Public Document Pack

Overview and Scrutiny Management Committee

Thursday 16 November 2017 at 1.30 pm

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillors Chris Peace (Chair), Ian Auckland, Penny Baker, John Booker, Denise Fox, Douglas Johnson, George Lindars-Hammond, Pat Midgley, Josie Paszek, Mick Rooney, Ian Saunders, Steve Wilson and Cliff Woodcraft

Substitute Members
In accordance with the Constitution, Substitute Members may be provided for the above Committee Members as and when required.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Overview and Scrutiny Management Committee comprises the Chairs and Deputy Chairs of the four Scrutiny Committees. Councillor Cate McDonald Chairs this Committee.

Remit of the Committee

- Effective use of internal and external resources
- Performance against Corporate Plan Priorities
- Risk management
- Budget monitoring
- Strategic management and development of the scrutiny programme and process
- Identifying and co-ordinating cross scrutiny issues

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

Members of the public have the right to ask questions or submit petitions to Scrutiny Committee meetings and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

Scrutiny Committee meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information about this Scrutiny Committee, please contact Emily Standbrook-Shaw, Policy and Improvement Officer, on 0114 27 35065 or email Emily.standbrook-shaw@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

OVERVIEW AND SCRUTINY MANAGEMENT COMMITTEE AGENDA
16 NOVEMBER 2017

Order of Business

1. Welcome and Housekeeping Arrangements

2. Apologies for Absence

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

4. Declarations of Interest
Members to declare any interests they have in the business to be considered at the meeting

5. Minutes of Previous Meeting
To approve the minutes of the meeting of the Committee held on 19th October, 2017

6. Public Questions and Petitions
To receive any questions or petitions from members of the public

7. Work-Based Development and Wellbeing
Report of the Director of Human Resources and Customer Services

8. January 2018 Full Council Meeting - Director of Public Health Report for Sheffield 2017

9. Issues to Raise from Other Scrutiny Committees
The Chairs of the standing Scrutiny and Policy Development Committees to report on any issues

10. Work Programme 2017/18
Report of the Policy and Improvement Officer

11. Date of Next Meeting
The next meeting of the Committee will be held on Wednesday, 14th February, 2018, at 10.00 am, in the Town Hall

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

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

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SHEFFIELD CITY COUNCIL

Overview and Scrutiny Management Committee

Meeting held 19 October 2017

PRESENT: Councillors Chris Peace (Chair), Ian Auckland, Penny Baker, John Booker, Denise Fox, Douglas Johnson, George Lindars-Hammond, Pat Midgley, Josie Paszek, Mick Rooney, Ian Saunders, Steve Wilson and Andrew Sangar (Substitute Member)

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Cliff Woodcraft (with Councillor Andrew Sangar attending as his substitute).

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 20th July 2017, were approved as a correct record.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 There were no questions raised or petitions submitted by members of the public.

6. MEDIUM TERM FINANCIAL PLANNING

6.1 The Committee received a report of the Director of Finance and Commercial Services, attaching a report of the Executive Director, Resources, on the Medium Term Financial Analysis (MTFA) 2018/19 to 2022/23, which had been considered by the Cabinet, at its meeting held on 19th July 2017. The report set out details of the forecast financial position of the Council for the next five years, and recommended the approach to budgeting and financial planning that would be necessary to achieve a balanced budget position over the medium term.

6.2 The report was supported by a presentation from Marianne Betts, Director of Finance and Commercial Services, on the revised approach to documenting Medium Term Financial Planning (MTFP) 2018/19 to 2022/23.

6.3 Ms Betts referred to the proposed reporting structure in terms of the Medium Term Financial Analysis (MTFA) and the Medium Term Financial Strategy (MTFS), and

reported on the key messages with regard to the budget planning process and the reporting with regard to the MTFA, including details relating to the assessment of the corporate gap and the portfolio gap. She reported on the proposed MTFS reporting, including the approach to balancing the corporate and portfolio gaps, an overview in terms of the Council's reserves and key dependencies in respect of the budget planning process. Ms Betts concluded by stating that the key aim was to develop a financial strategy that was linked to enabling the Council's priorities.

6.4 Members of the Committee raised questions, and the following responses were provided:-

- Financial analyses were generally based on assumptions, and this was particularly pertinent in the current unsettled economic climate. If there were any material changes in terms of the economic climate that were deemed likely to affect the Authority, any financial forecast would have to be reviewed. The next major Government financial announcement was the Autumn Budget, expected on 22nd November 2017, therefore a further review would be dependent on the nature of this. Whilst consideration could be given to including figures based on the likely effects of major economic drivers, such as Brexit, it was considered that, unless there was a clear statement, it would be difficult to include in the forecast numbers, so it was agreed a general position on the potential macro-economic impacts on the Council should be included in the future MTFS as a minimum.

- Assumptions in terms of contributions from the Better Care Fund and the Clinical Commissioning Groups had been included in the forecast.

- Whilst it was accepted that the South Yorkshire Pension Fund (SYPF) had received notification from its Actuary that the Fund may swing into surplus in the medium-term, contribution rates by admitted bodies, including the City Council, were set over a three-year period by the Actuary, and he had indicated that there was no opportunity for any interim changes. The next review of contribution rates would take place in 2019, and take effect from 2020/21. The Actuary had also cautioned that the currently forecast improvement in the Fund was subject to considerable uncertainty and fluctuation. Consequently, the Council could not yet use this potential improvement as an assumption on which to build its financial strategy. Any decisions regarding investment in terms of the SYPF were not the responsibility of the Council, therefore this could not be included in the Strategy.

- The amount of the Council's current reserves which had not been earmarked, stood at approximately £12.6 million, which was deemed to be the minimum assessed level of reserves for an Authority the size and scale of Sheffield. This money was classed as a safety net, to be used only in exceptional circumstances. The Authority did not agree with the Government's proposal with regard to local authorities borrowing from each other's reserves in order to invest. The Authority had not received any approach from any other local authorities, nor had any decisions been made with regard to the Authority approaching other local authorities.

- Officers regularly liaised with colleagues in the other Core Cities, with regard to their respective financial positions. Sheffield's position was more stable than some of the other Core Cities, mainly as a result of past, prudent decisions made with regard to its budget planning process. However, all the Core Cities have been under sustained financial pressure since 2010.

- The MTFS could include, within the appendices, a range of scenarios to present a range of eventualities, with the broad approach to the Council's MTFS and the key assumptions made, being clearly articulated in the body of the document.

- The MTFS sets out the Council's latest financial forecast at, and across, a specific point in time.

- It was accepted that the budget needed to be set in context with the Council's priorities. The Authority was aware, as part of its economic growth plan, as to what was required in order to improve the City's economic position. Income generated from the receipt of business rates was one such factor, and this would continue to be factored into the Strategy.

- It was accepted that the MTFS planning approach should look at the Council budget as a whole, and not just the revenue budget position. It should, for example, include details on capital expenditure. Also, the intent of the MTFA and MTFS was not to articulate a budget position statement (which was dealt with through budget monitoring processes), but to provide a medium-term view of how the Council could financially enable achievement of the Council's priorities, and to what extent.

6.5 RESOLVED: That the Committee:-

(a) notes the contents of the report now submitted, the information reported as part of the presentation and the responses to the questions raised;

(b) endorses the revised approach to documenting the Council's Medium Term Financial Planning 2018/19 to 2022/23; and

(c) thanks Marianne Betts for attending the meeting, making the presentation and responding to the questions raised.

7. PRESENTATION TOPICS FOR THE JANUARY 2018 COUNCIL MEETING

7.1 Members discussed the presentation topic for the Council meeting on 3rd January 2018, which had been agreed as the Annual Report of the Director of Public Health, as well as the wider issue regarding the purpose and structure of such Council meetings.

7.2 RESOLVED: That the Committee:-

(a) notes the information now reported, together with the comments now made;

and

(b) arising from the discussion, agrees that (i) due to the nature, and level of information, this be the only presentation at this Council meeting, (ii) for such Council meetings to be productive, the format of such meetings be arranged more like the existing Scrutiny Committee meetings, and with the officers making the presentations being tasked with one or a number of actions arising from the meeting and (iii) arrangements be made for members of this Committee to have sight of the Annual Public Health Report, at its meeting to be held on 16th November 2017, in order to look at possible lines of questioning.

8. ISSUES TO RAISE FROM OTHER SCRUTINY COMMITTEES

8.1 The Policy and Improvement Officer submitted a report attaching the draft Work Programmes of this, and the four standing Scrutiny and Policy Development Committees.

8.2 The Chairs of the Scrutiny and Policy Development Committees provided an update in terms of their respective Committee's work.

8.3 The Committee noted the contents of the report now submitted, together with the updates provided by the Chairs.

9. WORK PROGRAMME 2017/18

9.1 The Policy and Improvement Officer submitted a report attaching the Committee's draft Work Programme for 2017/18.

9.2 The Chair suggested that there should be a pre-meeting, for 30 minutes, prior to each public meeting of the Committee commencing.

