SHEFFIELD JOINT
health
& well being

STRATEGY 2019-2024

NHS
Sheffield
Clinical Commissioning Group

Sheffield
City Council

Contents

Foreword

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, but in the context of continuing austerity we are seeing disproportionate impacts on the health of those in our city who are worst off.

We know too many people in Sheffield are struggling with poor health and wellbeing, and this is inequitably distributed across our city. We also know that most of the solutions are not to be found within NHS and social care services alone.

Our first Strategy covered the five years up to the end of 2018. Over the last 12 months the Board has substantially reviewed its approach and priorities for promoting health and wellbeing to ensure a wider range of perspectives are incorporated into its work, based on the evidence in Sheffield's Joint Strategic Needs Assessment. We have taken this broader approach into this updated Joint Health & Wellbeing Strategy, which will guide our work for the next five years up to 2024.

The ambitions set out within the Strategy do not represent the totality of our commitment to health and wellbeing. There is much going on in Sheffield already that is essential for improving the health of our population; for example, in the last two years Sheffield made major commitments to reducing smoking and improving access to healthy food. Existing work such as these are not formally part of this Strategy, but remain important and the Board is clear that they and other strategic commitments continue to be delivered on as part of our overall approach.

What this Strategy does do is reflect and reinforce the Board's overarching commitment to reducing, and one day eliminating, health inequalities in Sheffield.

Inequality is bad for everyone: places that suffer from greater inequalities have worse overall outcomes, across all population groups, areas and communities. This makes tackling inequality a whole population issue.

We already have a clear vision for tackling inequalities. In the report of the Sheffield Fairness Commission, published in early 2013, a vision was set out for "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. In 2014 this was followed by the publication of our Health Inequalities Action Plan, and in 2015 by the Tackling Poverty Strategy. The actions and principles in that plan are still valid, based as they are on the recommendations of the Marmot Review and the Due North Report. This Strategy represents a continuing commitment to that vision, which remains widely accepted in our city.

Having the right Strategy is only the first step; what matters as much, if not more, is how we deliver it. There is a great deal we can learn from other places on this, in particular on how we can go about embedding our commitment to eliminating health inequalities in everything we do in Sheffield. For example, this could include incorporating wellbeing impacts in our budget decisions, so that they have parity with traditional economic considerations.

If we are to achieve our aim of improving health and wellbeing for everyone, and eventually eliminating health inequalities, every single sector, organisation and community has a role to play. We commit Sheffield's Health & Wellbeing Board to leading a whole city approach to delivering our Strategy.

Cllr George Lindars-Hammond & Dr Tim Moorhead,
Co-Chairs, Sheffield Health & Wellbeing Board
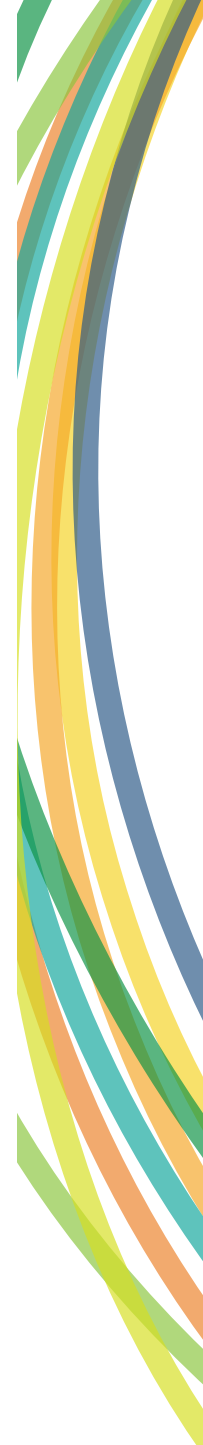
Introduction:
why health inequalities matter

We know that people in poorer parts of Sheffield live shorter lives and have worse health than those in more affluent areas. We also see similar disparities affecting groups with specific shared characteristics, such as people from Black, Asian, Minority Ethnic and Refugee backgrounds, or people with learning disabilities. These differences and disparities are the health inequalities that exist in our city, and that we see as unacceptable.

It is not right that some people can expect to live a less healthy life because of who they are or where they live. Equally, vibrant and healthy communities produce skilled, happy and productive people, leading to a stronger economy, which benefits everyone.

Inequality is not simply bad for those who are most disadvantaged, it is bad for everyone. This is because in unequal societies, social cohesion is poor, skill levels are low, businesses find it difficult to start up and sustain themselves, support services struggle to meet the challenge of rising demand, and environments are often degraded. Inequality is linked to lower levels of educational attainment, social divides and poverty, which in turn affect everyone's futures because successful economies need skilled healthy people. Health inequalities waste human potential and are a burden on society.

