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Sheffield Joint Health & Wellbeing Strategy

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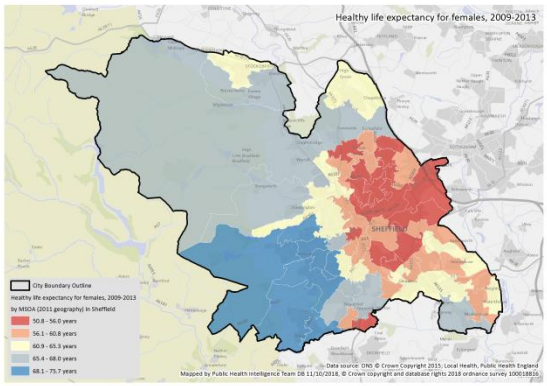
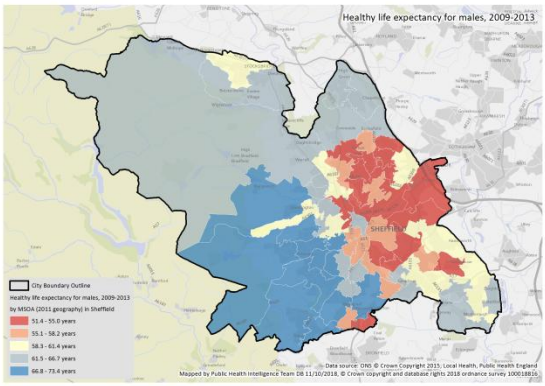
Contents

Introduction – Why should we focus on health inequalities?

Much has changed since Sheffield's Health & Wellbeing Board published its first Joint Health & Wellbeing Strategy in 2013. Much good work has been done to deliver on the aims of that Strategy, and broadly the health and wellbeing of Sheffield's population has held up well in the face of the significant challenges posed by national policy.

But we know that there is still more to do, and too many people in Sheffield still struggle with poor health and wellbeing.





We know that, in general, people in the more deprived parts of Sheffield live shorter lives than those in the richer parts; we also know that the gap in the length of life they can expect to live in good health is even greater. We also know that this challenge applies equally to vulnerable groups in the city as well, such as BME communities or those with learning disabilities; it is not just a matter of socio-economic and geographical distributions. This is the clearest expression of the health inequalities that exist in our city, and that we see as unacceptable.

Health inequalities are a social justice issue, but they are also an economic and a public service sustainability issue. It is not right that some people can expect to live a less healthy life because of who they are or where they live, but it is also not good for our economy, because people who are living with ill health cannot contribute to life in our city in the way they would want to. It is bad news for our public services, because people who live long periods of life with avoidable health needs represent demand that our public services must and should meet, but are struggling to do so.

And beyond this, it is bad for everyone in Sheffield: it has been definitively established that places that suffer from greater inequalities have worse outcomes at all levels of deprivation, not just for those who are worst off. In the report of the Sheffield Fairness Commission, published in early 2013, a vision was set out of "a city that is eventually free from damaging disparities in living conditions and life chances", along with an aspiration to be the fairest city in the country. This Strategy reflects a continuing commitment to that vision and aspiration, which remain widely accepted by stakeholders in our city.

Health inequalities will only be reduced in a meaningful way over a long period: we do not shy away from recognising that this is a generational challenge. There are three components to achieving this: a long term vision; a medium term strategy; and short term actions. This strategy does two of these. It commits the Board to a generational vision of a city free from health inequalities, and it sets out the things we can focus on over the next five years to set the foundational steps toward achieving that vision, with nine ambitions for the city that will help to reduce health inequalities.

The third will follow the strategy. This will be about the Board convening the system around those ambitions to set out in detail what we are all going to do together to achieve those ambitions, developing action plans against which the Board will hold the system to account. We think this is the right approach to achieve ambitions, and the right one for our city. Together, we can make this happen.

Health Inequalities and a Life Course Approach

What is our target?

Health inequalities manifest in many ways, and could be measured in a similar number of different ways. Our judgement is that the best way to look at this is through the lens of healthy life expectancy, as a measure that best captures the widest range of factors. With this in mind, the Board commits to

> ***Closing the gap in healthy life expectancy in Sheffield by improving the health and wellbeing of the poorest and most vulnerable the fastest***

How do we do this?

We know this is a long term vision. We cannot expect to close this gap in 10 years, never mind the five years this strategy runs for. It follows from this that we have to think long term, about the things we can do now that will make a difference 20 years from now.

But we cannot just think about these long term actions. We also need to think about what we can do now to make a difference to people's lives and about how actions in these different time frames relate to and impact on each other.

This means we need to focus on the upstream factors, structures and conditions that influence and shape our opportunities for a healthy life, throughout life. The way to do this is to take a Life Course Approach where the emphasis is on healthy ageing from pre-birth through to the end of life and on the range of interventions that support that.

What do we mean by a Life Course Approach?

This approach involves looking at the things that support healthy life, and how these change as people age.

We must recognise that most of the poor health experienced in later life is the result of what happened in earlier stages in life. If we do not try to prevent chronic conditions arising or delay their onset, we will always be managing or seeking to ameliorate them. From this point of view, a preventative approach from the beginning of life to death is our keystone.

