SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of: Dr Stephen Horsley, Director of Public Health

Date: 25 June 2015

Subject: Update on the Joint Health and Wellbeing Strategy:

Outcome 3 – Health inequalities are reducing

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Summary:

The Health and Wellbeing Board's Joint Health and Wellbeing Strategy is the overarching city strategy in all matters relating to health and wellbeing. Outcome 3 of the Strategy focuses on what the Health and Wellbeing Board can do to help reduce health inequalities.

This report sets out progress under each action over the past year and things the Health and Wellbeing Board can do to ensure progress continues.

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:
    - How to maximise other opportunities to target work on tackling health inequalities, such as Ageing Better, Prime Minister's Challenge Fund, Integrated Commissioning Programme.
    - How to better coordinate the work done to develop community resilience (see information on action 3.2).
    - How to support services in areas with high numbers of new arrivals (see information on action 3.6).
- Support the ongoing programme of needs assessment.
- Request another update on this outcome in June 2016.

Background Papers:

- Sheffield Joint Health and Wellbeing Strategy 2013-18: https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/joint-health-and-wellbeing-strategy.html.
- Report to the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee in February 2015 on the Health Inequalities Plan: http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=137&MId=5668&Ver=4.
- Report to the Health and Wellbeing Board in June 2014 about the Health Inequalities Plan and engagement event on the topic in May 2014: http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5547&Ver=4.
- Report to the Health and Wellbeing Board in June 2013 about its response to the Fairness Commission's recommendations: http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5088&Ver=4.

Sheffield Health and Wellbeing Board
Update on the Joint Health and Wellbeing Strategy
Outcome 3 – Tackling health inequalities
June 2015

1. What is this outcome about?

Outcome 3 is focussed on those people and communities who experience the poorest health and wellbeing. We need to address those communities who experience the worst health and wellbeing inequalities.

Sheffield is characterised by stark inequalities between different groups of people and between different geographical communities. People in the most deprived parts of the City still experience a greater burden of ill-health and early death than people in less deprived areas, demonstrating that inequalities in health and wellbeing are linked to wider social, cultural and economic issues.

It is acknowledged that putting additional support into the most disadvantaged areas and raising standards there will have a beneficial effect on the whole community. Groups such as 'Looked After Children', children with learning difficulties and disabilities, some Black and Minority Ethnic (BME) communities, migrant and asylum communities, homeless people, victims of domestic and sexual abuse, carers and lesbian, gay, bisexual and transgender people, are all reported nationally to have below average health.

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

2. How are we performing? – Indicators for outcome 3

The over-arching indicator for this outcome is the slope index of inequality in life expectancy at birth. This measures the gap (in years) in life expectancy between the most and least deprived people in the City (reported separately for males and females). Although the figures fluctuate from year to year, longer term trends show that: the gap is little changed for both men and women; the gap for women (6.9 years) is consistently smaller than that for men (9.7 years) and: remains worse than the national gap for men (9.1 years) and on a par with England for women (6.9 years). Efforts to reduce premature and preventable mortality from cardiovascular disease, cancer, liver disease and respiratory disease remain essential alongside wider work on poverty, income and employment.

There are similar fluctuations from year to year for the winter deaths indicator, although this has remained consistently better than the England average. Nevertheless, the most recent figure indicates that there were almost 240 excess winter deaths in Sheffield in 2012-13 of which around two thirds were in people aged 85 years and over. Reducing fuel poverty is a key factor in tackling this health inequality, alongside reducing social isolation for older vulnerable people.

The third indicator included under this outcome is excess premature mortality in people with a serious mental illness. The Disability Rights Commission has reported on serious inequalities experienced, in terms of reduced life expectancy, by those with severe mental

illness and there is extensive published evidence that people with severe mental illness, such as schizophrenia, die between 15 and 25 years earlier than the average for the general population. People with mental illness in Sheffield experience similar levels of inequality as people nationally but the actual local gap (based on 2012-13) is around 200 more premature deaths than people of a similar age without mental illness. Focussing on the physical health needs of people with mental illness is of paramount importance in terms of tackling this aspect of health inequality, reducing social exclusion for this group within our population is also important.