Our goal

Healthy life expectancy is the best overall measure of both health and health inequalities, representing as it does the number of years someone can expect to live in good health. In Sheffield, the gap between the best and worst off is around 20 years. Our goal is therefore:

We will close the gap in healthy life expectancy in Sheffield by improving the health and wellbeing of the poorest and most vulnerable the fastest

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 in 20 years time.

We do not shy away from recognising that this is a generational challenge. There are three components to achieving change on this scale: a long term vision; a medium term strategy; and short term actions. This strategy does the first two of these. It commits us to a vision of a city free from health inequalities, and it sets out ambitions to focus on over the next five years as the first steps to achieving that vision.

The third will follow the strategy. Since no one sector has all the answers to these difficult challenges it is important that people and communities are central to working with services and business to deliver this Strategy. We will convene the system around the ambitions in this Strategy to set out in detail what we

are all going to do together to achieve them, developing action plans against which we will hold the system to account. We think this is the right approach to deliver our Strategy, and the right one for our city.

A Life Course Approach

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. This 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.

For each of these we identify three ambitions to focus on over the coming five years. These ambitions have been identified on the basis of local evidence of what is most likely to improve life chances and reduce inequalities, focusing on factors that will support people to be healthy from the start, rather than on intervening once they are unwell.

That is not to say that other activity that improves or protects health and wellbeing is not important. There is much excellent work delivered in Sheffield in this regard that remains vital, such as work around tobacco control, and health protection, to name just two. We remain committed to this work, and will continue to ensure it delivers for the people of Sheffield.

Continuing to deliver on these, and refocusing the city to ensure people are healthy from the start of their lives will mean we can make significant progress towards achieving healthier lives for all the people of Sheffield, and begin our journey towards eliminating health inequalities.

The rest of this Strategy sets out our specific ambitions that we ask the city to implement with us in more detail.

Our approach to a healthy life is as follows:

- **Starting Well** - where we lay the foundations for a healthy life

- **Living Well** - where we ensure people have the opportunity to live a healthy life

- **Ageing Well** - where we consider the factors that help us age healthily throughout our lives

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 achieves a level of development in their early year for the best start in life

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

3 Every child and young person has a successful transition to independence

4 Everyone has access to a home that supports their health

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

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

7 Everyone has equitable access to care and support shaped around them

8 Everyone has the level of meaningful social contact that they want

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

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Starting 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. The evidence clearly demonstrates that promoting bonding and attachment and protecting babies' brain development provides the best start in life.

Evidence shows that children who do not achieve a good level of development by the age of four, and who continue to face challenges to their ongoing development, are less likely to have acquired the necessary vocational, social and health assets to transition successfully into healthy adulthood.

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

Evidence from our Joint Strategic Needs Assessment suggests that the factors causing childhood adversity and disadvantage are increasing in Sheffield. For example:

- Over a quarter of children and young people are in or at risk of poverty or social exclusion, higher than for the overall population, with 5 wards where over half of children live in poverty;
- Adverse Childhood Experiences (ACEs: stressful experiences such as neglect or abuse), are also common, as they are elsewhere, and lead to long term health and other challenges. Almost half of adults are estimated to have had at least one adverse experience during their childhood;

- Childhood obesity rates are increasing, particularly in the most disadvantaged areas. Economic deprivation is a predictor of obesity and overweight prevalence in 4 to 5 year olds;
- 1 in 10 5-15 year olds have a clinically recognisable mental health disorder and a similar proportion of 0-3 year olds 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;
- 2 out of 5 children experience insecure attachment, a risk factor for mental health.

Emotional wellbeing and mental health in the early years and families is therefore a key priority. Children facing multiple risks such as being a victim of abuse, living in poverty or poor housing have a heightened risk of multiple and sustained childhood mental health difficulties. Protective factors such as social support and good quality of work and employment conditions can help buffer the impact of adverse conditions on poor mental and physical health.

Bad experiences in childhood can impact on health for the rest of an individual's life. That is why starting well is a priority. The 'Great Start in Life' early years' strategy provides vision and direction for our work 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.

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

Our ambitions for Starting Well

- Every child achieves a level of development in their early years for the best start in life

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

- Every child and young person has a successful transition to adulthood

Every child achieves a level of development in their early years for the best start in 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, 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 capabilities 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.

