‘Health Inequalities and the Social Determinants of Health: The Evidence Base’

24th February 2015

Fairness Commission Session

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Research Fellow
UCL Institute of Health Equity
Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003

Source: Office for National Statistics
Key themes

Reducing health inequalities is a matter of fairness and social justice

Action is needed to tackle the social gradient in health – proportionate universalism

Action on health inequalities requires action across all the social determinants of health

Reducing health inequalities is vital for the economy – cost of inaction

Beyond economic growth to well-being of society: sustainability and the fair distribution of health
Marmot Review - 6 Policy Objectives

A. Give every child the best start in life
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
C. Create fair employment and good work for all
D. Ensure a healthy standard of living for all
E. Create and develop healthy and sustainable places and communities
F. Strengthen the role and impact of ill-health prevention
# Health Equity Evidence Reviews vs Health Equity Briefings

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<th>Early intervention</th>
<th>Education</th>
<th>Employment</th>
<th>Ensuring a healthy living standard for all</th>
<th>Healthy environment</th>
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<td>1b. Improving the home to school transition</td>
<td>3. Reducing the number of young people not in employment, education or training (NEET)</td>
<td>5b. Working with local employers to promote good quality work</td>
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<td>8. Improving access to green spaces</td>
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<td>5c. Increasing employment opportunities and retention for people with a long-term health condition or disability</td>
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<td>5d. Increasing employment opportunities and retention for older people</td>
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<td>9. Understanding the economics of investments in the social determinants of health</td>
<td>10. Tackling health inequalities through action on the social determinants of health: lessons from experience</td>
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**Commissioned by PHE, written by Institute of Health Equity**

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**Available on the PHE and IHE websites –**

[www.instituteofhealthequity.org](http://www.instituteofhealthequity.org)
Forthcoming – this summer

- The impact of physical housing conditions on mental health
- Adverse experiences for children and young people
- The potential of Social Value to impact on inequalities
- Can health literacy strategies improve health outcomes and reduce health inequalities?
- Social inequalities in the leading causes of early death – a life course approach
- Improving school transitions for health equity
- Creating good quality work for health equity
- Tackling social isolation
- Older people

UCL Institute of Health Equity
The Best Start in Life
Figure 2: Changes in risk of disease development with increased history of ACE, English survey data, 2013
Percentage of survey respondents who experienced a range of ACEs by deprivation quintile, England, 2013
Building resilience and capabilities - education
What can schools do to build protective factors and reduce risk factors?

- Improve achievements
- Promote healthy behaviours
- Enable positive transitions
- Support parents and carers
- Increase support from teachers
- Promote supportive peer relationships
- Implement a whole-school approach
- Position the school as a community hub

- Individual level
- Interpersonal level
- Community level
How can Local Authorities support and encourage these actions in schools?

- Responsibility for overseeing maintained schools
- Providing schools with data (local need, health changes)
- Enabling partnerships (other schools, community, LA, VCSE...)
- Connections to CCGs and commissioning
- Communicate national and local policy
- Work across governance frameworks
- Information on interventions
- Training school staff
Fair employment and good work
Figure 8 Mortality of men in England and Wales in 1981–92, by social class and employment status at the 1981 Census

![Bar chart showing standardized mortality rate by social class and employment status in 1981.](image-url)
Percentage of the economically active population aged 16+ without a job (2005-2013)

Reducing the number of young people not in employment, education or training (NEET)

Figure 7: NEET levels in Wales, Swansea and Wrexham, 2005–2012
Healthy standard of living - income
% of Households not reaching the Minimum Income Standard

Source: Joseph Roundtree Foundation 2014
Healthy and sustainable places and communities
Proportion of people reporting low mental wellbeing in good and bad housing, across the life course, England 2010-11
Housing condition problems, by deprivation of area, 2012

- **any category 1 hazard**
- **non-decent**
- **damp**
- **substantial disrepair**

% of households

- **most deprived 20% of areas**
- **2nd**
- **3rd**
- **4th**
- **least deprived 20% of areas**
Implementation and Delivery
The Social Value Act

The Social Value Act states that during procurement public bodies in England and Wales must consider:

“How what is being proposed to be procured might improve the economic, social and environmental well-being of the relevant area, and… How, in conducting the process of procurement, it might act with a view to securing that improvement.”
Definition of Social Value locally - we need to formulate a definition to make sense of ‘social value’ as a concept.