9.3 RESOLVED: That the Committee:-

(a) approves the draft Work Programme 2017/18 as set out in the report now submitted; and

(b) agrees that pre-meetings be held for 30 minutes prior to each public meeting of the Committee.

10. DATE OF NEXT MEETING

10.1 It was noted that the next meeting of the Committee would be held on Thursday, 16th November 2017, with Members meeting at 1.00 pm for a 30 minute pre-meeting, and with the public meeting commencing at 1.30 pm.

Report to Overview and Scrutiny Management Committee

Report of: Eugene Walker, Executive Director of Resources

Subject: Work-based Development and Wellbeing

Author of Report: Mark Bennett, Director of Human Resources and Customer Services, 0114 2734081

Summary:
This report details the activity being undertaken by the organisation to support and sustain a healthy and well developed workforce.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**X**
Other	

The Scrutiny Committee is being asked to:
Comment on progress against current activity and actions and to propose further interventions as appropriate to supporting the organisation to achieve its aims and objectives in relation to its workforce.

Background Papers:
List any background documents (e.g. research studies, reports) used to write the report. Remember that by listing documents people could request a copy.

Category of Report: OPEN

Report of the Executive Director of Resources
Work-based Development and Wellbeing

1. Introduction/Context

1.1 This report is provided at the request of the Committee detailing actions undertaken by the organisation to support its workforce specifically in relation to development and wellbeing.

1.2 For purposes of clarity the detail in this report focuses directly on the Councils strategic approach in relation to the development of the internal workforce.

1.3 Developing and sustaining a healthy, diverse, engaged, skilled workforce requires a number of components. These are elements of an overall strategic approach to our workforce and key components of our evolving workforce strategy. Our Workforce Strategy framework is appended to this document (appendix 1). It should be noted that none of these elements stand alone and all are integral to the sustainability of our desired workforce ambitions.

1.4 Our strategy is informed both from an organisational perspective but also from engagement with our workforce. Key issues raised from the Manager Annual General Meeting and our workforce opinion survey relate to our ability to manage change effectively, ensure we have effective tools for employees to undertake their duties, staff morale in the face of diminishing budgets and employee reductions. Due to the diverse nature of services across our organisation, our employees now require greater skill sets in order to deliver our strategic priorities and therefore the HR Service and organisation must be supported to respond to these challenges.

1.5 Headlines from the last employee survey results show:

- Response rates have fallen compared to October 2016
- Overall morale scores are similar to the last survey
- Ways of working scores (how we communicate, innovate and collaborate) are broadly the same as previously, however the measure for collaborate has fallen.
- The results of the last two surveys suggest that improvements in how we manage change is a weakness of the organisation
- A key area of strength is the relationships between staff and their manager and other colleagues
- In terms of working environment, the ICT network, heating and ventilation, and mobile phones received the lowest scores.

The results at portfolio and service level vary and show different strengths and issues. Managers in respective service areas are working on individual action plans to drive improvement.

1.5 The Strategic Workforce Board has responsibility for the development of the Workforce Strategy and monitoring progress against this. Portfolio Workforce Boards are established in each respective area of the organisation which feed into this. The detailed actions within the workforce strategy are still evolving with a view to completion of the detail of the strategy by the end of the calendar year with an implementation programme running to 2020. Feedback is welcomed from the Committee to inform the detail of the workforce strategy.

2. Workforce Strategy – Development and Wellbeing

2.1 The framework of our Workforce Strategy is key to an agreed direction of travel and it is essential that this is well communicated and that our HR reporting information begins to align against this. Whilst our Workforce Strategy is still evolving there are a number of significant interventions which are already taking place across the organisation in relation to helping the organisation to achieve its ambitions and these are referenced below (timescales for outstanding action/intervention are referenced in appendix 2).

2.2 To enable our staff to be healthy and effective we have introduced, and are further developing, interventions to support this. This will ensure our people have the right skills and supportive infrastructure to deliver their roles and also ensure that there is appropriate intervention and support available for the inevitable times, (when dealing with a large and complex workforce), that health and wellbeing pressures will occur. Interventions are detailed below;

2.3 We have developed an **apprenticeship strategy** for the organisation which is focused on developing a workforce for the future with the skills to deliver against our priorities. This year (to April 18) we have 134 apprenticeship starts/conversions identified (this is a mix of new starts/existing employees). This allows for the attraction of new talent into the organisation and allows us to develop the skills of our existing workforce. All planned apprenticeships are in accordance with business planning requirements of the Portfolios to deliver the strategic outcomes of the organisation. The delivery of apprenticeships across our organisation is managed through a steering group which reports to the Strategic Workforce Board on a quarterly basis. An overview of progress is provided to EMT. We are currently investigating how we may further utilise the levy to support care leavers across our city. As this is the first time the Council has developed an overarching apprenticeship strategy previous data is not available however reporting information which includes apprenticeship

conversions to employment and how the strategy is supporting the organisations workforce profile is part of the governance reporting against the strategy.

2.4 **Personal Development Reviews.** In response to feedback from the organisation in relation to performance management and personal development reviews (PDR) we are piloting a new **'Time to Sit down and Talk'** programme across the organisation. Traditionally the PDR has been an annual process, with a six monthly review, however completion rates recorded against the PDR on the Development Hub have been historically low (275 full completions recorded 16/17). This does not mean that PDRs have not been undertaken across the organisation but that managers are using alternative PDR methods and recording mechanisms. This prompted the HR Service to open up a discussion with the Portfolios who in turn requested a leaner PDR and recording process which is now being piloted and matches the approach undertaken by a number of large organisations have chosen to radically change their annual appraisal process in favour of less formal but more frequent discussions (timescales referenced in appendix 2).

2.5 **Leadership Development.** Effective leadership at all levels within the organisation is intrinsic to a healthy and developed workforce and the challenges of strategic leadership demand a number of qualities from setting the vision, role modelling, developing people, effective communication, acting as change agents and taking action in times of ambiguity and crisis. These leadership traits are not optional for individuals in such roles and our challenge is how we develop these. We are developing our **'Leading Together'** Programme to promote leadership across organisational and system boundaries (timescales referenced in appendix 3). It will bring together a collection of materials and programme of activity that will be tailored to meet the needs of individual leaders. As part of this programme the HR Service, Learning & Development and the Performance & Research Team have developed a 180 Degree Skills Questionnaire which will allow leaders to assess their strengths and weaknesses. This enables personal development plans to be focused upon priority areas and the Council can invest appropriate in training and support where required. The questionnaire will be piloted in a Portfolio Leadership Team prior to organisational release. Other solutions being considered within the programme by the Learning and Development Service include 1 to 1 Mentoring and Coaching; Shared Project Work; Job Shadowing & Rotation; Protected Learning Time Events; Regional Development Gatherings and Web-Based Forums. Development activity is currently being undertaken by the Directors Group.

2.6 There is a need for **Management Development** and ongoing support for new managers. There is a requirement for more than just training such as access

to mentors and networks of peers. Some managers and aspiring managers have attended a variety of training opportunities such as the ILM, Graduate Development Programme, short open programmes, e learning and Portfolio commissioned programmes. There needs to be a consistent approach, therefore, in order to build a confident and capable management and leadership cohort that has the core skills to take Sheffield City Council forward. A 'bite-size' programme, **'Raising the Bar'** is being developed in order to develop managers over a relatively short time frame based on real organisation challenges. Parts of the programme shall be piloted towards the end of 2017/18 with a full programme of activities commencing at the start of 2018/19. The programme will include key elements of people management, financial awareness and change management.

2.7 **Development Pathways** will be a new model for learning and development where all employees will be encouraged to review, renew and extend their skills and knowledge. Development opportunities will be provided at all levels (Apprenticeship to Senior Leader) allowing employees to progress along their chosen skills pathway as appropriate. It is envisaged that some employees may need to develop their skills at a particular level of responsibility, whereas others may choose to develop the skills necessary for the next level of responsibility. Developing these skills will not necessarily guarantee promotion or progression but it will put employees in a position to take advantage of opportunities that may become available. The advantages of this approach to learning & development include widening the skills base of existing employees, development of the workforce for the future, cost reduction, retention of talent, enabling the Council to be an employer of choice**.** The HR Service, Learning & Development are currently reviewing their current offer in order to provide clarity to the development opportunities available at each level in the Council. The new development pathways model will be promoted and marketed to Sheffield City Council early 2018 with the new model for development proposed to be live from April 2018.

2.8 There is currently a significant amount of activity being undertaken across Sheffield to tackle digital exclusion and to help people and organisations go online. The HR Service, Learning & Development are exploring maximising these opportunities to enable Sheffield City Council staff to enhance their **digital knowledge and skills**. Discussions have been held with the Google Garage, Barclays Digital Eagles and Make Learn Share Ambassadors to explore Digital Skills training opportunities. Two pilot areas were identified to undertake Digital Skills training. Currently software access restrictions have delayed the launch of the pilot, however, all staff in the two areas are receiving training from the HR Service, Learning & Development to enable them to use the specialist software required for their roles.

