HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Greg Fell
Date:	27th September 2018
Subject:	Health & Wellbeing Strategy – Proposed Approach
Author of Report:	Dan Spicer

Summary:

This paper sets out a proposed approach and timescale for producing a new Health & Wellbeing Strategy for Sheffield, and asks the Board questions to help guide its development.

Questions for the Health and Wellbeing Board:

How tightly drawn should the ambitions be within the Where we live and How we live sections of the Strategy, and where should the focus be?

Recommendations for the Health and Wellbeing Board:

It is recommended that the Board:

- Agree the proposed approach to developing the updated Health & Wellbeing Strategy
- Agree to receive drafts of the Strategy at their October private strategy session and December public meeting
- Agree to work towards signing off a final version of the Strategy at their March 2019 public meeting

Agree to discuss in further detail how successful implementation of the strategy will be delivered

Background Papers:

- *Sheffield Joint Health & Wellbeing Strategy 2013-18*

What outcome(s) of the Joint Health and Wellbeing Strategy does this align with?

All outcomes

Who have you collaborated with in the writing of this paper?

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Becky Joyce – Accountable Care Partnership Programme Director for Sheffield

HEALTH & WELLBEING STRATEGY – PROPOSED APPROACH

1.0 SUMMARY

1.1 This paper sets out a proposed approach and timescale for producing a new Health & Wellbeing Strategy for Sheffield, and asks the Board questions to help guide its development.

2.0 WHAT DOES THIS MEAN FOR SHEFFIELD PEOPLE?

2.1 The Health & Wellbeing Strategy is the Health & Wellbeing Board's view, based in the Joint Strategic Needs Assessment and other evidence, of the things it can best focus on to improve the health of Sheffield's population, over the short and long term.

2.2 The people of Sheffield are a critical part of getting this right: the strategy needs to speak to what matters to them in terms of good health and wellbeing.

3.0 REFLECTIONS ON THE CURRENT STRATEGY

3.1 Discussions across a range of contexts suggest that there continues to be agreement that the issues identified by the current strategy are important and relevant, and that they remain so five years after it was approved.

3.2 However, there is also a view that it is very broad document, and that this makes it hard to see precisely whether and how it has driven change, and conversely easy to connect a wide range of pieces of work to at least one of its objectives.

3.3 The specific work programmes described in the strategy do not appear to have progressed as intended; this is partly a reflection of resource constraints, with the Board lacking its own delivery function.

3.4 The Strategy proposed a dashboard of measures to provide an overview of health and wellbeing in Sheffield. This has been kept up to date, and the current iteration is attached as an appendix of this paper. However, although it allows us to track trends over time, it is of limited use when assessing the success of the strategy. Critically, it does not facilitate judgement of the prevailing context in which those changes happened, and the context of the last five years has been extremely challenging for Sheffield and a lot of its residents.

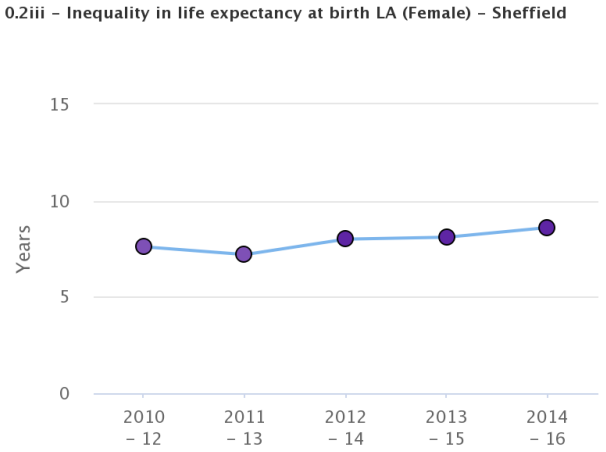
4.0 DEVELOPMENTS SINCE 2013

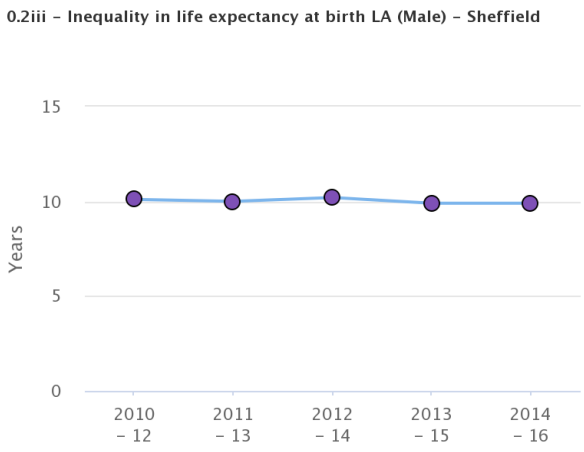
4.1 In addition to the weaknesses in the existing strategy identified above, it is also important to note that there have been a range of developments since it was published.

