Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Sheffield Health and Wellbeing Board Draft Health Inequalities Plan

Governing Body meeting

3 July 2014

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Author(s)	Tim Furness, Director of Business Planning and Partnerships
Sponsor	Tim Furness, Director of Business Planning and Partnerships

Is your report for Approval / Consideration / Noting

Consideration

Are there any Resource Implications (including Financial, Staffing etc)?

Yes, indirectly, as this plan will influence our Commissioning Intentions.

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?

3. To work with Sheffield City Council to reduce health inequalities in the city

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached?
No, not yet. However, as this plan is specifically intended to address health inequalities, an EIA would show that the report should have a positive effect on many of the protected characteristics.

PPE Activity

How does your paper support involving patients, carers and the public?
Engagement has been through the Health and Wellbeing Board mechanisms, as summarised in the accompanying report.

Recommendations

The Governing Body is asked to consider the implications of the plan for the CCG and how we can best contribute to achieving its aims.

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1. Introduction / Background

1.1. Reducing health inequalities in Sheffield is one of the five outcomes the Sheffield Health and wellbeing Strategy seeks to achieve. This plan – being discussed by the Health and Wellbeing Board on 26 June – proposes specific actions to achieve the aims of the strategy. It is presented to the CCG Governing Body for consideration of how we might best contribute to deliver and the implications for the CCG.

2. The Plan

2.1. The attached papers set out the proposed plan, with lead officers/clinicians identified for each action and timescales for them.

2.2. The CCG has specific responsibility for actions 3.4 (as the emphasis of this action is on access to health services) and 3.7.

2.3. In addition, we will need to contribute to many of the other actions identified led by our partners (and of course are already doing so in many instances).

2.4. For our contribution to be effective, we will need to consider the outcome of actions 3.4 and 3.7 in setting our detailed objectives for 2015/16 and future years, so that we take action to improve access to healthcare for any group of people who currently experience barriers, and so that we commission interventions that will reduce health inequalities, where necessary targeting these at specific populations.

3. Recommendations

The Governing Body is asked to consider the implications of the plan for the CCG and how we can best contribute to achieving its aims.

Paper prepared by Tim Furness, Director of Business Planning and Partnerships

24 June 1014

SHEFFIELD HEALTH AND WELLBEING BOARD PAPER

Report of: **Councillor Julie Dore Leader of Sheffield City Council and Dr Tim Moorhead Chair of NHS Sheffield Clinical Commissioning Group, Dr Jeremy Wight, Director of Public Health**

Date: **26 June 2014**

Subject: **Health Inequalities Plan**

Author of Report: **Jeremy Wight (0114 2057462)**

Summary:

Reducing health inequalities is a key priority for the Health and Wellbeing Board and is one of the identified outcomes in the Health and Wellbeing Strategy. Health inequalities are significant and persistent and are rooted in the unequal nature of society. The Fairness Commission considered health inequalities in detail and made a number of recommendations as to how they could be addressed. The Health and Wellbeing Strategy identified a number of actions aimed at reducing health inequalities in the City.

A draft Health Inequalities Action Plan, designed to implement the actions identified in the Health and Wellbeing Strategy, was discussed at a Strategy meeting of the Health and Wellbeing Board and at a well attended engagement event in May.

As a result of those discussions, a number of changes have been made to the plan, including identifying the different impacts that different actions are likely to have and the timescales. In addition a further action, not in the original Health and Wellbeing Strategy, has been added, which is to increase health literacy and early engagement with health services in disadvantaged communities. This is added as action 3.10.

Questions for the Health and Wellbeing Board:

- Is the Board content with the identification of leads and reporting mechanisms with regard to the actions identified in the Strategy and included in the plan?
- Is the Board content with the identified priority tasks?
- Is the Board content with the measures of impact?
- Does the Board agree to the addition of proposed action 3.10 to the Health and Wellbeing Strategy and to the plan?

Recommendations:

- That the Board should formally approve the plan, whilst accepting that further work is required on the detail.
- That the Board should request the identified lead individuals and relevant Groups / Boards to implement the plan.
- That the Board should request an annual report on progress.

