range from supporting networks of credit unions and other community finance initiatives to reduce the cost of credit for poor communities, controlling payday lenders, combating illegal money lending, providing debt counselling and benefits advice and working with the voluntary and community sectors to combat poverty, in addition to the following economic development recommendations.

— ***Focus public service reform on the prevention of poverty in the future and promoting the prosperity of the region by reorientating services to boost the prospects of people and places.***

One key priority would be to establish integrated support across the public sector to improve the employment prospects of those out of work or entering the labour market. This should include improving transitions from school to work for young people and providing support for adults out of work particularly those with chronic illnesses and disabilities. There is potential to build a far more integrated system locally, that joins up schools, vocational training, apprenticeships, employers and employment support to ensure that young people are given the best chance to develop the skills they need to get a good job and to support out of work adults into employment. This would involve local authorities, the NHS and other agencies developing integrated support to enable people to overcome barriers to employment. For people with chronic illness and disabilities this should involve integrated case management, which combines health support with training and workplace adjustment. The extent that local agencies can achieve this will depend in part on whether funding for skills and return-to-

work programmes (e.g. the Work programme) is devolved to local areas rather than being controlled centrally (see recommendation for central government below)

— ***Adopt a common progressive procurement approach to promote health and to support people back into work.***

Through the Social Value Act Public sector bodies have the means to procure in ways which maximise the social benefit for local communities. Procurement decisions must consider how they will improve the economic, social and environmental well-being of an area. Public sector organisations within each area should, therefore, develop progressive procurement strategies to achieve the following objectives:

- Promoting high quality local employment particularly for people living in disadvantaged circumstances, including the long term unemployed;
- Improving working conditions for people in the local economy, including promoting the Living Wage; and
- Expanding training and apprenticeships to support young people into work.

— ***Ensure that reducing economic and health inequalities are central objectives of local economic development strategy and delivery.***

Reducing poverty and health inequalities have not been a significant consideration of Local Enterprise Partnerships (LEP) to date. With the Government increasingly emphasising the role of combined authorities and Local Enterprise Partnerships in driving economic growth, it is essential that this changes. There is a need, therefore, to ensure that all combined authorities and/or Local Enterprise Partnerships have promoting health and reducing economic and health inequalities as central objectives and that this is reflected in strategy, delivery and monitoring of performance.

— ***Implement and regulate the Living Wage at the local authority level.***

Local authorities and other local public sector organisations should implement the Living Wage and explore the potential for requiring that a Living Wage is paid for contracted and procured services. Local authorities should also work with local businesses to promote the Living Wage, for example through recognition schemes.

— ***Increase the availability of high quality affordable housing through stronger regulation of the private rented sector, where quality is poor, and through investment in new housing.***

Many local authorities are exploring approaches to improve housing conditions in the private rented sector, including voluntary accreditation and compulsory schemes through the use selective licensing. These approaches need to be extended and evaluated. The increased reliance on poor quality private rented housing is being driven by a lack of high quality affordable housing. Public investment in new affordable homes has declined rapidly in recent years, but a number of local authorities are looking a new ways to bring in additional investment to build new affordable homes. There is scope for the creative use of local authority pension funds. For example a project in Manchester is using the Greater Manchester Pension Fund to invest in new affordable homes.

— ***Assess the impact in the North of changes in national economic and welfare policies on health inequalities in general and regional inequalities.***

Northern agencies could make a concerted effort to collect and collate the evidence on the consequences of central government policies, particularly the impact on the most disadvantaged communities in the region. This evidence can then be used to devise ways of ameliorating adverse consequences locally, as well as to lobby central government for change.

Central government needs to:

— ***Invest in the delivery of locally commissioned and integrated programmes encompassing welfare reform, skills and employment programmes to support people in work.***

— ***Extend the measuring national well-being programme to better monitor progress and influence policy on inequalities.***

The measuring national well-being programme of the ONS develops and publishes a set of National Statistics which are used to monitor national well-being across 10 domains. These include health and the main determinants of health. At present this programme just monitors average levels of well-being and does not assess socio-economic inequalities in these measures. Indicators should be developed as part of this programme to track inequalities in health and well-being across all domains. Government strategy in particular strategies related to economic development should be more closely aligned to these measures of national well-being with progress regularly assessed against these indicators.

— ***Develop a national industrial strategy that reduces inequalities between regions.***

At present the Government has invested £2 billion in an industrial strategy that is focused on supporting growth in particular sectors such as emerging technologies. Whilst this is important, there also needs to also be a clear objective to use industrial strategy to help spatially rebalance the economy and promote sustainable and quality employment that is good for health. A national industrial strategy should support decentralisation of decision-making to more effectively target resources to where they will make the greatest difference.

— ***Assess the impact of changes in national policies on health inequalities in general and regional inequalities in particular.***

— ***Expand the role of Credit Unions and take measures to end the poverty premium.***

Central government could help to create a regional infrastructure to support and greatly expand the role of local not-for-profit member owned and democratically run institutions that offer affordable credit, such as Credit Unions. The Government is currently rolling out a credit union expansion project with the Association of British Credit Unions (ABCUL) which involves £38m of funding over 3 years, to help credit unions expand and modernise. This now needs to be extended to develop a model that can realistically provide for the expansion of credit unions into disadvantaged communities on a scale that ensures they are an alternative to pay-day lenders. In addition, central government should take action to end the poverty premium, where the poorest often pay more for goods and services, such as utilities and banking.

— ***Develop policy to tackle the issue of the poor condition of the housing stock at the bottom end of the private rental market and to support local investment in affordable housing.***

Local authorities already have some powers to regulate the private rented sector where housing conditions are poor. Central government needs to work with local government to strengthen their ability to improve the quality of housing in the private rented sector. Greater flexibility needs to be given to local government to increase housing investment, including local borrowing and enabling local government to 'earn back' savings made to the housing benefit bill through investment in affordable housing.

— ***End in-work poverty by implementing and regulating a Living Wage by:***

- Legislating so that all public sector contractors and government departments pay the Living Wage.
- Providing incentives for private sector organisations to pay the Living Wage such as tapered tax breaks over a limited timeframe.

— ***Ensure that welfare systems provide a Minimum Income for Healthy Living (MIHL):***

Changes to the benefit system should take place to ensure that they provide a minimum level of income for those out of work and receiving benefits so that they can maintain health and well-being. The MIHL provides a benchmark for what is a safe minimum standard of living, which provides equality of opportunity for health and is supported by the World Health Organisation, Age UK and the Marmot Review of Health Inequalities in England. At the same time, current measures that are causing hardship, such as the 'Bedroom Tax', should be stopped.

— ***Grant city and county regions greater control over the commissioning and use of the skills budget and the Work Programme, to make them more equitable and responsive to differing local labour markets.***

Greater control over the use of the skills budget would allow city and county regions to address local skills gaps, improve school to work transitions, and develop integrated approaches that move those out of work into employment. At present, funding for adult further education (16-19+) and skills training, including apprenticeships, is mainly controlled centrally. Commissioning, accountability and planning of the Work Programme has been centrally managed by the DWP and this has not led to effective models of provision. A number of organisations and reviews have already called for some type of localisation of the Work Programme. Local partners including Local employers, local authorities and community and voluntary organisations are best placed to set local priorities and budgets and develop integrated approaches that support transitions into employment and progression within the workplace whilst delivering what is needed to achieve local economic priorities. This would include establishing integrated support across the public sector to improve the employment prospects of those out of work, shaping further education and training provision and apprenticeships, joining up schools, vocational training apprenticeships and employment support and better integrating skills and training into the Work Programme.

— ***Develop a new deal between local partners and national government that allocates the total public resources for local populations to reduce inequalities in life chances between areas.***

There needs to be a review of current systems for the central allocation of public resources to local areas to develop a coordinated approach across government departments that is focused on the objective of reducing the gap in joint public service outcomes (including for example health, well-being, education, housing, safety etc) between the most and least deprived areas. This must take into account the differential ability for areas to raise funds through other means such as local taxation and business rates. It must also show an appreciation of poverty in rural areas across the north, which has been underestimated in the past. For example there could be a place based weighting within funding formulas which applies across the public sector, from schools, local authorities, to the NHS, where the objective is to reduce the gap in outcomes between the most affluent and most deprived areas. Just allocating resource based on need will not on its own close the gap – for this to happen resources need to be distributed so that outcomes improve at a faster rate in poorer areas. This may require even greater investment than that solely based on an assessment of need.

4.2 Recommendation 2: Promote healthy development in early childhood

Why is this needed?

Children's health is a key indicator of the success or failure of national policies. Many health outcomes for children and young people in the UK remain poor and despite important improvements more children and young people are dying in the UK than in other countries in Western and Northern Europe. Children born in the North of England are expected to live for two years less than their counterparts in the south, and experience a range of worse health outcomes. These inequalities are unfair, and have their origins in early life experiences and the environmental and social conditions in which children grow up.

To effectively reduce health inequalities we need to invest a greater proportion of public resources in the early years. However at present the opposite is happening. There are clear indications that children's services are being disproportionately hit by current austerity measures, with early years budgets facing significant cuts. A key issue is that actions need to be taken at scale, since just targeting the most disadvantaged groups is not enough.

All children have a right to the best possible health. A high level commitment to a rights based approach to improve child health will be an important driver of policies to reduce health inequalities. For example Newcastle City Council and Leeds City Council last year became only two of six local authorities in the UK to sign up to a new partnership with UNICEF, which is about committing to respect, protect and fulfil children's rights.

Agencies in the North should work together to:

— ***Monitor and incrementally increase the proportion of overall expenditure allocated to giving every child the best possible start in life, and ensure that the level of expenditure on early years development reflects levels of need.***

— ***Ensure access to good quality universal early years education and childcare with greater emphasis on those with the greatest needs to ensure that all children achieve an acceptable level of school readiness.***

— ***Maintain and protect universal integrated neighbourhood support for early child development, with a central role for health visitors and children's centres that clearly articulates the proportionate universalism approach.***

This should include reviving a model of children's centres that is based on community ownership, involving strong outreach and hubs for all services working with children, not just those provided by councils. This should include providing evidenced-based parenting programmes and services that promote children and young people's resilience.