- Maximising community potential
- Tackling inequalities in our community
- Improving quality of life
- Community assets & resilience
- Creating flourishing individuals & communities
- Strengthening relationships

‘Freedom to live a valued life’ (Amartya Sen)

Framework for action – Marmot Review

We need this to determine where the energy and resources of ‘social value’ can be put to work to yield the greatest outcomes for the community we serve.

The English Review ‘Fair Society, Healthy Lives (Marmot, 2010) brought together the best available global evidence on health inequalities. That evidence highlighted that health inequalities arise from social inequalities in the conditions in which people are born, grow, live, work and age. The review highlighted that action to address health inequalities will require action across all the social determinants of health by central and local government, the NHS, the third and private sectors and community groups.

The Marmot Priorities

- Best start in life
- Ensure healthy standard of living
- Fair employment / good work
- Healthy & sustainable places & communities
- All people can maximise their potential / capabilities
- Prevention of ill health

LOCAL INTELLIGENCE – JSNA

COMMUNITY ENGAGEMENT & CO-PRODUCTION

- Peer support
- Parenting support
- Opportunities for families to come together
- Mentoring
- Community led projects
- Community led initiatives
- Healthy workplace schemes
- Worker reps on boards
- Living wage
- Good employer initiatives
- Thriving VCSE sector
- Green and blue space community projects
- Participatory budgets
- Allotments
- Hobby and interest groups
- Societies
- Social Entrepreneurship
- Time banking
- Intergenerational projects
- Food schemes
- Community sports projects
- Community navigators
- Befriending
- Bike sharing
- Sports clubs
Lessons from experience

Strategies for prioritising action
- Strong leadership advocating for equity
- Understand local populations
- Take evidence-informed action
- Make the links between SD and health clear and mobilise political capital

Principles for action
- Aim for health equity in all activities
- Use a life course approach
- Apply proportionate universalism
- Ensure partnerships across sectors and align strategies
- Work with the local community and local groups

Ensuring impact and continuity
- Promote accountability for equity
- Monitor, evaluate and share findings to inform future planning
- Aim for long-term sustainability

Understand local populations
Take evidence-informed action
Make the links between SD and health clear and mobilise political capital
Strong leadership advocating for equity
Promote accountability for equity
Monitor, evaluate and share findings to inform future planning
Aim for health equity in all activities
Use a life course approach
Apply proportionate universalism
Ensure partnerships across sectors and align strategies
Work with the local community and local groups
Aim for long-term sustainability
So, in summary…

• Health inequalities are unfair, unjust, and avoidable.
• They exist between and within countries, and also between and within areas.
• They are caused by the conditions in which people are born, grow, live, work and age.
• These conditions vary between and within areas (e.g. Redbridge compared to other boroughs – FSM within RB).
• Taking action on the SDH can improve health for all and reduce inequalities in health.
Thank you for listening!

Lots of information on our website:  
www.instituteofhealthequity.org
Reducing the burden of poor health

Figure 1: The health gradient

Summary

- Strong case for tackling health inequalities.
- Evidence base of what works is clear but still evolving.
- There are significant health inequalities in Redbridge.
- The Public Health team has a leadership role in tackling these.
- But action is required across local partnerships.
Today

- Evidence base- UCL institute of health equity.
- Role of Public Health in fairness.
- Healthwatch.
- Redbridge CVS.
- Positive East.
The role of Public Health in fairness

Presentation to Redbridge Fairness Commission

Vicky Hobart, Director of Public Health
Duduzile Sher Arami, Consultant in Public Health
Gavin Dabrera, Specialist Registrar in Public Health
Summary of evidence of health inequalities

Residents living in areas of higher deprivation generally experience lower life expectancy and poorer wellbeing than residents in least deprived areas.

- Life expectancy at birth.
- Life expectancy at age 65 years.
- Healthy life expectancy.
- Infant mortality.
- Childhood obesity.
Some examples of actions to address inequality by Redbridge PHT

1. Re-commissioning Integrated Drug and Alcohol services.


3. HIV Testing – outreach to at risk communities.

4. Health Checks – pilot of community provision to people unlikely to use Primary Care.

5. Targeted smoking cessation in Hainault ward.
Challenges to reducing inequalities

- Financial climate.
- Strong population pressures and increasing needs.
- Increasing inequality.
Distributing resources for public health

- Determining how resources should be allocated to specific uses of healthcare, is a common issue affecting many public services, including public health.