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

Although the Joint Strategic Needs Assessment contained detailed information on health inequalities and socio-economic deprivation at small area level, it recognised that further evidence was required in relation to other drivers of health inequalities. Specifically this related to personal characteristics such as gender, ethnicity or disability. The need for this type of evidence was reinforced in the Board's Health Inequalities Plan where it was identified that a programme of health needs assessments (HNAs) be undertaken for an agreed number of communities of interest. In addition, as part of signing up to St Mungo's Broadway Homeless Health Charter,[1] the Board committed to measure and understand homeless people's health needs and to use this information to help with future planning; this has been incorporated into the HNA programme for 2015-16.

The HNA programme being taken forward in 2015-16 is as follows:

April to September 2015	October 2015 – March 2016
Mental Health (adults) Learning Disabilities (all ages) Carers (all ages) Homeless (all ages) Roma Slovak (all ages)	Lesbian, Gay, Bi-Sexual & Transgender (all ages) Asylum Seekers and Refugees (all ages) Cognitive Impairment (Adults) Physical Disability (Adults)

HNAs of older people in care homes, people with sensory impairment, children and young people with complex needs, and children and young people's mental and emotional wellbeing were completed in 2014. Two further HNAs of communities of interest are being considered; veterans and offenders. All completed HNAs are published as supplements to the JSNA and are available on the Health and Wellbeing Board's website.[2]

[1] http://www.mungosbroadway.org.uk/homelessness/publications/latest_publications_and_research/2069_charter-for-homeless-health.

[2] https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/JSNA.html.

4. Examining outcome 3, action by action

The following table sets out a summary of progress under each outcome set out in the Joint Health and Wellbeing Strategy. It does not set out everything that is happening across Sheffield to tackle health inequalities, but is simply a snapshot of progress under each of the specific actions.

	Theme	Action	Progress	What one thing can the Health and Wellbeing Board do to make a difference?
3.1	**Data about health inequalities in Sheffield to be excellent so that commissioners can be well-informed in tackling the issues.**	Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them.	• To date a number of Community Knowledge Profiles have been produced and published, in the main using Census 2011 data. These are available on the Council's website.[3] • There are profiles covering various minority ethnic communities, people with disability, carers and sexuality as well as a number of other categories. The profiles set out the basic demographics of the community of interest and some of the key issues faced. • They provide a useful baseline for the JSNA which, as noted in Section 3, is being supplemented with a series of community specific Health Needs Assessments (HNAs) to provide more detailed information on health inequalities in Sheffield and approaches for tackling them.	*It should be noted that this programme of HNA work is particularly time-consuming and resource intensive, especially for the Communities Portfolio of the Council and the Public Health Intelligence Team. One of the issues that the Board may wish to consider therefore is the extent to which additional research resources could be secured to support this work.*
3.2	**Sheffield's communities to be strong, connected and resilient, able to withstand crises and to support members of**	Work with partners to agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities	• Sheffield First has led a collaborative process aimed at understanding how organisations in Sheffield work in relation to communities. This process has resulted in the production of a set of principles guiding the development of resilient communities, referred to as the Fuzzy Framework. These principles are being considered by Sheffield Executive Board, in response to the Fairness Commission recommendations of a single city approach to community empowerment.[4] • The Community Wellbeing Programme, the Health Trainers and	*Enable the Sheffield community resilience approach to be embedded in mainstream services and new programmes. This approach recognises the value of mobilising communities and builds on skills and capabilities and resources the community have to offer.*

[3] https://www.sheffield.gov.uk/your-city-council/sheffield-profile/community-knowledge-profiles.html.
[4] https://www.sheffieldfirst.com/dms/sf/management/corporate-communications/documents/SFP/SEB-Papers/March-2015/Item-7---Resilient-Communities-and-Citizen-Led-Design/Item%207%20-%20Resilient%20Communities%20and%20Citizen%20Led%20Design.ppt.