We will do this by approaching a healthy life in three stages:

- Starting & Developing Well – where we lay the foundations for a healthy life
- Living & Working Well – where we ensure people have the opportunity to live a healthy life
- Ageing & Dying Well – where we capitalise on the work done above to live a healthy old age

In each of these stages we identify three critical ambitions to focus on over the coming five years. These ambitions are based on local evidence of where there are likely to be significant opportunities to improve life chances. They don't cover every aspect of health and wellbeing; there are already a range of strategies and programmes to address these. Rather we want to focus on where we believe the upstream opportunities are greatest. If we get these right we will make significant progress towards achieving healthier lives for all the people of Sheffield, and begin our journey towards eliminating health inequalities in our city.

The rest of this Strategy will talk about each stage in more detail, and set out our specific ambitions for change that we will ask the city to implement with us.

Plan on a Page

This Strategy sets out the Board's view of the critical foundations on which a healthier population living longer lives free from health inequalities will be based.

Health and improvements in health start from pregnancy and build throughout life to its end.

This life course approach is used to develop a set of ambitions for a healthier city that will make a difference both in the short term and the long term, and that serve to support and reinforce each other.

They can be seen as setting out the Sheffield view of the important elements of a healthy life lived to its fullest extent.

Our ambitions are that:

1. Every child in Sheffield achieves the level of development needed in their early years to provide the foundation for a healthy life
2. Every child is included in their education and can access their local school
3. Every young person in Sheffield is equipped to be successful in the next stage of their life
4. Everyone in Sheffield has access to a home that supports their health
5. Everyone in Sheffield has a fulfilling occupation and the resources to support their needs
6. Everyone in Sheffield can safely walk or cycle in their local area regardless of age or ability
7. A decisive shift of resources from acute hospital settings to preventative primary and community settings
8. Everyone in Sheffield has the level of meaningful social contact that they want
9. Everyone in Sheffield lives the end of their life with dignity in the place of their choice

To be inserted

A diagram setting out the life course approach and showing how the ambitions relate to it and link to each other

Starting and Developing Well

Children's earliest experiences are the key to their success as adults and the business case for investing in the early years is compelling. It is estimated that there is a 6–10% annual rate of return on investment through funding early years developments. The evidence clearly demonstrates that promoting bonding and attachment and protecting babies' brain development provides the foundations for future health and wellbeing.

By addressing all types of childhood adversity and providing families and communities with the capacity, resources and support for young children to flourish, we are equipping them to lead healthy, fulfilling lives and to achieve their full potential.

Over a quarter of children and young people (age 0–19) in Sheffield are in or at risk of poverty or social exclusion, compared with the overall population of 22.6%. Adverse Childhood Experiences (ACEs) are also common and can cause chronic health outcomes. ACEs are stressful experiences such as neglect, abuse during childhood that directly harm a child or the environment in which they live. Almost half of adults are estimated to have been exposed to at least one adverse experience during their childhood. The downstream consequences are significant for crime, social, educational and health & wellbeing outcomes.

Childhood obesity rates are also increasing particularly in the most disadvantaged areas of Sheffield. The inequalities gap for Reception Year (4-5 year olds) overweight & obesity prevalence has increased from 9.4% in 2009/10 to 2011/12 to 13.1% in the most recent period (2014-15 to 2016-17). Economic deprivation seems to be an increasing predictor of obesity and overweight prevalence in Reception Year.

A Health Needs Assessment for Children & Young People's Emotional Wellbeing and Mental Health completed in 2014 estimated that 7000 5-15 year olds in Sheffield have a clinically recognisable mental health disorder and approximately 10% of 0-3 year olds in Sheffield are thought to have a mental health problem. It is estimated that 15,000 Sheffield children and young people live with a parent with a mental health disorder. 40% of Sheffield children experience insecure attachment which is a risk factor for poor mental health. Emotional wellbeing and mental health in the early years and families is a key priority.

Bad experiences in childhood can have an impact on health inequalities for the rest of an individual's life. By understanding ACEs and ensuring that children have a great start in life we can:

- improve health and wellbeing outcomes and prevent disease in adulthood
- improve emotional wellbeing and mental health
- reduce costs to the health and welfare system and increase economic productivity.

Starting and Developing Well is an existing priority for the Children & Young People's Health and Wellbeing Transformation Board. The 'Great Start in Life' early years' strategy provides vision and direction for our work focusing on maternity, early years and families and is directly informed by the Infant Mortality and Tobacco Control Strategies.

Our local Future in Mind Transformation plan for children and early years also reinforces the importance of attachment and bonding and the city's ambition to improve perinatal and infant mental health. The focus on school readiness and the development of an Inclusion Improvement Plan also shapes this work. The delivery of integrated support by Multi-Agency Support Teams (MAST) is key a priority in the Prevention and Early Intervention Strategy.

In making Sheffield an Adverse Childhood Experience Aware City we will bring together partners from across all sectors to mitigate the impacts on our most vulnerable families and protect future generations.

The evidence for improving early years and starting well is indisputable. Our local plans specifically draw on the evidence base focusing particularly on:

- Early Intervention and prevention
- Adverse Childhood Experiences (ACEs)
- Parenting
- Proportionate universalism (0-19 Healthy Child Programme)
- Building resilience - helping young people and communities develop successful response to life's challenges
- Oral Health Promotion and Dental Health
- The role of schools in developing sense of connectedness/wellbeing
- Transforming emotional wellbeing and mental health following our Future in Mind Plan
- Improved data collection, sharing across agencies and analysis
- Developing community based approaches such as 'Ryegate In The Community' which focus on prevention and ensure access to health services closer to home

What are the Board's ambitions?

