Sheffield's
Joint Strategic Needs Assessment
2013

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Sheffield's Joint Strategic Needs Assessment 2013

Contents

Executive summary

Based on the range of evidence gathered and the key themes to emerge from the four JSNA events held in January - March 2013, the following twelve local priorities have been identified by our Joint Strategic Needs Assessment:

1. **Limit the negative impact of welfare reform:** welfare reform will have a huge impact on the City and a negative impact on health and wellbeing, both for those affected by the reforms and those affected more broadly by health inequalities. We must minimise the negative impact where possible and in particular, the potential 'double negative impact' for families with children aged under five, families with more than two children and lone parent families.

2. **Focus on housing**: Conditions in the private rented sector and fuel poverty are both real concerns in Sheffield and interventions should prioritise these two issues and those most at risk.

3. **Improve employment opportunities:** Fewer people work in Sheffield than the national average and we need to improve volunteering, training and employment opportunities, particularly for young people.

4. **Better understand mental wellbeing:** Sheffield experiences poorer levels of mental wellbeing than the national average. We need a more comprehensive understanding of the specific factors that contribute to wellbeing if we are to improve locally.

5. **Focus on leading causes of mortality and morbidity:** Long terms conditions (such as coronary heart disease and cancer) are among the leading causes of premature death in Sheffield and dementia a significant factor in increasing morbidity**.** This will have significant implications for health and social care services including acute hospital services, residential care and end of life care. These must be a priority for health and social care commissioners for the foreseeable future.

6. **Smoking** remains the largest, reversible cause of ill health and early death in Sheffield. Evidence places increasing importance on implementation of a comprehensive tobacco control programme as the key means by which to reduce prevalence of smoking in the future.

7. **Identify geographical health spend:** We need to establish how health expenditure is distributed geographically within the City and map this against geographical health outcomes. Spend should reflect our aspiration to reduce health inequalities.

8. **Develop a better understanding of health inequality by 'group':** Whilst we have good data on inequality by geography, we do not have it by group. Groups such as BME communities, children with learning difficulties, homeless people, victims of domestic and sexual abuse and carers are all reported nationally to have below average health,

but local data are lacking.

9. **Map assets:** If we are to reduce health inequalities in the City, it is not enough to know about need alone – we also need to understand what assets we have so that we can build on them.

10. **Reduce dependence on high end health and social care services:** The growth and changes in our population and balance of our investment profile means that the current service model is unsustainable. We must therefore find new ways of responding to need which places a premium on prevention, early intervention, integrated working and care in the community. Although there is a move to do this, there is still a long way to go.

11. **Acknowledge the impact of spending cuts:** cuts that are impacting on the NHS, local government and the voluntary sector cannot be overlooked and are beginning to have a negative impact on service provision. It is important to question how realistic the outcomes of the Joint Health and Wellbeing Strategy are in light of these funding changes.

12. **Measure service access and experience:** more emphasis must be placed on collecting and analysing service access and experience data. Without this, it is impossible to measure the extent to which "people get the help and support they need and is right for them".

Introducing our Joint Strategic Needs Assessment

Purpose

Our **Joint Strategic Needs Assessment** (or JSNA for short) is the means by which we assess the current and future health, care and wellbeing needs of the Sheffield population. As the name suggests, it is **joint** because it involves working with a range of partners; it is **strategic** as it will influence the Health and Wellbeing Strategy and commissioning plans; and it is a **needs assessment** because it analyses and interprets health and wellbeing need in the City.

The Health and Wellbeing Strategy has been developed to identify the key priorities to improve health and wellbeing in Sheffield. As it is important that the strategy's priorities are based on a robust analysis of need, the Health and Wellbeing Board has commissioned this JSNA to inform and, if needed, challenge its overall approach to improving the City's wellbeing.

The Health and Wellbeing Board will use the JSNA to agree priorities in order to develop the next iteration of the City's Health and Wellbeing Strategy. The strategy will be used to shape local health and wellbeing commissioning plans.

Aims and principles

The JSNA is not a decision making document.

Instead, the JSNA has three **key aims**:

1. To provide a single, comprehensive and trusted analysis of the state of health and wellbeing in Sheffield.
2. To inform, and challenge where necessary, the key priorities of the Joint Health and Wellbeing Strategy.
3. To inform commissioning decisions taken by commissioners across health and social care and the wider determinants of health and wellbeing (such as poverty, employment, education, housing, community safety and environment).

To meet these aims, we have set out a number of **key principles** that the JSNA should fulfil:

- **Accessibility** - the JSNA must be accessible to everybody with an interest in the City's health and wellbeing. It must be easy to navigate, understandable, and rooted in the real world. It must become something that commissioners use on a regular basis when thinking about service provision.

- **Robustness** - the JSNA must be based on the evidence, and trusted as the primary source of intelligence for health and wellbeing issues. There should be no claim or assertion made in the JSNA that is not backed up by evidence.

- **Focus** - the JSNA must cover the key, pressing needs in the City - this does not mean that it is exhaustive, covering every condition or every need, although comprehensive, base information upon which the assessment is made should be readily available.

- **Analytical** - the JSNA must be a document that informs strategic commissioning decisions by providing analysis and interpretation of the key issues facing the City.

- **Timely** - the JSNA must be as up to date as possible - otherwise it will quickly become of little use in informing commissioning decisions. Therefore, the JSNA should not be simply a static document produced once a year.

- **Process and product** - the process of producing a JSNA is as important as the final product, involving as wide a range of people and stakeholders as possible and drawing on as wide a range of evidence as possible.

This document

This is the first JSNA for Sheffield developed under the new Health and Social Care Act (2012). Therefore, we have adopted a very different approach from previous JSNAs in the City.

We have taken the decision to organise the JSNA around the outcomes identified in Sheffield's Health and Wellbeing Strategy as we believe this will best help us to fulfil our remit of informing the Board's approach to tackling Sheffield's health and wellbeing challenges. The document is therefore structured as follows:

Chapter 1 → Outcome 1:"Sheffield is a healthy and successful city"
This chapter analyses the wider determinants of health. It focuses on the wider factors that influence our health and wellbeing, covering issues such as employment, poverty, housing, education, the environment, transport, crime and social networks.

Chapter 2 → Outcome 2: "Health and wellbeing is improving"
This chapter focuses on mortality (death) and morbidity (illness and disability). It looks at topics such as life expectancy, the causes of premature death, long term limiting illness and disability, infant mortality, healthy lifestyles and mental health and wellbeing.

Chapter 3 → Outcome 3: "Health inequalities are reducing"
This chapter looks at health inequalities. It focuses on geographical health inequalities and assesses these in terms of life expectancy, mortality and morbidity, children's health and services.

Chapter 4 → Outcome 4: "People can get the help and support they need" and…
→ Outcome 5: "People get the services they need and they're the sort of services they need and feel is right for them."
This chapter considers services. It focuses on service demand, primary care, hospitals, adult social care, children's services, housing, VCF sector and how services will need to change in the future.

Our approach

Our starting point for this JSNA was that we needed to bring together as wide an evidence base as possible. This meant including traditional sources of evidence, such as population statistics and academic research, as well as what we term 'voice' evidence. This involved

talking with a wide range of partners and stakeholders from across the public, private and voluntary sectors to gather a range of different perspectives and experiences.

We organised this through a series of JSNA events, which were held from January – March 2013. Four events were held in total, each one centred on a different JSNA chapter.

We have triangulated the voice evidence gathered from the events with other sources of evidence and used this information to prepare our JSNA.

We know that the JSNA cannot be a static document that is updated periodically. If it is to be of real use, it must be kept up to date. Our ultimate aim is to create an online JSNA that is constantly evolving to reflect the changing evidence. Crucial to this is the development of an online data repository. This would bring together in one place all of the intelligence that we have on health and wellbeing and allow organisations in the City who have evidence on health and wellbeing needs to deposit this. Ultimately, we believe this data repository will make gathering and sharing data much easier and although this is a longer term ambition it is one to which we are committed to achieving during 2013.

1 The wider determinants of health and wellbeing

Health and Wellbeing Strategy Outcome 1: Sheffield is a Healthy and Successful City

What does the draft Health and Wellbeing Strategy say?
"Health and wellbeing in Sheffield cannot be improved by health and care services acting alone. Absolute and relative poverty is at the root of poor health and wellbeing and there is good evidence to suggest that populations which experience lower levels of income inequality are less likely to be unhealthy than in those areas where there is a much larger gap between the best off and worst off in society.**"**

The **key measures** that the Health and Wellbeing Board have identified for this outcome are:
- Increased educational attainment
- Increased and better employment
- Reduced poverty
- Better housing
- Good communities
- Use of green space

What is the issue?