- There are a number of key Health Economic concepts which can be applied to these issues.
Technical Efficiency

- Producing a desired output for the lowest level of inputs.

- Example: *how to provide 1000 chlamydia screens for young people?*
How to achieve Technical Efficiency?
How to achieve Technical Efficiency?
Technical Efficiency

- Example: *how to provide 1000 chlamydia screens for young people?*

- If it was cheapest to provide these screens using existing general practitioners rather than a separate service to do this,
  
  *then this would be technically efficient.*
Social Efficiency

- In public services, we often need to consider other factors:
  - Social costs – costs to wider society, e.g. cost of travelling to general practice for some users.
  - Social benefits – savings for wider society, e.g. preventing other people getting infected.
Social Efficiency

- In public services, we often need to consider other factors:
  - Social costs – costs to wider society, e.g. cost of travelling to general practice for some users.
  - Social benefits – savings for wider society e.g. preventing other people getting infected.

- Therefore to achieve social efficiency, higher costs may be justified.
How to achieve Social Efficiency?
Social Efficiency

- To achieve social efficiency, another service may be needed in addition to the general practice testing.

- This could be justified by the wider benefits to society of all people being treated.
The Public Health Grant

- Based on calculated levels of historical spending on public health services (prior to transfer to local authority).

- Size of the grant per head of the population is low compared to other London boroughs including Outer North East London.
2015-16 PH Budget Allocation per Head £
(Based on ONS 2015 Population Projection)
The Public Health Grant

- Public Health is obliged to provide specific services such as comprehensive Sexual Health services, NHS Health Checks and the National Child Measurement Programme (NCMP).

- Also provides a range of other services to improve the health and wellbeing of the population.
The Public Health Grant

Other services include:

- NHS Health Checks (targeting vascular disease);
- Stop smoking services;
- Child and Adult Obesity Initiatives;
- Oral health promotion;

and many others

- Represents only a proportion of total public spending on these areas.
The Redbridge Pound

Central Government Allocation

NHS

Schools

Council Spending

Greater London Authority Spending

Police Spending

Local Enterprise

Social Capital

Voluntary Sector
Opportunities

- Build on excellent relationships RPHT have with wider LBR.
- Build on councils expertise in working with local people.
- Public Health Commissioning Responsibilities.
Opportunities

- Maximising the opportunities arising from the transfer of the Healthy Child Programme.
- Developing a local approach to health in all policies.
- Making every contact count in improving health and wellbeing.
- Helping service commissioners and providers to embed equity considerations in service planning.
Life Expectancy at Birth (Males) vs Deprivation (IMD 2010 Score),
Redbridge Electoral Wards 2009-13
Life Expectancy at Age 65 (Males) vs Deprivation (IMD 2010 Score), Redbridge Electoral Wards 2009-13

IMD 2010 Score (1.0 = Least Deprived)
Infant Mortality Rates (Deaths per 1,000 Live Births) vs Deprivation (IMD 2010 Score), Redbridge Electoral Wards 2003-11
2015 Approved Health Visitor Budget Spend per Head (0-5 Population) and the Original HV Spend for Those Councils Previously below the 160 Floor Threshold

- **Lambeth**: £361
- **Hackney**: £327
- **Hammersmith and Fulham**: £287
- **Greenwich**: £285
- **Lewisham**: £285
- **Newham**: £282
- **Tower Hamlets**: £274
- **Westminster**: £271
- **Southwark**: £261
- **Camden**: £251
- **Kensington and Chelsea**: £247
- **Islington**: £222
- **Waltham Forest**: £219
- **Barking and Dagenham**: £214
- **Wandsworth**: £198
- **Bexley**: £191
- **Harley**: £176
- **Croydon**: £169
- **Brent**: £166
- **Hillingdon**: £162
- **Kingston upon Thames**: £162
- **Bracknell**: £160
- **Ealing**: £160
- **Hounslow**: £160
- **Richmond upon Thames**: £160
- **Sutton**: £160
- **Merton**: £160
- **Barnet**: £160
- **Harrow**: £160
- **Redbridge**: £160
- **Havering**: £160