2.9 **Essential Training.** Sheffield City Council is committed to equipping staff with the knowledge and skills required to undertake their roles competently and confidently. In turn, staff are expected to take responsibility for developing and using these skills and participating in the lifelong learning process. An important part of this learning involves all staff undertaking a range of essential learning, thereby minimising risk to individuals and the organisation. Every member of staff has a responsibility to ensure they, and in turn, the organisation remains compliant with required standards. Currently there is some confusion within the organisation as to which learning activities are essential to all staff, which are essential to specific groups and the frequency of training updates. As a result we have 22 mandatory learning programmes which often means that the employee may be months into their employment before they have had the opportunity to complete the core mandatory programme. The HR Service, Learning & Development are currently remodelling the **essential training** requirements in order to provide a clearer programme of essential learning which should improve compliance with the programme and in turn successful employee development. At present time the consultation process is determining a reduction to 10 modules for employees within this programme without losing any of the essential core content, along with a reduction in the number of essential manager programmes.

2.10 The wellbeing of our workforce is essential to it performing its duties effectively and therefore we have a target **absence rate** of 9.5 days per year. This remains a challenging target and has not yet been achieved however absence rates continue to reduce quarter on quarter and in Q1 17/18 our quarterly absence figure was 2.75 days, and 2.85 days in quarter 2 - a reduction from 3 days for the same quarter the previous year (specific data is referenced in appendix 3). We recognise the importance of managing the health and wellbeing of our workforce and recognise that in comparison to other cities our absence rates are relatively high (it should be noted however that different cities record absence rates differently) and therefore to enable this change the HR Service have introduced additional supporting mechanisms for the management of sickness absence. This includes the provision of additional information to line managers on a weekly basis and dedicated advisory support.

2.11 We have reviewed our **Managing Attendance Procedure** to ensure that it is equally both supportive for the employee and enables managers to effectively manage sickness absence. Training for managers in relation to the new procedure is currently in place with the new procedure commencing in November 2017. This procedure operates alongside other initiatives such as Flexible Working, Dignity and Respect and Health and Safety policies to ensure an effective offer for our workforce.

2.12 The Councils '**Being Healthy at Work' strategy** is currently being consulted upon and reinforces the ambition in the Corporate Plan for Better Health and Wellbeing. The strategy sets out how we intend to drive and influence the delivery of wellbeing, shifting the focus from reacting to ill health to proactively supporting our employees' wellbeing. This links with Public Health England's 'Workplace health needs assessment' document. The strategy is a holistic approach to the physical, mental and social health of our employees and demonstrates our commitment to providing a healthy working environment and improving the quality of working lives of our employees.

2.13 The Health and Wellbeing elements of our overall strategy align clearly with the need for clear pathways and a manager development offer as effective management can clearly support and facilitate good health, wellbeing and improved productivity and performance of employees.

2.14 We have developed a number of **learning interventions** specifically linked to health and wellbeing. These include, healthy conversations, Managing Stress (e-learning and taught courses), Personal Stress Management, Mental Health Awareness, Mental Health First Aid, Mental Health in the Workplace, Managing and Supporting Employees through Change.

2.15 In conjunction with colleagues in Activity Sheffield and Facilities Management we developed an on-site **activity suite** in Moorfoot to support the Wellbeing aspects of intervention. This is coupled with a Calm Space to allow for 'break away' and reflection.

2.16 We have remodelled our internal Health, Safety and Wellbeing Service to allow senior consultants to lead on Portfolio matters. This is enabling more timely intervention of health and wellbeing matters to match our strategy of **intervention and prevention**. We have also remodelled our intranet site to ensure all initiatives are visible, promoted and detailed.

2.17 The Health, Safety and Wellbeing Service are actively working to ensure national campaigns are promoted and **health programmes** are delivered to worksites across our organisation. To date this has included interventions such as 'Shape up for Business', 'Drink Wise Age Well', 'Know Your Numbers', 'Time to Talk' and 'Mental Health Awareness'.

2.18 As an organisation we have invested in an **employee assistance programme** to support our employees with access to counselling, debt and legal advice, and other wellbeing resources. We are also actively working with our occupational health provider (HML) on prevention and absence management initiatives.

3 What does this mean for the people of Sheffield?

3.1 The interventions detailed in this document are important not only for our workforce but will ensure that the City receives its required services from the Council in the most effective and efficient way. The activity referenced in this document continues to evolve and is reviewed on a regular basis by HR Leadership.

4. Recommendation

4.1 The Committee is asked to note and endorse the current approach which is being undertaken by the Council and is asked to propose any variation or additions to the interventions proposed.

Appendix 1: Components of the Workforce Strategy

Appendix 2: Outstanding Action Areas and Timelines

Action	Action Dates
Time to Sit Down and Talk Pilot Areas: Resources Leadership team, Finance and Commercial Services, Children and Families, Parks and Countryside, HR leadership and Learning and Development, Corporate Repairs and Maintenance	Current and completion by December 17
Time to Sit Down and Talk report to Strategic Workforce Board (outcome from pilot and recommended actions)	December 17
Report to EMT further to agreed actions from Strategic Workforce Board (for agreed future direction from April 17)	January 2018
Communications activity further to Council decision	January –March 2018
Leadership Development 180 questionnaire pilot	November 17
Leadership Development Solutions – mentoring and coaching, shared project work, job shadowing, learning time events, regional development gatherings, web-based forums, management networks	April 18 onwards
'Raising the Bar' pilot	Up to December 17
Full 'Raising the Bar' programme	From April 18
Learning and Development review of internal offer	By December 17
Development, promotion and live activity date of new offer	By April 18
Discussions with external organisations exploring digital skills initiatives	Live and ongoing
Roll out of internal digital offer to priority areas	Live and ongoing
Proposal for essential learning requirements to Strategic Workforce Board following internal consultation	November 17
Communication programme, updated employee induction and hub improvements following outcome of above	December 17 to March 18

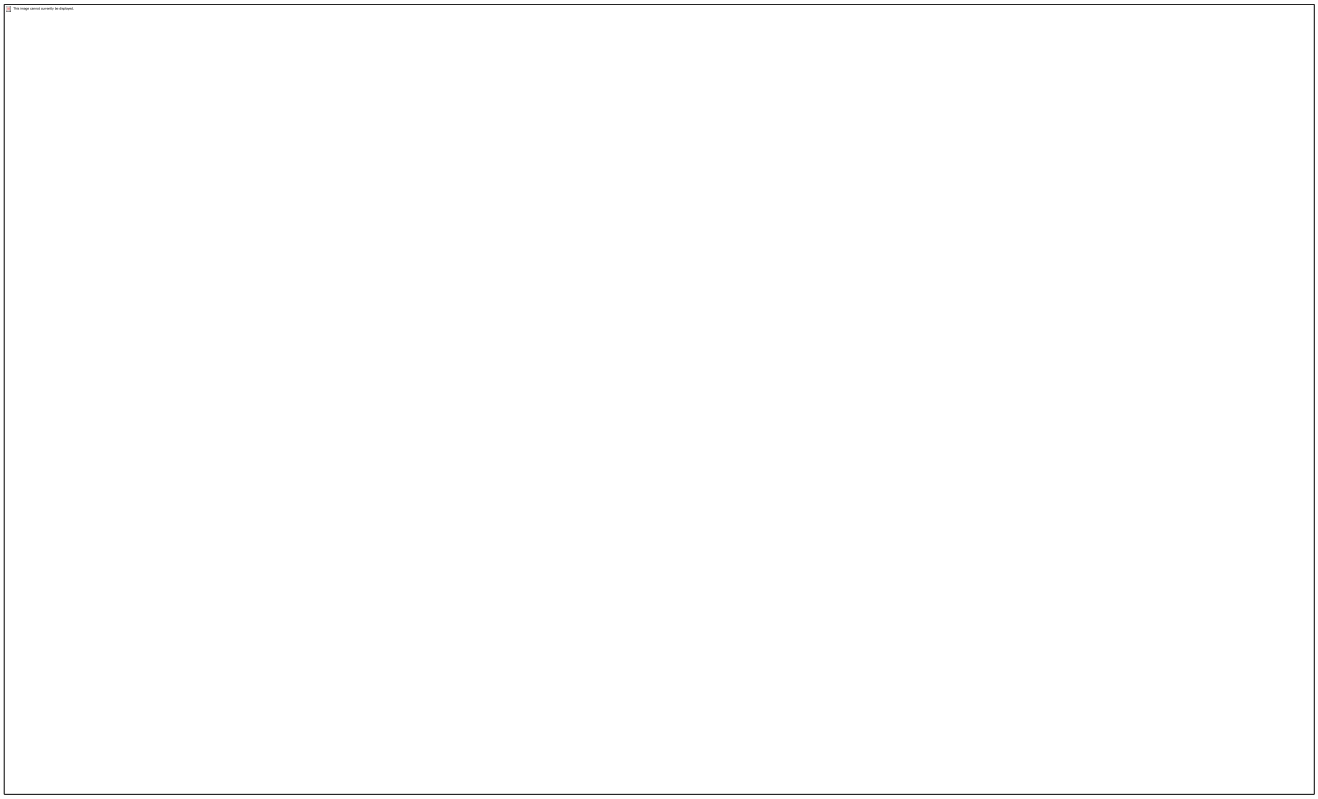
Appendix 3: Sickness absence information