— ***Collect better data on children in the early years so that we can track changes over time, monitor inequalities in child development and evaluate services for their effects on early disadvantage.***

— ***Develop and sign up to a Charter to protect the rights of children to the best possible health.***

A Charter would mean that participating local authorities would have a transformative look at the services they deliver to children and young families. It would also help in getting the message about the importance of early years embedded across different organisations. Putting child rights into public services would change practice, and in the long term deliver better outcomes for children and families.

Central government needs to:

— ***Embed a rights based approach to children's health across government.***

This would mean a high level commitment to children's rights with the aim of improving child health and reducing health inequalities. The arguments are not just about the evidence but also that investing in children is morally and legally the right thing to do. The benefits of investing in the early years are well demonstrated, and large numbers of children stand to benefit.

— ***Reduce child poverty through the measures advocated by the Child Poverty Commission***

which includes investment in action on the social determinants of all parents' ability to properly care for children, such as paid parental leave, flexible work schedules, Living Wages, secure and promising educational futures for young women, and affordable high quality child care;

— ***Reverse recent falls in the living standards of less advantaged families***

Recent economic improvements do not outweigh the damage inflicted during the downturn to the incomes of the poorest people across the country. Poorer members of society (both in and out of work) are under severe pressure. Urgent action is needed to address the cost of living faced especially by low income families, and to ensure all families can afford the 'basics'.

— ***Commit to carrying out a cumulative impact assessment of any future welfare changes***

To ensure a better understanding of their impacts on poverty and to allow negative impacts to be more effectively mitigated. This would focus on the impact on people living in vulnerable situations, especially children.

— ***Invest in raising the qualifications of staff working in early years childcare and education.***

The priority should be to raise the qualifications for all existing staff to level 3 and at least 30 per cent of staff trained to Level 6. The evidence clearly shows that it is essential that early years education and childcare is of high quality if children are to benefit. Extending access to childcare must therefore be supported by improvements in the quality and standards of childcare provision. The Nutbrown review commissioned by the Coalition Government has recommended that level 3 qualifications should become the baseline standard for all staff working with children.

— ***Increase the proportion of overall expenditure allocated to early years, and ensure expenditure on early years development, is focused according to need.***

The Government should gradually move funding to the early years and this funding should be weighted toward the most disadvantaged children. The Government should assess and monitor the level of public expenditure on the early years by all government departments and how this funding is distributed within the country, reporting progress on shifting resources to the early years annually. The Government appointed Frank Field to conduct a review of 'Poverty and Life Chances'. That review has recommended that resources are shifted to the early years. At present, however, it is not possible to assess the proportion of public resources from across government departments, that is being invested in the early years or to fully understand the impact on this of cuts in public expenditure.

— ***Increase investment in universal integrated neighbourhood support to families through parenting programmes, children's centres and key workers, delivered to meet social needs.***

The Government needs to re-affirm its commitment to providing key services through children's centres. Rather than reducing their capacity, children's centres should be the community hubs providing a range of support services for parents and children under one roof, including health services. Linked to health visiting and outreach work, children's centres should reach all families.

— ***Make provision for universal, good quality early years education and childcare proportionately according to need across the country.***

Providing any education is not enough, since it is the quality of pre-school learning that appears to be critical for longer-term beneficial effects. The evidence indicates that current universal entitlement to childcare is making the most difference to children from disadvantaged backgrounds and that expanding this would increase maternal employment and improve child development.[106] The Government should extend universal free entitlement of early years child care and education to 15 hours a week for 48 weeks per year, for all children from the age of two until they enter school, and guarantee an additional 20 hours of subsidised childcare a week for families in which all parents are in work. This recommendation would greatly expand the current free entitlement, reflecting the evidence base that this would benefit all families, with the benefits most pronounced for those on low incomes.

4.3 Recommendation 3: Share power over resources and increase the influence that the public has on how resources are used to improve the determinants of health

Why is this needed?

The diminishing proportion of public expenditure controlled by local government and limitations on local government's capacity to raise additional resources reduces its ability to develop solutions based on local priorities. The capacity of local government to shape how public resources are used to improve outcomes for their population has been undermined by successive governments. The proportion of public expenditure in local areas controlled by local government has declined for a number of years and recent cuts to local government budgets have exacerbated this.

There are growing calls from across the political spectrum for greater devolution to city and county regions within England. There is an opportunity to influence how the process happens so that budgets and powers are decentralised and used in a way that reduces inequalities. Devolution has the potential to be a powerful force for reducing health inequalities. Giving local government more control over more public resources and enabling them to raise additional funds and use these more flexibly would help them have a greater impact on health inequalities. For devolution to have the desired impact, however, local economic development must address social objectives, be accountable to local populations and be inclusive of less connected places. Devolution has to be about more than just providing more powers for economic development and growth: it is about authorities having the ability to do what is right for the population they serve at the right spatial scale.

The most disadvantaged members of society lack influence over how public resources are used. Democratic engagement in the UK, as in many other 'wealthy' countries has declined in recent years. The decline in political engagement is occurring at a faster rate in more disadvantaged groups. The UK has some of the lowest levels of voter turnout and some of the highest inequalities in democratic participation in Europe. The lack of influence that people from disadvantaged communities have has a number of consequences for policies to reduce health inequalities. It means that policies that could improve the health of people in these communities are less likely to be implemented and sustained and that there is less likely to be resistance to policies that exacerbate these inequalities. There is a growing body of evidence that people's health is improved when they have a greater say in the decisions that affect them and feel they can influence these. If solutions are developed locally rather than nationally, and tailored to local contexts, then they are more likely to be effective.

Agencies in the North should work together to:

— ***Establish deep collaboration between combined authorities in the North to develop a pan-Northern approach to economic development and health inequalities.***

Democratic structures such as combined authorities need to be used as a central vehicle to develop a pan Northern approach to economic development and health inequalities. There are already combined authorities in Liverpool City Region, Greater Manchester, Sheffield City Region, West Yorkshire and the North East. Together they could work to drive a programme of devolution and investment that promotes equitable economic growth, public service reform that addresses the determinants of health inequalities whilst using their combined scale to influence national policy that has an impact on health inequalities.

— ***Take the opportunity offered by the greater devolved powers and resources to develop, at scale, locally integrated programmes of economic growth and public services reform to support people in employment.***

— ***Re-vitalise Health and Well-being Boards to become stronger advocates for health both locally and nationally.***

Northern Health and Well-being Boards need to take responsibility for advocating for health equity to central government, in addition to their work with other local agencies and with neighbourhoods. Many of the determinants of local health and well-being require action at national, European or Global levels. Health and Well-being Boards in the North of England therefore could:

- Establish a Health Equity North Board with high-level political representation.
- Collectively produce an annual report detailing how regional and national policy needs to change to reduce health inequalities within the North and between the North and the rest of England.

— ***Develop community-led systems for health equity auditing and accountability***.

This requires local and national action to:

- Ensure the public reporting of actions and progress on health inequalities to encourage debate and challenges on progress by communities and other groups. Health and Well-being Boards, for example should report annually on the level of investment that has been made, actions that have been taken, and progress that has been made on reducing health inequalities.
- Make intelligence and data on health, equity and social determinants more accessible within the public domain – locally and nationally. The UK Government has led the way in developing an 'Open Data' policy in order promote transparency and accountability of public services.[181] This needs to be extended with a focus on health inequalities. All public services that have a direct and indirect impact on health should collect data and report on differential access and outcomes of services by socioeconomic group. This should include services commissioned with public money from the private or voluntary sector. Data should be published to high 'open data' standards providing a national view down to at least the local authority level and where possible enable analysis by socioeconomic group and life course stage.

- Develop indicators of progress with local communities. Healthwatch could, for example, work with community groups and Public Health England to develop measures of progress on health inequalities at the national and local authority levels. They could involve communities in tracking progress both in terms of the community as a whole and inequalities within and between communities.

— Expand the involvement of citizens in shaping how local budgets are used:

Use participatory budgeting processes to involve citizens in influencing how public resources are used so that these inform the use of a significant proportion of the total public sector investment in each area. This should involve the widespread participation of citizens in each area alongside elected representatives in the deliberation and agreement of local budgets. It should support rather than undermine the role of councilors in ensuring that public services within an area meet the needs of all citizens.

— Assess opportunities for setting up publicly owned mutual organisations for providing public services where appropriate, and invest in and support their development.

This would involve reviewing services contracted to the private and voluntary sectors as well as those directly provided by the public sector, to assess the potential for them to be provided through public sector mutual organisations, for example tenant and employee owned social housing organisations. It will be important for systems to be in place to ensure that public sector mutuals are democratically owned and governed by services users and employees and that there is sufficient representation from all sections of the community.

— Help communities to develop the capacity to participate in local decision-making and in developing solutions which inform policies and investments at local and national levels:

this should include action by local government and local NHS organisations to:

- Invest in voluntary and community sector organisations that can effectively support the greater participation of disadvantaged communities in the decisions that affect their environment.
- Invest in a process of training and action to engage community members in influencing the planning and delivery of services and to develop community assets that enhance the support available to the community.

Central government needs to:

— ***Grant local government a greater role in deciding how public resources are used to improve the health and well-being of the communities they serve.***

This could include:

- A specific aim to incrementally increase the proportion of total public expenditure controlled locally. This can help to rebalance the economy, bring national and local government closer to people, and curb inequality, but only if resources are allocated fairly and used to develop local social and economic policy that addresses health inequalities.
- Agreements between national and local government that ensure devolved funds address health equity. Any new devolution agreement or deal needs to have specific objectives to improve outcomes for disadvantaged residents - and therefore address economic and health inequalities (focusing on for example stronger communities, good quality employment, and focused help for those experiencing social and economic exclusion).