In particular, strengthening communities by supporting informal groups to do what they do well - for example parent and baby drop-ins, or good neighbour schemes. By doing this confidence is built, social connections are strengthened, and the resilience of individuals, families and communities is enhanced so that people stay well even when faced with adverse circumstances.

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, LearnSheffield, schools and beyond is essential to create a service which is joined-up, responsive, understanding, fair, and consistent.

Every child and young person has a successful transition to adulthood

Development in early years and an inclusive education are in large part about setting young people up for success in later life, but we know that the transition from childhood to adult life can be difficult for many. Standing on your own two feet for the first time is a challenge for anyone, and people who have already experienced a disrupted or disadvantaged childhood can find this more difficult than most.

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, and is not just about services for young people: it is also about links with and transitions to adult services. Where young people are receiving support from public services, the transition to adult services represents yet another challenge, and one that is currently harder than it needs to be.

In addition, some of this work needs different approaches to the conventional commissioner/provider or services/recipients of services models. An asset based approach values the capacity and skills of people and communities and sees citizens as co-producers of health and well-being not just as recipients of services. It is fundamental to place based strategies.

Living 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.

People with mental illness are more likely to have higher rates of: poverty; homelessness; incarceration; social isolation; and unemployment. Their needs tend to be more complex and urgent including issues such as finances and debt, essential services, housing, employment and the welfare system. Stable, good quality and rewarding employment is protective for health and can be a vital element of recovery from mental health problems. Stable and appropriate housing is another important part of the recovery pathway and can reduce the need for inpatient care.

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 NHS or the Council. To make a difference, we need to work together across the public and voluntary sector to advocate for health promotion 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 places where they live.

The contribution of citizens, users and families to improving health outcomes is central to co-production. It values what works well in an area, it sees the potential of people's knowledge and moves away from a deficit approach to recognising the assets people already have and can contribute to their neighbourhood.

In order to deliver public services with an equal and reciprocal relationship between professionals and people using services, as outlined above, new thinking and training will be required as well as a targeted commitment to work differently.

Our ambitions for Living Well

- Everyone has access to a home that supports their health

- Everyone has a fulfilling occupation and resources to support their needs

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

Everyone 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; or people 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 in Sheffield.

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, with homeless people having significantly shorter life expectancy than the rest of the population. 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 has a fulfilling occupation and the resources to support their needs

We know that one of the keys to a happy, healthy and fulfilling life in adulthood is being able to lead the life you want to. Fulfilment means something different to everyone, but having a constructive, meaningful and productive daily life is vital, whether through learning, caring, volunteering, or conventional paid work.

For most people, a good job or volunteering opportunity can significantly improve their life by offering security, rights, personal development, career progression, a supportive environment and a fair income. Equally, being unemployed or unable to work, because of caring responsibilities for example, can restrict 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 and the economy.

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 population.

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. Three-quarters of adults in working families in poverty are themselves working, with female employees as the single largest category in this group. We must also recognise that for many people, a bad job is worse for their health than no job.

For people a long way from the labour market, the contribution of intermediate labour market interventions to develop employability by acting as a bridge between unemployment and work, such as supported employment projects for those with intermittent mental or physical health problems, is particularly important.

Families with children are most likely to be locked in poverty despite being in work, especially 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 possible for some workers. 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. Longer term, we need to ensure that people have the right training to get on once in work and the opportunity to earn more to improve their living standards and reduce the need for welfare.

Everyone 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 two in every three 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 around 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 are affected disproportionately.

Walking and cycling is the most likely way that children and adults can achieve increased levels of physical activity. 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 Well

Ageing well is something that happens throughout our lives, not just in old age: Starting and Living Well contribute as much if not more to ageing well as anything that happens later in life. Despite this, 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. This sees things incorrectly: the problem is not that older people are a burden, it is that too often we leave ageing well too late in life.

For some people, later life can be marked by disability, dependency and inequality rather than offering opportunities

to continue leading a healthy and active life. 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 socio-economic conditions that shape earlier life, for example ACEs, low income, or lack of supportive social networks.

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 of these conditions are preventable or at least can be delayed, through delivering on the ambitions set out above, and by better shaping care and support around people and what matters to them.

Ageing Well 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. Our work on health inequalities in Sheffield over the past two decades, documented by successive reports from the Director of Public Health and the Sheffield Fairness Commission, has shown that later life is where health inequalities become most extreme. This can be most starkly seen through older people living isolated lives, with poor mental wellbeing.

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.