The wider determinants of health are often described as the 'causes of the causes' of ill health. These wider determinants include issues such as: employment, education and skills, housing, the environment and crime, and all of them impact upon our health in one way or another. These factors are often inter-related and outside of an individual's control. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet their needs and deal with changes to their circumstances. The diagram below shows these wider determinants in more detail and according to their influence, from those at the individual level to those in wider society.

This chapter analyses the wider determinants of health. We will focus on: employment, poverty and welfare reform, education, housing, crime, the environment and social networks.

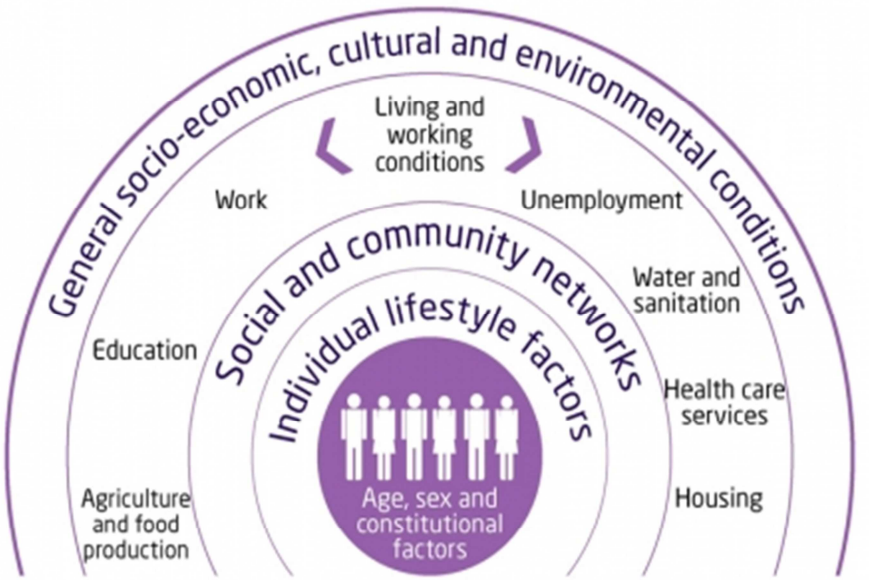


Figure 1: The Wider Determinants of Health

Dahlgren, G. & Whitehead, M. (1991) Policies and strategies to promote social equity in health. Institute for Future Studies, Stockholm. Page 8

What knowledge do we have?

Employment

1.1 There is a wide range of evidence that shows that work is good – and unemployment bad - for our physical and mental health[1].

[1] The Marmot Review: 'Fair Society Healthy Live

1.2 **Employment rate**

In Sheffield, 68.3% of the adult population (approximately 240,000 people) work. This is well below the national average of 72.9%[2]. In April 2012, 4.6% of the working age population was claiming Job Seekers Allowance (JSA), which was a fifth higher than the national average of 3.7%. Of particular significance is the increase in long term unemployment, which grew by 56% between November 2011 and November 2012 and youth unemployment, which has risen significantly from the pre-recession period (2,665 in February 2008 to 5,475 in July 2012), and far more rapidly than nationally[2]. **The long term unemployment trajectory and the issue of youth unemployment have significant implications for the health and wellbeing of the City and there is a need to support programmes which seek to address these issues. The 'Whole Household' approach being adopted within the City is one route in to doing so.**

1.3 Rates of unemployment in Sheffield vary by geography (with Hallam having an unemployment rate of 1.8% for example, whilst in Brightside it was 7.9%) and by an individual's characteristics (rates of unemployment are highest amongst those with no or few qualifications and skills, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers, young people, people with disabilities and mental ill health) [2]. **Any interventions to help people into work need to be targeted towards those areas and groups characterised by high unemployment levels.**

1.4 **Quality of employment**

As the Marmot Review argues, the quality of work matters and getting people off benefits and into low paid, insecure and health-damaging work is not a desirable option. Low paid work can result in a lower standard of living, lead to unhealthy lifestyle behaviours (such as smoking and alcohol consumption) and make it more difficult to overcome mental health problems[1]. Whilst we know that aaverage earnings in Sheffield in 2012 were £441 per week compared with £510 per week in the UK[2], it is more difficult to measure the security and quality of work. It would seem likely that there are many people whose work is characterised by long hours and pervasive job insecurity, but as there is no current way of measuring this, it is impossible to assess need. **Steps should be taken to measure the quality of work, increase awareness of the negative health impacts of 'bad work' and reduce their incidence and impact.**

Poverty and welfare reform

1.5 Poverty

As the State of Sheffield 2013 explains, the recession and on-going conditions of austerity raise serious concerns around poverty and inequalities in the City. Over one fifth of households in Sheffield are living in 'relative poverty'[3] (defined as having a household income less than 60% of the national average). It is no longer the case that work is the route out of poverty, as over 55% of children living in poverty in the UK live in a household where at least one adult is working[4], which equates to 15,000 children in Sheffield. In terms of future trends, many of those already in difficulty will potentially face even more extreme hardship; additional groups currently on the margins of poverty and new groups of households who may have been financially secure previously could have new challenges to face. The likelihood of

[2] State of Sheffield 2013, Sheffield First Partnership. 2013.
[3] Sheffield Fairness Commission Report,2012.
[4] A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives, DfE, 2011.

increasing numbers of people living in poverty presents a major challenge for improving health and wellbeing.

1.6 Financial inclusion

Financial inclusion was a major concern at our JSNA events and anecdotal evidence suggested that there had been significant growth in pay day loan companies and loan sharks in the City. This is reflective of the national picture, with demand driven by a combination of higher unemployment, low wage growth, rising fuel prices, food and transport costs and cuts in welfare spending[5]. We know that people living in poverty are most likely to use high cost credit and there is a danger that in doing so they become even more vulnerable and fall further into poverty. **The Fairness Commission recommendations around the development of affordable credit, Credit Union and financial skills for young people represent a good way forward on this agenda**

1.7 Food poverty

Rising cost of living, static incomes, changes to benefits, underemployment and unemployment have meant increasing numbers of people in the UK have hit a crisis that forces them to go hungry[6]. As the Fairness Commission report outlines, there are increasing numbers of people in Sheffield who are unable to access enough food or the right food to feed themselves and their families. Many people find fresh food expensive; struggle to access fresh food, cooking facilities and implements; do not know how to cook healthily and increasingly rely on processed and poor quality food. Nationally, there has been a 170% rise in numbers of people turning to food banks in the last 12 months, and Sheffield is no different[5]. According to the Sheffield Food Bank Network at least 11 food banks were known to be operating in Sheffield in October 2012, in comparison with 3 in early 2010[7]. The rise in food bank usage is dramatic, but predates the upcoming welfare reform, which could see numbers increase further in 2013-14. The increase in the number of food banks operating in the City indicates that food poverty is a growing problem. **It will therefore be important to ensure that there is an equitable distribution of access to this provision across the City.**

1.8 Welfare reform

Welfare reforms introduced by the Government as part of the 2010 Welfare Reform Act are already underway with more significant changes to be introduced. The overall impact is difficult to calculate at this stage, but our estimates suggest that Sheffield could lose £180m in benefits coming into the City per year[8]. There will be over forty changes to the welfare system between January 2011 and October 2013 and these will have a cumulative effect, with many households likely to be affected by more than one of the reforms. **It is worth questioning how realistic the Health and Wellbeing Board's aim of 'improving health outcomes' is given the impact that welfare reforms are likely to have, and the focus may be better placed on limiting the potentially negative impacts rather than health improvement per se.**

1.9 Welfare reforms are likely to have a negative effect on health and wellbeing and will be felt most in the areas already experiencing the poorest health outcomes[9]. Evidence suggests

[5] Centre for Economic and Social Inclusion, 2013.
[6] Biggest ever increase in UK food bank use, The Trussell Trust, 2012.
[7] Sheffield Third Sector Assembly Submission to the Fairness Commission, 2012.
[8] Estimate by Sheffield City Council.
[9] University College London Institute of Health Equity (2012) The impact of the economic downturn and policy changes on health inequalities in London. June 2012 P38

welfare reforms will impact severely on the lower half of the income distribution, those with children and those living in the most deprived communities. There is evidence that families with children aged under five, families with more than two children and lone parent families not in paid work will bear the biggest financial pain in the years ahead[10]**. It is important to ensure health and wellbeing provision in the City recognises the unequal impact of welfare reform, and in particular the potential 'double negative impact' for families with children aged under five, families with more than two children and lone parent families.**

1.10 Anecdotal evidence strongly suggests that there is very little awareness at the moment amongst those who will be affected[3]. High quality advice can have a positive impact beyond resolving the immediate crisis, including significant health benefits (particularly mental wellbeing) [11] however, the advice sector is struggling to respond to this increased demand, as it has seen reductions in local and, particularly, national funding. **Welfare reforms are still not well understood and their impacts not well anticipated by the public. Organisations are responding to this challenge but more support is needed to enable them to manage this effectively.**

Education

1.11 There is a clear association between education and health and those with better educational attainment usually experience better health. A good education can enable people to be more productive, earn a better living and enjoy a better quality of life.