— ***Revise national policy to give greater flexibility to local government to raise funds for investment and use assets to improve the health and well-being of their communities.***

This could include, for example:

- Granting councils greater freedom within prudential financial guidelines, to borrow to make investments that provide social and economic returns and improve health and well-being.
- Reviewing restrictions on investments by local authority pension schemes so that they can be used to make investments that promote economic development in the North that improves health and well-being, as well as providing a return on investment.
- Exploring the possibilities of giving local authorities in England a greater share of the existing tax base to make investments that provide social and economic returns and improve health and well-being. This would strengthen local democracy, allowing local people to see more clearly what their taxes pay for locally and enable local government to shape spending priorities. This must however be done in a way that does not increase inequalities between more prosperous and less economic successful places.

— ***Invest in and expand the role of Healthwatch as an independent community led advocate that can hold government and public services to account for action and progress on health inequalities.***

Healthwatch was established to have 'a role in promoting public health, health improvements and in tackling health inequalities'. However its focus has primarily been on promoting consumer rights for users of health and social care services. We recommend that local and national Healthwatch organisations are given a clearer remit to monitor progress and advocate for action on health inequalities and to hold local and national government to account for progress.

— ***Invite local government to co-design and co-invest in national programmes, including the Work Programme, to tailor them more effectively to the needs of the local population.***

4.4 Recommendation 4: Strengthen the role of the health sector in promoting health equity

Why is this needed

The health sector can still do much more to champion action on health inequalities and facilitating and influencing action across all sectors. Whilst action needs to be taken by a number of different agencies, the NHS and Public Health England have a specific role in leading change and advocating for health inequalities to be addressed in all policies. Following the transfer of some public health responsibilities from the NHS to local authorities, there has been a tendency to downplay the role of the NHS in reducing health inequalities. With Directors of Public Health transferring from the NHS to local authorities there are fewer voices in the NHS speaking out on issues relating to health inequalities. The House of Commons Health Committee recently expressed concern that Public Health England was not sufficiently independent of government and that it might avoid speaking out on important public health issues that are seen as 'too controversial.' It concluded that:

'Public Heath England was created by Parliament to provide a fearless and independent national voice for public health in England. It does not believe that this voice has yet been sufficiently clearly heard.'

Primary care is central to action on health inequalities, but it is under increasing strain and to remain effective needs to integrate effectively with support for the wider determinants of health and support for early child development. Increasing numbers of people are seeking help in primary care. Integrating support across agencies for the full range of problems that are driving them to seek help (e.g. employment support, debt, welfare advice, housing), will reduce pressure on GPs and enable early intervention to prevent the exacerbation of problems, reducing poverty among people with chronic illness and reducing children's exposure to poverty, and its consequences

The £100 billion spent every year by the NHS has huge potential to influence health inequalities, not just through the provision of services, but also through its impact on local economies. To date the NHS has not made the most of its procurement processes and employment conditions to promote high quality local employment, improve working conditions and expand training and apprenticeships.

Public Health England should:

— ***Conduct a cumulative assessment of the impact of welfare reform and cuts to local and national public services, in particular focusing on the impact on children and people with disabilities.***

This should include specific work to assess the health inequalities impact of the Government's reforms to disability benefits, return-to-work programmes (i.e. the Work Programme and Help to Work) and cuts to local government budgets and should lead to recommendations on how the policies can be modified to reduce health inequalities and how changes to the tax and benefit system can ensure a minimum Income for Healthy Living (MIHL) for those in and out of work.

— ***Support local authorities to produce a Health Inequalities Risk Mitigation Strategy for the financial years 2015/16-2017/18.***

— ***Help to establish a cross-departmental system of health impact assessment.***

This should ensure that the health inequalities impact of all relevant national policies, including the Government's industrial and economic strategies, is assessed with a particular focus on spatial inequalities to ensure that they do not widen regional inequalities and the North-South divide in particular. Many government departments currently carry out Equality Impact Assessments to assist in compliance with equality duties and the current Government requires impact assessments to be carried out on regulatory policies as part of its drive to reduce the impact of regulation on businesses and individuals. The Acheson Inquiry in 1998 recommended that all relevant policies should be evaluated in terms of their impact on health inequalities; however health inequalities impact assessment is still not routinely carried out on national government policy. Such assessments should be systematically carried out as an extension to current impact assessments processes, with a particular emphasis on the impact on regional inequalities. Public Health England should strongly advocate and influence government to ensure these policies are developed so that they can reduce health inequalities.

— ***Support the involvement of Health and Well-being Boards and public health teams in the governance of Local Enterprise partnerships and combined authorities to ensure that reducing economic and health inequalities and promoting health and well-being are central objectives in economic development strategies.***

— ***Contribute to a review of current systems for the central allocation of public resources to local areas, including systems for the allocation of NHS resources to maximise their impact on reducing health inequalities.***

— ***Support the development of a network of Health and Well-being Boards across the North of England with a special focus on health equity***

This would include establishing a Health Equity North Board with high-level political representation providing a stronger voice enabling them to influence national policy that has an impact on health inequalities (see recommendation 3).

— ***Collaborate in the development of a Charter to protect the rights of children to the best possible health that local authorities and other organisations across the North can sign up to.***

This should affirm the duty to protect the rights of all children to the best possible health. (see recommendation 2)

— ***Work with Healthwatch and Health and Well-being Boards across the North of England to develop community led systems for health equity auditing and accountability.***

Clinical Commissioning Groups and other NHS agencies in the North should work together to:

— ***Lead the way in using the Social Value Act to ensure that all of its procurement and commissioning maximises opportunities for high quality local employment, high quality care and reductions in economic and health inequalities.***

— ***Pool resources with other partners to ensure that universal integrated neighbourhood support for early child development is developed and maintained.***

— ***Work with the local authority and other agencies including the Department for Work and Pensions to develop 'Health First' type employment support programmes for people with chronic health conditions***

This would help people off-sick from work and to enable incapacity-related benefit recipients to enter or return to work. This should be based on implementing the recommendations outlined by NICE.

— ***Work more effectively with Local authority Directors of Public Health and PHE to address the risk conditions (social and commercial determinants of health) that drive health and social care system demand.***

This would mean CCGs and the local health system engaging more actively in lobbying, advocacy and public education on the prime causes of health and social care system demand. This should include ensuring that Directors of Public Health are members of their local CCG boards. This could include placing a duty to 'co-operate and collaborate' on CCGs, local authorities, and NHS Trusts.

— ***Support Health & Well Being Boards to integrate budgets and jointly direct health and well-being spending plans for the NHS and local authorities, including mechanisms to support their governance, leadership, performance monitoring and democratic accountability.***

— ***Provide leadership to support health services and clinicians to reduce children's exposure to poverty and its consequences.***

CCGs and NHS agencies should take a leading role. There is a need for better data, improved monitoring, and an increased awareness of the health impacts of poverty for staff working in health services. The medical profession also has an important role in assessing the adequacy of welfare benefits for supporting health and for maintaining the principles of equity in the NHS. Furthermore, health commissioners have a key role in influencing decisions on where the cuts fall in local services, and can advocate for more equitable reforms, with the test that they must protect the most vulnerable, particularly children.

Services should develop an increased focus on a whole family approach to the care of children, with care pathways that ensure linkage to the full range of social services support available to children and families living in disadvantaged circumstances in order to mitigate some of the effects of disadvantage. This would include supporting parents to access all the benefits and services that they are entitled to, and working to reduce any perceived stigma associated with using these services. Support with the additional costs of childcare, travel to clinic appointments, and any additional medical expenditure would also help reduce the financial burden on the most disadvantaged families. This should be coupled with support to develop patient and family self-management skills for children with chronic conditions.

— ***Encourage the provision of services in primary care to reduce poverty among people with chronic illness.***

This could include for example debt and housing advice and support to access to disability-related benefits.

5 REFERENCES

1 Whitehead M. The concepts and principles of equity and health. Health Promot Int 1991; 6: 217–28.

2 WHO Commission on Social Determinants of Health, World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health : Commission on Social Determinants of Health final report. Geneva, Switzerland, World Health Organization, Commission on Social Determinants of Health, 2008.

3 Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health: Levelling up Part 1. Copenhagen, World Health Organization Regional Office for Europe., 2007.

4 UCL Institute of Health Equity. Review of Social Determinants and the Health Divide in the Who European Region. , World Health Organization, 2013.

5 Nutbeam D. Getting evidence into policy and practice to address health inequalities. Health Promot Int 2004; 19: 137–40.

6 Iacobucci G. GPs' workload climbs as government austerity agenda bites. BMJ 2014; 349: g4300–g4300.

7 Ed Miliband: Labour will use devolution in England to rebalance UK growth | Politics | The Guardian. http://www.theguardian.com/politics/2014/apr/07/ed-miliband-labour-city-regions-uk-growth (accessed 29 Jun2014).

8 Heseltine M. No stone unturned: in pursuit of growth - Lord Heseltine review. London, Department for Business, Innovation and Skills, 2013 https://www.gov.uk/government/publications/no-stone-unturned-in-pursuit-of-growth (accessed 1 Jul2014).

9 Lyons M, Lyons Inquiry into Local Government (Organization). Place-shaping: a shared ambition for the future of local government : executive summary. London, TSO, 2007.

10 David Williams. Lansley: CCG allocations should be based on age, not poverty. Health Serv J. http://www.hsj.co.uk/news/finance/lansley-ccg-allocations-should-be-based-on-age-not-poverty/5044219.article (accessed 2 May2012).

11 Local Government Finance Settlement 2014-15 and 2015-16. .

12 Department of Health. Exposition book 2011-2012 - Publications - GOV.UK. https://www.gov.uk/government/publications/exposition-book-2011-2012 (accessed 17 Sep2013).

13 Beatty C, Fothergill S. Hitting the poorest places hardest. , Centre for Regional Economic and Social Research, 2013.

14 Bambra C. All in it together'? Health Inequalities, Austerity and the 'Great Recession'. In: Woods C, ed. Health and Austerity. London, Demos, 2013.

15 Krieger N, Rehkopf DH, Chen JT, Waterman PD, Marcelli E, Kennedy M. The Fall and Rise of US Inequities in Premature Mortality: 1960–2002. PLoS Med 2008; 5: e46.