Current Trends on Sickness

Our Council wide target for sickness during 2017/18 is 9.5 days per FTE. The last 6 years sickness levels are as follows;

Year	Days lost per FTE
11/12	11.60 days per FTE
12/13	12.34 days per FTE
13/14	11.45 days per FTE
14/15	12.22 days per FTE
15/16	12.62 days per FTE
16/17	12.16 days per FTE

Quarterly Comparison of Sickness – Organisational Level



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Report to Overview & Scrutiny Management Committee

16th November 2017

Subject: January Full Council Meeting – Director of Public Health Report

Contact Officer: Emily Standbrook-Shaw, Policy & Improvement Officer
emily.standbrook-shaw@sheffield.gov.uk

The Director of Public Health has a statutory duty to produce an annual report on the health of the local population. This year's report sets out the three key strategic messages from the Joint Strategic Needs Assessment (JSNA) and why these are priorities for the City's health and wellbeing in terms of their impact on healthy life expectancy and life expectancy: adverse childhood experiences; mental health (across the life course); and multi-morbidity. The report also makes 3 recommendations to the Council and the CCG for further research as well as reporting on the progress made with the recommendations from the 2016 report.

Cabinet considered the report at its meeting on the 20th September 2017, where it noted the contents of the report and the recommendations it makes, requested that the report be presented to full Council on 3 January 2018 and agreed that the report be published on the Council's website.

At the October meeting of the Overview and Scrutiny Management Committee, members asked for sight of the Director of Public Health's Annual Report in order to prepare for the January 2018 Full Council Meeting at which this report will be presented. The report is attached.

The Scrutiny Committee is being asked to:

Consider the Director of Public Health Annual Report in advance of January's full Council meeting.

Category of Report: OPEN

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ADDING LIFE TO YEARS AND YEARS TO LIFE

Director of Public Health Report for Sheffield 2017

Sheffield City Council

Contents

1. Introduction

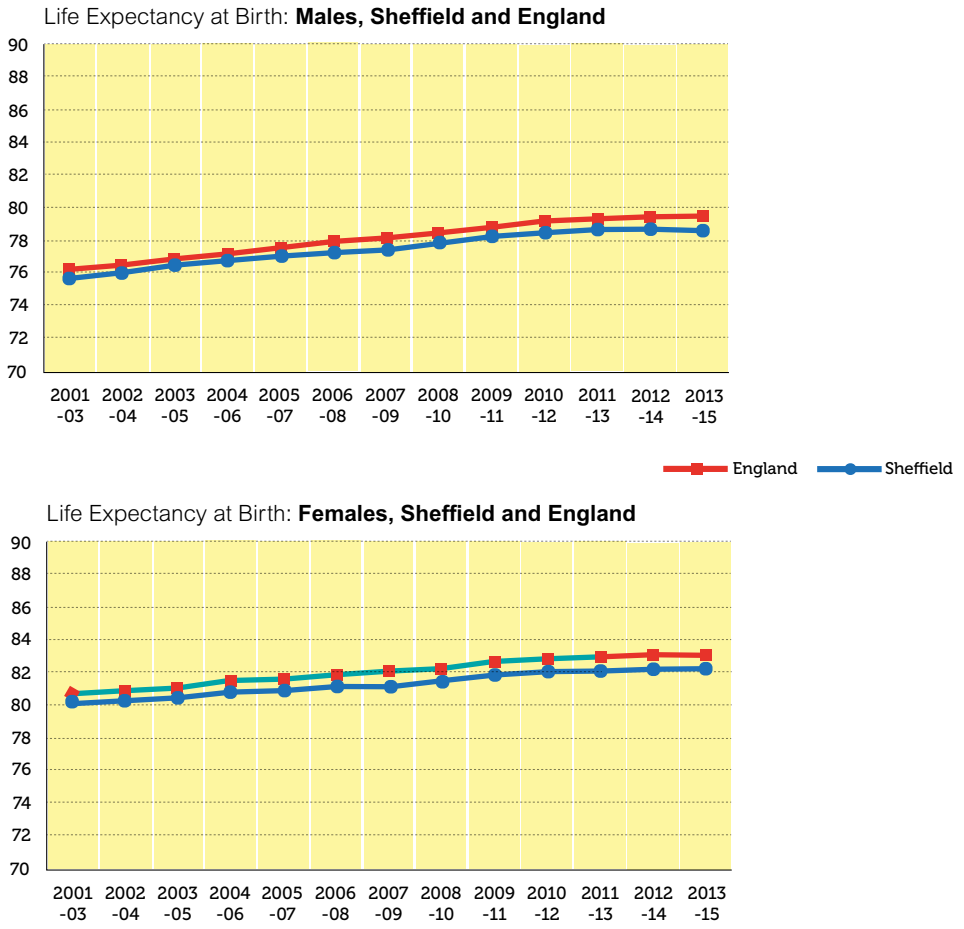
Health is an essential part of everything we do, yet we are still tempted to think of it as being about "not being sick" and our automatic response is therefore to see "health" as the same as "health care services".

As I attempted to describe in my report last year, if we take an individual, community and population approach, health is the building block of personal fulfillment, prosperity, resilience and sustainable growth. That's why a loving family, a safe home, educational achievement, a decent income, a good job, friendly neighbours, clean air, and an environment that lets us all start, live and age well are all far more influential factors in securing good health outcomes than health and social care services alone.

Despite this universal truth, we continue to focus our attention in the health domain on health and social care services and how to reduce our expenditure on them. As I have blogged many times, prevention is the key to addressing growing expenditure on health and social care and until this is addressed robustly and improved outcomes secured, the issue of care costs will remain. This consideration is even more pressing given that the key indicators of a healthy population (life expectancy and healthy life expectancy) are beginning to tell a worrying story: one which should give us serious pause for thought.

The most recent data on average life expectancy for both men and women in the UK show that the rate of annual increase has been slowing down over the last few years.

Figures 1 & 2: Trends in Male and Female Life Expectancy 2001-03 to 2013-15 (Sheffield & England)



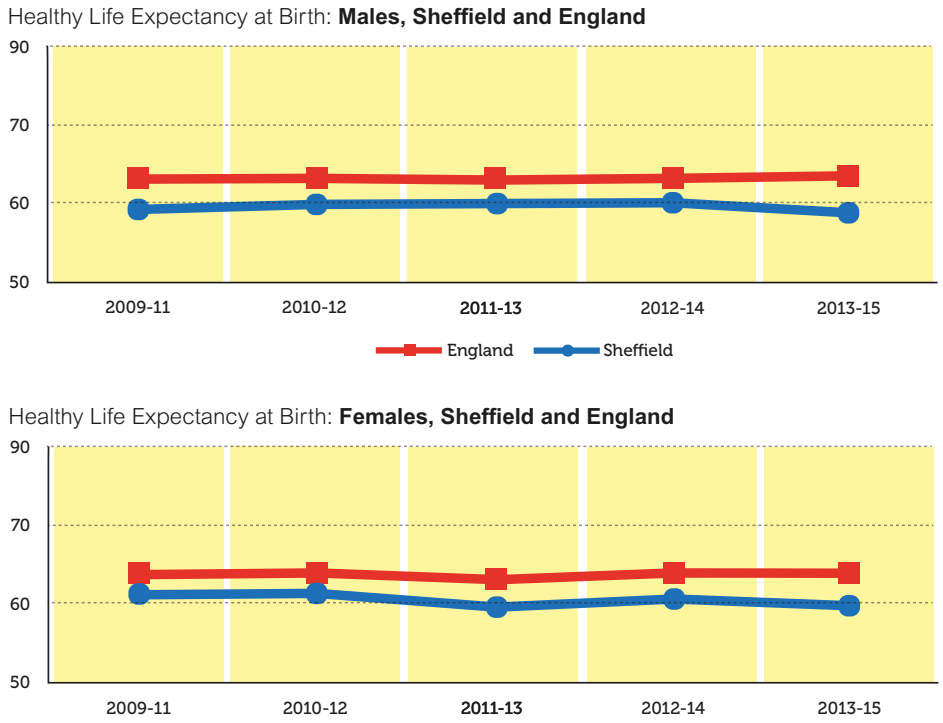
In Sheffield we have noted very little improvement in women's life expectancy over the last 10 to 15 years. For men, we have seen a decrease in average life expectancy from 78.8 years in 2012-2014 to 78.7 years for the most recent period of 2013-2015. This is deeply concerning. There are many theories to explain this stall in improvement, but the direct and indirect impact of continuing austerity ranks highest among these.