- Every child in Sheffield achieves the level of development needed in their early years to provide the foundation for a healthy life
- Every child is included in their education and can access their local school
- Every young person in Sheffield is equipped to be successful in the next stage of their life

Every child in Sheffield achieves the level of development needed in their early years to provide the foundation for a healthy life

Children's experiences in their earliest years directly affect their lifelong health, wellbeing and life chances. All children need a supportive and nurturing environment and to be protected from harm - this begins in the antenatal period and should continue throughout childhood.

The Joint Strategic Needs Assessment shows the progress Sheffield has made in improving outcomes and reducing vulnerabilities for children and families, examples include the reduction in teenage conceptions and rates of sudden infant death. Significant inequalities remain within this, however, and these continue to widen. This is our biggest challenge

We want all children in the city to have the best life chances and families to be empowered to provide healthy, stable and nurturing environments. We want to connect people to the right levels of support at the right time through universal and targeted prevention, early identification and early support. Local communities also play a vital role by offering family activities which promote child development and building parents' confidence, and offering peer support and volunteering opportunities which help build skills and can provide a pathway into employment.

Evidence shows that secure relationships with key adults and established routines in the first months of life are the best way to achieve good outcomes in adulthood. The First 1001 days All Parliamentary Group Report sets out a range of recommendations for re-focussing support around a baby's first two and a half years. These align with Sheffield's plans to develop prevention and collaborative action using both universal and targeted approaches in health care and other services.

Children's earliest experiences have an enormous influence on later life chances. A good start at home and in school will reduce the risk of exclusion, not being in employment, education and training and reduce the risks of loneliness and isolation. Poor maternal health increases the risk of birth complications, adverse mental health and the risk of ongoing problems in adult life. Supporting families to make healthy choices including diet and lifestyle provides the foundation for future health and wellbeing and reducing the risk of multiple long term illnesses and the need for healthcare in later life.

Inequalities in early learning, early achievement, health and wellbeing lead to poorer outcomes for children from disadvantaged homes. We are committed to helping all families get the support they need at the right time and in the right place to help reduce this gap. Children with speech and language and literacy needs should have prompt access to help in schools and nursery education settings.

By developing parents' confidence in their own skills and capability and improving access to advice and support through Family Centres, GP practices and other community settings, we can help families to: develop positive and fulfilling relationships with their children; reduce social isolation; and improve resilience, health and wellbeing.

Success will rely on continuing to build effective relationships with key partners in the Council, NHS, Schools, Communities, the Voluntary Sector, the Private Sector and with Parents and Carers.

Every child is included in their education and can access their local school

An approach to education that addresses the individual needs of each child will benefit everyone within a school community. The school-age population is growing and schools report that they are responding to more children with complex and challenging needs. The link between outcomes and exclusions is life-long and brings long term costs to individuals, communities and the state.

Needs must be identified early and met through high quality, flexible support provided within mainstream settings wherever possible. The Joint Strategic Needs Assessment highlights particularly high exclusion rates in certain communities including Roma, Eastern European and Traveller populations. Sheffield must be an inclusive city where all children and young people, including those with additional needs get the education, health, and care they need to achieve their potential and go on to make a positive contribution to society and lead a fulfilled adult life.

Evidence from the Institute for Public Policy Research illustrates that official exclusions have been rising for the past 3 years and are continuing to rise. Exclusions data are known to underestimate the school exclusion challenge. Although there are other less formal ways to exclude children from education they may still have the same consequences as a formal exclusion. Four priorities for development are identified:

- improving preventative support for young people with complex needs in mainstream schools
- improving the commissioning and oversight of alternative provision for excluded pupils
- increasing and then maintaining the supply of exceptional teachers and leaders into alternative provision
- developing an understanding of 'what works' in improving trajectories for excluded young people.

Children who have been excluded are at greater disadvantage across the life course. They are at greater risk of not being in education, employment or training after the age of 16, and of experiencing loneliness and isolation. Research shows that only 1% of excluded pupils get five good GCSEs, which directly affects their opportunities to access training and employment. Raising awareness of ACEs in the early years will help us to identify families where children are at a greater risk of exclusion.

There is a key connection between socio-economic disadvantage, exclusions and children with special educational needs and/or disability. This can create a cycle of poor health and social outcomes. More co-ordinated early help and targeted support within mainstream settings should lead to improved outcomes and enable all children to reach their full potential. Children and young people not accessing education may find it more difficult to have their health needs identified and met at an early stage.

Children with special educational needs and/or disability, or who are excluded from education are at greater risk of being marginalised or experiencing a mental health problem. This can in itself lead to antisocial behaviour, aggression and substance misuse problems. Meeting needs better at an earlier stage can help to reduce the risks of exclusion, and the negative consequences of being disconnected from a normal school or community environment.

No single organisation can achieve this vision independently. A strong partnership involving the Council, the NHS and schools is essential to create a service which is joined-up, responsive, understanding, fair, and consistent.

Every young person in Sheffield is equipped to be successful in the next stage of their life

Young people who fall out of education and employment can experience a range of negative outcomes with costs for both individuals and wider society. The case for identifying young people at risk of not being involved in education, employment or training after the age of 16 and developing a range of local actions designed to improve their life chances as a whole is clear.

By strengthening young people's resilience, enhancing educational attainment and building social and emotional skills, they will have a greater opportunity to achieve their full potential and make a positive and rewarding contribution within the community. This in turn will bring positive consequences for their own children by breaking the damaging cycle of deprivation and disadvantage within families.