16 Shaw C. Do social and economic reforms change socioeconomic inequalities in child mortality? A case study: New Zealand 1981-1999. J Epidemiol Community Health 2005; 59: 638–44.

17 Blakely T, Tobias M, Atkinson J. Inequalities in mortality during and after restructuring of the New Zealand economy: repeated cohort studies. BMJ 2008; 336: 371–5.

18 Cities Outlook 2014 | Centre for Cities. http://www.centreforcities.org/research/outlook14.html (accessed 21 Feb2014).

19 Hacking JM, Muller S, Buchan IE. Trends in mortality from 1965 to 2008 across the English north-south divide: comparative observational study. BMJ 2011; 342: d508–d508.

20 Whitehead M, Doran T. The north-south health divide. BMJ 2011; 342: d584–d584.

21 Bambra C. Reducing health inequalities: new data suggest that the English strategy was partially successful. J Epidemiol Community Health 2012; 66: 662–662.

22 Baby boys in most deprived areas show greatest increase in life expectancy - ONS. http://www.ons.gov.uk/ons/rel/subnational-health4/life-expec-at-birth-age-65/2006-08-to-2010-12/sty-life-expectancy-gap.html (accessed 24 Jun2014).

23 Barr B, Bambra C, Whitehead M. The impact of NHS resource allocation policy on health inequalities in England 2001-11: longitudinal ecological study. BMJ 2014; 348: g3231–g3231.

24 Barr B, Taylor-Robinson D, Whitehead M. Impact on health inequalities of rising prosperity in England 1998-2007, and implications for performance incentives: longitudinal ecological study. BMJ 2012; 345: e7831–e7831.

25 New Economics Foundation. Towards a Welsh industrial strategy. , 2012.

26 Bambra C, Barr B, Milne E. North and South: addressing the English health divide. J Public Health 2014; 36: 183–6.

27 TUC. Economic Report: the labour market in the regions of England. , TUC, 2014.

28 Policy Network. Mending the fractured economy -Final report of the Adonis Review. , Policy Network, 2014.

29 Office for National Statistics. NOMIS--official labour market statistics. 2013.http://www.nomisweb.co.uk/ (accessed 10 Jan2013).

30 Erdem E, Glyn A. Job deficits in UK regions. Oxf Bull Econ Stat 2001; 63: 737–52.

31 Nickell S. The Recent Performance of the UK Labour Market. Oxf Rev Econ Policy 2002; 18: 202–20.

32 Bambra C, Garthwaite K. Welfare and Austerity. A discussion paper submitted to the Inquiry into Health Equity in the North of England. , Durham University, 2014.

33 Neets are 'public health time bomb'. BBC. 2013.http://www.bbc.co.uk/news/health-24745612 (accessed 8 Jul2014).

34 National Housing Federation (NHF). Impact of welfare reforms on housing associations. National Housing Federation (NHF), 2014. http://www.housing.org.uk/publications/browse/impact-of-welfare-reforms-on-housing-associations (accessed 31 Jul 2014).

35 Households Below Average Income -An analysis of the income distribution 1994/95 – 2012/13 July 2014 (United Kingdom). London, Department for Work and Pensions, 2014.

36 The Living Wage Comission. The scale of low pay in the UK | Living Wage Commission. http://livingwagecommission.org.uk/new-report-from-the-living-wage-commission-sets-out-the-scale-of-low-pay-in-the-uk/ (accessed 27 Jun2014).

37 Commission publishes response to the draft child poverty strategy - News stories - GOV.UK. https://www.gov.uk/government/news/commission-publishes-response-to-the-draft-child-poverty-strategy (accessed 27 Jun2014).

38 Taylor-Robinson D, Rougeaux E, Harrison D, Whitehead M, Barr B, Pearce A. The rise of food poverty in the UK. BMJ 2013; 347. doi:10.1136/bmj.f7157.

39 Food aid research report - Publications - GOV.UK. https://www.gov.uk/government/publications/food-aid-research-report (accessed 30 Jun2014).

40 Morris N. Demand for food banks has nothing to do with benefits squeeze, says Work minister Lord Freud. The Independent. http://www.independent.co.uk/news/uk/politics/demand-for-food-banks-has-nothing-to-do-with-benefits-squeeze-says-work-minister-lord-freud-8684005.html (accessed 30 Jun2014).

41 Centre for Social Justice. Maxed Out Serious personal debt in Britain. London, Centre for Social Justice. 2013

42 Lawrence, M, Cooke, G. Jumping the Shark Building Institutions to spread access to affordable credit. London, IPPR. 2014

43 Banks S, Brown G, Flaherty J, Herrington T, Waters M. Debt on Teesside: Pathways to Financial Inclusion. , Durham University, 2013.

44 Bryan, M, M T, Veliziotis, M. Over-indebtedness in great britain: an analysis using the wealth and assets survey and household annual debtors survey. Essex, ISER. 2010

45 Local authority non-decent homes: provisional estimates 2009 to 2010 - Publications - GOV.UK. https://www.gov.uk/government/publications/local-authority-non-decent-homes-provisional-estimates-2009-to-2010 (accessed 27 Jun2014).

46 Kelly L. Census 2011: the facts about the housing crisis. The Guardian. 2012.http://www.theguardian.com/housing-network/2012/dec/12/census-housing-at-a-glance (accessed 30 Jun2014).

47 Northern Economic Futures Commission. Northern Prosperity is National Prosperity. , IPPR North, 2012. http://indice.astrid-online.it/La-produtt/Studi--ric/IPPR_northern-prosperity_Nov2012.pdf (accessed 31 Jul2014).

48 Benefit expenditure and caseload tables 2013 - Publications - GOV.UK. https://www.gov.uk/government/publications/benefit-expenditure-and-caseload-tables-2013 (accessed 1 Aug2014).

49 Bambra C, Eikemo TA. Welfare state regimes, unemployment and health: a comparative study of the relationship between unemployment and self-reported health in 23 European countries. J Epidemiol Community Health 2008; 63: 92–8.

50 Barr B, Taylor-Robinson D, Scott-Samuel A, McKee M, Stuckler D. Suicides associated with the 2008-10 economic recession in England: time trend analysis. BMJ 2012; 345: e5142–e5142.

51 Bambra C. Work, Worklessness, and the Political Economy of Health, 1 edition. Oxford ; New York, OUP Oxford, 2011.

52 Moser KA, Fox AJ, Jones DR. Unemployment and Mortality in the OPCS Longitudinal Study. Orig Publ Vol 2 Issue 8415 1984; 324: 1324–9.

53 Strandh M, Winefield A, Nilsson K, Hammarstrom A. Unemployment and mental health scarring during the life course. Eur J Public Health 2014; 24: 440–5.

54 Hammarstrom A. Early unemployment can contribute to adult health problems: results from a longitudinal study of school leavers. J Epidemiol Community Health 2002; 56: 624–30.

55 Marmot M. Fair Society, Healthy Lives. London, UCL, 2010.

56 Kuper H, Marmot M. Job strain, job demands, decision latitude, and risk of coronary heart disease within the Whitehall II study. J Epidemiol Community Health 2003; 57: 147 –153.

57 Marmot MG, Bosma H, Hemingway H, Brunner E, Stansfeld S. Contribution of job control and other risk factors to social variations in coronary heart disease incidence. The Lancet 1997; 350: 235–9.

58 Stansfeld SA, Head J, Marmot MG. Explaining social class differences in depression and well-being. Soc Psychiatry Psychiatr Epidemiol 1998; 33: 1–9.

59 Robone S, Jones AM, Rice N. Contractual Conditions, Working conditions, Health and Well-Being in the British Household Panel Survey. , HEDG, c/o Department of Economics, University of York, 2008.http://ideas.repec.org/p/yor/hectdg/08-19.html (accessed 13 Jun2014).

60 Gibson M, Petticrew M, Bambra C, Sowden AJ, Wright KE, Whitehead M. Housing and health inequalities: A synthesis of systematic reviews of interventions aimed at different pathways linking housing and health. Health Place 2011; 17: 175–84.

61 Liddell C, Morris C. Fuel poverty and human health: A review of recent evidence. Energy Policy 2010; 38: 2987–97.

62 Richardson T, Elliott P, Roberts R. The relationship between personal unsecured debt and mental and physical health: A systematic review and meta-analysis. Clin Psychol Rev 2013; 33: 1148–62.

63 O'Neill B, Sorhaindo B, Xiao JJ, Garman ET. Financially Distressed Consumers: Their Financial Practices, Financial Well-Being, and Health. Rochester, NY, Social Science Research Network, 2013. http://papers.ssrn.com/abstract=2255121 (accessed 1 Aug2014).

64 Patel V. Chronic fatigue in developing countries: population based survey of women in India. BMJ 2005; 330: 1190–0.

65 Ochsmann EB, Rueger H, Letzel S, Drexler H, Muenster E. Over-indebtedness and its association with the prevalence of back pain. BMC Public Health 2009; 9: 451.

66 Webley P, Nyhus EK. Life-cycle and dispositional routes into problem debt. Br J Psychol 2001; 92: 423–46.

67 THE CITY GROWTH COMMISSION. Connected Cities: The link to growth. , RSA, 2014.

68 The New Economics Foundation. The Good Jobs Plan. , 2011.http://www.neweconomics.org/publications/entry/the-good-jobs-plan (accessed 29 Jun2014).

69 Stiglitz JE, Sen A, Fitoussi J-P. Report by the commission on the measurement of economic performance and social progress. Paris Comm Meas Econ Perform Soc Prog 2010.http://www.citymaking.com/wp-content/uploads/2010/01/19784660-Happiness-and-Measuring-Economic-Progress-by-Joseph-Stiglitz.pdf (accessed 24 Feb2014).

70 Barr B, Clayton S, Whitehead M, et al. To what extent have relaxed eligibility requirements and increased generosity of disability benefits acted as disincentives for employment? A systematic review of evidence from countries with well-developed welfare systems. J Epidemiol Community Health 2010; 64: 1106 –1114.

71 Holland P, Burström B, Whitehead M, et al. How Do Macro-Level Contexts and Policies Affect the Employment Chances of Chronically Ill and Disabled People? Part I: The Impact of Recession and Deindustrialization. Int J Health Serv 2011; 41: 395–413.

