

**ITEM 4**

Working with you to make Sheffield

**HEALTHIER****Sheffield  
Clinical Commissioning Group****The CCG's Contribution to Reducing Health Inequalities****Governing Body meeting****8 January 2015**

<b>Author(s)</b>	<b>Susan Hird</b>
<b>Sponsor</b>	<b>Ted Turner/Tim Furness</b>
<b>Is your report for Approval / Consideration / Noting</b>	
Approval	
<b>Are there any Resource Implications (including Financial, Staffing etc)?</b>	
No additional staffing or financial implications currently, as work is either part of portfolios' plans or included in the public health core offer. Possibility of future resource implications depending on the recommendations that come out of various projects underway in the health inequalities action plan.	
<b>Audit Requirement</b>	
<b><u>CCG Objectives</u></b> Which of the CCG's objectives does this paper support?  1. To improve patient experience and access to care 2. To improve the quality and equality of healthcare in Sheffield 3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield	
<b><u>Equality impact assessment</u></b> Have you carried out an Equality Impact Assessment and is it attached? If not, why not?  No EIA has been carried out, since the purpose of this paper is to identify actions the CCG can take to reduce health inequalities. Individual projects or programmes arising from this paper may require an EIA.	
<b><u>PPE Activity</u></b> How does your paper support involving patients, carers and the public?  Implementation of the recommended actions contained in this paper is likely to require the involvement of patients, carers and the public.	
<b>Recommendations</b>	
The Governing Body is asked to approve the contents of this report and support the inclusion of the health inequalities actions in the CCG commissioning intentions for	

**ITEM 4**

2015/16.

## **The CCG's Contribution to Reducing Health Inequalities**

### **Governing Body meeting**

**8 January 2015**

#### **1. Introduction**

- 1.1. There are significant health inequalities in Sheffield. These inequalities are described in detail in various reports including the JSNA<sup>1</sup> and the Health and Wellbeing Strategy.<sup>2</sup> People in Sheffield's disadvantaged and marginalised communities are more likely to have cancer, cardiovascular disease, respiratory disease and mental illness. They are more likely to be diagnosed late, to have more years of poor health and to die prematurely.<sup>3</sup>
- 1.2. Health inequalities are largely driven by social inequalities, but up to 20% of the life expectancy gap between the most and least deprived communities can be accounted for by inequalities in health care.<sup>4</sup> The causes of this include differential access to and unwarranted variation in healthcare, which is a circular problem – social inequalities lead to differential access to healthcare which leads to poorer outcomes and so on.
- 1.3. Reducing health inequalities is one of the five outcomes identified by the Sheffield Health and Wellbeing Board that it wishes to achieve for the people of Sheffield. The nine actions identified in support of this outcome, plus five actions identified under another outcome (health and wellbeing is improving), make up the Sheffield Health Inequalities Action Plan (HIAP) which was agreed by the Health and Wellbeing Board in June 2014.<sup>3</sup>
- 1.4. There are three actions in the HIAP for which the CCG has lead responsibility:
- Action 2.8: Continue to prioritise and focus attention on cancer and cardiovascular disease, the main causes of premature mortality in Sheffield.
  - Action 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.
  - 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.

---

<sup>1</sup> <https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/JSNA/positionstatement.html>

<sup>2</sup> <https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/joint-health-and-wellbeing-strategy.html>

<sup>3</sup> <https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/priorities/tackling-health-inequalities.html>

<sup>4</sup> King's Fund Broader determinants of health <http://www.kingsfund.org.uk/time-to-think-differently/trends/broader-determinants-health#messages>

- 1.5. There are a number of other actions where the CCG has a key role to play, in particular action 3.5: Ensure every child has the best possible start in life, including: focused action, reducing infant mortality, improving parent/child attunement, childhood immunisations, reducing A&E attendances, reducing maternal smoking, improving children's dental health, increasing breastfeeding, reducing teenage conceptions, reducing obesity.
- 1.6. The Secretary of State for Health, in a letter dated 27 November 2014 (appendix 1) has set out his health inequalities assessment criteria for CCGs for 2014/15. These include routinely monitoring inequalities in access and outcomes, and ensuring progress in addressing health inequalities is being maintained across key priorities, including reducing inequalities in CVD, cancer, and infant mortality.
- 1.7. The HIAP actions, along with the CCG's own priorities and the Secretary of State's assessment criteria, have informed the recommendations outlined in this paper.
- 1.8. The NHS England planning guidance, published at the end of December, states "Clinical Commissioning Groups (CCGs) should work with local government partners to set and share in 2015/16 quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing. These should be supported by agreed actions to achieve these, such as specifying behavioural interventions for patients and staff, in line with NICE guidance, with respect to smoking, alcohol and obesity, with appropriate metrics for monitoring progress." The actions proposed in this paper, and the CCG's commitment to the city Health Inequalities Action Plan, should meet the requirements set out in the planning guidance.