Research on improving outcomes for young people at risk of these adverse outcomes conducted in Newcastle recommended that a hierarchy of risk should be used to identify the young people with the highest probability of experiencing multiple poor life outcomes. Services should be designed to identify these risk indicators (including those relating to their wider family), and early action taken.

Young people in this group are also vulnerable to a range of poor outcomes in later life, resulting in significant inequality. Looked after children, those with a history of social care involvement and children with disabilities are at particular risk. They are more likely to present as homeless, claim housing benefit, become involved with police, become pregnant at a young age, and are 50% more likely to have a prescription for depression and anxiety, and 1.6-2.5 times more likely to experience poor physical health.

By intervening early it is possible to help build self-esteem and resilience, improve attainment and increase the employment prospects of disadvantaged young people. Our ambition for early development will help address this, particularly where there are difficult family circumstances or children are identified as facing ACEs. Positive engagement with school is also a key protective factor and so our ambition for an inclusive education system will contribute to this too. There should be a focus on providing tailored support for vulnerable young people at key transition points to maximise their life chances and break the cycle of deprivation

The Council and Sheffield NHS must work together to find ways to jointly commission services including a therapeutic element for young people and/or their families. Social, emotional and mental health issues are increasingly a barrier for young people progressing in education and employment post 16. This work must include health partners, schools, employers and providers of careers advice and the voluntary sector.

Living & Working Well

Positive early experiences are vital for children so they are ready to learn, ready for school and given the best possible start in life. What happens in our younger years affects our social circumstances, physical and emotional health as we move into adulthood, a time in our lives when generally we are looking to find meaning and satisfaction through relationships, family life and work.

Those who are most at risk of poor health usually have least access to health-enhancing living and working conditions such as decent housing, a fulfilling occupation and a safe environment. Having access to a warm, comfortable place to live; our work and financial situation; and staying active make a difference to our chances of remaining healthy and well during this time of life and into older adulthood, as well as playing a material role in the development of the next generation.

In Sheffield, people living in the most deprived areas or who have limited choice over where they live, due to low income, lack of available work or disability, are more likely to find themselves in circumstances that have a harmful impact on their health and wellbeing. This can lead to people being cut off from important aspects of life, and a widening of health inequalities in the city.

There are already a number of strategies for Sheffield that set out to improve access to the living and working conditions and environments that support health and wellbeing, such as the Council's Housing Strategy, Economic Strategy, Transport Strategy, and the city's Food, Tobacco Control, and MoveMore strategies, to name just a few.

Designing and providing services that are accessible and enhance people's health are an essential part of preventing health inequalities. This is not just the role of the health service or the Council. To make a difference, we need to work together across the public and voluntary sector to advocate for health to be considered in strategies for housing, the economy, the NHS, transport and the local environment, and we need to put communities at the heart of decision-making to influence the choices made to improve the place where they live.

What are the Board's ambitions?

- Everyone in Sheffield has access to a home that supports their health
- Everyone in Sheffield has a fulfilling occupation and resources to support their needs
- Everyone in Sheffield can safely walk or cycle in their local area regardless of age or ability

Everyone in Sheffield has access to a home that supports their health

No-one in Sheffield should live in a home that damages their health.

Cold housing is a risk to health and those with the poorest health live in the coldest homes. People living in cold homes are far more likely to suffer from illnesses such as asthma, 'flu and bronchitis and it can increase the risk of a heart attack or stroke. In Sheffield, around 5,500 owner-occupied and private rented properties across the city are classed as having an excess cold hazard due to a mix of financial hardship and poor property conditions. 12% of households are living in fuel poverty as a result of low income, high fuel prices and homes which are expensive to heat and run. This contributes to winter deaths, cold-related illnesses, unplanned admissions to hospital and delayed discharge, particularly in older adults. Children in poor housing are more likely to have mental health problems, contract meningitis, have respiratory problems, experience long-term ill health, disability, slow physical growth and delayed cognitive development, giving them a much poorer start in life.

The current shortage of affordable housing is the greatest threat to health for many people if they become homeless or are forced to wait for new homes in unsuitable conditions or in places away from their social networks. There is little competition at the more affordable end of the private rented sector, which can offer poor housing conditions where vulnerable people find it impossible to ensure basic maintenance of the property. Overcrowding is also detrimental to health, in particular mental health. The shortage of affordable housing means a lack of properties for families in the social and private rented sectors. The city needs more affordable homes than are currently being built, in particular for households unable to afford market price. This could include first time buyers on a low income; families seeking homes across all tenure types; vulnerable groups who need accessible or supported accommodation; single people under 35 years affected by changes in the benefits system.

Home improvements can significantly improve social functioning as well as physical and emotional wellbeing. For example, adequate heating systems improve asthma and reduce the number of days off school. Some private rented homes in the city have a hazard that could pose a serious threat to the health or safety of people living in or visiting the home. It is estimated that the removal of all hazards could provide £13.5 million annual savings to society, including £5.4 million savings to the NHS.

This is not just about the quality and affordability of the bricks and mortar; we also know that homelessness is tied to some of the most significant health inequalities in our city. Homelessness and tenancy failure can affect all groups: however, some groups are more vulnerable than others including young people, older people, people with mental health issues, people with drug and alcohol problems, people leaving hospital, care leavers, people released from prison, and former members of the armed forces.