Health Inequalities Plan:

Introduction

Inequalities in health in Sheffield have been well documented for over a century. They are significant and persistent, in spite of much good work that has been done to address them. Their nature and extent are documented in the Joint Strategic Needs Assessment and elsewhere. The roots of health inequalities lie in the unequal nature of society, and they will persist as long as society remains unequal. But this does not mean that we cannot do anything about them. The work of the Health Inequalities National Support Team, and the Marmot review, as well as recent King's Fund and British Academy reports provide extensive guidance for us to use locally.

Here in Sheffield, the Fairness Commission considered health inequalities in detail, and made a number of general recommendations as well as more specific ones relating to inequalities in the health system, mental health and wellbeing, and carers. The Joint Strategic Needs Assessment, as well as describing the health inequalities of the City, also made a number of recommendations.

The Health and Wellbeing Board has identified addressing health inequalities as one of its priorities (the other being the integration of health and social care). This is because not only are health inequalities unfair in themselves, but also because we will <u>all</u> benefit from a coherent and effective programme of work to address them. This is partly because any one of us may benefit directly from actions taken, even if they are undertaken specifically to address inequalities, and partly because reducing inequality is good for all of us.

Any of us can benefit from action to address health inequalities because although most diseases are more common in more disadvantaged communities, there are practically none that are exclusive to them. This means that systematic programmes to promote early diagnosis and effective treatment will have benefits across the whole City, even if a major part of the rationale is to address health inequalities. But perhaps less well recognised is the fact that the whole City will benefit if we improve the health of disadvantaged groups and so reduce health inequalities. This is because the whole City will benefit economically from a healthier workforce, (the Marmot report estimates health inequalities cost society £60Bn per year, nationally), because improving the health of disadvantaged groups should reduce the burden on the health and social care system overall, and because, as the work of *Wilkinson and Pickett* has shown, more equal societies are of benefit to everyone in those societies, not just the most disadvantaged.

The Board has approved a Health and Wellbeing Strategy, based on the JSNA, that identifies five outcomes which describe what it wishes to achieve for the people of Sheffield. One of these is that *health inequalities are reducing*, and nine actions are identified in support of that. However there are also actions in support of another outcome, *health and wellbeing is improving*, which will, when implemented, have also a significant impact on health inequalities. This is because any action that improves health for a section of the population that is in worse health than the rest, will in so doing reduce inequalities. Five (of the eight) specific actions identified in the Strategy in support of this outcome are included in this Action Plan, because they will have a particular impact on addressing health inequalities, if implemented effectively.

An earlier version of this plan was discussed at an engagement event, attended by over 80 members of the public and representatives from partner and stakeholder organisations, on 29th May 2014. Following that, a number of changes have been made to the plan, in

particular a strengthening of emphasis on increasing health literacy, and appropriate demand for health services, in more disadvantaged communities.

This is not another strategy, but an *Action Plan*. It picks up the actions identified in the Health and Wellbeing Strategy, expands on them where necessary, identifies who should be responsible for their implementation, over what timescale and where in the governance structures of the Council and CCG these actions should be reported to. Ultimately, the Health and Wellbeing Board has final responsibility, and it is recommended that an annual report should be taken to the Board on progress overall, and discussed.

The Health and Wellbeing Board has also agreed an *Outcomes Framework* to be used to monitor implementation of the Strategy. That can also be used to monitor progress in addressing health inequalities, but some additional measures are needed to monitor the implementation of this plan.

Impact and timescales

Health inequalities are multifaceted, and can be described and measured in countless different ways. There are many different ways to divide up society into different groups whose health can be compared. We tend to use divisions based on where people live, partly because many of the root causes of health and hence health inequality are strongly linked to that, but also because almost all health data comes with a postcode attached, which makes analysis more straightforward. But there are other ways to divide society, such as by ethnicity, or by identifying specific 'communities of identity'.

Equally, there are many different aspects of health that can be measured. We place a lot of emphasis on life expectancy, partly because it has resonance with the population in general, but also because it can be calculated reasonably straightforwardly from death certification data. But it is only one measure, and some would argue a rather limited one, of the health of a population. Inequalities in mental health, for example, are little reflected in differences in life expectancy between geographically defined communities.