1.12 **Early years**

The early years (0-5) are central to the life chances of children[12]. The Early Years Foundation Stage (EYFS) assessments[13] show that the City's performance has improved considerably since 2006, from a position of around the lowest 25% of local authority areas, to being broadly in line with the national average. Concerns were raised at our JSNA events that cuts to early years funding were contradictory to Marmot evidence and Sheffield City Council's assertions of the importance of the early years. However further investigation revealed careful impact assessment is undertaken before this type of reduction is undertaken. **Given that the early years are central to the life chances of children, any reductions in investment in this area could have a large impact and the impact of any such proposals should continue to be tested and evaluated.**

1.13 **Age 11**

At Key Stage 2, 77% of children in Sheffield achieved at least Level 4 in both English and Maths, which was below the national average of 79%. Performance has improved significantly from the (very low) 2006 position and the gap between Sheffield's performance and the national average has narrowed. **Sheffield should continue to improve its results at Key Stage 2 and continue to narrow the gap with the national average.**

1.14 **Age 16**

The key measure of educational achievement by age 16 (Key Stage 4) is the percentage of young people who achieve 5 GCSEs at grade A*-C including English and Maths. In 2012, 55.6% of Sheffield's children achieved this level, which is below the national average of 59.4%. Between 2006 and 2011, the gap between Sheffield and the national average narrowed somewhat, although the performance of other local authorities improved faster

[10] The Equality & Human Rights Commission (2012) The equality impacts of the current recession. Research Report No 47, P38
[11] The Sheffield First Partnership report on Financial Inclusion, Sheffield First Partnership, 2009.
[12] Report on Poverty and Life Chances, Frank Field, 2010.
[13] *The most comprehensive measure currently available of the educational and social development of children at the age of 5*

than Sheffield. The City's ranking out of 152 local authorities in England worsened to 139th. 2012 saw a major improvement in Sheffield's ranking position to 112th. **As with Key Stage 2, the efforts to narrow the gap with the national average at Key Stage 4 should continue.**

1.15 **Skills**

The emphasis cannot only be on formal education and there needs to be a focus on skills as well. The Sheffield skills profile now matches or exceeds national averages and outperforms most Core Cities at National Vocational Qualification levels 2, 3 and 4. The proportion of the working age population in Sheffield qualified at degree level or equivalent compares well to the national average. Employers, when asked, were clear that they needed people who were ready for work and can perform in the workplace however they stated that they could not always find this[14]. There is growing evidence that more intermediate and technical level skills are needed in the labour market, but improvements have been static in this area. **A greater emphasis on intermediate and technical level skills would be beneficial.**

1.16 Skills are not just important in getting a job but in life more widely. Information and Communications Technology (ICT) skills are particularly important as society becomes ever more reliant on ICT, whether it be for shopping, finding information or accessing services. A concern raised at our JSNA events was the proportion of the population lacking ICT skills, particularly older people. Research clearly shows the benefits of digital inclusion. As such older people should not be regarded as a' lost cause'; rather that they just need support[15]. **It is crucial that, as we become ever more reliant on ICT, this is not seen as the only option and that alternative formats are provided and support is made available for those lacking in relevant skills**.

Housing

1.17 **Quality**

Housing forms an important part of people's material living conditions and contributes to their health and their life chances[16]. Good quality housing is important for the health and wellbeing of the City's population and by the end of 2012/13**,** 91% of Council properties were up to the Government's Decent Homes standard.[17]

1.18 Whilst the Council's housing stock has received significant investment in recent years, the private housing sector has not, and a lack of investment, high demand and ageing stock are creating unsatisfactory housing conditions for a significant proportion of the City's population. Only 64% of all private housing meets the Decent Homes standard[18] and of particular concern is the private rented sector where just 55% meet this standard. A quarter of homes have Category 1 hazards[19] (hazards that pose a considerable risk to the health and safety of the household such as damp and mould growth, excess cold and overcrowding). **The poor condition of properties in the private rented sector should therefore be regarded as one of the biggest challenges facing the Council going forward, especially given the significant cuts to government funding in this area.**

[14] State of Sheffield 2013, Sheffield First Partnership. 2013.

[15] Introducing another world: Older people and digital exclusion, Age UK.

[16] The links between housing and poverty, Joseph Rowntree Foundation, 2013

[17] *This ensures that homes are warm, weatherproof and have reasonable facilities. See here for further information.*

[18] Private Sector House Condition Survey, Sheffield City Council, 2009.

[19] Sheffield Housing Strategy 2011—2021, Sheffield City Council.

1.19 **Building**

In terms of house building, the current financial crisis has meant the scale of house building has fallen substantially from pre-recession levels and this has impacted on the availability of low cost homes in the City. The number of new housing completions has fallen from a peak of 2,882 in 2007/8 to 919 in 2010/11 and the number of low cost homes provided through developer contributions (where a developer builds a number of low cost homes as part of receiving planning permission for a certain site) was only 21 in the last three years combined[19]. The lack of house building, combined with difficulties in getting a mortgage, means that more and more of the population is being forced into renting, often in the private sector, where quality is typically poorer. Paragraph 1.18 refers.

1.20 **Fuel poverty**

Fuel poverty[20] is a real issue for the City and living in cold homes can damage people's health as well as being a potentially significant problem or risk factor in relation to winter deaths, people with chronic health conditions, and mental ill-health[21].The elderly, children and those with long-term limiting conditions (which keep them at home a lot) are especially vulnerable**.** In 2010, 18.3% of households (42,190) in Sheffield experienced fuel poverty[22], which is 1.9% above the national average but the 6th lowest rate amongst the Core Cities.

1.21 The key contributory factors to fuel poverty are fuel prices, household fuel requirements, and property-related energy efficiency. Looking forward, the negative drivers are that fuel prices will continue to rise, household incomes are falling or are set to fall at the lower end; and climate change. More positively, property-related and behaviour-related energy efficiency is improving and there is increasing co-ordination of fuel poverty initiatives in the City to maximise their impact. **Realistically, fuel poverty is unlikely to be eradicated and therefore the aim should be to hold the rate of fuel poverty where it is or even reduce it by some percentage points and to ensure that interventions prioritise those households whose health is most adversely affected.**

1.22 **Homelessness**

Becoming homeless has a huge impact on people: damaging their mental and physical health; chances of finding work; attendance at training; educational attainment; and disrupting family life. Many people who experience homelessness are able to find suitable alternative accommodation and move on to a more settled life quickly. For others, homelessness can go on for some time or recur and they may need more help and support to find a settled home. The rate of homeless acceptances in Sheffield in 2011/12 was 6 per 1000 households. The national average was 2.3 per 1000 households and the average for the core cities was 4.4. This is linked to Sheffield historically having more stock then demand. In 2010 Sheffield City Council agreed a three year homeless strategy at a time when homelessness was decreasing. **The planned review of this strategy should be supported to ensure implementation in 2014.**

1.23 **Temporary accommodation**

In 2004 the government set a target to reduce the use of temporary accommodation by half by 2010. The target for households in temporary accommodation in Sheffield was 121 but by 2012/13 the actual number of households in temporary accommodation was 160. Sheffield also wants to reduce the number of households placed in bed and breakfast accommodation in an emergency and the aim is to stop using it all together. Sheffield compares well to other

[20] *A household is considered to be in fuel poverty if it needs to spend more than 10% of its income on fuel for adequate heating (usually 21 degrees for the main living area, and 18 degrees for other occupied rooms).*

[21] The Health Impacts of Cold Homes and Fuel Poverty, UCL Institute of Health Equity, 2011.