In Sheffield, support is focused on preventing people from becoming homeless and helping people to resettle after a period of homelessness. Although homelessness in Sheffield has reduced in recent years, there was an increase in homeless acceptances in 2016-17. In addition, an estimated 9,200 households are likely to be adversely affected by ongoing welfare reforms including the introduction of Universal Credit in Sheffield from November 2018. We need to make sure we have the right type, amount and quality of accommodation to take account of any changes in need.

Everyone in Sheffield has a fulfilling occupation and the resources to support their needs

A good job can significantly improve a person's life by offering security, rights, personal development, career progression, a supportive environment and a fair income. Being unemployed or unable to work, because of caring responsibilities for example, can have a damaging effect on people's health and quality of life. We must do all we can to support people who are able and want to find a fulfilling occupation, whether in a paid job or a voluntary role. For children and young people to be prepared for work, they need access to education, training and employment as this will improve their long-term life chances and help them to make a positive contribution to their community, the economy and the city.

Many people find work is important for their mental wellbeing and helps them feel good about themselves, although sometimes problems at work can be a cause of stress. In Sheffield, over half of the people claiming out of work benefits are affected by mental health problems. If people have been out of work for a while, they are likely to need support when they feel ready to return. This could be through rebuilding their self-confidence through voluntary work, a phased return to work, or working with an employer to put in place reasonable adjustments to help them stay in work. As well as supporting people to return to work, preventing others from becoming long-term unemployed or having to leave work due to mental illness is part of maintaining a healthy city.

Work should be a way out of poverty. However, even though the number of households where nobody is working has declined and the employment rate is up, the number of people struggling to make ends meet has increased. Across Sheffield, there are people with multiple jobs, who are in and out of insecure, low hour, temporary employment and struggling to afford even life's basics. In-work poverty is increasing with over half of households in poverty now having someone that is in work[1]. Three-quarters of adults in working families in poverty are themselves working, with female employees as the single largest category in this group.

Families with children are the most likely to be locked in poverty despite being in work, particularly lone parents, and in-work poverty is associated with poorer mental health. Because of rising costs and the increasing gap between income and the cost of a minimum acceptable standard of living, low income workers and families are less likely to manage when unforeseen costs hit. In this situation, choices become more restricted – cut back, go without or borrow – leading to further financial problems and detrimental effects on health.

This is not just about getting people into any job or working more hours, which is not even possible for some workers. In Sheffield, we need to work with employers to create more and better paid jobs with fair contracts. The Sheffield Fair Employer Charter includes the aspiration for employers to exceed the recognised living wage. By paying the National Living Wage of £7.83 per hour for people over 25 years of age, an employer is helping workers to earn enough to cover their basic costs of living. Longer term, we need to ensure that people have the right training to get on once in work and have the opportunity to earn more to improve their living standards and reduce the need for welfare.

[1] Joseph Rowntree Foundation

Everyone in Sheffield can safely walk or cycle in their local area regardless of age or ability

A physically active lifestyle reduces the risk of cardiovascular disease, diabetes, obesity, osteoporosis and colon or breast cancer, improves mental wellbeing and, in older adults, increases functional capacities. In Sheffield 67% of those aged 19 and over are physically active. However, one adult in four is classed as physically inactive compared with one in five nationally. Of the Core Cities, we have the second highest percentage of regular walkers with just over half of the 16-plus population walking at least five times a week, but conversely the lowest percentage of regular cyclists with only 2.2% of the 16-plus population cycling at least three times a week. Despite the many parks in the city, use of green and open spaces for health and exercise is slightly lower than the national average.

Active travel, such as walking or cycling to school, work or the shops, provides people with daily physical activity and is a sustainable way of getting around the local community. Good street design and lighting can make places easier, safer and more pleasant to move around which can encourage walking and cycling. Road safety has a direct impact on health inequalities so lower speed limits reinforced by other traffic calming measures in local areas can reduce the risk of injury or death for pedestrians making it safer to walk or cycle in their neighbourhood. Providing or designing-in safe, direct walking and cycling routes within a neighbourhood can help people get to work, school or college, as well as recreational facilities, green and open spaces which can have a positive effect on physical and mental health.

More active travel will also help reduce pollution and improve the air we breathe. Poor air quality results in more respiratory conditions such as asthma, higher levels of physical inactivity and higher levels of mortality. In addition, noise pollution such as the noise from traffic is also associated with poorer mental wellbeing and greater levels of stress. People living on lower incomes are more likely to live in high traffic areas and urban centres which discourage walking and cycling so experience these impacts disproportionately.

Walking and cycling is the most likely way that children and adults can achieve the recommended levels of physical activity: that is, walking for at least 10 minutes on at least five days a week. The physical health benefits associated with regular walking include reduced risk of coronary heart disease, cancer, stroke and type 2 diabetes. People living closer to green space are likely to be more physically active than those who do not.

Safe, clean and walkable local environments improve social connections within neighbourhoods, offering places for people to meet and children to play, with resulting benefits to mental and physical well-being. People are more likely to use green space if they think it is safe, well-maintained and easy to reach.

Walking and cycling can help to improve an individual's mental wellbeing including concentration, decision-making and enjoyment of normal daily activities. It can help reduce the feeling of being constantly under pressure. Greater proximity to green space has been associated with lower prevalence of a number of diseases, reduced premature mortality and improved mental health and wellbeing. For some outcomes, particularly mental health, the effect has been shown to be greater for those on lower incomes, demonstrating the potential of access to green space to reduce health inequalities.