As a result, it is difficult to say categorically which actions will have the biggest impact on health inequalities: it all depends on what aspect of health inequalities one is considering, and for which groups in the population.

Having said that, it is clear that those actions that will have a big impact are those that relate to a cause of ill health that is amenable to intervention, where that cause is common (i.e. relatively large numbers are affected), where it is unevenly distributed across society, and where the adverse health consequences are severe. Smoking is one such cause, for example, so that the abolition of smoking within society would have an enormous impact on health inequalities. The plan does categorise actions according to whether the impact will be low (relatively small gain in health and reduction in inequalities, affecting few people), medium or high (large health gain, deaths avoided, large reduction in inequalities, affecting many people).

The root causes of health inequalities lie in the structure of our society, and many of the actions identified in this plan will take years to have an impact on any measure of health inequality. But that does not mean everything is very long term. A balanced approach to addressing health inequalities has to incorporate actions that can have a short (1 – 3 years) and medium (4 -10 years) term impact, as well as over the longer term (ten years and more). If we take differences in life expectancy as a measure of health inequality, and note that three quarters of the differences in life expectancy across the City is caused by

premature death due to cardiovascular disease, cancer and respiratory disease, all of which are chronic diseases developing over years or decades, then it is clear that to have an impact in the short term we need to be offering better treatment and care for people who already have, or are at high risk of developing, those conditions. This means improving access to treatment and care, risk stratification to identify those at highest risk, and systematic case finding and optimal treatment. On the other hand these actions would be of limited value without others that will have an impact over the medium (e.g. helping people to address unhealthy lifestyles), and longer (addressing the 'root causes') terms.

This *Plan* includes actions that will have an impact in the short, medium and long term.

Use of resources

Resources in the public sector are extremely tight, and there are no new resources available for the implementation of this plan. However many of the actions are either already incorporated into existing budgets and commissioning plans, or may be cost saving. Where there is a need for additional investment for specific actions, business cases will have to be made to the appropriate budget holders, and the relevant bodies will have to consider the extent of their commitment to reducing health inequalities and the opportunity cost of shifting resources.

When resources are tight, it is more important than ever to take into consideration the cost effectiveness of different interventions, since it would be wrong to pursue actions that have a modest impact, or an impact on only a small number of people, if this is done at the cost of not doing things that have a greater impact on larger numbers. Unfortunately the information needed to make detailed methodical judgments about this (cost, extent of measurable health improvement, numbers who will benefit) is not always available, but that should not prevent us from considering the issue.

One critical issue is the question as to whether the mainstream Council and Health Services expenditure is appropriately distributed across the City to reflect the differing levels of need of different communities. In health services, the *Inverse Care Law* describes the way that resources tend to be skewed, not towards the communities that have the worst health and need them most, but towards those that have the best health and need them least. This is a natural consequence of a demand led system, and persists despite many years' efforts to redistribute resource. Council provided (or commissioned) services are not demand led in quite the same way. The first action in this plan – Action 3.1 – incorporates the intention to understand better how the use of our resources matches need, in order to be able better to devise strategies to do this better.

Governance and review

Any action plan is only as good as its implementation. There is no one body, apart from the Health and Wellbeing Board itself, that has responsibility for all of the actions in this plan. What the plan does do is to identify the individual who has responsibility for leading the delivery of each action, and the Board or Committee that must oversee it. Within the Council this will be in most cases the *Better Health and Wellbeing Strategic Outcomes Board*, and in the CCG, the *Clinical Executive Team.* It is suggested that an annual report is prepared on progress overall, for the *Health and Wellbeing Board* itself. Although all the actions are to be led by statutory bodies within the health and social care sector (the Council, CCG or NHS England Local Area Team), they will undoubtedly be looking for support as appropriate from other agencies in the public, voluntary and private sectors. In that respect, this is a health inequalities plan for the whole City.