72 Stuckler D, Basu S, Suhrcke M, Coutts A, McKee M. The public health impact of economic crises and alternative policy responses in Europe. Lancet 2009; 374: 315–23.

73 Health Action Partnership International and the Scottish Government. Working for Equity in Health. , HAPI, 2012.http://www.hapi.org.uk/what-we-do/working-for-equity-in-health/ (accessed 5 Mar2012).

74 Clayton S, Bambra C, Gosling R, Povall S, Misso K, Whitehead M. Assembling the evidence jigsaw: insights from a systematic review of UK studies of individual-focused return to work initiatives for disabled and long-term ill people. BMC Public Health 2011; 11: 170.

75 Clayton S, Barr B, Nylen L, et al. Effectiveness of return-to-work interventions for disabled people: a systematic review of government initiatives focused on changing the behaviour of employers. Eur J Public Health 2011. doi:10.1093/eurpub/ckr101.

76 Warren J, Bambra C, Kasim A, Garthwaite K, Mason J, Booth M. Prospective pilot evaluation of the effectiveness and cost-utility of a 'health first' case management service for long-term Incapacity Benefit recipients. J Public Health 2014; 36: 117–25.

77 Nice. Management of Longterm Sickness and Incapacity from Work. , 2009.

78 Data shows Work Programme failures | News | theguardian.com. http://www.theguardian.com/news/datablog/2012/nov/27/data-work-programme-failures (accessed 24 Feb2014).

79 Riley T, Bivand P, Wilson T. Making the Work Programme work for ESA claimants. , Centre for Economic and Social Inclusion, 2014.

80 Lawton P, Cooke G, Pearce N. The Condition of Britain: Strategies for social renewal. , IPPR, 2014.http://www.ippr.org/read/the-condition-of-britain-strategies-for-social-renewal (accessed 1 Aug2014).

81 Pickett K. Addressing health inequalities through greater social equality at a local level: Implement a Living wage Policy. London: The British Academy, 2014

82 The Living Wage Comission. Work That Payrs the Final Report of The Living Wage Commission. http://livingwagecommission.org.uk/living-wage-commission-reveals-blueprint-for-lifting-1m-out-of-low-pay/ (accessed 30 Jun2014).

83 Chernev A. The Psychology of Choice Overload: Implications for Financial Services. Madison, Filene Research Institute., 2011.

84 Gibbons D. Improving practice in the rent to own market. , London: Centre for Responsible Credit, 2012.http://www.friendsprovidentfoundation.org/wp-content/uploads/2013/03/Church_Action_on_Poverty_-_Improving_Practice_in_the_Rent_to_Own_Market_-_Full_Report.pdf (accessed 1 Aug2014).

85 NAO. The Decent Homes Programme. , NAO, 2010.

86 NAO. Housing market renewal Housing, programme review. London, National Audit Office, 2011.

87 Hull A, Cooke G. Together at home. A new strategy for housing. London, IPPR. 2012

88 AGMA. Stronger Together Greater Manchester Strategy 2013. , 2013.

89 Lucas L. A third of councils are considering compulsory landlord licensing. The Guardian. 2013.http://www.theguardian.com/housing-network/2013/may/29/councils-considering-compulsory-landlord-licensing (accessed 30 Jun2014).

90 UNICEF's report on child well-being | UNICEF UK. http://www.unicef.org.uk/UNICEFs-Work/What-we-do/Issues-we-work-on/Child-well-being/ (accessed 30 Jun2014).

91 Wang H, Liddell CA, Coates MM, et al. Global, regional, and national levels of neonatal, infant, and under-5 mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet 2014. doi:10.1016/S0140-6736(14)60497-9.

92 Taylor-Robinson D, Higgerson J, Anwar E, Gee I, Barr B. A Fairer Start for Children in the North of England. , Univeristy of Liverpool, 2014.

93 Mackenbach JP. Can we reduce health inequalities? An analysis of the English strategy (1997–2010). J Epidemiol Community Health 2011. doi:10.1136/jech.2010.128280.

94 Department of Health. Tackling health inequalities: A Programme for Action. London, Health Inequalities Unit, 2003.http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268 (accessed 20 Dec2011).

95 Judge L. Ending child poverty by 2020: progress made and lessons learned. London, Child Poverty Action Group, 2012.

96 Reed H, Portes P. Understanding the parental employment scenarios necessary to meet the 2020 Child Poverty Targets. , The Social Mobility and Child Poverty (SMCP) Commission, 2014.

97 Brown. The Impact of Austerity Measures on Households with Children. , Institute for Fiscal Studies, 2012.

98 Taylor-Robinson D, Barr B. Cuts to early years children's services threaten the most disadvantaged. The Conversation. 2014. http://theconversation.com/cuts-to-early-years-childrens-services-threaten-the-most-disadvantaged-25280 (accessed 9 Apr2014).

99 Allen G. Early intervention: smart investment, massive savings, the second independent report to Her Majesty's government. , The Stationery Office, 2011.

100 Heckman J. Skill Formation and the Economics of Investing in Disadvantaged Children. Science 2006; 312: 1898–900.

101 Bremberg S. Does an increase of low income families affect child health inequalities? A Swedish case study. J Epidemiol Community Health 2003; 57: 584–8.

102 Rajmil L, de Sanmamed M-JF, Choonara I, et al. Impact of the 2008 Economic and Financial Crisis on Child Health: A Systematic Review. Int J Environ Res Public Health 2014; 11: 6528–46.

103 Field F. The Foundation Years: preventing poor children becoming poor adults. The report of the Independent Review on Poverty and Life Chances. , HM Government, 2010.

104 Esping-Andersen G. Untying the Gordian Knot of Social Inheritance. Res Soc Stratif Mobil 2004; 21: 115–38.

105 Shonkoff JP, Bales SN. Science Does Not Speak for Itself: Translating Child Development Research for the Public and Its Policymakers: Translating Research for Policymakers. Child Dev 2011; 82: 17–32.

106 Ben-Galim D, Pearce N, Thompson S. NO MORE BABY STEPS A STRATEGY FOR REVOLUTIONISING CHILDCARE. London, IPPR, 2014.

107 Melhuish E, Belsky J, Leyland AH, Barnes J. Effects of fully-established Sure Start Local Programmes on 3-year-old children and their families living in England: a quasi-experimental observational study. The Lancet 2008; 372: 1641–7.

108 Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New Framework for Health Promotion and Disease Prevention. JAMA 2009; 301: 2252.

109 Roberts H. What Works in Reducing Inequalities in Child Health? , Policy Press, 2012.

110 Sen A. Development as Freedom, New Ed edition. , Oxford Paperbacks, 2001.

111 Pickett K, Wilkinson R. The Spirit Level: Why Greater Equality Makes Societies Stronger. , Bloomsbury Publishing, 2010.

112 OECD. Government at a Glance 2011. , OECD Publishing, 2011.http://www.oecd-ilibrary.org/governance/government-at-a-glance-2011_gov_glance-2011-en (accessed 8 Jul2014).

113 Michelsen C, Boenisch P, Geys B. (De) Centralization and voter turnout: theory and evidence from German municipalities. Public Choice 2014; 159: 469–83.

114 Lodge, G, Gottfried, G. Democracy in Britain: Essays in honour of James Cornford. London, IPPR, 2014.http://www.ippr.org/publications/democracy-in-britain-essays-in-honour-of-james-cornford (accessed 1 Jul2014).

115 HM Treasury. Public expenditure statistical analyses 2013. London, The Stationery Office, 2013.

116 LGA. Council leaders say these cuts simply cannot go on. 2013.http://www.theguardian.com/theobserver/2013/jun/16/letters-council-leaders-protest-cuts (accessed 12 Sep2013).

117 Lodge G. Divided democracy: Political inequality in the UK and why it matters. , IPPR, 2013.

118 Barr B, Higgerson J. Local democracy – Enhancing community control to reduce health inequalities. , University of Liverpool, 2014.

119 Bosma H, Van Jaarsveld CHM, Tuinstra J, et al. Low control beliefs, classical coronary risk factors, and socio-economic differences in heart disease in older persons. Soc Sci Med 2005; 60: 737–45.

120 Syme SL. Social Determinants of Health: The Community as an Empowered Partner. Prev Chronic Dis 2004; 1.http://www.ncbi.nlm.nih.gov.ezproxy.liv.ac.uk/pmc/articles/PMC544525/ (accessed 21 Feb2014).

121 Chandola T, Kuper H, Singh-Manoux A, Bartley M, Marmot M. The effect of control at home on CHD events in the Whitehall II study: Gender differences in psychosocial domestic pathways to social inequalities in CHD. Soc Sci Med 2004; 58: 1501–9.

122 Griffin JM, Fuhrer R, Stansfeld SA, Marmot M. The importance of low control at work and home on depression and anxiety: do these effects vary by gender and social class? Soc Sci Med 2002; 54: 783–98.

123 Bosma H. A critical reflection on the role of social democracy in reducing socioeconomic inequalities in health: A commentary on Sekine, Chandola, Martikainen, Marmot and Kagamimori. Soc Sci Med 2009; 69: 1426–8.

124 Franco A. Effect of democracy on health: ecological study. BMJ 2004; 329: 1421–3.

125 Powell-Jackson T, Basu S, Balabanova D, McKee M, Stuckler D. Democracy and growth in divided societies: A health-inequality trap? Soc Sci Med 2011; 73: 33–41.

126 Krieger N, Chen JT, Coull B, Waterman PD, Beckfield J. The Unique Impact of Abolition of Jim Crow Laws on Reducing Inequities in Infant Death Rates and Implications for Choice of Comparison Groups in Analyzing Societal Determinants of Health. Am J Public Health 2013; 103: 2234–44.

127 Mackenbach JP, McKee M. Social-Democratic Government and Health Policy in Europe: A Quantitative Analysis. Int J Health Serv 2013; 43: 389–413.

128 Kawachi I, Kennedy BP, Lochner K, Prothrow-Stith D. Social capital, income inequality, and mortality. Am J Public Health 1997; 87: 1491–8.