[22] Annual Review of Fuel Poverty Statistics, The Department for Energy and Climate Change (DECC), 2012.

local authorities; as at 31st September 2012 Sheffield had 0.7 families in temporary accommodation per 1000 households compared with a national average of 2.3. Homeless prevention is key to the work that needs to be undertaken to tackle homelessness and a homeless prevention plan will accompany the new homeless strategy. **The clear priorities should continue to be to reduce the use of temporary and bed and breakfast accommodation and to focus more effectively on homeless preventions**

Environment

1.24 **Area satisfaction**

Where we live and how we feel about the area can have a huge impact on our health and wellbeing. The results from the 2009 Place Survey[23] showed that Sheffield residents were generally happy with the local area and the homes they live in. Around 80% remain satisfied with the local area, whilst almost 90% are satisfied with their homes. It has been shown that places where people get along well together tend to be places where people feel safer, live longer and respond better to emergencies or unexpected events, including adverse weather events. 75% of people agreed that people from different backgrounds did get on well together in their area, once those who had no opinion were excluded. Resilience was a big issue at our JSNA events; the more resilient a community is the better it can deal with change, but we do not currently have a consistent or comparable way of measuring resilience reliably. The Place Survey was disbanded in 2009 and there is currently no replacement measure, making it difficult to assess how people feel about the areas in which they live. **Consideration should be given to exploring methods for developing reliable and timely methods for capturing information on resilience.**

1.25 **Green spaces**

Green public spaces are free for everyone to use and provide opportunities to increase physical activity, improve mental wellbeing and bring about community cohesion. They also represent a low carbon resource and are relatively low cost in terms of maintenance. Sheffield's green spaces were seen at our JSNA events as a positive asset that the City needs to build upon, but it was also stressed that there are inequalities in terms of access to green space and in terms of the quality of green spaces themselves. Sheffield's Green & Open Strategy 2010-2030 contains ambitious targets for improving access to open spaces in all areas of the City and has established the "Sheffield Standard" - a quality standard for all of Sheffield's green and open spaces. The key aims of this Standard are to ensure that Sheffield's green and open spaces are safe, accessible, welcoming and clean in all areas of the City. **45% of all the sites Sheffield City Council manage now meet the Sheffield Standard and the aim is to increase this total by a further 3% per year (approximately 30 more sites in 2013/14)[24]. Every effort should be made to ensure this local target is achieved.**

1.26 This said, more needs to be done to ensure that land outside of the Council's control is equally well maintained. Anecdotal evidence suggests that there are several sites in the

[23] Sheffield Interim Place Survey, Sheffield City Council, 2009.
[24] Sheffield's Green & Open Strategy 2010-2030, Sheffield City Council, 2010.

City that are not looked after[25]. **This land could be used in a more beneficial way and pressure should be placed on those with such land to take responsibility for it.** One specific example concerns opportunities for outdoor play for children. There is extensive evidence to illustrate the importance of outdoor play opportunities[26]. It is important for the future health of the City that play opportunities are maximized, that developers understand the importance of such provision, and that their contributions are used in a way which maximises health gain and minimises the barriers to being able to play outside (vehicles can present particular barriers , and reducing vehicle intrusion can present particular opportunities[27]). **Pressure should be exerted to ensure that green spaces not owned by the Council are well maintained and in particular this should focus on providing good quality places for children to play outside.**

1.27 **Air pollution**

Air pollution has short and long term negative health impacts, particularly in relation to respiratory and cardiovascular health, including increasing hospital admissions. The overall mortality burden estimated to be attributable to long term exposure to particulate air pollution ($PM_{2.5}$)[28], at current levels (2010-2012) within the Sheffield population, is likely to be equivalent to between 231 and 292 deaths per year.[29] The impact on mortality and morbidity is unequal however, with a disproportionate impact being experienced by the poorest, older people, the very young and people with existing heart or lung problems. There are therefore particular implications for health inequalities. Essentially poorer people are more likely to experience such pollution, usually because they live closer to major roads and industrial areas, and yet are least likely to produce it, given lower levels of car ownership or usage.

1.28 Like many other major cities in the UK, Sheffield currently breaches UK and European Union thresholds for air quality. Overall, air quality is generally improving in Sheffield, however in many areas, such as near the motorway and in the city centre, it has not improved, and some places have even experienced worsening quality. **Sheffield's 'air quality action plan' aims to improve air quality and it is important that this is delivered comprehensively across the City but with particular attention being paid to those most at risk.**

Transport

1.29 **Road safety**

In 2011 there were 1,233 recorded injury collisions, in which there were 1,692 casualties of all severities; nine people were killed; and 154 people were seriously injured. Compared with the 2005-09 average, in 2011, the number killed was 40% lower; the number reported killed or seriously injured casualties was 36% lower; and the number of children killed or seriously

[25] JSNA Event, Sheffield City Council, 2013.

[26] NICE (2012) 'A world without play' A literature review on the effects of a lack of play on children's lives. Play England

[27] The 'Playing Out' scheme in Sheffield is being piloted as part of the launch of the Council's 20mph policy. In the 'playing out' areas, relevant streets are closed to traffic for a few hours to allow children to play on the road.

[28] Particulate air pollution ($PM_{2.5}$) refers to fine particles in the air that are associated with human activity. Many are sulphates and most derive from combustion, particularly petroleum products (e.g. diesel) in vehicles.

[29] Committee on the Medical Effects of Air Pollution (2012) Statement on estimating the mortality burden of particulate air pollution at the local level – 95% confidence interval range shown.

injured was 15% lower. No child has been killed in a road collision in Sheffield since 2007[30]. **Overall, this downward trend is encouraging and these figures further reinforce the points made in paragraph 1.30 regarding the need to encourage active travel solutions such as walking and cycling as well as supporting the roll out of the Council's 20mph policy.**

1.30 Nevertheless, road traffic casualties have a particularly strong correlation with deprivation. Residential areas with the highest levels of road traffic accidents and casualties, especially amongst children, correlate broadly with levels of deprivation. In these areas, children are more likely to play in the streets due to limited suitable play areas inside or in gardens, which reinforces the need for suitable outdoor play areas. **Interventions on road safety prioritised in the areas where the casualty rates are highest should continue**. Another key statistic is that young drivers are four times more likely to be killed or seriously injured on the roads than any other road user. Projects targeted at this road user group have seen the largest reduction in casualty rates in recent years and this work needs to be continued. **Given the strong correlation between road traffic accidents and both deprivation and young drivers, interventions that target these should continue to be priorities for making Sheffield's roads safer[31].**

1.31 **Healthy transport**

Active travel, such as walking and cycling (or even taking the bus instead of the car), provide effective ways of integrating and increasing levels of physical activity into everyday life, and are associated with a number of health benefits including improved mental health, reduced risk of premature death and prevention of chronic diseases[32]. We know that around 21% of adults are physically active in Sheffield, but do not have reliable data on how many people walk or cycle although there is good provision within the City for cycle training, incorporating cycling as an everyday mode of transport and local forums for promoting active travel. **Steps should be taken to gather reliable data on active travel to help us know how many people make active transport choices and, where they are not able to do so, to promote them.**

1.32 **Accessible transport**

Anecdotal evidence from our JSNA event and evidence from the Fairness Commission highlighted that some people could not access public transport which left them feeling isolated and excluded. Those living on isolated housing estates, in deprived areas, or rural areas can be at risk of being excluded from accessing opportunities as it is often not profitable or viable to run public transport services in these areas. Similarly, people may be unable to get to the bus stop, or if they can, find getting on a bus unaided impossible. This is typically the case for older people and those with a disability. For older people, there was clear, anecdotal evidence that simply getting from A to B can be extremely difficult, especially as the cost of a taxi is prohibitive on a low income. In addition, evidence from the South Yorkshire Transport Strategy (2011-2026) indicates that feelings of safety about using South Yorkshire Transport Strategy (2011-2026) indicates that feelings of safety about using

[30] All figures - Report on road casualties on Sheffield's roads: 2011 Annual Report, Sheffield City Council.

[31] Sheffield City Council (2011) Annual Report on Road Casualties on Sheffield's Roads

[32] 'Healthy transport = healthy lives', British Medical Association, 2011.

public transport can also act as a barrier to use, particularly in terms of fear of verbal or physical abuse on buses[33].