H&WB Strategy *Action* 2.5 Commission and implement an integrated approach to reducing levels of tobacco use through integrating work on: 1) helping people to stop smoking; 2) Smokefree environments; 3) Smokefree C&YP 4) community based action on illegal tobacco 5) Social Marketing and communications to reduce smoking prevalence and denormalise tobacco use; 6) reduce smoking prevalence amongst pregnant women.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Lynsey Bowker	Commission a comprehensive programme of tobacco control to reduce citywide smoking prevalence. The programme will be based on evidence from World Health Organisation, comprehensive consultation and local need.	Programme fully commissioned	80% completion by August 2014 100% Completion by April 2015	Tobacco Control Programme Board	High impact. Reducing smoking prevalence will significantly improve health and impact on inequalities in the short, medium and long term.	All contracts will contribute towards the following PHoF indicators: i) 2.14: Smoking prevalence adults over 18 ii) 2.9: Smoking prevalence 15 year olds iii)2.3: Smoking status at time of delivery Local ECM survey: CYP tobacco use	H&WBB members should ensure that as a city we uphold principles outlined in the Local Gov. Declaration on Tobacco Control, signed by SCC Jan '14. Key action includes: act at a local level to reduce smoking prevalence, raise the profile of the harm caused by smoking in communities and develop plans with our partners to address the causes and impacts of tobacco use.	Model developed in line with WHO evidence, full consultation and South Yorkshire led programme budgeting style exercise. Programme and funding signed off within SCC

H&WB Strategy *Action* 2.5 Commission and implement an integrated approach to reducing levels of tobacco use through integrating work on: 1) helping people to stop smoking; 2) Smokefree environments; 3) Smokefree C&YP 4) community based action on illegal tobacco 5) Social Marketing and communications to reduce smoking prevalence and denormalise tobacco use; 6) reduce smoking prevalence amongst pregnant women.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
		All services commissioned for three year period 2014 -17 (with option to extend for an additional year).	Contracts awarded 1st Feb '14					Six services (lots) commissioned in total. Lots 1-4 procured and fully mobilised by 1 April '14. Contract for Lot 5 (marketing and comms) awarded April '14 and service in place by Jun '14. Lot 6 smoking in pregnancy delayed. Need to ensure approach is aligned to strategy within SCC CYP.
		Services fully mobilised	By 1 April '14					
		Ongoing programme delivery with quarterly monitoring and routine evaluation	April '14 – March 2017 (Contracts all include option to extend for an additional year)					Tobacco Control 'Hub' established. All providers will be part of the 'hub' to ensure coordinated action across the city. Quarterly performance meetings with all providers. Ongoing programme evaluation.

H&WB Strategy *Action* 2.6 Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Jo Daykin-Goodall	Implement the DACT Commissioning & Procurement Plan for community substance misuse treatment approved by Sheffield City Council Cabinet (January 2014).	Award of three contracts – Opiates, Non-Opiates, Alcohol.	Opiates and Non-Opiate contracts to commence 1st October 2014, Alcohol to commence 1st April 2015.	Director of Commissioning Safer & Sustainable Comm-unities Partnership	Low to medium Timescale short to medium term	Performance against PHOF 2.15i and ii DOMES (PHE) and LAPE performance	-	
Victoria Horsefield CYPF, SCC	Ongoing Implemention of the city wide Hidden Harm Strategy			Sheffield Safe guarding Children Board		As above No of children in need/child protection/in care, where parental substance misuse a safeguarding risk		
Sue Greig, CYPF, SCC	Continued implementation of the Novel Psychoactive Substances (NPS) plan underpinned by accessible targeted & specialist sub-stance misuse services which focus on reducing harm of substances misuse, including alcohol, & a reduction in associated risk taking behaviours & poor outcomes.	Ongoing		Substance Misuse Joint Commissioning Group		No of young people leaving specialist treatment in a planned way No of Looked After Children accessing early support ECM survey		

H&WB Strategy *Action* 2.6 Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	Refreshed substance misuse curriculum tool available in all primary and secondary schools		Q2 14/15			substance misuse and alcohol misuse		