4.2 In particular, and while acknowledging it was one of the five outcomes set out in the strategy, there has been an increasing focus on and concern around health inequalities

in Sheffield, including the development of a specific Health Inequalities Action Plan in June 2014.

4.3 Health inequalities have remained broadly static over recent years, as shown in the following charts. None of the variations shown are statistically significant. It is important to note the background context of continued austerity, which is likely affecting some places more than others. Thus health inequities not getting worse in a challenging context is an important way to frame the overall message.





Source: Public Health Outcomes Framework: https://fingertips.phe.org.uk/ The charts show the gap in life expectancy between the most and least deprived people in Sheffield over a period of 6 years, with females on the left and males on the right.

4.4 In June 2016, the Health & Wellbeing Board agreed to refresh the city approach to health inequalities.

4.5 Following this, the Board held a facilitated workshop in February 2018 to consider further the response to health inequalities in Sheffield.

4.6 This reaffirmed the Board's commitment to and focus on reducing health inequalities in Sheffield, and also its commitment to consideration of both short- and long-term impacts and changes, with both seen as important and requiring consideration together.

4.7 As part of this session, the Board discussed the value of clear, easily articulable propositions or ambitions as a tool for the system to unite around, and to campaign around.

4.8 The discussion in the session also noted the need to refresh the Health & Wellbeing Strategy, as it expires at the end of 2018, and the potential benefits of drawing the two more closely together.

5.0 THE NEW STRATEGY – STRUCTURE AND APPROACH

5.1 Following the February workshop, the Board have held a number of conversations around the development of a new Health & Wellbeing Strategy. These have iteratively developed a proposed approach to the new document, reflecting the following key points of concern.

5.2 Firstly, that health inequalities should be front and centre, with the strategy making a clear statement that this is the focus of the Board and the lens through which it will examine everything.

5.3 Secondly, that it should actively avoid replicating existing strategies and focus on areas where the Board can add value. For example, in February 2017 Sheffield City Council approved a Tobacco Control Strategy up to 2022; the Board remains interested in the success of this and is clear that reducing smoking will benefit the health of the Sheffield population, but sees that it can add little value to this beyond ensuring its delivery. Its focus need to go beyond this and similar strategies. Similarly, there is an agreed strategy for the city on Air Quality, with no need to rewrite this. The focus of the Board and Strategy in this space should be to accelerate and coordinate implementation and ensure all sectors are involved.

5.4 Thirdly, it is now well understood that only around 20% of health outcomes are due to health and care service inputs. If this is to be a Health & Wellbeing Strategy, it will need to put the focus on the whole 100%.

5.5 Fourthly, that the Strategy should consider impacts and actions over both short- and long-term timescales, and they can support and reinforce each other.

5.6 With these in mind, the following is proposed for the new Strategy.

5.7 Health inequalities should be the single headline focus of the Strategy, with a central aim that

"Health inequalities in Sheffield are reducing, because the health and wellbeing of the poorest is improving the fastest."

5.8 The Strategy will take a life-course approach, allowing for a range of short and long term activity and focus.

5.9 This will be done by breaking the Strategy down into three sections:

- Starting & Developing Well;
- Living & Working Well; and
- Ageing & Dying Well.

5.10 Within each of these, to reflect the Board's interest in clearly articulable ambitions of propositions, there will be three ambition areas as follows:

5.11 Starting & Developing Well:

- School Readiness: an ambition that all children in Sheffield are able to take full advantage of their educational opportunities from the start;
- Inclusion in Education: an ambition that all children and young people in Sheffield have the opportunity for a full and rounded education;
- Post-16 Destinations: an ambition that education leads to a productive outcome in terms of employment, further education or training.

5.12 Living & Working Well:

- Where we live: an ambition that everyone in Sheffield has access to a home, neighbourhood and community that supports their health;
- How we live: an ambition that everyone in Sheffield has a fulfilling occupation and the resources to support themselves;
- How we move: an ambition that the Sheffield environment supports everyone to have an active lifestyle.

5.13 Ageing & Dying Well:

- Multiple morbidity: an ambition that resources are shifted from acute hospital settings to primary care to respond to the increasing importance and early onset of multiple morbidity;
- Loneliness and isolation: an ambition that no-one in Sheffield suffers from loneliness or isolation, recognising it both as a health issue for all ages, and a particular risk factor for older people;
- End of life: an ambition that everyone in Sheffield lives the end of life with dignity, as independently as possible, in the place of their choosing, and with the support they and their family need.

5.14 The intention of this structure is to describe the critical staging posts of a healthy life from cradle to grave.

5.15 Discussions within Board to get to this point have produced clarity on ambition areas within Starting & Developing Well and Ageing & Dying Well; these are well defined and clear to articulate, though precise measures are yet to be identified

5.16 In relation to Living & Working, discussions within the Board have been less clear. In relation to Where we live, some Board members have expressed a desire to focus on housing and how it supports health, while others feel the strategy should look beyond this to include an interest in community and social infrastructure.