- **Approved Spend (2015)**
- **Original Spend (if less)**

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London Borough of Redbridge

[Logo]
Public Health Budget 2014/15 - £11.4 M

- Sexual Health: 29.8%
- Public Health Staff: 10.7%
- Children 5-19 Public Health Programmes: 8.7%
- Public Health Support: 4.1%
- Stop Smoking Service & Interventions: 3.3%
- Other PH Services*: 13.4%
- Substance Misuse Service: 30.1%
Fairness in Redbridge: the challenge of community engagement in a time of austerity

Cathy Turland CEO, Healthwatch Redbridge
HWR Vision

• Healthwatch aims to be a channel between health and social care providers and local communities

• Seek out the people we don’t yet talk to, and get better at communicating with all sectors of the community

• Make information widely available locally: e.g. libraries, pharmacies, community centres, GP surgeries, day centres

• Work in partnership with the Council, health and social care services and voluntary organisations, and other Local Healthwatch's
‘Everything we do starts with a conversation…’
Engagement in Redbridge

• be creative!

• be flexible!

• appreciate diversity

• make it accessible!

• make it easy!
Gathering Information: be creative!

There are lots of ways to gather information:

- Documents
- Face-to-face (formal & informal)
- Email
- Observation
- Telephone
- Mail
Community Engagement: be flexible!

• Projects Development Group
• Enter & View
• Engagement Champions
• Consultations
• Outreach
• Telephone research
• Reports
Keep people informed: appreciate diversity

Have Your Say:
Thinking about what you’ve just heard, tell us your views on the proposals

What happens next?
Completing a consultation response
Engagement: Make it Accessible!
Engagement: Make it Easy!

Improving Dignity in Health and Care

Join the Healthwatch Redbridge campaign and help us to identify and improve services for local people.

Please complete the questions overleaf. If you would like more information or want to be kept informed regarding the campaign please provide contact details:

Name: 
Tel: 
Email: 

Tel: 020 8553 1236
Email: info@healthwatchredbridge.co.uk

Freepost Address (no stamp needed)

FREEPOST RTEK-HYXH-RLZT
Healthwatch Redbridge
5th Floor, Forest House
16-20 Clements Road
Ilford, Essex
IG1 1BA

What do the words Dignity and Respect mean to you?

Make sure that we are treated with Dignity and Respect?
Reports and Projects

- Ageing Well in Residential Sheltered Housing
  - April 2014

- School Nursing Support

- Were you consulted?
  - A report on moving

- Pharmaceutical Needs Assessment in Redbridge
  - Executive Summary
  - February 2015
Thank you: Any Questions?
Contribution of the Voluntary Sector in Reducing Health Inequalities in Redbridge

Swati Vyas
Health Partnerships Manager

RedbridgeCVS
Fairness

• Equal access to services – need based
• Equal access to resources
• Equal opportunities
Contribution of the Voluntary sector improving health and wellbeing in Redbridge
Some community engagement models that help in improving health inequalities

1. Health Buddies model - raising awareness on Tuberculosis and HIV
Some community engagement models that help in improving health inequalities

2. Fit For Fun

- Successfully in our 7th year and funded by Redbridge Public Health, we offer 20 weeks of free fitness and fun exercise classes to groups in an activity of their choice. From gentle chair based exercises, golf, yoga or something a bit more taxing like Zumba, boxing fitness or keep fit to help groups have fun and get fit at the same time.
- We match them with a vetted and fully qualified instructor who will run sessions that meet the needs of the participants in the groups.
- Each group chooses the venue where their activity will take place so they do not feel isolated or self-conscious being in a public setting. We will also help groups to continue beyond the 20 funded weeks.
- We work with hard to reach groups who would not normally undertake physical activities within public settings.

- 40 groups take part each year with approximately 3000 participants so far.
Those who have benefited have been aged between 5 and 100 years old, and included Mums and their babies through to those living in residential accommodation, physical and learning disabilities, ethnic minority groups, mental health, women and men only groups and children and young people’s groups.

For those groups suffering from mental health issues, the programme has been a stepping stone to independence as they feel more confident to attend sessions run by the instructor at their venues or join a class run by other organisations.
We concentrated on people who were elderly with some sort of disability such as arthritis, poor mobility and in some cases chair bound for Yoga Exercises.

One or two patients I know used to use a walking stick and now do without it. Talking to people who came to the group they said that they were visiting their doctors less and some are taking less pain killers. I think on the whole the group enjoyed it so it was a social occasion. It also improved their mobility quite a lot.