H&WB Strategy *Action* 2.8 Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
Susan Hird	Cancer and cardiovascular disease continue to be specific priority in JSNA and JHWS. These should include information about the underlying causes of these diseases and what we know about where they are most prevalent in the City.	Cancer and cardiovascular disease in JSNA and JHWS	Ongoing	CCG Clinical Executive Team	Medium to high impact, short to medium term.	2.17 Recorded diabetes 2.19 Cancer diagnosed at stage 1 and 2 (placeholder) 2.20 Cancer screening uptake and coverage 2.22 Health Checks uptake and coverage 4.3 Mortality from preventable causes 4.4 to 4.7 Under 75 mortality from CVD, cancer, liver disease, respiratory disease 4.9 Excess under 75s deaths in people with SMI 4.12 Preventable sight loss		Overlap with action 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.

H&WB Strategy *Action* 2.8 Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.								
Lead	**Priority *task***	**Measures of *task* completion**	**Timescale for completion of *task***	**Reporting to**	**Impact (and timescales)**	**Measure of impact (e.g. PHOF measure)**	**How can the H&WBB add value?**	**Comments**
	Identify 2-3 key actions/interventions that can be taken city-wide to reduce premature deaths from cancer and cardiovascular disease, taking into account work that is already happening. Prevention should be a priority.	Report completed, identifying agreed priority actions/interventions	September 2014					
	Implementation of interventions	Intervention incorporated into organisational objectives and plans	April 2015					

Appendix: Local recommendations aimed at addressing health inequalities

Fairness Commission:

General

1. All organisations in Sheffield should explicitly commit to tackling the wider determinants of health and using their services (commissioning or direct delivery) to reduce health inequalities wherever possible.
2. The NHS and Sheffield City Council should use their available budgets to **prevent health and wellbeing problems from occurring** in the first place.
3. Sheffield City Council and the Sheffield Clinical Commissioning Group should spend a progressively increasing amount, both in absolute terms and as a proportion of their budgets, on **initiatives addressing the wider determinants of health**, aimed in particular at people in poverty and with the worst health, or those in danger of having the worst health. This expenditure should be identified and accounted for in an annual report.
4. **Health and Wellbeing Board (HWB) members must fully utilise their individual and collective position, influence and resources** to achieve better health outcomes for Sheffielders in most need. The HWB comprises some of the city's most senior politicians, officials and medical professionals and the Board must act to address the wider determinants, champion and challenge Government and partners in the city (e.g. employers) to contribute to a holistic approach to wellbeing in Sheffield and stand up for the city's health needs.
5. Public sector organisations should implement a **health inequalities assessment** for all major strategies and developments. This should also form part of a voluntary 'Fair Employer' code and the City Council and NHS 'Compact' with the voluntary sector
6. The city should **promote women's health in general, pre-pregnancy, in pregnancy and after giving birth**. This would include, for example, promoting early registration with a midwife when pregnant, and promoting breast feeding and post-natal support.

Inequalities in the health system

7. The HWB should **use the Joint Strategic Needs Assessment to better understand the equity of the health spend** in Sheffield
8. The HWB partners from the Clinical Commissioning Group and Sheffield City Council must **ensure that health spending in the city is more fairly utilised** based on the relative needs of communities. This includes making services more accessible and appropriate to groups who currently underuse services.
9. That there is a significant **increase in primary and community care** in Sheffield, particularly in the most deprived areas of the city delivered locally in accessible venues
10. That the quality of health, care and public health services is of a **consistent, high quality** across all areas of the city
11. Communities are supported with the necessary skills and information to recognise health concerns and have the confidence to seek advice and support from health services. This should include **removing barriers to services** which are disproportionally experienced by some communities.

Mental health and wellbeing

12. **Supporting people to receive early diagnosis** to reduce the health inequalities experienced by those individuals and prevent other problems spiralling from the mental health issue, for example debt.

13. **The diagnosis and treatment of mental wellbeing problems in children** needs to improve.
14. That commissioners need to **increase the prominence given to mental health and wellbeing in commissioning plan**s, to fulfil the aspirations around this area in the Health and Wellbeing Strategy. This should include moving existing resources from other areas of the health system to strengthen mental health and wellbeing services, particularly if this is likely to improve the prevention of mental ill health.
15. That the **commissioning of services for the physical health care of people with mental health problems needs to be radically rethought**. This means the strengthening of the local evidence base in this area, and the re-prioritisation of resources from other areas of the health service.