Neighbourhoods with safe walking and cycling as standard will contribute to improving air quality, improving poor health, strengthening communities and promoting healthier lifestyles for all.

Ageing and Dying Well

Older age is too often viewed as a societal 'burden', with phrases like 'the demographic time bomb' evoking images of an inevitable, overwhelming and impending health and social care crisis. Yet many individuals enjoy the opportunity of older age, seeing it as a time of positive change. This gulf between public and media perceptions and lived experience is a function of deeply ingrained ageism which sees old age in negative terms.

For some people later life can be marked by disability and dependency rather than offering opportunities to lead an active life. Thus the experience of later life is therefore deeply divided, especially along the lines of social class, relative deprivation, gender and ethnicity. These factors are strongly associated with the number of healthy life years a person is able to enjoy into retirement and old age.

Long term ill health tends to be associated with later life and, as a result of population ageing, the need for health services is increasingly shifting from short-term, curative treatment to managing long-term conditions. However the distribution of NHS resources remains focused on the former.

The good news is that many long term conditions are preventable or at least delay-able: the evidence on this is overwhelming. Relevant actions range from simple activities such as physical exercise through to societal changes which ensure access to good quality housing, clean air, green spaces, safe and meaningful employment and access to fresh food, whilst also limiting access to alcohol, tobacco and highly calorific food. These interventions will be most effective if they are made at earlier stages if the life course, from birth in fact or even earlier.

Many of the chronic conditions affecting older people have their causes at earlier stages of life; therefore the support and care we give in later years is often remedial or palliative. The main challenge is to prevent those conditions or to delay their onset or progression, and to ensure that good health in old age is evenly spread through the population.

This is more than a stage in the life course, it is in itself an expression of inequalities in health: not everyone in Sheffield has the opportunity to age well. Research in the city covering more than two decades has shown the stark inequalities in both life expectancy and healthy life expectancy between the most and least deprived areas. These inequalities, documented by successive reports from the Director of Public Health and the Sheffield Fairness Commission, demonstrate that later life is where health inequalities become most extreme.

For men in Sheffield life expectancy ranges from 85.3 years in parts of Fulwood, Dore & Totley to 73.2 years in parts of Beauchief & Greenhill, a gap of 12 years. Female life expectancy varies from 90 years in parts of Stocksbridge & Upper Don to 76.2 years in parts of Park & Arbourthorne, Gleadless Valley and the City Centre, a gap of 13.8 years. Healthy life expectancy in Sheffield is falling meaning that people are living more years of life in poor health. On average older men spend 18 years in poor health and women 22 years. The healthy life expectancy gap between the most and least deprived areas is even wider than for overall life expectancy. For men this gap is 18.8 years and for women it is 19.7 years.

In 2012, the Sheffield Fairness Commission, documented inequalities in life expectancy as an expression of unfairness and set out an aspiration that Sheffield should be the fairest city in the country. For this reason, the Council is developing the concept of a Sheffield Healthy Lifespan, setting a target for all residents of a number of years lived free from chronic ill-health. Whilst the details are yet to be finalised, this target

would be a bold step towards eradicating health inequalities in Sheffield and setting an example to other parts of the country.

It is not inevitable that later life should be a time of senescence. A whole life course approach to prevention, which includes teaching children how to age well, is the most effective way of maximising healthy life expectancy. Remedial actions undertaken later in life, such as eating a healthy diet, aerobic and weight bearing exercise, maintaining mental stimulation and participating in social activities can improve outcomes in later life.

What are the Board's ambitions?

- A decisive shift of resources from acute hospital settings to preventative primary and community settings
- Everyone in Sheffield has the level of meaningful social contact that they want
- Everyone in Sheffield lives the end of their life with dignity in the place of their choice

A decisive shift of resources from acute hospital settings to preventative primary and community settings

It is a common misconception that the ageing population is responsible for inexorable increases in demand for health and social care services. This is not the case. Many older people, including very elderly people, live fully independent lives and the increase in demand far outweighs the increase in older people.

The demand on services is, in fact, due to increasing numbers of people living with one or more long term condition. GP records show that almost two-fifths of the population in Sheffield has at least one long term condition and almost one-fifth have two or more. The most common conditions are hypertension (high blood pressure), depression and diabetes. Whilst the prevalence of long term conditions tends to increase with age, this does not mean that age is specifically responsible. Indeed multiple chronic illnesses are more common in the 60-69 years age group than in those aged 80-89 years.

Multiple chronic illness has a devastating impact on health and wellbeing outcomes for individuals, is in danger of overwhelming the health and social care system and has a detrimental economic impact on the city when people of working age are rendered unable to work.

Long-term ill health is more common in deprived areas, starts at a younger age and is more likely to include mental health conditions. Local data show a 15 year gap in the onset of multiple illnesses between the most and least deprived people in Sheffield. Two-fifths of 50 year olds in the most deprived groups have multiple long term conditions compared to just under one-fifth in the least deprived.

Depression is the second most common condition found in people with chronic conditions, present in two out of every five people. Not only is depression more likely in individuals with a physical long term condition, but the presence of depression makes taking steps to maintain good physical health even harder. It thus represents a vicious cycle of worsening outcomes.

Our long term ambition is to delay and prevent multiple chronic illness, as well as ameliorating its effects. We are planning to take this forward through the Sheffield Healthy Life Span concept: the number of healthy life years all Sheffield residents should expect to live, irrespective of who they are or where they live. This means a city-wide life course focus on healthy ageing aimed at increasing the number of healthy life years lived.