	Theme	Action	Progress	What one thing can the Health and Wellbeing Board do to make a difference?
Page 18	**the community to live whole and healthy lives.**	and exploiting community assets, and which supports community-based organisations.	Health Champions Programmes have continued to develop resilience by mobilising the community, building on individual and community assets and skills. The Practice Champions have been successful in embedding this approach in GP Practices. These programmes work with the most deprived communities in Sheffield to develop social capital and resilience and aim to reduce health inequalities. • Developing social capital and building community capacity will improve health and wellbeing and reduce the escalation of demand on health and social care services. This whole community approach can make a significant contribution to Integrated Health and Social Care and the Keeping People Well in their Community work stream. • The Strategy for Best Start Sheffield, Early Support and Intervention focuses on a whole family approach which builds family resilience and in turn will engage local communities to develop streamlined services. This will be achieved through the continued development of our MAST services, key worker model and achieving the outcomes of our Building Successful Families Programme. • The 7 Local Area Partnerships are now well established and have identified key priorities to develop resilience in each area. These priorities include tackling social isolation and tackling financial inclusion. • In the past year the Thriving VCF Leadership Group has worked with public sector partners to consider complex issues that require a cross-sector response. They have identified new ways of working collaboratively to help communities grow and develop. • Libraries, Archives and Information have eleven ‘Hub’ libraries across the city which all work with local community group. They employ a Volunteer Co-ordinator to develop and support volunteering through the community groups who now run ten ‘Associate’ and five ‘Co-	

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			delivered' Libraries.	
3.3		Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined-up city localities.	• Through Streets Ahead the Council engages with communities to see if there are any opportunities that can be aligned with the work to deliver something more than just the core renewal of roads, lighting and footpaths. We have aligned wider transport investment in things like dropped crossings, highway safety improvements, cycling improvements and small measures which can make a big difference. • We are supporting a few communities to develop Neighbourhood Plans – these are community led and will often pick up a wide range of key planning issues but also issues such as access, movement, and local community facilities. We are also working with communities through our New Homes Bonus funded projects to support more resilient communities. • We are working to ensure our long term land-use and transport plans promote 'active city' and 'healthy city' agendas, including a long term transport strategy and rolling out 20mph zones across the city. • Transport Capital Programme investment focuses on major priorities around road safety, accident reduction, creating better pedestrian and cycle access and improving the access to and quality of public transport provision. • We are supporting the provision of new sport and leisure facilities to encourage more active and healthy lifestyles and link to wider regeneration plans where possible e.g. the NCSEM centre at Graves, North Active, the support for new FA playing pitches initiative, and the promotion of new sports and leisure facilities at the Olympic Legacy Park.	*Consider how wider public health funding is aligned with other funding to achieve benefits greater than the sum of the individual parts. For example, in some cities public health funding is used to support/match fund cycling (training and infrastructure), safe travel to school, 20mph zones, private sector housing standards improvement work, etc. on the basis that these initiatives can have a positive impact on health, safety and therefore have a beneficial impact on primary health spend.*

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3.4	**Those groups especially impacted by health inequalities to have early support and sensitive and appropriate services that meet their needs and improve their health and wellbeing.**	Identify which groups are least able to access services and establish reasons for difficulties and the health consequences of this. Work to improve access, prioritise those areas where the difficulties in access have significant health consequences, and simplify how people access care.	• Although we don't have robust baseline data, elected members and others felt we already knew a lot about which groups of people are least able to access services. Therefore it was agreed we should move forward with identifying interventions/actions to improve access, rather than focusing on more data collection. An outline plan to develop actions was approved by the CCG and Council in March 2015. A stakeholder workshop was held in April 2015 to test and further refine recommendations, and get wider stakeholder buy-in to the plan. Stakeholders were supportive of the approach. An action plan has been produced, incorporating stakeholder views and advice. • This plan acknowledges that there is already much work underway (through statutory and voluntary organisations) that is improving access but isn't labelled as such. The next step will be to use local knowledge and successes around improving access alongside other evidence to develop practical guidance/principles (taking a quality improvement approach) for services, organisations and the Sheffield system on how to improve access. 'Improving access to services' needs to be an integral part of all the big transformational programmes in the city including the Integrated Commissioning Programme and the Prime Minister's Challenge Fund.	*Make sure that 'improving access to services' is an explicit and monitored part of transformational plans for the city such as the Integrated Commissioning Programme and the Prime Minister's Challenge Fund.* *The CCG Governing Body agreed an action in March 2015 to 'measure how well services are meeting needs in the city'. This substantially overlaps with the 'improving access to services' action. The H&WBB could agree to broaden the 'improving access to services' action to include the CCG Governing Body action.*
3.5		Ensure every child has the best possible start in life, including: focused action with the most deprived areas and groups, reducing infant mortality, developing strategies that	• Best Start Sheffield, a joint early years' strategy for a great start in life 2015-17, has been developed which outlines the commitment to redesign services and a focus to address health inequalities in early years for families living in the most deprived areas of the city. The strategy has jointly been developed by Sheffield City Council and Sheffield CCG and prepared in partnership with a range of other stakeholders including schools, health, private, voluntary, community and faith sectors. • Key to the strategy are priorities which include:	*Ensure that partners/organisations signed up to the Best Start Strategy implement the changes required and prioritise service delivery to ensure that every child has the best start in life.*