5.17 Similarly, in relation to How we live, the Board's original focus was on good employment, but discussion within the Board has raised concerns that this would omit a portion of the population who most suffer from the impacts of health inequalities, such as unpaid carers, those on welfare, or volunteer workers.

5.18 This is not the case in relation to How we move, where there is a degree of consensus within the Board that a focus on creating more active and accessible environments is appropriate.

5.19 This paper does not make a recommendation either way on these two ambition areas, but does note that they currently do not meet the Board's stated desire to have tight, focused, clearly articulable ambitions to work towards. It would be helpful for the Board to achieve clearer consensus on what it wishes to see in order to guide development of the strategy more clearly.

6.0 MEASURING SUCCESS

6.1 This paper has already identified the difficulty of determining whether the existing strategy has been successful or not. In light of this, it is sensible for the Board to consider exactly how this challenge could be addressed in the production of the new strategy.

6.2 Two points are particularly important in this. Firstly, that a population shift in health inequalities will only happen over generational timescales; we cannot expect to make a major difference within the timescale of this strategy alone.

6.3 Secondly, that the changing context within which the Strategy operates is critical, and that we can only judge success once this has been accounted for and incorporated into our understanding. Whatever measure of success we use, we need to be able to judge fairly against changing circumstance.

6.4 One suggestion could be to model what the expected trajectory is in each of the ambition areas, based on assumptions about prevailing conditions, with success seen as bending the curve of that trajectory. This would allow us to judge success incorporating how those assumptions have held up, allowing for some degree of assessment of the context in understanding the level of progress made.

6.5 It should be noted that long-term nature of changes in health inequalities raises other questions around commitment to that target beyond the life of this strategy. It may be that the Board should consider making a longer term commitment to a focus on health inequalities, with subsequent reviews of the Strategy focusing on the ambition areas rather than the headline target.

7.0 PRODUCING THE NEW STRATEGY

7.1 A partnership strategy needs to be produced **by** its partners and should not be imposed. With this in mind, lead authors for each chapter both from within the Board and beyond it have been recruited to ensure that the content of the strategy is owned by system leaders.

7.2 There remains a need to go beyond this to ensure the content is owned and understood by as many actors in the system as possible, we are seeking to involve the whole system in developing the strategy, under the auspices of those lead authors.

7.3 To this end it is proposed that the Board work with Healthwatch and VAS to run a range of engagement and consultation activity during the development of the strategy to reach out to different parts of the system and get their input, particularly including the population who the strategy is ultimately for, and voices that are not usually heard.

7.4 In relation to this, it is noted that the Accountable Care Partnership is planning to refresh the Sheffield Place Based Plan at the same time. These two documents need

to be synchronised, and will be seeking to engage similar groups in their development, so it is recommended that this work be developed and carried out in tandem.

7.5 Properly incorporating a wide range of voices beyond the Board and across the system means taking an iterative approach to developing the strategy, to enable a balance to be made between the Board's intentions as described above and the response received through engagement and consultation.

7.6 This needs time to get right, and with this in mind the following schedule is proposed:

- A rough first draft of the Strategy to be brought to the Board's strategy development session on 25th October for discussion
- Incorporating feedback from that session, this draft to be used as the basis for engagement with the system through November and December to produce a public first draft
- This public first draft to be presented to the Board at its formal public meeting on 13th December for discussion and comment
- More formal consultation on this draft to take place in January and February 2019, leading to development of the final Strategy
- The final Strategy to be presented to the Board for agreement at its formal public meeting on 28th March 2019.

8.0 DELIVERY AND IMPLEMENTATION

8.1 As noted above, the Board has extremely limited resources of its own, and these are insufficient for it to direct delivery programmes independently.

8.2 Instead, it will need to work with the wider system to deliver the Strategy collectively, starting by setting aspirations and ambitions for health and wellbeing improvements, as the proposed Strategy aims to do.

8.3 No proposals for how this should be achieved are made here, other than to note that the iterative, collaborative approach to developing the strategy described above should be supportive of this.

8.4 Beyond this, the Board does need to recognise that this challenge needs thinking through carefully, especially if the Board is to avoid the difficulties in evidencing impact in relation to the existing Strategy.

8.5 With this in mind it is suggested that the Board commit time to considering their approach to delivery carefully at an upcoming strategy development session.

9.0 QUESTIONS FOR THE BOARD

9.1 How tightly drawn should the ambitions be within the Where we live and How we live sections of the Strategy, and where should the focus be?

10.0 RECOMMENDATIONS

10.1 It is recommended that the Board:

- Agree the proposed approach to developing the updated Health & Wellbeing Strategy
- Agree to receive drafts of the Strategy at their October private strategy session and December public meeting
- Agree to work towards signing off a final version of the Strategy at their March 2019 public meeting
- Agree to discuss in further detail how successful implementation of the strategy will be delivered and evaluated

APPENDIX A – HEALTH & WELLBEING STRATEGY DASHBOARD

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