## **2. CCG role in and opportunities to reduce health inequalities**

- 2.1. Reducing health inequalities is a major priority for Sheffield CCG for two reasons:
  - Taking action to reduce health inequalities will result in substantial population health gains, reduced healthcare spend and improved health outcomes.<sup>5</sup>
  - The Health and Social Care Act 2012 places a legal duty on CCGs to tackle health inequalities.
- 2.2. The CCG has three main routes through which it can have an impact on health inequalities:
  - Direct commissioning of services. This includes universal healthcare services that meet the needs of all who need to use the service; as well as targeted services that meet the particular needs of specific vulnerable groups such as asylum seekers and refugees.
  - Influence over member practices e.g. improving quality of primary care by supporting a reduction in unwarranted variation in access and treatment between practices (this could also be through direct commissioning e.g. a locally commissioned service).
  - System leadership e.g. taking the lead in coordinating action by all local organisations around a particular health inequalities issue, for example liver disease.

---

<sup>5</sup> Marmot et al. Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010. February 2010  
<http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf>

2.3. There are a number of specific actions the CCG can take to reduce health inequalities, particularly the gap in life expectancy between the best and worst off.<sup>6</sup> These mainly take effect through tackling differential access to services, and unwarranted variation in healthcare:

- Ensure widespread, systematic adoption of the most cost-effective high impact interventions as recommended by the National Audit Office report into Health Inequalities,<sup>7</sup> and the Public Accounts Committee Report into Tackling Inequalities in Life Expectancy.<sup>8</sup> This includes:
  - Improving blood pressure control
  - Increase smoking cessation services
  - Increased anticoagulant therapy in atrial fibrillation
- Increase targeted approaches to case finding in hypertension, COPD, lung cancer, cardiovascular risk and harmful drinking.
- Improve access to health care for vulnerable populations.
- Involve people and communities in designing services to meet their health and care needs, to ensure we break down any barriers stopping people from fully utilising services.
- Integrate care and services, so that they are commissioned around the needs of the patient and community rather than the needs of the professional or the service.
- Ensure commitment to and delivery of the 'Making Every Contact Count' initiative.<sup>9</sup>
- Use the Equality Delivery System (EDS)<sup>10</sup> as a toolkit to drive improvements, strengthen the accountability of services to those using them, and bring about workplaces free from discrimination.

2.4. The Five Year Forward View also presents an opportunity for the CCG to have a bigger impact on health inequalities through different models of care, including a bigger role for voluntary organisations.<sup>11</sup> Voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs.

### 3. Health inequalities action plan for 2015/16

3.1. The actions in the CCG action plan (table 1) have come from three main sources:

- issues identified by CCG portfolios;
- issues identified by the JSNA and Health and Wellbeing Strategy; and
- actions from the Health Inequalities Action Plan.

3.2. These actions have been discussed with the portfolios and the majority have been incorporated into portfolio commissioning intentions for 2015/16 (with some already part of portfolio activity in 2014/15). Additional public health support will

---

<sup>6</sup> NHS England. Promoting Equality and Tackling Health Inequalities. December 2013

<sup>7</sup> <http://www.nao.org.uk/wp-content/uploads/2010/07/1011186.pdf>

<sup>8</sup> <http://www.publications.parliament.uk/pa/cm201011/cmselect/cmpublicacc/470/470.pdf>

<sup>9</sup> <http://www.makingeverycontactcount.co.uk/index.html>

<sup>10</sup> <http://www.england.nhs.uk/ourwork/gov/equality-hub/eds/>

<sup>11</sup> <http://www.england.nhs.uk/ourwork/futurenhs/>

available through the council's public health core offer mandate. A small number of actions are being led directly through the public health core offer (both the healthcare public health team based in the CCG, and other public health staff based in the council).

3.3. The actions in table 1 (attached) are not intended to be a comprehensive overview of all work related to health inequalities that the CCG is taking forward. Most notably it does not include the Equality and Diversity programme of work, which clearly is a core part of reducing health inequalities.