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		improve parent/child attunement in early years, increasing the uptake of childhood immunisations, reducing the number of under 5s A&E attendances, reducing smoking rates in expectant mothers, improving children's dental health, increasing the rate of breastfeeding, reducing teenage conceptions, reducing obesity in children and young people.	○ Empowering parents, families and carer to provide health, stable and nurturing family environments. ○ Improving access to and co-ordination of health and wellbeing initiatives for children and families. ○ Improving prevention, early identification and early intervention. ○ Providing accessible and flexible high quality child care. • Best Start Sheffield describes priorities for future action to increase breastfeeding rates, reducing smoking rates and A&E attendances. These are also addressed as strategic objectives in Sheffield's Reducing Infant Mortality Delivery Plan. Alongside this the Children's Health and Wellbeing Partnership Board has been monitoring uptake of childhood immunisations. Sheffield has been successful in receiving resources from NHS England to focus activity on increasing vaccination and improving dental health in children living in care. • The National Child Measurement Programme provides robust data to monitor the prevalence of childhood obesity in Sheffield.	
3.6		Recognising that the city has growing numbers of new arrivals, including Roma, develop appropriate strategies to ensure families are appropriately accessing health, social care and education services.	• New arrivals and Roma immigration in the city continues to have an impact on key services including education and health services. Multi-agency plans and a range of interventions are in place. Further long term plans are being developed, and the Public Service Transformation Network is working with us to develop a long-term invest to service business plan for the areas concerned. • The New Arrivals Health Needs group has worked together to implement a range of interventions to address need in relation to health services and also with regard to public health community interventions. This is a partnership including Public Health, local GP practices, the CCG, Health Protection, and the hospitals. A health	*Services in the areas with high numbers of new arrivals require sustained additional resources. The Wellbeing Board should consider how this can be achieved, how services can work well and effectively together, and also continue to raise this issue at a national level.*

	Theme	Action	Progress	What one thing can the Health and Wellbeing Board do to make a difference?
			needs assessment has been commissioned so that we understand the health needs of this group but also how CCG, NHS England and Public Health monies in the city are being deployed. • There has been Infectious Disease training delivered to over 80 schools to date, delivered in partnership with Public Health England. Those Roma Classroom assistants working in Sheffield schools have been provided with a bespoke Public Health training module focusing on communicable disease, sexual health, use and access of NHS Services, and input on vaccination and immunisations. The aim is for these staff to use this information to provide support, guidance and information to Roma families. • Additional resources have also been made available to manage environmental issues. Selective licensing is also well underway and where over 89% of landlords have applied for licences and are improving homes to a reasonable standard. • A detailed schools and young people plan is in place to provide a targeted language and learning programme both in schools and in the community to increase appropriate access to services. • A range of interventions are being undertaken in the local community to tackle inequality and build cohesion. The new cohesion strategy will address some of the inequalities and the impact immigration has in the city. Funding has been secured from CLG for community development and language support.	
3.7		Commission disease-specific interventions to tackle poor health in population groups that have worse health, including a	• The CCG is continuing to increase action to reduce health inequalities through the services it commissions. The commissioning plan for 2015/16 includes a health inequalities plan, which embeds action to reduce health inequalities in each of the CCG's clinical portfolios. • The commissioning plan includes: an aim to achieve parity of esteem	*Ensure that reducing health inequalities is explicitly embedded in transformational programmes such as the Integrated Commissioning Programme and the Prime Minister's Challenge*