I think it is an excellent programme that gave us the opportunity to encourage patients that would normally not participate in activities to exercise.

Dr Sharma comments - Wanstead Patients Participation Group

They successfully received further funding and have set up three further yoga sessions in nursing homes.
Sustainability

Groups have found a variety of innovative ways of continuing to exercise up to 6 months beyond the 20 free weeks. Ways that groups have continued: Self-funded the activity with their members paying a small fee for the instructor and venue, received external funding, training a member of their group as a trainer, undertake different activities such as walking and attend sessions run by Vision Leisure and other leisure organisations.

What we have learnt:

All of our participants say they have seen improvements in their physical and mental health and wellbeing:

• Self assessed fitness levels increase by an average of 3 points on a scale of 1-10
• Around 90% of groups continue to exercise regularly when their sessions finish
• Coupled with healthy eating, they have noticed real differences in their ability to do things as a result of regular exercise
• They feel better able to get involved with other activities and socialise with other people
• It has provided motivation for them to “get out of bed in the morning”!
• Participants say taking part in Fit for Fun significantly reduces their stress levels.
Some community engagement models that help in improving health inequalities

3. Social Prescribing
From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot
• 22% community based activity
• 15% info and advice
• 11% befriending
• 9% community transport
• NHS *and* LA benefited
• People with long term conditions and their carers benefited
• Voluntary sector providers benefited
• Accident and Emergency attendances reduced by 20 per cent within the 12 month cohort and by 12 per cent within the six month cohort.
• Inpatient admissions reduced by 21 per cent within the 12 month cohort and by 14 per cent within the six month cohort.
• Outpatient appointments reduced by 21 per cent within the 12 month cohort and by 15 per cent within the six month cohort.
• Improved Wellbeing of patients referred.
• Estimated total cost reductions by the end of the Pilot:
  • £552,000
  • A return on investment of 50 pence for each pound (£1) invested.
• http://www.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf
Some community engagement models that help in improving health inequalities

3. Redbridge First Response Service (ReFRS) – similar to Social Prescribing model

The Redbridge First Response Service (ReFRS) is a multi-agency scheme working together to provide Redbridge residents with easy access to services that can support their wellbeing, safety, choice and independence.

The scheme is a referral service for vulnerable adults aged 18 and over living in Redbridge and in partnership with trusted providers’ e.g the council, police service, fire service, voluntary groups and other organisations who work with vulnerable adults.
Inequalities faced by Redbridge community and voluntary groups and their members

- Although, very small percentage of community and voluntary groups receive funding from the statutory sector they contribute hugely towards health and wellbeing of local residents. Continue and enhance the funding to the voluntary sector for greater health outcomes for Redbridge.

- Investment to fill current gaps in services that contribute towards to social determinants of health – housing, leisure, access to green spaces, access to advice and support, infrastructure for community groups

- More needs to be done with regards to Prevention of ill health and Health Promotion using good practice models

- Continue ring-fenced Public health budget beyond 2015-16

- Need for greater involvement of the voluntary sector in Co-designing of local services

- Lack of voluntary sector engagement in the Commissioning process
Thank you
Impact of HIV on Individuals & Communities

Redbridge Fairness Commission
24th February 2015
HIV in Redbridge

- HIV Prevalence 2.78 per 1000
- 53.8% diagnosed late
- 498 people living with HIV
- 23% MSM & 53% African Communities
Challenges

- Stigma & Discrimination
- Late Diagnosis & Undiagnosed HIV
- Social Isolation
- Poverty, Poor Housing and Employment
- Access & Engagement with Services
- Drugs & Alcohol
- Immigration
- Ageing
- Mental Health
- Faith
Prevention
Escalation of Need

Promotion of Health & Wellbeing

HIV Prevention

3Ps
Crisis
Independence
Sustained Independence
Support pathway

- **From crisis** – counselling, advice, help with benefits/housing, legal situation, food parcels/bank, recently diagnosed support

- **To independence** – 1:1 or group support, health and wellbeing, complementary therapies, employability, volunteering

- **Sustained independence** – Self management, peer support networks, adherence, app and web based information, being in the community

- Different Types of support are needed at different life stages. “being Positive may resurface with a different face. The condition brings up challenges all the time.”
People supported by Positive East