Carers

16. **All employers are encouraged to support carers to be in work**, for example through paid leave for carers and flexible working arrangements for all employees which would have particular benefits for carers.
17. **All schools in Sheffield recognise, identify and support young carers** as a vulnerable group of young people who have a right to an education, aspiration and achievement and to ensure a successful career and adult.
18. Making sure that the right level of **respite care** is available in the city.
19. The city needs to **identify 'hidden carers'**, those people who take on caring responsibilities but have not been identified as a carer and therefore potentially missing out on support available to them. This should focus on young people and certain BME groups who are group of people likely to have a greater proportion of hidden carers.
20. The **'With Carer Pass' should be extended to all carers caring for a disabled person**.
21. The **special needs of older lifelong carers** are recognised by commissioners and service providers.

Joint Strategic Needs Assessment

1. Limit the negative impact of welfare reform: welfare reform will have a huge impact on the City and a negative impact on health and wellbeing, both for those affected by the reforms and those affected more broadly by health inequalities. We must minimise the negative impact where possible and in particular, the potential 'double negative impact' for families with children aged under five, families with more than two children and lone parent families.

2. Focus on housing: Conditions in the private rented sector and fuel poverty are both real concerns in Sheffield and interventions should prioritise these two issues and those most at risk.

3. Improve employment opportunities: Fewer people work in Sheffield than the national average and we need to improve volunteering, training and employment opportunities, particularly for young people.

4. Better understand mental wellbeing: Sheffield experiences poorer levels of mental wellbeing than the national average. We need a more comprehensive understanding of the specific factors that contribute to wellbeing if we are to improve locally.

5. Focus on leading causes of mortality and morbidity: Long terms conditions (such as coronary heart disease and cancer) are among the leading causes of premature death in Sheffield and dementia a significant factor in increasing morbidity**.** This will have significant implications for health and social care services including acute hospital

services, residential care and end of life care. These must be a priority for health and social care commissioners for the foreseeable future.
6. **Smoking** remains the largest, reversible cause of ill health and early death in Sheffield. Evidence places increasing importance on implementation of a comprehensive tobacco control programme as the key means by which to reduce prevalence of smoking in the future.
7. Identify geographical health spend: We need to establish how health expenditure is distributed geographically within the City and map this against geographical health outcomes. Spend should reflect our aspiration to reduce health inequalities.
8. Develop a better understanding of health inequality by 'group': Whilst we have good data on inequality by geography, we do not have it by group. Groups such as BME communities, children with learning difficulties, homeless people, victims of domestic and sexual abuse and carers are all reported nationally to have below average health, but local data are lacking.
9. Map assets: If we are to reduce health inequalities in the City, it is not enough to know about need alone – we also need to understand what assets we have so that we can build on them.
10. Reduce dependence on high end health and social care services: The growth and changes in our population and balance of our investment profile means that the current service model is unsustainable. We must therefore find new ways of responding to need which places a premium on prevention, early intervention, integrated working and care in the community. Although there is a move to do this, there is still a long way to go.
11. Acknowledge the impact of spending cuts: cuts that are impacting on the NHS, local government and the voluntary sector cannot be overlooked and are beginning to have a negative impact on service provision. It is important to question how realistic the outcomes of the Joint Health and Wellbeing Strategy are in light of these funding changes.
12. Measure service access and experience: more emphasis must be placed on collecting and analysing service access and experience data. Without this, it is impossible to measure the extent to which "people get the help and support they need and is right for them".