129 Hill KQ, Leighley JE. The Policy Consequences of Class Bias in State Electorates. Am J Polit Sci 1992; 36: 351.

130 Yodanis CL. Gender Inequality, Violence Against Women, and Fear A Cross-National Test of the Feminist Theory of Violence Against Women. J Interpers Violence 2004; 19: 655–75.

131 Swiss L, Fallon KM, Burgos G. Does Critical Mass Matter? Women's Political Representation and Child Health in Developing Countries. Soc Forces 2012; : sos169.

132 Young FW. Structural pluralism and life expectancy in less-developed countries: The role of women's status. Soc Indic Res 2001; 55: 223–40.

133 Ahmed S, Creanga AA, Gillespie DG, Tsui AO. Economic Status, Education and Empowerment: Implications for Maternal Health Service Utilization in Developing Countries. PLoS ONE 2010; 5: e11190.

134 Scanlan SJ. Gender, development, and HIV/AIDS: Implications for child mortality in less industrialized countries. Int J Comp Sociol 2010; 51: 211–32.

135 Whitehead M. Is control in the living environment important for health and wellbeing, and what does this mean for public health interventions? http://phrc.lshtm.ac.uk/project_2011-2016_004.html (accessed 29 Nov2013).

136 Popay J, Attree P, Hornby D, et al. Community engagement to address the wider social determinants of health: A review of evidence on impact, experience & process. London, National Institute for Health and Clinical Excellence, 2007. http://www.nice.org.uk/guidance/index.jsp?action=folder&o=34709.

137 Costa-i-Font J. Does devolution lead to regional inequalities in welfare activity? Environ Plan C Gov Policy 2010; 28: 435–49.

138 Pierson P. The new politics of the welfare state. World Polit 1996; 48: 143–79.

139 Local People Demand More Power To England's Cities | Core Cities. http://www.corecities.com/news-events/local-people-demand-more-power-englands-cities (accessed 2 Aug2014).

140 GM Growth and Reform Plan : GMCA : AGMA Policy and Research Unit. http://www.agma.gov.uk/gmca/gm-growth-reform-plan/index.html (accessed 2 Aug2014).

141 Devolution for the North-east? The possibility that Scotland will govern itself has re-invigorated those in the north of England who want more local powers - UK Politics - UK - The Independent. http://www.independent.co.uk/news/uk/politics/an-independent-northeast-the-possibility-that-scotland-will-govern-itself-has-reinvigorated-those-in-the-north-of-england-who-want-more-local-powers-9292704.html (accessed 11 Jul2014).

142 Cabannes Y. Participatory budgeting: a significant contribution to participatory democracy. Environ Urban 2004; 16: 27–46.

143 Sintomer Y, Herzberg C, RöCke A. Participatory Budgeting in Europe: Potentials and Challenges: Participatory budgeting in Europe. Int J Urban Reg Res 2008; 32: 164–78.

144 Communities in the driving seat: a study of Participatory Budgeting in England Final report. .

145 McKenzie K. Using Participatory Budgeting to Improve Mental Capital at the Local Level. London: The British Academy, 2014

146 DCLG. A National Strategy for Participatory Budgeting, Giving more people a say in local spending. , DCLG, 2008.

147 Reed S, Usher K. Towards co-operative councils: empowering people to change their lives. , The Cooperative, 2013.

148 NICE. Community engagement. NICE. http://www.nice.org.uk/ (accessed 24 Feb2014).

149 Davis K, Stemikis K, Squires D, Schoen C. Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally. New york, The Commonwealth Fund. http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror (accessed 9 Jul2014).

150 Whitehead M, Doran T, Exworthy M, Richards S, Matheson D. Delivery systems and mechanisms for reducing inequalities in both social determinants and health outcomes. Final report of Task Group 7. London, Institute of Health Equity, 2009.

151 Campbell S, Reeves D, Kontopantelis E, Middleton E, Sibbald B, Roland M. Quality of Primary Care in England with the Introduction of Pay for Performance. N Engl J Med 2007; 357: 181–90.

152 Mackenbach JP. An analysis of the role of health care in reducing socioeconomic inequalities in health: the case of the Netherlands. Int J Health Serv Plan Adm Eval 2003; 33: 523–41.

153 Department of Health. The NHS Plan: A Plan for Investment : a Plan for Reform. Lodon, Stationery Office, 2000.

154 Tudor Hart J. THE INVERSE CARE LAW. The Lancet 1971; 297: 405–12.

155 Hanratty B, Zhang T, Whitehead M, How Close have Universal Health Systems Come to Achieving Equity in Use of Curative Services? Int J Health Serv 2007. 37 (1) 89–109.

156 Dixon A, Le Grand J, Henderson J, Murray R, Poteliakhoff E. Is the British National Health Service equitable? The evidence on socioeconomic differences in utilization. J Health Serv Res Policy 2007; 12: 104–9.

157 Thompson G. NHS expenditure in England. London, The Library of the House of Commons, 2009.

158 Barr B, Taylor-Robinson D. Poor areas lose out most in new NHS budget allocation. BMJ 2014; 348: g160–g160.

159 Rimmer A. GPs vote against charging patients for their services. BMJ 2014; 348: g3498–g3498.

160 Wanless D. Securing Good Health for the Whole Population: Final Report. , H.M. Stationery Office, 2004.

161 Brook R, Ware J, Rogers W, Keeler E, Davies A, Sherbourne C. The Effect of Coinsurance on the Health of Adults. , RAND Corporation, 1984.

162 Bambra C, Garthwaite K, Hunter D. All things being equal: Does it matter for equity how you organise and pay for health care? a review of the international evidence. Int J Health Serv 2014; : 457–72.

163 Boorman S. NHS Health and Wellbeing. The Boorman review. Final Report. London, Department of Health, 2009. http://www.nhshealthandwellbeing.org/FinalReport.html (accessed 9 Jul2014).

164 FE data library: apprenticeships - Statistical data sets - GOV.UK. https://www.gov.uk/government/statistical-data-sets/fe-data-library-apprenticeships--2 (accessed 4 Jul2014).

165 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005; 83: 457–502.

166 Cooper C, Sandhu S. NHS crisis: Tory health expert warns we have 'the wrong workforce' for the future due to 'huge bias' towards training specialists - and leaving surgeries crying out for GPs. The Independent. http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-crisis-tory-health-expert-warns-we-have-the-wrong-workforce-for-the-future-due-to-huge-bias-towards-training-specialists--and-leaving-surgeries-crying-out-for-gps-9587247.html (accessed 9 Jul2014).

167 Millions facing postcode lottery over GP appointments. http://www.rcgp.org.uk/news/2014/june/millions-facing-postcode-lottery-over-gp-appointments.aspx (accessed 9 Jul2014).

168 Plans to improve primary care - Publications - GOV.UK. https://www.gov.uk/government/publications/plans-to-improve-primary-care (accessed 9 Jul2014).

169 GPs at the Deep End. What can NHS Scotland do to prevent and reduce health inequalities? Proposals from General Practitioners at the Deep End. 2013.

170 Greasley P, Small N. Welfare Advice in Primary Care. , University of Leeds, Nuffield Institute for Health, 2002.

171 Bewley H, Dorsett R, Ratto M. Evidence of the effect of Pathways to work on existing claimants. , 2008.

172 Popay J, Kowarzik U, Mallinson S, Mackian S, Barker J. Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part I: the GP perspective. J Epidemiol Community Health 2007; 61: 966–971.

173 De Maeseneer J, Willems S, De Sutter A, Van de Geuchte I, Billings M. Primary health care as a strategy for achieving equitable care. , The Health Systems Knowledge Network WHO Commission on the Social Determinants of Health, 2007. http://wwwlive.who.int/entity/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf (accessed 9 Jul2014).

174 Watt G. What can the NHS do to prevent and reduce health inequalities? Br J Gen Pract 2013; 63: 494–5.

175 HDA. NHS as a good corporate citizen – procurement. , HDA, 2004.

176 HDA. NHS as a good corporate citizen – employment. , HDA, 2004.

177 Buck D. Tackling health inequalities: we need a national conversation. http://www.kingsfund.org.uk/blog/2014/02/tackling-health-inequalities-we-need-national-conversation (accessed 20 Jun2014).

178 Scally G. Have we lost the battle to improve health inequalities? | The King's Fund. http://www.kingsfund.org.uk/time-to-think-differently/blog/have-we-lost-battle-improve-health-inequalities (accessed 7 Jul2014).

179 National Audit Office. Cross-government landscape review Formula funding of local public services. , The Stationery Office, 2011.

180 Nutbrown review reports - GOV.UK. https://www.gov.uk/government/collections/nutbrown-review (accessed 11 Aug2014).

181 Improving the transparency and accountability of government and its services - Policy - GOV.UK. https://www.gov.uk/government/policies/improving-the-transparency-and-accountability-of-government-and-its-services (accessed 1 Jul2014).

APPENDIX 1

Wintnesses to the Inquiry

At stated at the introduction of this report, there were three focused policy sessions over the course of the Inquiry which played a key role in the development of the recommendations. Each of these sessions was attended by panel members and invited practitioners, with expertise in the relevant policy fields. The invited witnesses were.

Session one: Community and democracy

- Jo Whaley, Policy Lead, Regional Voices (Voluntary and Community Sector partnership)
- Robin Lawler, Chief Executive, Northwards Housing
- Alyson McGregor, Director, Altogether Better
- Craig Sharp, Assistant Director of Environmental Health, Preston City Council
- Paul Foley, Health Lead, UNISON North West
- Councillor Margaret Morris, Assistant Mayor, Health and Well-being, Salford City Council

Session two: Early years

- Wendy Meredith, Director of Public Health (Greater Manchester early years lead), Bolton Council
- Hazel Paterson, Service Manager, Children's Centres, Early Help Team, Liverpool City Council
- Liz Gaulton, Director of Public Health, St Helens Council
- Beatrice Merrick, Chief Executive, Early Education (membership organisation providing support for early years work and education)
- Bev Morgan, Chief Executive, Homestart Wirral
- Councillor Mark Dennet, Halton Borough Council (Chairman of Halton's Young People and Families and Policy and Performance Board)

Session three: Economic development and welfare policies

- Dr Paul Williams, GP in Stockton-on-Tees
- Charlotte Harrison, Northern Housing Consortium
- Isobel Mills (former) BIS Regional Director, Yorkshire and Humber
- Mark Jones, Head of Economic Development, Hull City Council
- Phil Witcherley, Head of Policy, York City Council
- Andrea Edwards, Stockton Food Bank

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of:	Joe Fowler, Director of Commissioning, Sheffield City Council
Date:	25 September 2014
Subject:	Funding Transfer from NHS England to Social Care
Author of Report:	Laura Pattman, 0114 273 5763

Summary:
An update to the Board of details of the Section 256 transfer from the NHS to fund adult social care services.