A hospital system designed to treat people with single episodes of ill-health is not the best response to this challenge. We need to focus on prevention, early identification and a person-centred approach. This must be done at the community level and we must shift resources accordingly. The Joint Strategic Needs Assessment shows that a one year delay in onset and development of complexity could save £4 million per year in hospital costs alone. This could be achieved in part by shifting the focus of monitoring the known diseases of people on GP registers, to using that as an opportunity to prevent second and subsequent long term conditions.

A highly specialised, disease specific approach is not appropriate for people with multiple long-term conditions as focusing on disease markers for one illness can have a detrimental effect on another and pharmacological interventions can interact with each other producing unpredictable and difficult to manage side-effects that can end up being worse than the symptoms of the diseases. Consequently a whole population, person-centred approach must be taken to understand what is most important to any given person and how they may be enabled to care for their own health and live a meaningful life within the confines of their illness.

Improved outcomes due to the prevention or delay of long-term ill health could be seen as the culmination of all the ambitions related to starting and developing and living and working well. Prevention of multiple chronic illness is everyone's business and must engage all ages across the life course. Implementing the aim of becoming a person centred city is the responsibility of the Long Term Conditions Board of Sheffield's Accountable Care Partnership, as is the development of a business case for prevention.

Everyone in Sheffield has the level of meaningful social contact that they want

Loneliness and social isolation are linked, but are not the same. One way of describing the distinction between the two is that you can be lonely in a crowded room, but you will not be socially isolated.

They can affect anyone of any age, and the relationship with health and wellbeing is strong: They have an impact on mortality that is comparable to obesity or smoking, are associated with raised risk of coronary heart disease and stroke, increase the risk of high blood pressure, and are associated with a higher risk of the onset of disability. They affect our mental health and are linked to cognitive decline, increased risk of dementia and depression and risk of suicide.

There is no single, objective measure of loneliness in use in the UK. The Joint Strategic Needs Assessment suggests there could be as many as 12,000 older people in Sheffield who are often or always lonely. This does not mean it is just an issue for older people; loneliness and isolation affects people of all ages, and has long term impacts for those who suffer from it.

There is no silver bullet to reduce loneliness; we are all unique as are the factors behind loneliness. We need to focus on identifying the risk factors and taking a person centred, asset based approach to encouraging greater social contact and stronger community networks. Reducing loneliness and social isolation across the life course will improve the health and wellbeing of the whole population. It is estimated that around half of all loneliness experienced is linked to inherited factors and the other half to socio-economic factors. This is good news because it means the risk can be modified.

In addition, there are strong connections to the other areas set out in this Strategy: Supportive development in the early years sets us on the course of developing the social skills and empathy needed to sustain relationships; An inclusive education offers the opportunity to develop social bonds that can be sustained across the life course; A fulfilling occupation and resources to live on provide the opportunity to participate in a range of activities and more broadly in the community; Walkable spaces in communities make it easier for people to mix with each other and maintain relationships; Loneliness and isolation are linked to a range of long term conditions; and People with strong and supportive social networks are more likely to live the end of their lives in dignity and independence.

Loneliness can be felt by people of all ages, but the likelihood of experiencing loneliness increases with age and there is evidence that ethnic minority elders may be amongst the loneliest. Friendship and loneliness are often significant contributors to young people's self-esteem and emotional wellbeing. Schools participating in our local Healthy Minds Framework model have identified that friendship and loneliness are the significant self-reported issues impacting on emotional wellbeing and mental health for young people.

Evidence also shows that men and women respond differently to loneliness and social isolation with older women more likely to admit to feeling lonely than older men. Perhaps not surprisingly, people who live alone are more likely to say they feel lonely and, in particular, this is the case for people who are widowed and living alone. Gay men and lesbians also seem to be at greater risk of becoming lonely and isolated as they age. The risk of loneliness in Sheffield is inequitably distributed across the city, with greater risk focused around areas of greater deprivation.

Everyone has an opportunity to make a difference to this, from services incorporating an understanding of risk factors into their delivery, commissioners focusing on the development of assets at the community and individual level to sustain relationships, to voluntary and community organisations working to build and develop links within and between communities.

Everyone in Sheffield lives the end of their life with dignity in the place of their choice

On average, 14 people die every day in Sheffield. End of life care has a profound effect on individuals, families and friends and staff. It can be a very positive and meaningful experience, wherever someone dies. But delivery of a consistent experience and standard of care that is personalised and responsive to people's needs is not yet the case in Sheffield.

Experience and standards vary according to the type of illness someone has, their personal characteristics and where they live. In Sheffield 7% of people have three or more hospital admissions in the last three months of life. Whilst Sheffield does not perform the worst on this measure, it is by no means the best, and a similar situation exists with regard to access to palliative care services. Evidence tells us that people who receive early palliative support require less specialist care at the end of their life, have better quality of life, experience better mental health, and actually live longer as a result.

Whilst it is said that we are all equal in death, sadly that cannot yet be said for the circumstances in which we die. People living in more affluent areas are more likely to die at home than those living in deprived areas; this is both worse for them, and more costly to provide.

Whilst frailty and chronic diseases such as coronary hearth disease are the biggest killers, most people receiving hospice services in particular will have a diagnosis of cancer. Older people, those from black and minority ethnic groups, lesbian, gay, bisexual and transgender people, homeless people or people in secure or detained settings, people with dementia, a learning disability or mental health condition can all experience barriers to good quality care at the end of their life.