But the story doesn't end there. We are also seeing a similar problem emerging with how long we can expect to live in good health ('healthy life expectancy'), although we do not have reliable data going back as far as we do for life expectancy.

Latest figures for Sheffield show that average healthy life expectancy for women decreased from 61.5 years in 2009-11 to 59.9 years in 2013-15. The decrease in men's healthy life expectancy has been less sharp over the same period, reducing from 59.3 years to 59 years. It should also be noted that Sheffield's figures, for both life expectancy and healthy life expectancy, are worse than for England and for Yorkshire and Humber. This means more people in poor health at a (slightly) younger age than previously.

We are currently updating our Joint Strategic Needs Assessment and, in so doing, taking a much more in-depth look at health and wellbeing in the city. This has included for example, examining our progress across all the 159 indicators in the national Public

Figures 3 & 4: Trends in Male and Female Healthy Life Expectancy 2009-11 to 2013-15 (Sheffield & England)



Source: https://www.ons.gov.uk/releases/healthstatelifeexpectanciesuk2013to2015

Health Outcomes Framework[1]. Together with the latest data on life expectancy and healthy life expectancy, this work is pointing to the need to focus on a number of areas as a priority.

In this year's report, I draw attention to three particularly important priorities for the health of our city. They are not the only priorities, but they are three that warrant careful consideration.

Adverse childhood experiences (ACEs)

There is increasing evidence that both positive and negative childhood experiences have a tremendous impact on future violence (victimisation and perpetration) and lifelong health and life chances. Moreover, early childhood development programmes targeted towards the most vulnerable show good rates of return on investment across many social outcomes, albeit over the long term. Sheffield is no exception to the effects of ACEs but it is also well placed to respond. This section of the report therefore considers why ACEs matter so much to longer term health outcomes and sets out some of the work already taking place in the City to address the adverse effects.

Mental wellbeing for life

Good mental wellbeing is essential for a healthy and prosperous society and it is just as important as good physical health. But it is all too easy to focus on what happens when someone becomes mentally ill and how specialist services respond to that rather than how to stay well in the first place, prevent problems from arising, intervene early if problems do emerge, and help people to manage and look forward with their lives. In this second section of the report I therefore look at some of the key determinants of mental health and wellbeing and what we can do locally to ensure there is no health without mental health.

Multiple morbidity (ill health and disability)

The practice of hospital based medicine is highly specialised with specific conditions treated individually and usually in isolation from each other as well as from the lived context of the person with the condition. The reality however is that we are seeing more and more people with two or more long term conditions at a time – known as multi morbidity. In this third and final section of the report I suggest it is this expansion of multi morbidity, both in terms of overall numbers and at earlier ages, that is not only impacting adversely on healthy life expectancy but is also the key factor driving the increase in the demand for health and social care services, rather than the ageing of the population.

For each of the three areas covered in the report I identify a number of priorities for action over the short, medium and longer term. This year I am also making the following three recommendations for further research:

1 Access the Public Health Outcomes Framework here: http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000049/pat/6/par/E12000003/ati/102/are/E08000019

The Council and the CCG should request Public Health England to co-ordinate further research on identifying and describing the long term return on investment of tackling ACEs and effective primary and secondary prevention models.

The Council and the CCG should review the Sheffield strategy and evaluate the city's approach to mental health and wellbeing against the current evidence base for high impact/high value interventions, including the economic case for investment in good mental health.

The Council and the CCG should commission more in-depth epidemiological analysis of changes in multi morbidity and enhance their approach to healthy ageing, including care of people who have multiple illnesses.

The report also includes a progress report on the recommendations I made in last year's report and provides details on how to access further information about health and wellbeing in Sheffield.

Greg Fell
Director of Public Health for Sheffield

Acknowledgements

Reports such as this are always the result of many people's work.

I am grateful this year to the following contributors: Ian Baxter, Kieran Flanagan, Mark Gamsu, Muir Gray, Susan Hird, Mike Hunter, Anant Jani, Jim McManus, Lisa McNally, Karen O'Connor, Matthew Peers, Bethan Plant, John Soady, Dan Spicer, Sarah Stopforth, Steve Thomas, Julia Thompson and Scott Weich.

I would also like to thank Louise Brewins, who puts this report together. The report wouldn't happen without her hard work. Final responsibility for the content rests with me.

2. Adverse Childhood Experiences

Why ACEs matter

There is a growing body of evidence showing the profoundly damaging impact that adverse childhood experiences (ACEs) can have on a child's future outcomes across many areas including health and wellbeing, and these effects can last a lifetime.

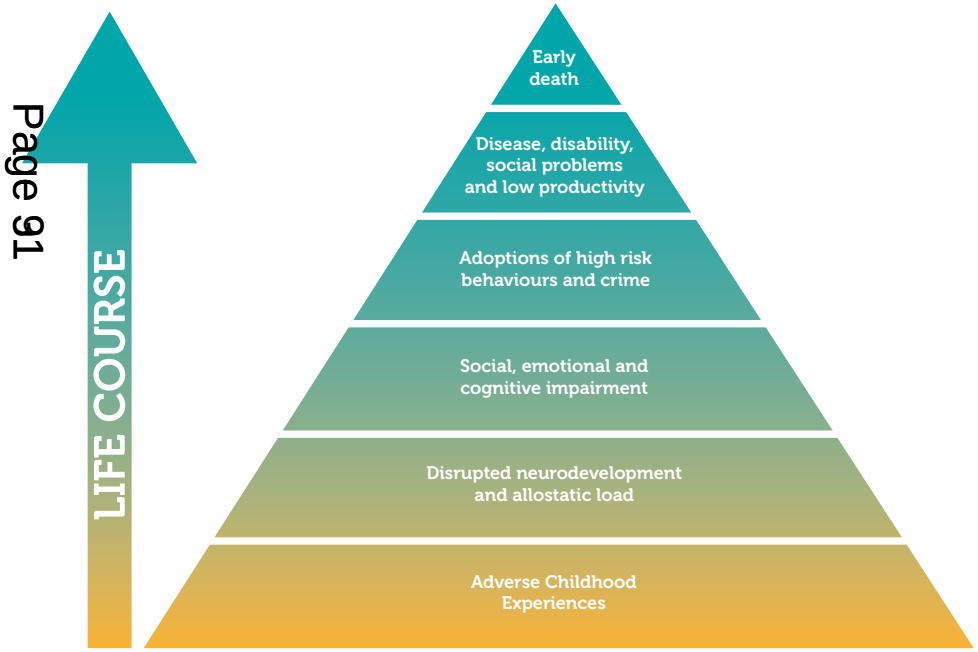
ACEs are stressful experiences occurring during childhood that directly harm a child or affect the environment in which they live and grow up. It is estimated that almost as many as 50% of adults may have been exposed to at least one adverse experience during their childhood (indeed some studies have put this higher at around two thirds of all adults).

Types of ACEs include child abuse (which includes emotional, physical or sexual abuse), neglect (both physical and emotional) and household challenges such as growing up in a household where there is substance misuse, mental illness, domestic violence, parent separation/divorce or where a member of the household is sent to prison. Evidence shows there is a strong graded relationship between the number and category of childhood exposures and the risk of developing emotional and physical health problems in later life.

Children who experience ACEs are more likely to become parents who raise their children in family environments where these risk factors are more common. This can result in a cycle of disadvantage and poor health outcomes. By preventing or reducing the impact of ACEs there is a real opportunity to break these destructive cycles and reduce the impact on future health and wellbeing outcomes.

Impact on healthy life expectancy

Figure 5: Model of ACE impacts across the life course



Source: Public Health Wales NHS Trust (2015). Adverse Childhood Experiences - and their impact on health harming behaviours in the Welsh adult population. Page 7

The 'Great Start in Life' Best Start strategy[2] describes Sheffield's ambition that every child, young person and family achieves their full potential. We aim to do this by providing families and communities with the capacity, resources and support that will enable young children to flourish. Exposure to ACEs can have a direct negative effect on these aspirations.

We are increasing our understanding of the biology of ACEs, their social and physical causes and what we can do to respond. Recent evidence for example, shows that chronic traumatic stress in early life alters how a child's brain develops as well as changing the development of their immune and hormonal systems. Such changes can have a detrimental impact on a child's capacity to learn, and on their physical health, increasing the risk of illnesses such as cancer and heart disease. The combination of these factors may lead to mental health problems and a greater likelihood of adopting harmful behaviours in adulthood, such as smoking, poor diet, substance misuse and early sexual activity. By understanding ACEs and developing interventions that reduce the risk factors in vulnerable families we have an opportunity to:

- improve health outcomes and prevent disease across the life course
- improve individuals' mental and emotional wellbeing
- increase economic productivity
- reduce costs to the health and welfare system.