Recommendations:
To note and approve the funding transfer.

Reasons for Recommendations:
To evidence the agreement of the Health and Wellbeing Board and enable the transfer to take place.

Funding Transfer from NHS England to Social Care

Joint Proposal from Sheffield City Council and NHS Sheffield CCG

1.0 SUMMARY

1.1. In the Comprehensive Spending Review (CSR) it was announced that social care nationally would receive funding from the NHS funds. For Sheffield, this amounts to £12,399,125 (an increase on the 2013/14 allocation, which was £9,682,589).

1.2 The Department of Health has asked that as part of the agreement to transfer these funds Health and Wellbeing Boards approve the use of the funding. This joint report from the Clinical Commissioning Group (CCG) and Local Authorities sets out the agreement regarding the use of the funding, the measured outcomes and the agreed monitoring arrangements.

1.3 In line with the notification from the Department of Health this level of funding was factored in to the Councils 2014/15 budget plans when the budget was set in March.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE

2.1 This funding will enable the city council to continue with the existing eligibility criteria and support early hospital discharge.

2.2 It is important, particularly in the current economic climate, that Sheffield City Council spends its money effectively, efficiently and with a targeted approach.

3.0 MAIN BODY OF THE REPORT

3.1 The Department of Health has specified that the funding must be used to support adult social care services in each local authority, which also has a health benefit. The Department considers that Health and Wellbeing boards is the natural place for discussions between the NHS England, Clinical Commissioning Groups and Local Authorities on how the funding should be spent, and what outcomes will be achieved, as part of their wider discussions on the use of their total health and care resources.

3.2 As a condition of the transfer, local authorities and CCGs need to have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in determining how the funding is used. Local authorities also need to demonstrate how the funding transfer makes a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

3.3 Discussions were held in early 2014 between Sheffield City Council and NHS Sheffield CCG regarding the priorities for use of this funding. It was agreed that the majority of the funding should be prioritised to maintain the existing eligibility criteria (in line with the use of the funding received in 2013/14). It was also agreed that the priority for the use of the additional funding allocated in 2014/15 (compared to

2013/14) should be used to support the priorities agreed in the partnership wide 'Right First Time' Programme, specifically ensuring that there is sufficient capacity in social care services to enable people to be discharged from hospital as soon as they no longer need acute medical care with the appropriate care and support.

3.4 It is proposed that the funding is transferred to the local authority under an NHS Act (2006) S256 agreement, and that expenditure is committed in line with existing priorities as listed below

Service Area	**Allocation (£)**	**Outcome**
Maintaining the existing eligibility criteria	10,000,000	Maintaining care support levels for those eligible under Sheffield City Council's current eligibility criteria (substantial and critical only)
Early supported hospital discharge	2,399,124	Continued provision of support to ensure the early discharge from hospital, including short term intervention teams.
	12,399,124	

3.5 To ensure that the Department of Health's requirement for Health and Wellbeing Boards to consider this funding transfer as part of forward planning, a further report will presented to the Board with regard to the Councils budget process and the use of this funding for 2014/15.

3.6 The Department of Health guidance also requires quarterly updates on expenditure plans, as this funding has already been allocated in the Council's spending plans as outlined above the spend has already been committed and Adult Social Care is forecasting an overspend as at month 4 (July).

4. FINANCIAL IMPLICATIONS

4.1 The use of the funds has already been agreed as part of the City Council's budget and has been applied to provision of services. If the Board choose to determine a different allocation, the services provided will need to alter which may result in reduced packages of care depending on the decisions made.

5. RECOMMENDATION

5.1 The Board is recommended to agree the approach outlined in this report and support use of the Health Transfer as outlined above.

Eugene Walker
Executive Director of Resources
Sheffield City Council

Julia Newton
Director of Finance
NHS Sheffield CCG

This page is intentionally left blank

SHEFFIELD CITY COUNCIL

Sheffield Health and Wellbeing Board

Meeting held 26 June 2014

PRESENT: Dr Tim Moorhead (Chair), Clinical Commissioning Group

Ian Atkinson, Accountable Officer, Clinical Commissioning Group

Richard Armstrong, Interim Director of Commissioning, NHS England

Dr Nikki Bates, GP Governing Body Member, Sheffield Clinical Commissioning Group

Councillor Jackie Drayton, Cabinet Member for Children, Young People and Families

Councillor Mazher Iqbal, Cabinet Member for Communities and Public Health

Councillor Mary Lea, Cabinet Member for Health, Care and Independent Living

John Mothersole, Chief Executive, Sheffield City Council

Sue White, Chief Executive, Voluntary Action Sheffield

Dr Jeremy Wight, Director of Public Health

In Attendance

Tim Furness, Director of Business Planning & Partnerships, Sheffield Clinical Commissioning Group

Joe Fowler, Director of Commissioning, Sheffield City Council

Sue Greig, Consultant in Public Health, Sheffield City Council

Luke Morton, Programme Manager, Communities, Sheffield City Council

.....

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Julie Dore, Professor Pam Enderby, Margaret Kitching, Jayne Ludlam, Laraine Manley, Dr Zak McMurray, Dr Ted Turner and Moira Wilson.

2. DECLARATIONS OF INTEREST

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

3. PUBLIC QUESTIONS

3.1 Public Question Concerning Supported Living Services

Susan Highton asked a question concerning the proposal to look at alternative

providers of Supported Living, rather than these services remaining with the existing provider, the Sheffield Health and Social Care NHS Foundation Trust, which she stated, had a series of significant consequences, as follows:

- The cost of running down the service within the NHS are estimated in excess of £6M.

- The service users will not have a choice of service provider as suggested but rather will be told who has been chosen to provide the service for them.

- The current service provided by the NHS routinely has high dependency cases referred to it as other providers do not appear able or willing to take up these, with no NHS provision remaining who will pick up these high dependency cases.

- At meetings with service users' families and carers we have consistently been told they wish to remain with the NHS provider. Why has no thorough and full consultation been undertaken with them in advance of any changes?

- One proposal is to split the current service into several smaller contracts and these could include separate contracts for individual units on the same site. Currently, in busy times and emergencies NHS colleagues can call on other care workers providing the contract to assist in maintaining safe care provision. How will this work if 2 or more contractors are working across the same site.

Susan Highton stated that the budgetary pressures the City Council and the NHS have had and continue to face were understood, but this proposal involves high cost to the public purse and risk that with no proper alternative provision to fall back on, service users in crisis will be referred to hospital and then expensive out of city support as the only option available.

She asked why this proposal hasn't been referred to the appropriate Scrutiny Committee and a thorough and proper consultation carried out with service users, their families and carers.

Councillor Mary Lea, the Cabinet Member for Health, Care and Independent Living, responded to the questions. She said that the safety and wellbeing of service users was paramount. The Council had, over the past 3 years, increased the budget for services to people with learning disabilities, despite the context of funding cuts to the Council. The Council needed to ensure that it could deliver services in a cost effective way and make sure that people received the right care and were safe and well.

The Supported Living model for people with learning disabilities had general support and was considered the best model. It gave people independence and allowed them to make their own choices and was different to the service required in a residential care home.

The Health and Social Care NHS Foundation Trust had put itself forward as a potential service provider and there were also other supported living providers which had also put themselves forward. Approximately only 1 in 10 people in Sheffield in Supported Living settings were supported by the Health and Social Care NHS Foundation Trust.

The Council will work with residents in the 9 residential homes in order to select a provider and make sure there were high quality standards and that costs were reasonable. In similar processes within other care settings, residents had been engaged and independent advocacy had ensured that they had a say.

Financial pressures meant that the Council could not justify paying a high price for a service, if it was able to obtain services of an equivalent or higher quality from another provider.

Consultation had taken place with carers and service users.

Councillor Lea stated that she would provide a detailed response to the questions in writing.

3.2 Public Question Concerning Governance of the Health and Wellbeing Board

John Kay asked whether there were opportunities to use the Foundation Trust model, which had been in place for some time, and apply it in the governance of the Health and Wellbeing Board, to promote resource-sharing and increase engagement with the Health and Social Care NHS Foundation Trust.

Tim Moorhead, the Co-Chair of the Board, responded to the question. He stated that the Board was a formal committee of the City Council and there were not separate arrangements in place for governance. The overarching role of the Board was to make sure it was satisfied that the respective organisations in the City were delivering, including the Clinical Commissioning Group, the City Council and providers of health and social care. There had already been several engagement events with patients, service users and the public in general. However, the membership model adopted by the Foundation Trust may have some aspects which were worth further consideration.

Ian Atkinson, Accountable Officer, Sheffield Clinical Commissioning Group (CCG), stated that it would be potentially sensible to see how the existing membership of an organisation like the Foundation Trust might be used by the Clinical Commissioning Group.

Sue White, Chief Executive, Voluntary Action Sheffield, stated that Healthwatch was the mechanism through which patient and public voice could be represented and there was a need to take stock of all the organisations in the City that performed such a role. Healthwatch had a place on the Health and Wellbeing Board, through which the views of patients and public could be brought to the Board's attention.

4. INTEGRATION OF HEALTH AND SOCIAL CARE AND THE BETTER CARE FUND

4.1 The Board received a presentation on the integration of Health and Social Care and the Better Care Fund from Joe Fowler, Director of Commissioning, Sheffield City Council and Tim Furness, Director of Business, Planning and Partnerships, Sheffield Clinical Commissioning Group.