#### **4. Recommendations**

4.1. The Governing Body is asked to approve the contents of this report and support the inclusion of the health inequalities actions in the CCG commissioning intentions for 2015/16.

Paper prepared by: Susan Hird  
On behalf of: Ted Turner/Tim Furness  
8 January 2015

**Table 1: health inequalities actions**

Portfolio	Suggested action	Timescale	Lead	Link to city Health Inequalities Action Plan
LTCs	Develop a CCG strategy for reducing health inequalities from cardiovascular disease (CVD)	To be agreed (will build on Potential Years of Life Lost plan and other work already underway in LTCs portfolio)	Portfolio	2.8 Retain focus on CVD and cancer
	Develop a CCG strategy for reducing health inequalities from cancer	To be agreed (will build on work already underway in LTCs portfolio)	Portfolio	2.8 Retain focus on CVD and cancer
	Ensure the developing CCG respiratory strategy reduces health inequalities and inequalities in access to services	Started Oct 2014 Implementation 2015/16	Portfolio	3.7 Commission disease specific interventions 3.4 Improve access to services
	Undertake a health equity audit on access to End of Life Care services for BME/vulnerable population groups	Due Apr 2015	Public health core offer	3.4 Improve access to services
MH&LD	Review the programme of work aimed at improving the physical health of people with Serious Mental Illness, to assess comprehensiveness and impact of programme	To be agreed	Portfolio	2.8 Retain focus on CVD and cancer 3.4 Improve access to services
	Review the programme of work aimed at improving the physical health of people with Learning Disability, to assess comprehensiveness and impact of programme	To be agreed	Portfolio	2.8 Retain focus on CVD and cancer 3.4 Improve access to services
	Undertake a health equity audit of inequalities in access to primary care and prevention services experienced by people with Learning Disability	Due Apr 2015	Public health core offer	2.8 Retain focus on CVD and cancer 3.4 Improve access to services
	Improve equity of access to primary and community care mental health services for people from vulnerable groups, by implementing the three-part model of care tested by the National Institute for Health Research (NIHR) <a href="http://www.journalslibrary.nihr.ac.uk/pgfar/volume-1/issue-2#abstract">http://www.journalslibrary.nihr.ac.uk/pgfar/volume-1/issue-2#abstract</a>	To be agreed	Joint portfolio and public health core offer	3.4 Improve access to services
Acute	Ensure that the programme of work to transform outpatient appointments (CASES) contributes to reducing inequalities by improving access for underserved groups	To be agreed	Portfolio	3.4 Improve access to services
	Support STH and SHSC Trusts to complete audits of services with high levels of people who do not attend (DNA) [this action is part of the citywide Health	Due Jun 2015	Public health core offer	3.4 Improve access to services

	Inequalities Action Plan]			
	Ensure this information is used to inform transformation of outpatients programme		Portfolio	
<b>CYPF</b>	Develop a citywide strategy and joint commissioning plans (with SCC) to address the needs identified in the children's emotional wellbeing and mental health needs assessment (published 2014)	In progress	Portfolio	3.5 Best start
	Develop a pathway for low level maternal mental health care, to ensure all women receive access to the right care at the right time	In progress	Portfolio	3.5 Best start
	Ensure targeted provision of allergy services throughout the city in community settings	In progress	Portfolio	3.5 Best start
	Ensure disabled children and their families have access to a range of services and support to meet their identified needs	In progress	Portfolio	3.5 Best start
	Increase the health outcomes of looked after children by development of a targeted Looked After Children (LAC) health strategy and plan	In progress	Portfolio	3.5 Best start
<b>Cross-cutting</b>	Consider commissioning a migrant health service for new arrivals, asylum seekers and refugees that encompasses testing and treatment of (latent) TB, viral hepatitis and possibly HIV	To be agreed	To be agreed	3.7 Commission disease specific interventions 3.4 Improve access to services
	Develop a CCG strategy for improving outcomes from and reducing health inequalities in liver disease	Starting Jan 2015	To be agreed	3.7 Commission disease specific interventions 3.4 Improve access to services
	Build on GPs' and community anchor organisations' experience of addressing health inequalities in Sheffield to develop coherent plans for addressing inequalities at a local level	Started Oct 2014	Mark Gamsu/Leigh Sorsbie/Katrina Cleary	3.4 Improve access to services