2 http://www.sheffield.gov.uk/home/schools-childcare/childcare-free-early-learning

Breaking the cycle

We know children's earliest experiences are the key to their success in adulthood. Significant developments have been made over the last few years to improve Early Years provision in Sheffield and deliver interventions from pregnancy through to early childhood that promote bonding and attachment, and protect babies' brain development.

Joint working is key and partnerships involving statutory organisations, the voluntary sector and local communities are using a range of evidence-based programmes to provide universal and targeted support, which also offer opportunities to identify families at risk or in need of greater support. This activity has been supported by the delivery of skills development and training to over 3,000 practitioners on attunement[3], regulation and its critical importance in infancy.

The new Family Centres, which build on the role that Children's Centres played in prevention and early intervention, offer an extensive range of early help services across Sheffield. These can be tailored around the needs of individual families with children from pre-birth up to 19 years, and include input from partners in health, education and the wider community. Provision includes support with physical and emotional health, practical advice on keeping children safe, support with education and learning, support with parenting, home, money, work, training, and volunteering.

Whilst action to address ACEs is not currently an explicit feature of this work, existing activities provide an excellent foundation for greater understanding and awareness. They also offer the opportunity for further collaborative action to support prevention, early intervention and to mitigate the impact of ACEs.

3 "Attunement" describes how reactive a person is to another's emotional needs and moods. A person who is well attuned will respond with appropriate language and behaviours based on another person's emotional state.

Priorities and recommendation

Growing knowledge and understanding of the effect that ACEs have in early life and their damaging consequences for lifelong outcomes cannot be ignored. Tackling their presence and impact is important for reducing inequalities across the community.

We will work with our Children's Health and Wellbeing Transformation Board[4] to agree a plan that provides a detailed programme of work on ACEs for Sheffield, based on our priorities for action. This plan will include a simple framework that identifies innovative ways to build a systematic approach to ACEs into our early years' delivery model, including prevention and harm reduction. The work will complement the city's Tackling Poverty Strategy[5] and the work of the Fairness Commission[6].

We want every child to grow up free from ACEs and reach their full potential. The social and economic benefits of taking forward this approach are compelling - the costs of not doing so are far greater.

Recommendation: The Council and the CCG should request Public Health England to co-ordinate further research on identifying and describing the long term return on investment of tackling ACEs and effective primary and secondary prevention models.

Priorities for action

- Increase public awareness of ACEs and their lifelong consequences in childhood, and gain political and organisational commitment for a coherent programme of work to prevent ACEs.
- Identify what can be done at individual, family and community level to put in place effective interventions in the pre-natal period and first 3 years after birth for the most disadvantaged children and families.
- Explore how we can incorporate our response to ACEs into our Early Years' delivery model, its pathways and services. This model provides an ideal basis for identifying vulnerable children and families, and providing appropriate and timely support.
- Equip Early Years' practitioners with a full understanding of ACEs, the importance of promoting bonding and attachment for good parent-child relationships and secure emotional attachment, and also promoting positive maternal, family and emotional health and resilience.

4 http://www.sheffield.gov.uk/home/public-health/children-health-wellbeing
5 http://democracy.sheffield.gov.uk/ieDecisionDetails.aspx?AIId=10078
6 http://www.sheffield.gov.uk/home/your-city-council/fairness-commission

3. Wellbeing for life

No health without mental health

The statement “no health without mental health” and the underlying meaning of parity of esteem between physical and mental health is widely accepted, but achieving this aspiration in practice is more challenging: the fact remains that much more needs to be done to secure good mental wellbeing and emotional resilience in both children and adults. This means going further upstream to prevent illness and promote positive health.

Many people prefer the term “mental wellbeing” to “mental health” as the latter can focus attention on psychiatric conditions and related specialist mental health care services. This can lead us to assume that good mental wellbeing outcomes can only be achieved through better mental health services. Good service provision is necessary but it is not sufficient for achieving mental wellbeing. Good mental wellbeing is about feeling good and functioning well, comprising an individual’s experience of their life and a comparison of life circumstances with social norms and values. It also means increasing the focus and emphasis on population and community level resilience and risk factors without losing focus on the need to continue to improve services for those who are ill. A social and economic environment that supports good mental wellbeing is as important as high quality specialist services.

The economic case for good mental wellbeing is also increasingly well evidenced. For example, it has been estimated that doubling the number of people offered good quality employment would cost approximately £54 million but could generate savings to the NHS alone of £100 million in under two years with significant additional savings for other parts of the public sector, not to mention the impact on individual and family incomes.

Blending the social and medical models to promote good mental wellbeing is critical to achieving our aspiration of no health without mental health. On the whole we have good clinical services including both pharmacological and psychological treatments and support. However, if we focus only on the service response we miss the opportunity to prevent poor mental wellbeing and secure longer term positive outcomes.

The determinants of mental wellbeing

The determinants of mental wellbeing can be thought of as both protective of and risk factors for mental health outcomes, and operate at individual, family, community and population levels. Traditionally our focus has been on how we treat and support severe mental illness rather than how we promote and protect wellbeing.

Evidence relating to the detrimental impact of poverty, financial and housing insecurity and the ongoing consequences of austerity on mental health and wellbeing is growing. Whilst there may be little that we can do to change national policy, there is still considerable potential to achieve positive change at the local level, and Sheffield already has a strong offer in this regard. It is worth noting, for example, that ensuring timely, effective and appropriate access to the £126 billion social welfare system represents a significant priority for local action.

However, these factors and responses are primarily focussed on adults, at least at the first point of contact. If we are determined to prevent poor mental wellbeing we need to go further upstream and start much earlier.

Risk factors

- Housing insecurity, homelessness and fuel/food poverty
- Debt problems, financial insecurity and exclusion
- Low wages, insecure employment and long term unemployment
- Welfare rights and ongoing consequences of welfare reform and austerity
- Bereavement, family breakdown, social isolation

Protective (local) services

- Housing Plus (covering Council Homes) and homelessness support services
- Financial inclusion strategy
- Help for people with mental health problems back into work
- Sheffield Citizens' Advice Bureau
- Voluntary, Community and Faith (VCF) sector services supporting community based asset development and resilience

Starting early

Promoting, protecting and improving our children and young people's mental health and wellbeing are national and local priorities. Experiences in childhood have a profound effect on our adult lives. Many mental health conditions in adulthood show their first signs in childhood and, if left untreated, can develop into conditions that need regular care. Indeed, it is estimated that 75% of mental health illnesses (excluding dementia) emerge before the age of 18.

Our local priorities and actions for improving children's emotional health and wellbeing are set out in our 'Future in Mind' plan[7]. This plan has enabled us to access an additional £1.3 million per year of national funding from 2015-16. We are using this in a number of ways including:

- improving access to and reducing waiting times for therapeutic services
- improving support for our most vulnerable children and young people, including those living in care, those involved in the Youth Justice System and children in need
- providing the Sheffield workforce with the training and development it needs to support the emotional wellbeing and mental health needs of children and young people
- providing help and support to young people experiencing low level mental health problems at the earliest opportunity in schools and other settings
- redesigning child and adolescent mental health pathways, suicide prevention and crisis response.

A whole system approach to improving children and young people's emotional wellbeing and mental health promotes protective factors at all levels:

- **Individual:** balanced nutrition, regular physical activity, sufficient sleep
- **Family:** things are spoken about and someone listens, feeling safe and loved, free from harm
- **School:** personal, social and health education (PSHE), sense of belonging, feeling safe, positive relationships with teachers and peers, achievement
- **Community:** good places to spend time, trusting people and feeling safe

7 https://www.sheffield.gov.uk/home/public-health/children-health-wellbeing

Priorities and recommendation

As part of our JSNA we have undertaken in-depth analysis of mental health needs in Sheffield including a health needs assessment (HNA) for children and young people (2014) and for adults (2015)[8]. These HNAs continue to help shape and structure our approach to mental health and wellbeing in the City. Based on what these tell us, the main priorities for mental health across the life course are:

- Promoting wellbeing - a good and positive state
- Promoting psychosocial resilience - skills to cope with stressors and life's problems
- Preventing ill health - spotting signs, intervening early with basic interventions
- Addressing and recovering from mental ill health - coping, functioning and best possible recovery.

Ensuring we have the right mix of asset based community development, primary care, early intervention, treatment & support and recovery is an ongoing challenge. We should not abandon difficult future challenges in the face of overwhelming immediate pressures. The approach we develop should include population and individual level interventions (risks, assets and protective factors) and connect services that deliver care and support with the "determinants" of mental health.

Recommendation: The Council and the CCG should review the Sheffield strategy and evaluate the city's approach to mental health and wellbeing against the current evidence base for high impact/ high value interventions, including the economic case for investment in good mental health.