1.33 Difficulty in accessing transport is also cited as one of the main reasons why disabled people are excluded from doing the things that other people do[34.] Local evidence indicates that transport is high on disabled people's list of concerns, with over 50% saying that transport improvements would have a positive impact on their life.[35] **Making public transport accessible is key if we are to reduce isolation and enable people to have more control over their own lives.**

Crime and safety

1.34 Crime causes poor wellbeing for communities and serious health issues for victims and their families. Sheffield is the safest major city in England in terms of the levels of violent crime experienced. Recorded crimes for violence against the person fell steadily over 2011/12 ending the year 13% lower than the year before, which equates to 793 fewer victims of violence[36]. The recent introduction of alcohol diversionary schemes for example (such as Alcohol Fixed Penalty Notice Waivers), have contributed to reducing alcohol-related anti-social behaviour and violence. Conversely, domestic abuse related reported incidents continue to increase year on year, with over 10,000 incidents in 2012/13. This should not necessarily be interpreted negatively as we know a significant number of incidents go unreported and the rise may be a reflection of increasing public awareness following national and local campaigns alongside improved police domestic abuse processes[37]. When other cities experienced riots in the summer of 2011, Sheffield remained trouble-free. The numbers of households who reported Anti-Social Behaviour (ASB) at least once during the past year reduced by 2.5% from 12,338 to 12,027 over the same period. This is equivalent to 311 fewer households affected. There is a long-established link between drug use and offending with 23% of all individuals in drug treatment in Sheffield coming through the criminal justice system/drug interventions programme route. In terms of re-offending generally, South Yorkshire Probation Trust is the top performing Trust in England and Wales at reducing reoffending, and there has been a consistent reduction in the reoffending rate of around 12% over the past 3 years. **Sheffield remains a safe city and the trends in falling crime and reoffending should be encouraged to continue.**

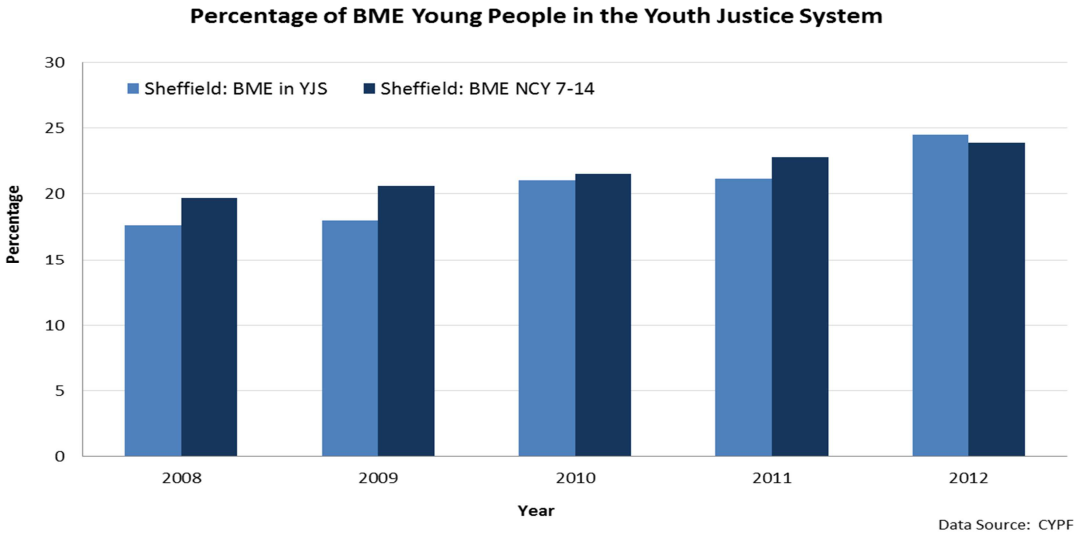
1.35 **Youth crime**

There has been a significant reduction in the number of first time young offenders over the last five years, from 1,018 in 2006/07 to 279 in 2011/12. This is in line with the national trend, although Sheffield's rate of improvement over the period has been slightly greater than in other areas. The City's rate of first time offending is now less than the national average. However, the rate of reoffending rose between 2009 and 2010. Although the latest data indicate some improvement, this stood at 33.5% in early 2003. As the graph in Figure 2

[33] http://www.syltp.org.uk/documents/SCRTransportStrategy.pdf
[34] Improving the Life Chances of Disabled People, Cabinet Office, 2005.
[35] Sheffield Fairness Commission Report, 2012.
[36] South Yorkshire Police Data, 2012.
[37] British Crime Survey (2010)

illustrates, the proportion of BME young people in the youth justice system (YJS) in comparison with the proportion of BME young people in national curriculum year (NCY) groups 7 to 14 (ages 11 to 18 years) has risen over the last four years and in 2012 the proportion in the youth justice system outstripped the proportion in national curriculum year groups 7 to 14. **The overall picture in terms of youth offending is positive, although the increasing proportion of BME young people in the youth justice system should be prioritised as an area of concern.**

Figure 2: Proportion of young people in the Youth Justice System (YJS) compared with the proportion in National Curriculum Years 7 to 14 (NCY).



1.36 **Domestic abuse**

Domestic abuse can have significant, negative impact on people's health and wellbeing and significant implications for services, particularly the NHS. Nationally 50% of women accessing services in the mental health system are survivors of domestic violence[38] and in Sheffield, 50% of people in domestic abuse support services reported mental health problems[39]. It is estimated that around 10,500 Sheffield women (16-59 years) experience domestic abuse each year although approximately 2% of victims recorded by the police are in people over 59 years of age and around 5% of victims accessing support services are men and 1% are Lesbian, Gay, Bi-sexual or Transgender[40]. Sheffield is in the process of reconfiguring the support service provision for domestic abuse victims. **A key focus will therefore be to increase the number of referrals from healthcare services, given that almost a third of individuals suffering from the physical or emotional effects of violence seek medical advice[41].**

[38] Department of Health (2003) Women's Health into the Mainstream

[39] Sheffield Drug and Alcohol Commissioning Team (DACT)data.

[40] Sheffield Drug and Alcohol Commissioning Team (DACT)data.

[41] Department of Health. Protecting People, Promoting Health (2012)

Social networks

1.37 Strong social networks are often overlooked but are in fact critical to our health and wellbeing. A lack of social interactions can be as bad for health as smoking, obesity, lack of physical activity or misuse of alcohol[42]. Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely.[43]

1.38 Anecdotal evidence from our JSNA event suggested that loneliness and isolation were big issues in the City, especially for older people, but due to the nature of isolation it is difficult to measure this. **More work should be undertaken to understand the extent of isolation in the City. The health benefits of interventions that enable people to meet new people and develop social networks should be given greater recognition in our plans.**

In summary

1.39 The **wider determinants** impact on our health and wellbeing and can lead to significant inequalities in health.

1.40 The **long term unemployment** trajectory and the issue of **youth unemployment** have significant implications for the health and wellbeing of the City. The quality of work is important for our health and steps should be taken to try and measure this and to increase awareness of the issue.

1.41 Over one fifth of households in Sheffield are living in poverty and **food poverty** is a growing concern. **Welfare reforms** will impact negatively on health and affect the poorest and more vulnerable members of the community disproportionately.

1.42 Sheffield must continue to improve its **KS2 and KS4 results** to narrow the gap with the national average. The focus must be on school age education and **lifelong learning**. One example is ICT, with those lacking in ICT skills feeling increasingly excluded.

1.43 The poor condition of properties in the **private rented sector** is one of the biggest challenges facing the Council going forward, especially given the significant cuts to government funding in this area. **Fuel poverty** is a real issue for the City and realistically we should aim to hold the overall rate of fuel poverty where it is or even reduce it by some percentage points as we are unlikely to be able to eradicate it.

1.44 How we feel about our **environment** has a real impact on our health and wellbeing but it is difficult to assess this. Sheffield's **green spaces** are an asset for the City, and it is crucial this land is well maintained and used to its full advantage. In particular it is important that **play opportunities** are maximised by providing good quality places for children to play outdoors. **Air pollution** is an issue and the 'air quality action plan' should be delivered comprehensively across the City.

[42] Social Relationships and Mortality Risk: A Meta-analytic Review, PLoS Medicine, 2011.
[43] The Marmot Review: 'Fair Society Healthy Lives, UCL Institute of Health Equity, 2010.

1.45 The trend in **road traffic collisions** is encouraging although there is a strong correlation with deprivation and young drivers. Interventions targeting these aspects should continue to be priorities. Reliable data on **active travel** is critical if we are to know how many people make active transport choices and to help target where to promote them where such choice are not possible. Making **public transport accessible** is key if we are to reduce isolation and enable people to have more control over their own lives

1.46 Overall, Sheffield is a relatively **safe city** but too many people do not feel safe when walking alone at night and this is an area that warrants greater attention

1.47 More work needs to be undertaken to understand the extent of **isolation** in the City, the way in which it impacts on health and wellbeing and the health benefits of interventions that enable people to meet new people and develop **social networks** (such as lunch clubs for older people).

Priorities:

1. **Limit the negative impact of welfare reform:** Welfare reform will have a huge impact on the City and a negative impact on health and wellbeing, for both those affected and health inequalities more broadly. We must minimise the negative impacts where possible and in particular the potential 'double negative impact' for families with children aged under five, families with more than two children and lone parent families.