Our understanding of a healthy life must also include how it ends. Too often, we see people unable to live their last days and weeks where they want to, with their loved ones, and with the support they all need, both at that time and in bereavement. We should see a good end as being as important as a good start.

Our ambitions for Ageing Well

- Everyone has equitable access to care and support shaped around them
- Everyone has the level of meaningful social contact that they want
- Everyone lives the end of their life with dignity in the place of their choice

Everyone has equitable access to care and support shaped around them

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 live fully independent lives and the increase in demand for services far outweighs the increase in the number of older people.

The demand is, in fact, due to increasing numbers of people living with one or more long term conditions, and at younger ages. Currently, 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 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 many people in this situation are of working age.

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. There is a 15 year gap in the onset of multiple illnesses between the most and least deprived people in Sheffield.

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. Our ambition is therefore to delay and prevent multiple chronic illness, as well as ameliorating the effects.

A key starting point is to understand that a health system designed around hospitals treating people with single episodes of ill-health is not the best response to this challenge. A highly specialised, disease specific approach is not appropriate for people with multiple long-term conditions. 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. This can end up being a worse experience than the symptoms of the diseases.

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. This must be done at the community level and we must shift resources accordingly. Primary and community care has for too long been underfunded relative to the rest of the NHS, and this needs to change. The Accountable Care Partnership will be a key

partner in delivering on this ambition, but it will be the work of the whole system to truly make it a reality.

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.

Everyone has the level of meaningful social contact that they want

Evidence from the National Loneliness Strategy demonstrates the importance of meaningful social contact and the role it can play in underpinning a healthy and happy life.

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. Beyond this, evidence tells us that the most negative impacts happen when these are severe and enduring.

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 miracle cure 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, not least because of the strong connections to the other areas set out in this Strategy:

- supportive early development sets us up with the social skills and empathy to sustain relationships;

- an inclusive education offers the opportunity to develop social bonds;

- 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 and maintain relationships;

- loneliness and isolation are linked to a range of long term conditions; and

- people with good social networks are more likely to end 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. Men and women also respond differently to loneliness and social isolation with older women more likely to admit to feeling lonely.

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 may also 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 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. Targeted measures to tackle loneliness by supporting small community organisations, valuing and resourcing volunteering and linking into the intelligence and know-how of the voluntary sector will be pivotal.

Everyone 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 deprived areas are less likely to die at home than those living in more affluent areas; this is both worse for them, and more costly to provide.

Whilst frailty and chronic diseases such as coronary heart 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

We also need to consider those who are left behind. This relates both to the immediate aftermath of someone's death, such as in relation to funeral costs which can be a major source of difficulty for many people, and to the need for support and help that families have in dealing with the longer term effects of bereavement.

A good end to life should be seen as being as important as a good start, and there is a role for all partners and communities in delivering this.

Delivering on our ambitions

As we said in the introduction, our ultimate goal of reducing the gap in healthy life expectancy is a generational mission. This Strategy is focused on the foundations for achieving that goal, that are each major ambitions in themselves. It does not make many specific commitments about precisely what we need to do to achieve them, and deliberately so.

The ambitions set out in this Strategy are intentionally stretching, and we cannot pre-judge all the activity that will be necessary to achieve them. Reaching our ambitions will require not just the insight, commitment and action of the partners around the Health & Wellbeing Board, but that of all partners and stakeholders across Sheffield. In producing this Strategy, the Board commits to focusing its attention on these ambitions, using its time and resources to challenge the system in Sheffield to agree together what needs to change to get there, and then work together to do just that.

The Board's role in this will be to convene those conversations, to challenge the system to develop action plans, and then to hold all partners in Sheffield to account for delivering on the commitments they make. We will use already scheduled Board

meetings for this, and run additional events wherever necessary to ensure the development of these plans is as inclusive as possible.

Through this work we will establish:

- A set of action plans, developed with and owned by all stakeholders, setting out clearly what we need to do in Sheffield to deliver on our ambitions; and

- A set of measures, tied to and developed alongside those action plans, that the Board will use to ascertain whether the necessary change and progress is being delivered.

- An active programme of engagement (with partners in the voluntary and community sector, including Healthwatch) to enable the assets and energy of communities and citizens to be central to this Strategy.

To support this work and ensure it is focused correctly, we will engage on an ongoing basis across the city on the question of what it is to be healthy in Sheffield, feeding what we hear back from the people of Sheffield into our thinking and the work that flows from this Strategy.