2013/14

- 179 people supported in the financial year 2013/14
- 52% women 48% men
- 73% heterosexual, 22% gay 3% bisexual 2% did not state
- African 58%, White British 18%, Asian 8%, Black British 5%, White Eastern European 2%, White Western European 2%, Caribbean 2% other 5%
- U16: 5%, 18-24: 9%, 25-34: 16%, 35-44: 27%, 45-65: 52%, 65+: 1%

- In this financial year we have seen 147 people, This is 25% up on the same 9 month period in the previous financial yr. The other demographics are roughly the same as the previous financial year.
Up skill individuals living with HIV through involvement in Service Delivery

Reduce demand on services and change attitude and culture

Build Community Capability and Capacity

Sustain Service Delivery through involving Volunteers

Improve Service Delivery and Development through involving Volunteers
Recommendations

Challenge stigma

- SRE education in schools inc tackling homophobic bullying
- All public sector and NHS staff are HIV aware through appropriate training
- Engage with and challenge Faith communities where they contribute to continuing stigma and poor adherence
- Involve service users and the organisations that support them in service planning, improvement and delivery
- Public sector use opportunities to role model good practice, celebrating and honouring diversity

Tackling poverty

- Invest in specialist services along the care pathway where support around disclosure of HIV is essential
- Invest in services and activities that mitigate the harms of welfare reforms which contribute to poor health and social outcomes - continued access to local housing, Emergency Support Fund, good child care

Good wellbeing

- Good joint working with alcohol and substance misuse services
- Good joint working with mental health services
- Employment opportunities for PLWHIV by local jobs, encouraging in local voluntarism, challenging poor employment practice and discrimination
We live in a completely interdependent world, which simply means we can not escape each other. How we respond to HIV depends, in part, on whether we understand this interdependence. It is not someone else's issue. This is everybody's issue.”

(with thanks to Bill Clinton)
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<th>Direct action</th>
<th>Influencing place</th>
<th>Influencing government</th>
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<td><strong>PLYMOUTH</strong></td>
<td>Extend FSMs to all primary school children</td>
<td>Joint review for appropriate crisis responses to mental health needs</td>
<td>National legislation to limit 24-hour licencing in areas where alcohol is causing harm</td>
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<td>Pilot providing a meal a day to disadvantaged pupils outside of term time and assess costs and benefits</td>
<td>Coordinate food poverty initiatives across the city, reach ‘Plymouth’s food deserts’</td>
<td>DWP to address delays in benefit payments and inappropriate use of sanctions</td>
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<td><strong>ISLINGTON</strong></td>
<td>Thirteen active spaces are being developed across the borough, each with a dedicated activity programme to encourage children and families to be physically active</td>
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<td><strong>BIRMINGHAM</strong></td>
<td>Develop open spaces and community assets, with user-led design projects</td>
<td>Organisations to follow council's example in adopting the five ways to wellbeing as a set of shared indicators</td>
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<td><strong>WAKEFIELD</strong></td>
<td>Train health champions in the statutory and voluntary sector on emotional health and resilience, financial capability and alcohol interventions</td>
<td>A social investment bond to enable community enterprises to provide combined health and employment solutions in two priority areas</td>
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<td><strong>SHEFFIELD</strong></td>
<td>Spend an increasing proportion of budgets on initiatives which address the social determinants of health</td>
<td>Advocate the Food Plan developed by a Public Health dietician which promotes local produce and healthier eating</td>
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<td>Radically re-think commissioned services for the physical health care of people with mental health problems - through the CCG</td>
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<td>Make sure respite care is available for carers</td>
<td>Sheffield Council to introduce a 'Fair Employer' code of practice, encouraging annual reporting on living wage, training, health screening for employees, pay ratio, bonus levels, diversity, working environments</td>
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<td>Extend 'With Carer Pass' (for city bus travel) to all carers caring for a disabled person</td>
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<td>Establish a mechanism to distribute decent, edible food to people in food poverty</td>
<td>Stronger measures to encourage walking, cycling and use of public transport</td>
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<td>LIVERPOOL</td>
<td>Ensure the provision of school meals (both breakfast and lunch) for children and young people whose families are in receipt of welfare</td>
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<tr>
<td>BLACKPOOL</td>
<td>Make it easier and cheaper for local residents to use sports, entertainment and transport services</td>
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