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	Theme	Action	Progress	What one thing can the Health and Wellbeing Board do to make a difference?
		programme to improve the physical health of the severely mentally ill or those with a learning disability.	for mental health and learning disability (including showing a real terms increase in mental health spending in 2015/16); the pilot of a community 'tier 3.5' for Child and Adolescent Mental Health Services; development of strategies to reduce inequalities in respiratory, cardiovascular and cancer outcomes; and improving TB services in line with the national TB strategy.	*Fund.*
3.8		Support quality and dignity champions to ensure services meet needs and provide support.	• Healthwatch Sheffield met regularly with the former Director of Public Health to discuss how to investigate the issue of dignity, the role of dignity champions and the dignity network, and how best to highlight good and bad practice citywide. • A mapping exercise was conducted with local care settings around dignity champions, but received a very poor response. Some organisations said they didn't like the idea of dignity champions as they felt dignity should be everyone's business. We thought it was not a good thing to wholeheartedly support dignity champions unless we are clear that they add value and are the best way of ensuring dignity remains high on the agenda. • Further work will be carried out to investigate the wider issues of dignity, how Sheffield might remodel how dignity is represented, and how good practice can be better disseminated.	*Take forward the recommendations Healthwatch Sheffield will be making in August/September 2015 about how dignity should be dealt with. This may mean altering the relevant section of the health inequalities plan.*

	Theme	Action	Progress	What one thing can the Health and Wellbeing Board do to make a difference?
3.9		Work to remove health barriers to employment through the Health, Disability and Employment Plan.	This topic was looked at closely at March's Health and Wellbeing Board meeting.[5] Progress includes: • Existing commissioned supported employment provision across SCC and CCG was reviewed. A proposal was produced with the Public Sector Transformation Network for changes to the City system which currently results in poor employment outcomes for those with health conditions and disabilities. • The Sheffield Occupational Health Advisory Service was commissioned to deliver the Occupational Health Service and Workplace Wellbeing Charter, which supported 300 people to remain in work in 2014/15. • A pilot project for ESA Clients was commissioned (with Job Centre Plus and SCC Lifelong Learning and Skills), with the aim of creating a clear referral pathway from Primary Care into Employment. There were 16 referrals in first month from JCP and GPs, and 1 self-referral. • Work with Macmillan was carried out on a vocational rehabilitation pilot to improve employment outcomes for people living with and recovering from Cancer.	*Bring the supported employment commissions across LA and NHS and the LEP under one banner and ensure the single pathway from Health to employment balances supply and demand and covers referral into intervention and referral out of intervention and into employment.* *The Board may also wish to consider encouraging the Government not to remove Access to Work support.*

[5] http://sheffielddemocracy.moderngov.co.uk/ieListDocuments.aspx?CId=366&MId=5651 and http://www.slideshare.net/SheffieldHWB/health-disability-and-employment-update-for-the-health-and-wellbeing-board-march-2015.

5. Appendix – outcome indicators for outcome 3

Indicator: Slope index of inequality in life expectancy (Men)

Definition: Gap (in years) in life expectancy at birth between the most and least deprived men in the City

	2009-11	2010-12	2011-13
Sheffield	9.6	10.0	9.7
England	9.4	9.2	9.1
Core City Rank (1 is best)	4	6	5

Indicator: Slope index of inequality in life expectancy (Women)

Definition: Gap (in years) in life expectancy at birth between the most and least deprived women in the City

	2009-11	2010-12	2011-13
Sheffield	7.4	7.2	6.9
England	6.9	6.8	6.9
Core City Rank (1 is best)	3	3	3

Indicator: Excess winter deaths

Definition: Percentage of expected deaths based on non-winter deaths. Single years, all ages.

	2010-11	2011-12	2012-13
Sheffield	15.6	10.0	15.6
England	17.0	16.1	20.1
Core City Rank (1 is best)	4	1	3

Indicator: Excess premature mortality in people with a serious mental illness

Definition: Directly age standardised mortality rate per 100,000 population aged 18-74 years.

	2010-11	2011-12	2012-13
Sheffield	384.7	365.9	380.8
England	335.3	337.4	347.2
Core City Rank (1 is best)	5	2	5

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