Department  
of Health

From the Rt Hon Jeremy Hunt MP  
Secretary of State for Health

Richmond House  
79 Whitehall  
London  
SW1A 2NS

Una O'Brien CB, Perm Sec DH  
Professor Sir Malcolm Grant/ Simon Stevens, NHS England  
Professor David Heymann CBE/Duncan Selbie, Public Health England  
Sir Peter Carr CBE/David Flory CBE, NHS Trust Development Agency  
Professor Jonathan Montgomery/Dr Janet Wisely, Health Research Authority  
John Pattullo/Ian Trenholm, NHS Blood and Transplant  
Prof. Sir Gordon Duff/Dr Ian Hudson, Medicines & Healthcare Regulatory Agency  
Silla Maizey/Nick Scholte, NHS Business Services Authority  
Ian Dilks/Catherine Dixon, NHS Litigation Authority  
Sir Keith Pearson/Ian Cumming, Health Education England

Tel: 020 7210 3000  
Mb-sofs@dh.gsi.gov.uk

And copied to:  
David Bennett, Monitor  
All DH ministers  
CMO

27 NOV 2014

Dear Colleague,

**Health Inequalities: working together to reduce health inequalities; assessment of the fulfilment of the Secretary of State's and NHS England's health inequalities duties in 2014-15**

Good progress has been made on the importance of reducing health inequalities across the system since I wrote to you in January 2014. I would like to set out the basis of assessment for the Secretary of State's and NHS England's health inequalities duties for 2014-15. Building on the progress made in 2013-14, the aim is to develop the system further towards real and measurable reductions in health inequalities. The criteria for 2014-15 focus on stronger strategic goals and actions, supported by effective local delivery, partnerships and communities.

I know there is a commitment to address health inequalities across your organisations. Although some of the drivers of health inequalities lie outside the health sector, together there is much we can do to confront this challenge.

Real reductions in health inequalities will mean more people can enjoy health throughout life, regardless of where they live or their social circumstances. The goal is for this to happen across the health and care system and to achieve this, we need a whole-system evidence-based approach, in which services take account of population needs at all stages of life.

For 2013-14 I set assessment criteria designed to establish the system to address health inequalities and to meet the requirements of the legal duties. My assessment, across the system, was that good progress was made in 2013-14 with more to do. My assessment for 2014-15 will be based on the following criteria. Having considered its potential impact on health inequalities and the application of the legal duties to its work, each organisation will need to decide appropriate action:

- Are governance and accountability arrangements for health inequalities appropriate and in use?
- Does the organisation have a strategic and evidence-based approach to identifying clear goals, priorities and actions that are most likely to lead to measurable reductions in health inequalities?
- Is the organisation working collaboratively with partners, including at local level and with individuals where appropriate, to help reduce health inequalities?
- Is there an assurance process to ensure the duties are being applied across all relevant functions?
- Are inequalities in access and outcomes being routinely monitored?
- Is progress in addressing health inequalities being maintained across key priorities, such as reducing premature mortality as set out in *Living Well for Longer: national support for local action to reduce premature avoidable mortality* (April 2014)? Are the actions identified by the Inclusion Health being considered and put into practice where appropriate?

Additionally for NHS England:

- Has it ensured CCGs are capable of fulfilling their duties?
- Has it put in place robust arrangements for assessment and publication of CCGs' fulfilment of their duties?

I expect you to report on how you are developing an outcomes-focused approach through meeting each of the above criteria. I will report on the fulfilment of my duty on health inequalities in my Annual Report for 2014-15, and will write to NHS England about fulfilment of their duty.

As the system develops, the basis for assessment will shift towards measures of access and outcomes. This will be measured by the NHS and Public Health Outcomes Frameworks. The Public Health Outcomes Framework already includes an overarching inequalities indicator, and there have been widespread discussions on suitable inequalities measures for the NHS Outcomes Framework during summer 2014. I hope that it will be possible to use some measures to inform this assessment from 2015-16.



## Department of Health

Since health inequalities are deeply entrenched in our society and some of the interventions are long-term, there is likely to be varied progress across different measures. In 2014-15, I hope to see action to ensure that the progress made over the last decade or so is maintained, in particular in the following areas:

- Reduction in absolute inequalities in CVD mortality under 75 years for men and women.
- Reduction in absolute inequalities in cancer mortality under 75 years for men and women.
- Reduction in inequalities in infant mortality.

As national leaders, working together and with local leaders and individuals themselves, our work must be relentless, evidence-based and systematic. Your focus on addressing health inequalities will be vital in driving positive change not just for those who are disadvantaged but for society as a whole.

*Yours sincerely*

**JEREMY HUNT**