Good quality, personalised care at the end of life is the responsibility of the health and care system and the wider community. In order to achieve our ambition of ensuring everyone in Sheffield lives the end of their life with dignity in the place of their choice, we need to embed the six End of Life Care ambitions:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

As can be seen from those ambitions, this is not just about NHS and social care services working together; this is the responsibility of everyone in all our communities.

Implementation

The Health & Wellbeing Board is not an executive board. It is a partnership group that brings together a collective view on a strategic approach to improving health and wellbeing in Sheffield. It has a role in shaping, influencing and focusing attention on issues that determine wellbeing and health outcomes.

Implementation of this strategy will be the responsibility of the board, but it will only be effective if all relevant stakeholders participate. We commit to focusing our discussions over the coming period around the ambitions of this strategy, seeking to understand the motivations of stakeholders, and the best intervention & inflection points.

The Board will convene a set of workshops, bringing together insights and perspectives of different stakeholders, for each of the ambitions. This process will shape and define the steps needed to achieve those stated ambitions.

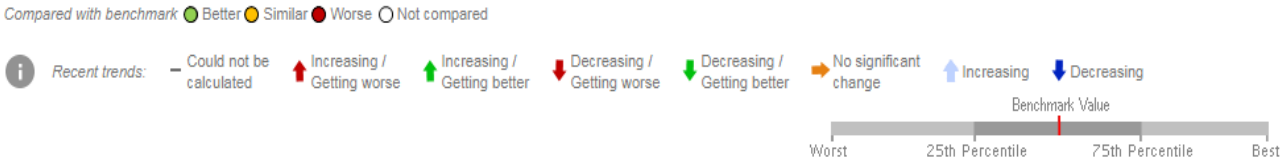
This Strategy is a document against which the Board will attempt to hold the whole system to account, not just the partners around the table. We have engaged with the whole system as far as possible while developing it to ensure the strongest possible buy-in from all parts of the city. To continue this approach through to delivery, the Board will develop an ongoing engagement process feeding into those workshops and generating a city wide conversation about what different approaches are needed, and develop broader support for change.

The Health & Wellbeing Board is a committee of the Council and as such it will seek to advocate for positive change from Government in support of its ambitions. Similarly, it will advocate for positive change both within agencies in the city and with government and other national and regional stakeholders.

The partners in the board will commit their resources to implementing the objectives set out in the strategy. The role of the board is to exert influence in a complex system rather than implementing a defined set of programmes. Individual members of the board and the agencies they represent are already involved in other partnerships or individual agency boards responsible for improving outcomes. Members of the Health & Wellbeing Board commit to influencing other bodies to ensure we build a culture of improving health and wellbeing into the core business of our respective organisations.

Outcome measures

The Board will continue to monitor the overall health and wellbeing of Sheffield, but this represents an assessment of health rather than an assessment of the success of this strategy. The following indicators are based on those identified by the Marmot Review as based on the wider determinants of health and wellbeing across the life course whilst providing context and direction for tackling health inequalities.



Indicator	Period	Sheffield			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Healthy life expectancy at birth (Female)	2014 - 16	–	-	57.5	61.5	63.9	54.6		71.1
Healthy life expectancy at birth (Male)	2014 - 16	–	-	60.4	61.3	63.3	54.3		69.9
Life expectancy at birth (Female)	2014 - 16	–	-	82.6	82.4	83.1	79.4		86.8
Life expectancy at birth (Male)	2014 - 16	–	-	79.0	78.7	79.5	74.2		83.7
Inequality in life expectancy at birth (Female)	2014 - 16	–	-	8.6	-	-	-	-	-
Inequality in life expectancy at birth (Male)	2014 - 16	–	-	9.9	-	-	-	-	-
People reporting low life satisfaction	2016/17	–	-	5.2%	5.1%	4.5%	-	*Insufficient number of values for a spine chart*	-
School readiness: Good level of development at age 5	2016/17	↑	4,578	69.8%	68.8%	70.7%	60.9%		78.9%
School readiness: Good level of development at age 5 with free school meal status	2016/17	↑	817	55.1%	53.2%	56.0%	43.9%		70.7%
GCSE achieved 5A*-C including English & Maths	2015/16	–	2,879	54.0%	55.9%	57.8%	44.8%		74.6%
GCSE achieved 5A*-C including English & Maths with free school meal status	2014/15	–	247	27.6%	28.5%	33.3%	20.5%		60.0%
19-24 year olds not in education, employment or training	2017	–	-	-	13.3%	13.2%	-	*Insufficient number of values for a spine chart*	-
Unemployment	2017	–	17,200	6.0%	5.0%	4.4%	10.3%		1.7%
Long term claimants of Jobseeker's Allowance	2017	↓	2,522	6.6*	4.7*	3.5*	13.3		0.7
Individuals not reaching the Minimum Income Standard	2013/14 - 15/16	–	-	-	31.9%	30.3%	-	*Insufficient number of values for a spine chart*	-
Work-related illness	2014/15 - 16/17	–	-	-	4490	3980	-	*Insufficient number of values for a spine chart*	-
Fuel poverty	2016	↑	28,658	12.2%	12.1%	11.1%	17.0%		6.5%
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	–	-	15.3%	17.5%	17.9%	5.1%		36.9%

Just as the actions to deliver on our ambitions must be developed with the system, so must the success measures be developed. We commit to developing a robust approach to judging whether our ambitions have been achieved, and whether they have had the impact we expect.