Health and Wellbeing Strategy
Outcome 3: Health inequalities are reducing

1. Promote appropriate gathering of data to better understand the health inequalities in Sheffield and inform approaches to tackling them.
2. Agree a coherent approach to strengthening community resilience and social capital, which has a shared understanding of building communities and exploiting community assets, and which supports community-based organisations.
3. Work with partners including planning, transport, education, businesses, community groups, and health and wellbeing services to support coherent, joined-up city localities.
4. Identify which groups are least able to access services and establish reasons for difficulties and the health consequences of this. Work to improve access, prioritise those areas where the difficulties in access have significant health consequences, and simplify how people access care.
5. Ensure every child has the best possible start in life, including: focused action with the most deprived areas and groups, reducing infant mortality, developing strategies that improve parent/child attunement in early years, increasing the uptake of childhood immunisations, reducing the number of under 5s A&E attendances, reducing smoking rates in expectant mothers, improving children's dental health, increasing the rate of breastfeeding, reducing teenage conceptions, reducing obesity in children and young people.

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.
7. Commission disease-specific interventions to tackle poor health in population groups that have worse health, including a programme to improve the physical health of the severely mentally ill or those with a learning disability.
8. Support quality and dignity champions to ensure services meet needs and provide support.
9. Work to remove health barriers to employment through the Health, Disability and Employment Plan.

Outcome 2: Health and wellbeing is improving

1. Promote a city-wide approach to emotional wellbeing and mental health, focusing on promotion of wellbeing and resilience and early support, and embed this into strategies, policies and commissioning plans.
2. Commission a needs-led response to support children and young people's emotional development to enable them to develop personal resilience and manage transition from childhood to adulthood.
3. Support the implementation of the new city Parenting Strategy which focuses on positive parenting and developing resilient families and communities so that all children have a stable and enriching environment in which they will thrive.
4. Support the 'Move More' initiative to encourage people to be more physically active as part of their daily lives.
5. Commission and implement an integrated approach to reducing levels of tobacco use through integrating work on: smoke-free environments; helping people to stop smoking; using mass media by reducing the promotion of tobacco; regulating tobacco products; reducing the affordability of tobacco; and substance misuse services.
6. Commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol or misusing illicit or illegal substances, including reducing the 'hidden harm' to children living in households where adults abuse alcohol or drugs.
7. Commission a joint plan and integrated pathway across the city including schools and the commercial sector to act preventatively and with lower-tier interventions to tackle obesity, providing accessible information.
8. Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.

Sheffield Health and Wellbeing Board

Engagement Event 29 May 2014

Tackling Health Inequalities

Event Summary

What was the event?

Sheffield's Health and Wellbeing Board is a group of senior councillors, GPs, managers and representatives of Sheffield people who work together to connect health, social care and wellbeing in Sheffield. It has several engagement events a year.

This event's main focus was on looking at what Sheffield's Health and Wellbeing Board could do to tackle health inequalities, a topic that has been a priority for the Board since it was created.

Who came to the event?

A wide variety of people attended – members of the public, service users, providers including NHS hospitals and voluntary, community and faith sector organisations, frontline workers, and statutory organisations – as well as Health and Wellbeing Board members.

What did people say about the event?

People enjoyed the event, with all but one giving it 4/5 or 5/5. They enjoyed meeting others and talking about different themes.

What's next?

The Health Inequalities Action Plan will be discussed at the Health and Wellbeing Board on 26th June 2014. The feedback from this event will be fed into the final version of the plan.

Summary of conversations and views

We have summarised some of the main themes coming out of the event below:

- We need to be sure to promote and communicate good health and wellbeing, and promote the services which'll help and support people to be healthy and well.
- See people as a whole, covering mental *and* physical health; don't just offer medical solutions.
- Work should be done to increase spend in preventative activity.
- Develop the role of the GP (and other frontline workers), ensuring their awareness of key services that support those who are particularly affected by a health inequality.
- People and communities have a range of resources and assets at their disposal – they should be used as partners.
- We need to ensure we involve people, their families and providers in decision-making and use their feedback.
- Access to services is a crucial issue – and there *are* things we can do to improve this.
- Organisations should work together to achieve better outcomes for people. Some professional cultures may need to be challenged.
- Quality and dignity are really important things.
- Pilot projects are good but we need to make sure that projects that work become widespread.
- The Health and Wellbeing Board can add value – and attendees and organisations can add value as well.

Sheffield Clinical Commissioning Group
NHS England
healthwatch Sheffield
Sheffield City Council

www.sheffield.gov.uk/healthwellbeingboard