2. **Focus on housing**: Conditions in the private rented sector and fuel poverty are both real concerns in Sheffield and interventions should prioritise these two issues by focussing on those most at risk.

3. **Improve employment opportunities:** Fewer people work in Sheffield than the national average and we need to improve volunteering, training and employment opportunities, particularly for young people.

2 Health and wellbeing

Health and Wellbeing Strategy Outcome 2: Health and Wellbeing is Improving

What does the Health and Wellbeing Strategy say?
"Health and wellbeing in Sheffield has improved in the past few decades and we have the highest male life expectancy and the third highest female life expectancy of the eight biggest cities outside London. People in all parts of the City are living longer, deaths from major illnesses, especially heart disease and cancer, have reduced markedly and there has been a reduction in the number of people, particularly children, killed or seriously injured on our roads. However, there are significant differences in the life expectancy between our least and most deprived communities as a result of wider social and economic influences."

The key measures that the Health and Wellbeing Board have identified for this outcome are:

- Increased healthy life expectancy
- Reduced infant mortality
- Improved lifestyle choices
-Increased wellbeing

What is the issue?

Health in Sheffield has improved significantly in the past few decades. People in all parts of the City are living longer and deaths from major illnesses, especially heart disease and cancer, have reduced. However, there are a number of areas of concern, such as infant mortality rates, unhealthy lifestyles, dementia and poor mental health and wellbeing that will require concerted action over the coming years if this trend in improving health and wellbeing is to be maintained.

This chapter considers mortality and morbidity. We will focus on: life expectancy, the main causes of premature death, long term limiting illness and disability, infant mortality, healthy lifestyles and mental health and wellbeing.

What knowledge do we have?

Life expectancy

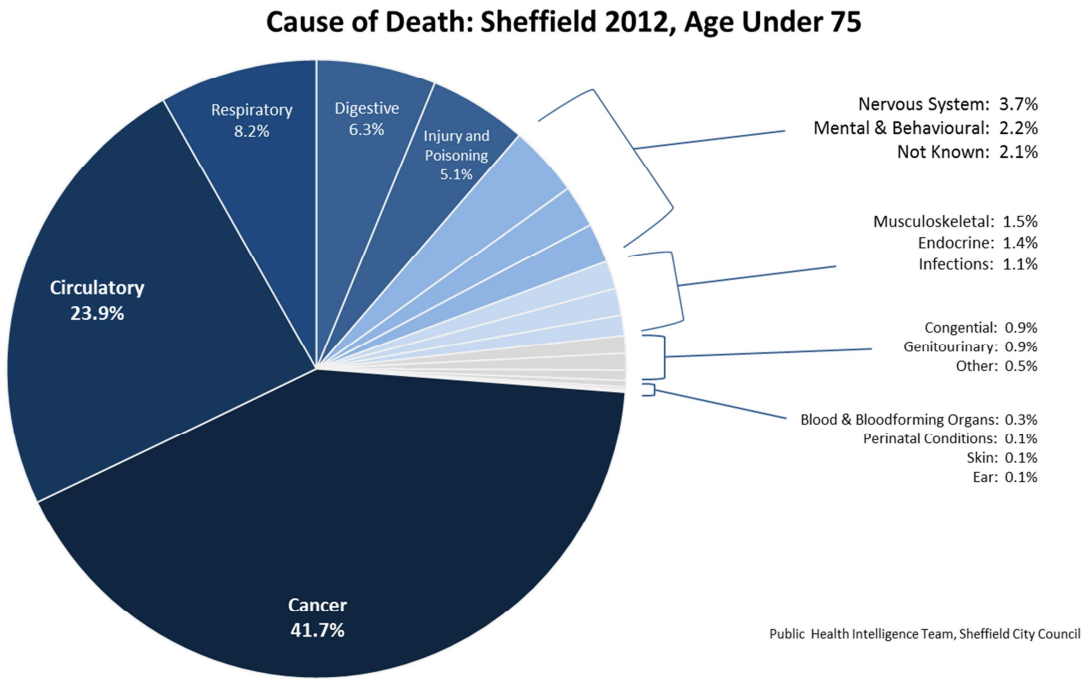
2.1 One of the key indicators of health and wellbeing is life expectancy. Currently (2008-2010) in Sheffield average life expectancy at birth is 78.1 years for men and 81.8 years for women – a gap of 3.7 years between the genders. In 1975-77 life expectancy was 69.7 years for men and 75.8 years for women with a gap between the genders of 6.1 years. As well as year on year improvements in life expectancy therefore, the gender gap has also narrowed. The narrowing of the gap is almost certainly linked to changes in employment patterns (especially types of work) and smoking habits. Comparing Sheffield to available England data shows that Sheffield's life expectancy rates remain lower than the national average of 78.5 years for men and 82.5 years for women[44]. **Sheffield should seek to improve life expectancy for men and women further, so as to bring it in line with the national average whilst seeking to maintain the narrowing of the gender gap.**

[44] Sheffield Director of Public Health report 2011 – http://www.publichealthsheffield2011.nhs.uk

The main causes of premature death

2.2 If one of our key ambitions for improving health and wellbeing is to increase life expectancy in line with the national average then we need to understand the factors that will contribute most to achieving that increase. We can see the main causes of premature death in Sheffield in the chart below.

Figure 3: The main causes of premature death in Sheffield



2.3 **<u>Cancer and cardiovascular disease</u>**

It is clear that cancer and cardiovascular disease (such as heart attacks and strokes) account for around two thirds of premature deaths, which is consistent with the national picture. For all cancers, the premature mortality rate is equivalent to almost 600 deaths a year. Whilst this represents a continuing decrease, it is higher than the national rate, but the lowest rate amongst the eight Core Cities[45]. The leading causes of cancer are smoking, alcohol and diet. For cardiovascular disease the local rate equates to around 340 deaths per year, which is higher than the national rate but again the lowest of the Core Cities. An additional 50 lives per year would need to be saved to bring us in line with the national rates. The leading causes of cardiovascular disease are high blood pressure, smoking and diet. **Cancer and cardiovascular disease are the leading causes of premature death in Sheffield and make a major contribution to the gap in life expectancy between the City and England as whole. As such these diseases, and the principal factors that cause them, should continue to be prioritised within health improvement plans.**

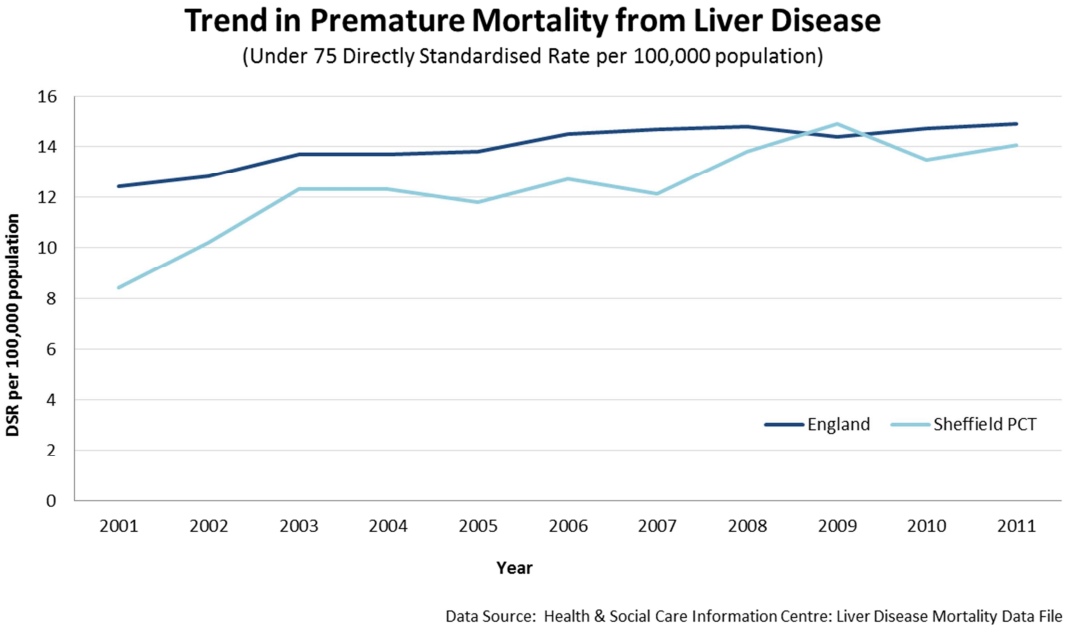
[45] *The Core Cities are the economically most important cities outside of London in England. They are: Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham, and Sheffield.*

2.4 Cardiovascular outcomes are the strongest indicator of the overall effectiveness of local prevention programmes[46]. Both 'cardiovascular premature mortality' and 'cardiovascular premature mortality considered preventable' rates in Sheffield are higher than England (66.7 versus 62.0 per 100,000 population, and 46.0 versus 40.6 respectively in 2009-11). However, both measures are within the 25th percentile range of the England average and second only to Bristol of all the Core Cities. All have premature mortality rates within the 25th percentile range from the England average and so the overall preventable premature mortality rate for the City lies quite close to the England average (155 versus 146 per 100,000 population in 2009-11). Over the last decade, cardiovascular premature mortality has reduced at a significantly faster pace in Sheffield than that experienced by England or the Core Cities. The picture is similar for the other major causes of premature mortality considered preventable, such as cancer. **We should focus our efforts on maintaining and, where possible, escalating this trend.**

2.5 **Liver disease**

One preventable disease area that merits closer attention however is liver disease. Although Sheffield liver disease mortality is currently in line with the national average, this masks the fact that premature deaths in Sheffield have been increasing at a much faster rate than experienced in England overall, although the most recent data show a decline.