8 https://data.sheffield.gov.uk/stories/s/Sheffield-Health-Needs-Assessments/hb5c-7389

Ten ways to improve mental wellbeing

1	Promote mental wellbeing as something everyone can improve on, not just those using mental health services
2	Tackle the things that impact on mental wellbeing such as bullying, financial stress, abuse and social isolation
3	Fight mental health stigma with positive social marketing and personal 'real life' stories
4	Design campaigns and initiatives in collaboration with target audiences
5	Support mental wellbeing and resilience in schools and tackle bullying as a priority
6	Encourage employers to take ownership of their employee's mental wellbeing, and offer support and training
7	Recognise healthy lifestyle choices as being both a cause and effect of mental wellbeing
8	Treat social isolation as a threat to mental and physical health and work to link people up with their community
9	Consider the effect of public policy on mental health and wellbeing
10	Ensure everyone has access to timely support - waiting lists and restricted access are a false economy

4. Multiple morbidity

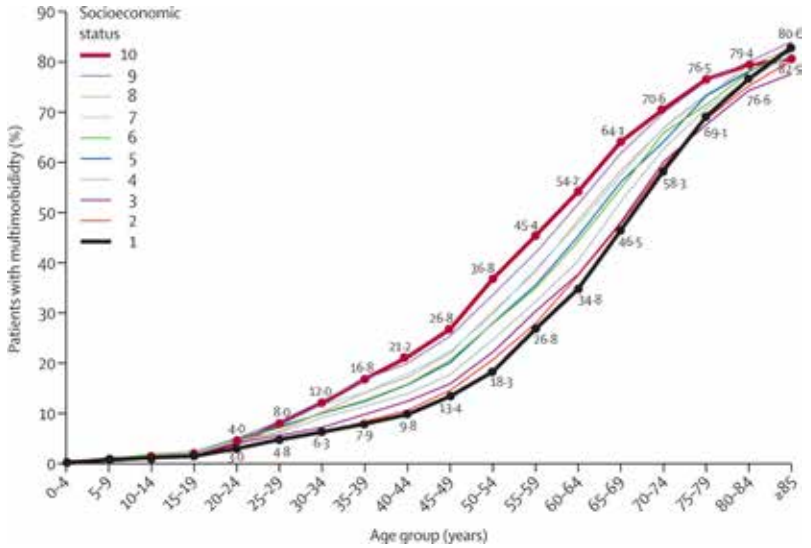
What drives demand for health and social care?

The most popular answer to this question is “the ageing population”. Evidence derived from Sheffield and across the UK clearly shows this is the wrong answer to the question and that it is to the issue of multiple morbidity (people with many illnesses) that we should look for our answer.

We know that healthy life expectancy is not improving. This means we are developing long term illnesses earlier in our lives and therefore living longer in poor health. GP records show that almost 40% of the Sheffield population (all ages) has at least one long term condition and all the indications suggest this percentage is not likely to decrease anytime soon. This leads to more ‘unhealthy person years’ in a fixed capacity system that is designed to respond to single diseases and acute health problems. Moreover, the ‘unhealthy person years’ are not evenly spread across the population with the burden falling disproportionately on poorer people.

Contrary to conventional wisdom, while the number of older people in Sheffield and nationally (people age 65 and over) is rising, the basic age structure of the population isn’t changing very much. If the ageing population was the key driver for increasing demand for health and care services, we would expect to see this changing impact reflected in increases in hospital admissions for selected one-year periods. However, when we look at national hospital admission data for 1994-1995, 2004-2005, and 2014-2015, for example, the proportion of increase that can be attributed to ageing factors are 0.33%, 0.63%, and 0.80%, respectively. Demand for health and social care in England is currently increasing by about 4% per year, far faster than the ageing population. Moreover, there is now consistent evidence from a macro perspective that the key drivers of cost growth are: disease incidence (prevention); lack of attention to primary care, high cost technology (manufacturer pressure & patient expectation); and over diagnosis (clinical culture and system pressure)[9] [10] [11] [12].

Figure 6: Prevalence of multi morbidity by age and deprivation



Source: Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012) Epidemiology of multi morbidity and implications for health care, research and medical education: a cross-sectional study. The Lancet 2012 Jul7; 380 (9836): 37-43.

9 NHS Greater Glasgow and Clyde http://www.gla.ac.uk/media/media_443695_en.pdf & http://www.gla.ac.uk/media/media_443697_en.pdf

10 Office for Budget Responsibility http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf

Prevalance of multi morbidity in Sheffield

Information derived from GP practice medical registers shows that in 2017, 94,110 people in Sheffield had been diagnosed with two or more long term conditions. The most common conditions are hypertension (high blood pressure), depression and diabetes.

In terms of age distribution, multi morbidity is most common in people aged 70 to 79 years followed by 60-69 year olds and then people aged 80-89 years. Overall, there are more people under the age of 70 with two or more long term conditions in Sheffield than there are over the age of 70.

If we focus only on the ageing population, the wrong response becomes more likely. So, for example, if we think the increase in demand for health and social care services is an inevitable consequence of more, older people, we may prepare for this incorrectly by building bigger hospitals and increasing the number of hospital beds provided to cope with this demand. But as we can see, it is multi morbidity that drives demand.

The response should therefore be about prevention, early identification and management of these conditions within primary care. We are in danger of losing our focus on healthy life expectancy by fixating on something we can't control (people getting older) rather than on something we can control (preventing onset of ill health).

Table 1: Prevalence of individual conditions in Sheffield people having two or more physical and/or mental health long term conditions

Condition	Number	Proportion
Hypertension	54,906	58.3%
Depression	37,711	40.1%
Diabetes	25,658	27.3%
Asthma	25,053	26.6%
Chronic kidney disease	18,924	20.1%
Coronary heart disease	18,028	19.2%
Hypothyroidism	15,471	16.4%
Cancer history	13,581	14.4%
Stroke or transient ischaemic attack	10,608	11.3%
Chronic obstructive pulmonary disease	10,499	11.2%
Atrial fibrillation	9,718	10.3%
Heart failure	6,080	6.5%
Epilepsy	4,532	4.8%
Dementia	4,468	4.7%
Serious mental illness	3,907	4.2%
Peripheral vascular disease	3,659	3.9%
Learning disability	2,226	2.4%

The table is based on the 94,110 people in Sheffield who have two or more long term conditions. 54,906 (or 58.3%) of these people have hypertension as one of these long term conditions

Source: Sheffield GP Practice Registers (June 2017).

11 Nuffield Trust http://www.nuffieldtrust.org.uk/blog/nhs-financially-sustainable

12 Centre for Health Economics (University of York) http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP127_medical_spending_hospital_inpatient_England.pdf

Shifting the curve

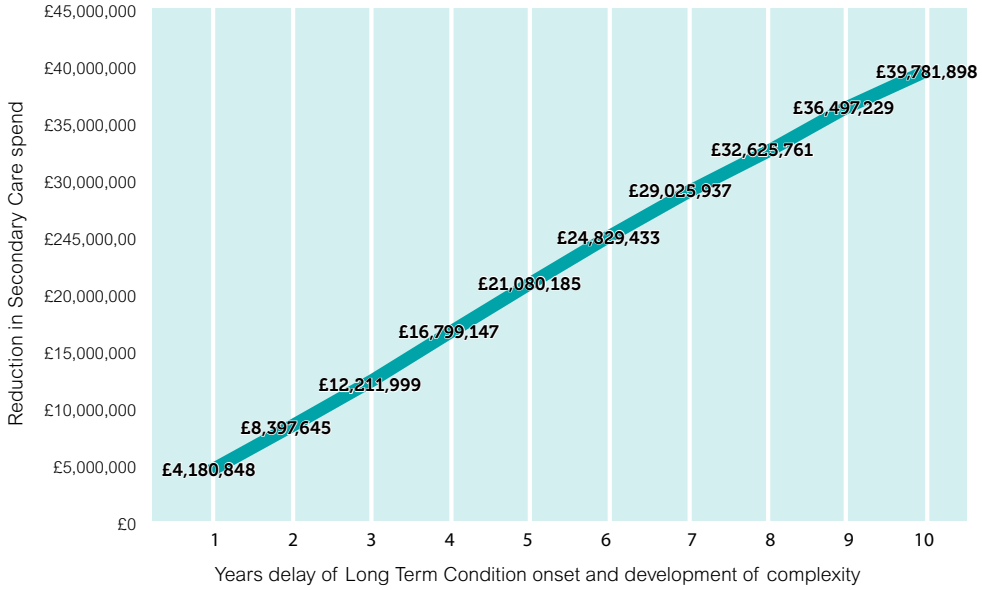
Our overall aspiration should be to move the whole multi morbidity curve downwards such that, instead of developing your first long term condition in your late fifties, you develop it in your sixties instead, as well as having fewer long term conditions overall.