Beyond this, the Board will use its position as a statutory committee of the local authority to advocate for change wherever necessary, both within the Sheffield system and upwards to central government.

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 taken from the Marmot Review and are based on the wider determinants of health and wellbeing across the life course whilst providing context and direction for tackling health inequalities.

As noted above, just as the actions to deliver on our ambitions must be developed with the system, so must the success measures. We will work with the rest of the Sheffield system to develop robust approaches to judging whether we have achieved our ambitions, and commit to publishing regular updates on our progress against them.
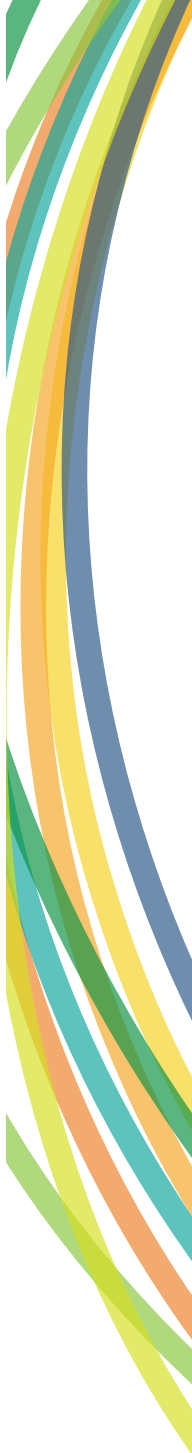
Quintiles: Best ●●●●● Worst ○ Not applicable

Indicator	Period	Sheffield			Region	England		England		Best
		Recent Trend	Count	Value	Value	Value	Worst	Range		
Healthy life expectancy at birth (Female)	2015-17	-	-	60.1	61.5	63.8	53.8			71.6
Healthy life expectancy at birth (Male)	2015-17	-	-	62.5	61.7	63.4	54.7			69.8
Life expectancy at birth (Female)	2015-17	-	-	82.4	82.4	83.1	79.5			86.5
Life expectancy at birth (Female)	2015-17	-	-	79.2	78.7	79.6	74.2			83.5
Inequality in life expectancy at birth (Female)	2015-17	-	-	8.3	-	7.4	14.3			2.0
Inequality in life expectancy at birth (Male)	2015-17	-	-	9.3	-	9.4	14.8			3.7
People reporting low life satisfaction	2017/18	-	-	*	4.9%	4.4%	-	Insufficient number of values for a spine chart		-
School readiness: Good level of development at age 5	2017/18	▲	4,451	70.3%	69.5%	71.5%	63.9%			80.5%
School readiness: Good level of development at age 5 with free school meal status	2017/18	▲	744	54.6%	54.1%	56.6%	43.0%			72.1%
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 years old 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%

Recent trends: - Could not be calculated   ▲ Increasing/Getting worse

▲ Increasing/Getting better   ▼ Increasing/Getting worse

▼ Decreasing/Getting better

Benchmark Value

Worst   25% Percentile   75% Percentile   Best
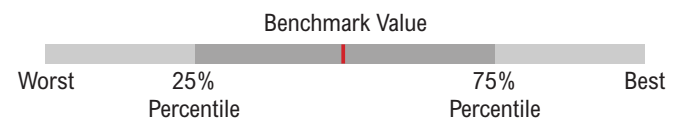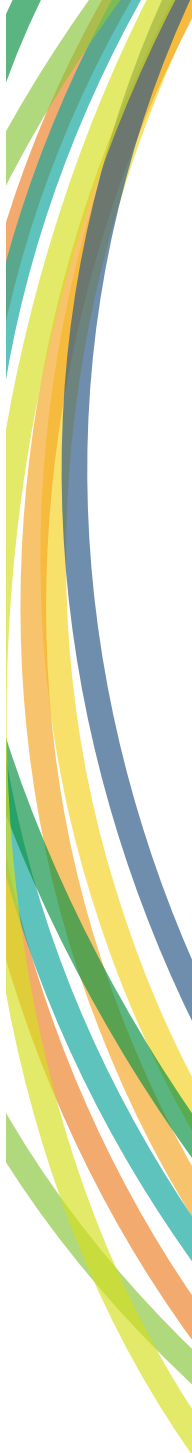
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www.sheffield.gov.uk/home/public-health/health-wellbeing-board

For more information on health and wellbeing in Sheffield
please have a look at our Joint Strategic Needs Assessment:
https://sheffielddcc.maps.arcgis.com/apps/Cascade/index.html?appid=96383090af4149b49112b66dadf2ea3a