Figure 4: Trend in premature liver disease mortality



[46] This is because these are sensitive to a wide range of primary prevention measures (related to smoking, diet, alcohol, physical activity and air pollution), secondary prevention of cardiovascular disease and diabetes (such as drug treatments) and tertiary prevention (for example hospital-based cardiac and stroke care and rehabilitation).

Estimates of the present make up of annual liver related deaths in the City show that alcoholic liver disease deaths predominate. Problem alcohol consumption also contributes to fatty liver disease, liver cancer and pancreatitis.[47] **This means ensuring that measures aimed at early liver disease detection and treatment are prioritised as a key means of reducing problem alcohol consumption and maintaining a reduction in premature liver disease mortality.**

Long term limiting illness and disability

2.6 Living with a long term illness or disability can limit a person's ability to cope with everyday life, lead to significant health and social care needs and impact significantly on mental health and wellbeing, especially depression. As average life expectancy has increased, so the demands on services that deal with longer term and chronic disease and disability have increased; and this trend is expected to continue.

2.7 **Neurological conditions**

10 million people in the UK are affected by a neurological condition and neurological conditions are the most common cause of serious disability[48]. They have a major, but often unrecognised impact on health and social care and 17% of GP visits and 19% of hospital admissions are for a neurological problem (mostly stroke, epilepsy, dementia, headache, head injury and multiple sclerosis)[48]. The number of people with neurological conditions will grow sharply in the next two decades due to improved survival rates and better health and social care. **Comprehensive and up-to-date local data on neurological conditions is needed if we are to accurately assess need and to determine where best to focus interventions for improvement.**

2.8 **Dementia**

There are currently around 6,400 people living with dementia in the City but this is expected to rise to over 7,300 by 2020 and 9,300 by 2030, with the biggest increase in people aged 85 and over. The population distribution varies with age across Sheffield's neighbourhoods with the majority of people aged 85 and over living in Chapeltown, Burncross, High Green, Mosborough and across the south west of the City. It is especially important to target these areas with regard to planning for dementia care[49]. The anticipated rise in the number of people with dementia represents significant need and this will be particularly great in areas that have higher numbers of older people.

2.9 Around one third of people with dementia currently live in largely private sector care homes, and the trend is towards entering care with more severe disease. Unpaid carers (mainly female family members) provide the majority of care in the community. If current policies remain in place, by 2025 the demand for this type of care home accommodation is predicted to increase by 55% with 71% of the increase coming from people aged 85 and over. **There will be a significant increase in demand placed on the health and social care system in Sheffield and as such dementia should be regarded as a top local priority.**

2.10 Early intervention can be cost effective and improve the quality of life for people with dementia and their families and carers, through enabling people to access suitable support

[47] Deaths from Liver Disease, NHS End of Life Care Programme, March 2012.
[48] Neuro Numbers, Neurological Alliance, 2003.
[49] Sheffield Dementia Health Needs Assessment, 2011.

services, delay or prevent premature and unnecessary admission to care homes[50].

- Carer support and counselling at diagnosis can reduce care home placement by 28%.
- Early provision of support at home can decrease institutionalisation by 22%.
- Active case management can reduce admissions to care homes by 6%.
- Investing in preventative approaches helps maintain older people's independence and wellbeing and contributes to efficiencies within the health and social care system.
- Improving the experience of hospital care for people with dementia will assist in taking forward the reform agenda[51].

Sheffield has been chosen as an early adopter of the Prime Minister's Dementia Challenge where the focus will be on creating dementia friendly communities. To support this work a local Dementia Action Alliance will be established. **Overall therefore the key priorities should be to increase awareness and understanding of dementia and promote early diagnosis and intervention.**

2.11 Diabetes

In Sheffield around 1,000 new cases of diabetes are diagnosed every year and diabetes prevalence is expected to continue to rise for the foreseeable future. In spite of the rate of increase there is evidence that diabetes care is improving in the City. For example, the proportion of diabetes patients with good control of their blood sugar level, according to their GP record, has improved from 63% in 2009 to 73% in 2012[52]. This means that Sheffield has a favourable profile in terms of preventable morbidity and mortality outcomes and the individual disease contributions to that; especially so for a city population. **The challenge for the City will be to at least maintain this favourable trend over the coming years in the context of economic and migration pressures and an ageing population.**

2.12 Chronic obstructive pulmonary disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term that is used to describe conditions including chronic bronchitis and emphysema. COPD leads to progressive damage to airways in the lungs causing them to become narrower and making it increasingly hard to breathe. It is an incurable yet largely preventable disease. With early diagnosis and the right interventions, the disease can be slowed down allowing people to live healthy and active lives for longer. The most important risk factor is smoking, followed by social deprivation, diet, occupational exposure to fumes/dust, indoor pollutants such as smoke from wood and coal fires, and in some cases, inherited faulty genes. The number of people dying from COPD in Sheffield has remained relatively unchanged over the last few years. Recorded prevalence of the disease is 1.8% of the total Sheffield population, lower than the regional average of 1.9%. However, it is estimated that there are an additional 2.4% people (approximately 10,520) aged over 16 who are undiagnosed with COPD. **We therefore face the continuing challenge of identifying undiagnosed patients and referring them for early intervention and treatment, both to increase survival rates and reduce the significant ill health burden sufferers can face.[53]**

[50] Impact assessment of the National Dementia Strategy, The Department of Health, 2009.
[51] Evidence from the Sheffield Teaching Hospitals NHS Foundation Trust audit
[52] Public Health Outcomes Framework 2013-2016, Public Health England.
[53] COPD Dashboard: NHS Sheffield, Yorkshire and Humber Public Health Observatory (YHPHO), 2011.

2.13 **Learning disabilities**

People with learning disabilities often face significant disadvantages in terms of their health and wellbeing. These can include shorter than average life expectancy, higher rates of avoidable or preventable ill health, unequal access to or low uptake of services and poorer outcomes in relation to the wider determinants of health and wellbeing such as employment or independent living. [54] Sheffield has a higher rate of people with learning disabilities than the national average – this relates both to adults (18-64 years) where the rate is 5.17 per 1,000 people registered with a GP compared with 4.33 nationally, and to children where 35.20 per 1,000 known to schools have a learning difficulty compared with 24.61 nationally[55]. There is local evidence that these rates are all increasing[56]. **As such commissioners will need to ensure services across the range of health, housing and social care (including prevention, early intervention, specialist care and transition from child to adult services) are able to respond to increasing numbers and need.**

2.14 The health and wellbeing of people with learning disabilities in Sheffield is generally on a par with the average for other people with a learning disability in England with some notable exceptions. For example, we know that people with a learning disability have been found to be 25% more likely than the general population to be admitted to hospital as an emergency, particularly for physical health conditions that would not necessarily require a hospital admission[57]. However, the emergency hospital admission rate for people with a learning disability in Sheffield (2010/11) is significantly lower than the national average. This relates both to admissions for physical and mental health needs[58]. Despite this finding however, more recent local data concerning the proportion of eligible adults (18-64 years) with learning disability who receive a GP check on their health has decreased in Sheffield from 58.7% in 2010/11 to around 45% in 2012/13[59]. Whilst Sheffield uses the entire learning disabled population in this calculation (so a larger population than just 18-64 year olds is used) this could be indicating less effective primary care for people with learning disabilities. **Trends in both GP health checks and emergency admission rates for people with learning disabilities should remain under surveillance to ensure appropriate action is taken as required.**

2.15 In terms of broader health and wellbeing outcomes, a lower than average proportion of people with a learning disability in Sheffield live in settled accommodation (68% of all adults with a learning disability in Sheffield compared with 70% for England) or are in paid employment (5.9% of all adults with a learning disability in Sheffield compared with 6.6% for England)[60]. Overall however the key concern is that the median age at death of people with learning disabilities in Sheffield is 46 years compared with 55 years in England[61]. This represents a significant gap, or health inequality, both between Sheffield and the rest of the country and between people with learning disabilities and the general population. **As such,**

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[54] Improving Health and Lives: Learning Disabilities Observatory – www.gov.uk/government/organisations/public-health-england

[55] Data relate to January 2011. For children all four levels of learning difficulty are included (i.e. specific, moderate, severe and profound). Learning Disability Profiles (2012). Public Health England.