Local analysis demonstrates the tangible financial savings that can be achieved by delaying the onset of multiple illnesses. As Figure 7 shows, a one year delay in onset and development of complexity overall could yield savings of approximately £4 million per year in NHS hospital costs in Sheffield alone. In addition to the financial saving there is a tangible improvement in health and wellbeing outcomes and, for those of working age, a clear economic benefit as well.

Work on shifting the curve will need to focus on inequalities. There is already a 15 year gap in onset of multiple illnesses between the most and least deprived people in Sheffield. For example, approximately 18% of the least deprived people in Sheffield have developed a long term condition by their fifties whereas as many as 40% of the most deprived 50 year olds have developed one or more chronic conditions.

This will mean shifting our health and social care system away from treating individual diseases on an episodic basis towards providing help for people with a number of different conditions, earlier on and in their own communities.

Figure 7: Impact of delaying onset of multiple illness in adults on hospital care expenditure in Sheffield



Source: Sheffield GP Practice Records

Priorities and recommendation

To shift the curve, reduce demand for hospital care and ultimately improve healthy life expectancy there are a number of key actions and approaches we need to pursue, although fundamentally increasing emphasis must be given to preventing illness and better management of complications in those who are ill. No developed healthcare system is particularly good at this, so we shouldn't underestimate the level of challenge we face. Our main focus should be on:

- Preventing illness and supporting healthier ageing in the widest possible sense
- Altering the balance of investment and provision in community and hospital based care. Broadly we need to double the level of investment in primary and community based care and ensure this investment is allocated according to where multi morbidity is prevalent and investment is matched to need
- Developing the generalist workforce (rather than specialist healthcare staff) and reviewing the type and combination of hospital bed provision within the City
- Developing a 'person centred' city approach. The aim would be to develop a shared culture and ethos that recognises the value of a person and a community centred approach in how the local health and social care system operates and the range of capabilities and opportunities that are vested within people. We should strive to create conditions for people to achieve the life they have reason to value, whatever their starting point may be, and for services to be tailored to this range of abilities and starting points.

Recommendation: The Council and the CCG should commission more in-depth epidemiological analysis of changes in multi morbidity and enhance their approach to healthy ageing, including care of people who have multiple illnesses.

Page 104

[10] http://www.kingsfund.org.uk/projects/improving-publics-health

5. Progress on last year's recommend-ations

Page 465

Creating the environment for living well

Each year the Director of Public Health report makes a set of recommendations for improving health and tackling health inequalities within the local population. Here we summarise the progress made on the recommendations from last year's report.

Recommendation	Progress
The Health and Wellbeing Board should take forward a series of learning events / appreciative enquiry on different approaches to health and wellbeing to explore what optimising "health and wellbeing" could look like in a number of key policy areas.	The Health and Wellbeing Board has reviewed how it works and committed to consider how it uses engagement events in the development of its thinking. This work is still in progress and learning events will be built into the future programme of Board meetings.
The Council, as part of Public Sector Reform, should consider a healthy population and minimising health inequalities as a core infrastructure investment for a prosperous economy.	The Council is developing its approach to inclusive growth and redefining its understanding of "the economy" and the relationship between economic, health and social policy. It is also seeking to develop a citywide strategy for work and health. The Sheffield City Partnership Board is due to discuss the link between health and the economy in September 2017 and this will be developed further in the 2018 State of Sheffield report, feeding into the wider inclusive and sustainable growth focus. Nevertheless, ongoing austerity and cuts to public services mean this work operates in a highly challenging context.
The Council and the CCG should explore the development of a 'Heart of Sheffield' structural model to coordinate and shape a policy approach to improving living well options (such as increasing physical activity and reducing smoking) in the City.	The Council and the CCG developed the Sheffield 'Healthy Lives' Programme, agreed by the Health and Wellbeing Board in January 2017. The programme is part of the Sheffield Place Based Plan. There are three components: hospital-led smoking cessation and alcohol brief interventions; CCG-led cardiovascular disease risk factor management; and Council-led healthy public policies for tobacco, alcohol, sugar and food.
The Council and the CCG should develop a joint neighbourhood delivery system with a broad model of primary care as the main delivery mechanism for services.	Primary care neighbourhoods have been set up across the City based on federations of GP practices and community, social care and third sector services. A Programme Board oversees this, covering the Council, CCG, housing and voluntary sector organisations and is part of the 'People Keeping Well' partnership. The SCC Libraries and Communities Service is working with Voluntary Action Sheffield to enhance capacity and capability of the VCF sector to support this.

Further information

For more information on health and wellbeing outcomes in Sheffield you can access various data, maps and graphs, in-depth health needs assessments and other resources from our online JSNA resource, although please be aware this is still a work in progress and there will be many more topics to be added over the rest of the year:

https://data.sheffield.gov.uk/stories/s/fs4w-cygv

You can download a copy of this report here:

https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report.html

We're keen to hear your views on this report and in particular on the themes and issues we've raised. Please complete our online feedback sheet available from our website at

https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report.html

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Report to Overview & Scrutiny Management Committee (OSMC)

Thursday 16th November 2017

Report of: Policy & Improvement Officer

Subject: OSMC Work Programme 2017/18

Author of Report: Emily Standbrook-Shaw, Policy and Improvement Officer
emily.standbrook-shaw@sheffield.gov.uk
0114 273 5065

The Committee's draft Work Programme is attached for consideration, Appendix 1. The Work Programme focusses on performance management, finance and a small number of corporate and city-wide issues; as well as having an overview of the work of the four Scrutiny Committees. This gives each meeting a specific focus, with 1-2 main agenda items and brief standing items on 'Issues to raise from other Scrutiny Committees' and the Work Programme.

The work programme will remain a live document and is brought to each committee meeting for consideration and discussion.

The Scrutiny Committee is being asked to:

- Consider and discuss the committee's Draft Work Programme for 2017/18

Appendix 1

Overview & Scrutiny Management Committee (OSMC)
Work Programme 2017-18

Chair: Cllr Chris Peace
Meeting Papers on SCC Website **Meeting day/ time**: Thursday 1.30-4pm *(apart from February 2018)*
Please note: the Work Programme is a live document and so is subject to change.

Topic	Reasons for selecting topic	Lead Officer/s	Agenda Item/ Briefing paper
Thursday 16th November 2017			
Work Based Development and Wellbeing	To provide an update on the development of the Workforce Strategy, with a particular focus on employee wellbeing and development.	Mark Bennet, Director of Human Resources and Customer Services. Lynsey Linton, Head of Human Resources	Agenda Item
OSMC Work Programme 2017-18	To consider and discuss the committee's Work Programme for 2017/18.	Emily Standbrook-Shaw, Policy & Improvement Officer	Agenda Item
Issues to raise from other Scrutiny Committees	To receive any updates from scrutiny chairs.	Scrutiny Chairs	Agenda Item

14th February 2018 (10am-1pm)			
Revenue Budget 2018/19 and Capital Programme 2018/19	To consider the Council's budget proposal in advance of Cabinet.	Cllr Olivia Blake, Deputy Leader and Cabinet Member for Finance Eugene Walker, Acting Executive Director of Resources Dave Phillips, Head of Strategic Finance Other attendees tbc	Single Agenda Item
Draft Work Programme 2017-18	To consider and discuss the committee's Work Programme for 2017-18	Emily Standbrook-Shaw, Policy & Improvement Officer	Agenda Item
Issues to raise from other Scrutiny Committees	To receive any updates from scrutiny chairs.	Scrutiny Chairs	Agenda Item
19th April 2018			
How Sheffield City Council Would like to do Business - Ethical Procurement	Details tbc	Marianne Betts, Director of Finance & Commercial Services (Interim) Other attendees tbc.	Agenda Item

Customer Experience Strategy, including an update on the new Council website, a report of the Director of Policy, Performance and Communications	To provide an update on the Customer Experience Strategy and the Councils New Website, which launched in April 2017. To include performance and customer feedback. Following discussion at the February 2017 OSMC meeting, it will also cover accessibility of EIA's (Equality Impact Assessments).	James Henderson, Director of Policy, Performance and Communications - tbc Other attendees - tbd	Agenda Item
Scrutiny Annual Report 2017-18 Draft Content & Work Programme 2018-19	This report provides the Committee with a summary of its activities over the municipal year for inclusion in the Scrutiny Annual Report 2017-18. It also includes a list of topics which it is recommended be put forward for consideration as part of the 2018-19 Work Programme for this committee.	Diane Owens, Policy & Improvement Officer	Agenda Item
Issues to raise from other Scrutiny Committees	To receive any updates from scrutiny chairs.	Scrutiny Chairs	Agenda Item
Other Possible Topics			
Sheffield City Region - Devolution Update	To provide an update on Sheffield City Region Devolution and outlining next steps.	Leader of the Council & Chief Executive Other attendees tbc	Single Item agenda – date tbd
Public engagement	To discuss public engagement in scrutiny.		

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