4.2 There were four main areas for commissioning, namely: keeping people well in their local community; intermediate care; independent living solutions; and long-term high support and these were outlined in more detail in the presentation. The presentation also provided an update on progress and a summary of forthcoming activity.

4.3 Members of the Board made comments on the issues raised by the presentation, as follows:-

4.4 There were risks in pursuing greater integration of health and social care and also risks in not doing so. It was considered that by working together, there might be mitigation of risks and this may include learning from pilots and some recalibration. Some capacity to deal with potential risks would be created by the City's health and social care organisations working together.

4.5 Whilst there was not, as yet, definitive data, some of the available data on integration was beginning to support the view that investment in prevention and at community level does pay-off. An evidence and scale based approach was required.

4.6 The approach taken might vary according to the circumstances in a particular area. Each area was different and the infrastructure and capacity of the community, for example in terms of the voluntary and community sector, may vary.

4.7 Academic partners may be engaged in evaluating the process of integration to see whether it was leading to the desired/intended results.

4.8 The approach which was being adopted was ambitious and was also the right one, which in the long term would improve services. It was recognised that there were risks and that change in respect of ethos, culture and expectations would take time to implement. Resources were being brought together and each of the respective organisations had its own governance arrangements. It was noted that Sheffield had the lowest number of children and young people in care as a result of the investment in early intervention and prevention.

4.9 NHS England were connected with the co-commissioning and integration plans.

4.10 There had been national challenge about how effective the approach being adopted would be. However, it was considered the right thing to do and, in

Sheffield, such changes were taking place before the Better Care Fund.

4.11 **Resolved:** that the Board notes the presentation.

5. THE CARE ACT 2014

5.1 The Board received a presentation form Luke Morton, Programme Manager, Communities, Sheffield City Council, concerning the Care Act 2014, which set out in law reforms to care and support services and changes to the funding of those services.

5.2 The presentation set out the implications of the changes, which would be brought about by the Act, both for Sheffield and for the Health and Wellbeing Board in relation to areas including the principle of wellbeing, a person-centred approach, prevention, supporting people to stay independent, increased co-operation in health and social care and service integration. The aims of the Better Care Fund aligned with the principles of the Act as did the commissioning workstreams and the financial implications of the Care Act would impact upon pooled budgets.

5.3 Consultation on draft regulations and guidance had begun on 6 June and would close on 15 August 2014.

5.4 Members of the Board commented upon the matters raised in the presentation, as summarised below:

5.5 In relation to standards of care set out in the Act and in terms of ensuring standards and possible rights of appeal, there was potential redress through the local authority, the Ombudsman and through Judicial Review. Case law would inform future judgements in circumstances where there were appeals or challenges to decisions.

5.6 It was confirmed that the implementation project group, which was in place to deliver change, included representation from other services including children's and adults' services, to make sure implications of the changes brought about by the Act were properly considered, for example the transition from childhood to adulthood.

5.7 **Resolved:** that the Board notes the presentation.

6. THE CHILDREN AND FAMILIES ACT 2014

6.1 The Board received a presentation from Sue Greig, Consultant in Public Health, Children, Young People and Families, concerning the Children and Families Act 2014, which would come into force in September 2014. The main aspects of the Act related to adoption, children in care and contact, family justice, Special Educational Needs, childcare reform and the welfare of children. It also included measures such as the rights of parents to request flexible working patterns and partner leave (for example to attend antenatal classes) and adoption leave and reinforced the office of the Children's Commissioner.

6.2 Key Issues for Health and Wellbeing Board Partners arising from the Act were joint accountability across health, education and social care for assessing and responding to children's needs, for example Education, Health and Care Plans; support for young carers, including in relation to their mental and emotional health needs as well as practical/social support; and support in school for children with medical conditions.

6.3 The Board commented on issues arising from the presentation, as follows:-

6.4 It was envisaged that integration would result in better outcomes for less, whilst there would be some cost associated with change. For example, there was the potential for reducing duplication and streamlining systems and greater efficiency.

6.5 Whilst it was disappointing that the City had not been successful in its 'best start' bid to the Lottery Fund, there had also been some transformational change as part of the preparations for the Lottery bid. The process had opened dialogue and there was most certainly commitment and momentum in this regard. In fact, the process was now not tied into the more prescriptive aspects of the Lottery bid. There were some indications of how external support might be obtained; and consideration was being given as to where effort would be focussed. The strategy group was meeting to look at potential opportunities.

6.6 Some work relating to children and young people which addressed issues within the Act was already happening. For example, the creation of a Head of Virtual School for Looked After Children. In Sheffield, opportunities had been created for young people in care, who might previously have left care at age 18, which the Act had now sought to address in law. The challenge was with regard to transition from child to adult services and in seeing a person in the context of their whole life and not simply a child or adult.

6.7 The Care Act and the Children and Families Act shared a policy backbone and local authorities and partner organisations were encouraged to identify an individual's ongoing need and to avoid implementing the two Acts in isolation of one another.

6.8 **Resolved:** that the Board notes the presentation.

7. HEALTH INEQUALITIES PLAN

7.1 The Board considered a report of the Leader of Sheffield City Council and the Chair of NHS Sheffield Clinical Commissioning Group concerning the Health Inequalities Action Plan. The report sought approval to the plan, which was designed to implement the actions identified in the Health and Wellbeing Strategy during the financial years 2014/15 to 2016/17.

7.2 Dr Jeremy Wight, Director of Public Health, introduced the report and stated that the plan was work in progress, which was subject to adaptation and change. Engagement events had been held, which looked at what the Health and

Wellbeing Board could do to tackle health inequalities. The plan would be subject to an annual report of progress.

7.3 The Board was asked to consider several areas, including the identification of leads and reporting mechanisms relating to the actions identified in the Strategy and included in the plan; the identified priority tasks; and the measures of impact. The Board was also asked to consider the addition of the action proposed at paragraph 3.10 in the report to the Health and Wellbeing Strategy and to the plan, which was to promote health literacy and early engagement with health services in disadvantaged communities.

7.4 Members of the Board made comments on the matters contained in the report and accompanying Health Inequalities Plan, summarised as follows:-

7.5 The Clinical Commissioning Group (CCG) should take the lead in relation to actions 3.4 (Identify which groups are least able to access services and establish reasons and consequences. Work to improve access, prioritise areas with significant health consequences, and simplify how people access care.) and 3.7 (Commission disease-specific interventions, including a programme to improve the physical health of the severely mentally ill or those with a learning disability).

7.6 The engagement events had been positive and Healthwatch would work with public health colleagues to identify what was and what was not working well. The plan had been changed in light of the engagement events, which included the addition of the action to increase health literacy. Further engagement events would be welcomed.

7.7 The work relating to children with complex needs, special educational needs and disabilities would require more development and would be connected with action relating to children's mental health, emotional wellbeing and resilience.

7.8 NHS England had ambitions to improve public health services and were keen to work with the Clinical Commissioning Group in relation to implementation in Sheffield through the CCG and the local authority.

7.9 The Health Inequalities Action Plan represented progress and was core business of the Health and Wellbeing Board.

7.10 Health inequalities were a consequence of the inequalities in society at large and the Action Plan included measures to help mitigate those wider inequalities but would also require long term change.

7.11 The identified leads for each action would be notified that they would be responsible for delivery and to report on actions allocated to them.

7.12 **Resolved** that the Board:

1. Formally approves the Health Inequalities Action Plan, whilst accepting that further work is required on the detail;

2. Approves the addition of the action 3.10 to the Health and Wellbeing Strategy and to the Plan, which was to promote health literacy and early engagement with health services in disadvantaged communities;

3. Requests the identified lead individuals and relevant Groups and/or Boards to implement the Plan; and

4. Requests an annual report on progress.

8. HEALTHWATCH SHEFFIELD ANNUAL REPORT

8.1 The Board received a presentation concerning the Healthwatch Sheffield Annual Report from Sue White, Chief Executive, Voluntary Action Sheffield and acting Chief Officer Healthwatch Sheffield. The Annual Report would be launched on 16 July 2014.

8.2 The presentation outlined the role and reach of Healthwatch Sheffield with regard to engagement, gathering peoples' views and providing information and advice. Healthwatch also had a role in raising awareness and influencing and improving services. Reports and recommendations had been produced for the CCG Group Select Committee inquiry; concerns over a specialist care provider had led to an escalation of concerns to the Care Quality Commission; and consultation had been undertaken in relation to the Adult Social Care Review.

8.3 Challenges for Healthwatch included resources and capacity and concerned how collectively the organisations represented on the Health and Wellbeing Board could make the most of the various means of listening and involving people.

8.4 Members of the Board commented and raised matters arising from the presentation, as summarised below:-

8.5 The 100,000 people 'reached' referred to information on websites, and media including newspapers and radio stations and the figure was an estimate of the number of listeners or readership of a particular publication and included dialogue events.

8.6 Those groups which were considered to be hard to reach were contacted through existing networks of organisations, for example, Sheffield carers' organisations, the Black and Minority Ethnic (BME) Network and a community event with members of the Roma community. It was also requested that young persons' groups including the young carers' group were included in such activity.

8.7 The former Chief Officer of Healthwatch had left in April 2014 and the organisation was considering whether the post would be replaced or not in the new structure. Interim arrangements were in place. The situation would be kept under review.

8.8 It was recognised that Healthwatch had to continue to be effective and also maintain an independent voice and that it might need support in that regard. This

might include learning from elsewhere in the country.

8.9 The health and social care system was undergoing significant change and this also needed to be reflected in the work of Healthwatch, which was listening to people with regard to the effect of decisions relating to change on patients and the public.

8.10 **Resolved:** that the Board notes the presentation concerning the Healthwatch Annual Report 2013/14.

9. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the Board held on 27 March 2014 were approved as a correct record.

10. DATE AND TIME OF NEXT MEETING

The next meeting of the Board would take place on Thursday 25 September 2014 at 2.00pm.

This page is intentionally left blank