[56] Sheffield Joint Strategic Needs Assessments for 2008 and 2010.

[57] Glover, G. and Evison, F. (2013) Hospital admissions that should not happen: admissions for ambulatory care sensitive conditions for people with learning disabilities in England. Learning Disabilities Observatory.

[58] Data relate to the period 2010-11. Learning Disability Profiles (2012) Public Health England

[59] Sheffield City Council – Adult Social Care Services performance data (2013)

[60] Public Health Outcomes Framework (2012) – Public Health England

[61] Data relates to the period 2010-2011. Learning Disability Profiles (2012). Public Health England

improving life expectancy for people with learning disabilities should feature as a key priority for improving health and wellbeing in Sheffield.

2.16 **Autistic spectrum disorders (ASD)**

There are as many as 6,000 adults with Autistic Spectrum Disorders (ASD) locally[62] and we know this is the fastest growing area of 'primary need' in Sheffield.[63] Whilst some adults with autism live fulfilling lives, contributing to their communities, the economy and their own families, too many are not able to do this, and are dependent on benefits and on the care and support of their families.[64] Those without this support are at increased risk of physical health and mental health problems, homelessness, of being involved in crime, and of addiction. Autism is approximately four times as common in men as in women[65] and it is significantly higher in adults with a learning disability - approximately 19% of adults with a learning disability have autism.[66] **There is a need for further work to better understand the number and needs of local adults with autism, improve the sensitivity of local services to people with autism, increase awareness within strategic planning and establish a local diagnostic pathway.[67]**

2.17 **Sensory impairments**

Sensory impairments can have negative consequences for people's health and wellbeing, and often lead to significant formal and informal caring costs. They affect older people disproportionately and can have a particularly serious impact on this population group in terms of social isolation and depression.[68] In Sheffield around 2,600 people are registered blind or partially sighted (broadly on a par with national averages) and just over 700 people are registered as deaf or hard of hearing[69]. Despite this, over 40% of people over 50 years of age, for example, are estimated to experience some kind of hearing loss, rising to over 70% in people over 70 years. [70] Sensory impairments are also on the increase with the leading causes of blindness and partial sight loss and hearing loss estimated to grow by around 14% every 10 years. [71] Sensory impairment will therefore be an issue of growing importance.

2.18 A significant proportion of problems with hearing and sight can be prevented, treated or reduced yet the biggest problems faced are the degree of under-diagnosis of people with such problems, low levels of referral to appropriate services and, in certain cases, low uptake of relevant specialist screening services. This suggests there may be much greater numbers of people in Sheffield with such problems and these are increasing year on year. **A more detailed assessment of sensory impairment is currently being undertaken and this should be used to identify the priorities for responding to this area of need.**

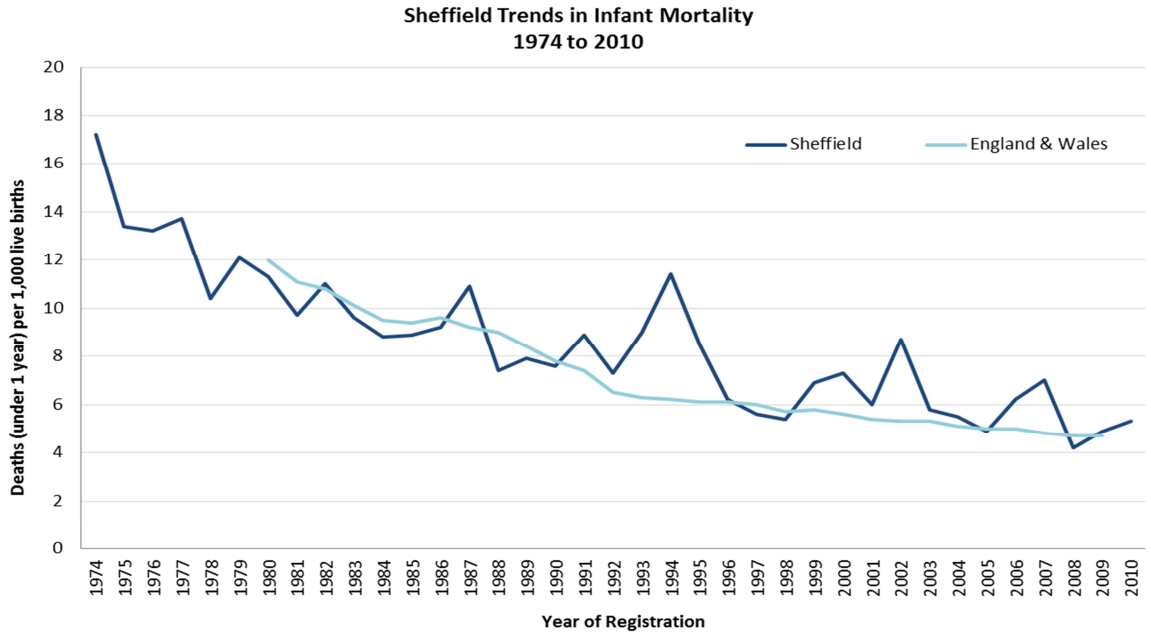
[62] National Autistic Society projections
[63] Comprehensive Health and Wellbeing Needs Assessment for Children and Young People with LDD (Learning Disabilities or Disabilities), The Consultancy Company, June 2009.
[64] Fulfilling and rewarding lives: the strategy for adults with autism in England, 2010.
[65] "Estimating the prevalence of autism in adults: Extending the 2007 Adult Psychiatric Morbidity Survey", NHS Information Centre for Health and Social Care, January 2012.
[66] Sheffield Case Register records
[67] Autism Strategy Implementation Plan, Sheffield City Council, 2013.
[68] UK Vision Strategy and Action on Hearing Loss 2011.
[69] Older People's Atlas, West Midlands Public Health Observatory 2012 – now part of Public Health England.
[70] Older People's Atlas, West Midlands Public Health Observatory 2012 – now part of Public Health England.
[71] Older People's Atlas, West Midlands Public Health Observatory 2012 – now part of Public Health England.

Child and maternal health

2.19 Infant mortality

Whilst not as great in terms of overall numbers of deaths, infant mortality (deaths in babies under the age of 1 year) impacts significantly on the overall average calculation of life expectancy. Currently the Sheffield rate is 5.2 per 1,000 live and still births (2011) compared with a national rate of 4.3 per 1,000 and is ranked fifth of the eight Core Cities[72]. As the graph in Figure 5 shows, since falling significantly between 2007 and 2009, the infant mortality rate in Sheffield has been rising slowly, widening the gap with national outcomes. **Bringing infant mortality rates in line with the national average must be a priority for Sheffield.**

Figure 5: Sheffield trends in infant mortality



Data Sources: Public Health Common Data sets 1990-2002 , 2003 onwards Public Health Births & Deaths files . OPCS VS1 1986-, SD52 & SD52A 1968-1985, pre 1968 from Annual Reports of Medical Officer of Health

2.20 Survival rates for babies born prematurely have increased significantly. Table 1 shows survival to discharge for babies born between 20 and 32 weeks in three time epochs; from the entire Trent region in 1996, from Jessop Wing figures from 2001-2, and from the North Trent Neonatal Network in 2008-10.[73]

[72] Public Health Outcomes Framework (2012) – Public Health England

[73] *Due to data collection discrepancies, figures cannot be calculated purely for Sheffield. Although some of these figures are regional, they are reflective of the general trend in Sheffield over this period.*

Table 1: Percentage survival to discharge for babies born between 20 and 32 weeks

Gestational age (weeks)	Trent 1996	Jessop Wing 2001/2	NTNN 2008-10
23	2.7	16.7	34.3
24	28.0	68.4	54.2
25	36.5	70.8	77.4
26	55.3	80.0	85.7
27	71.0	74.0	90.6
28	79.7	88.2	97.5
29	86.5	95.5	98.3
30	89.9	93.3	99.4
31	93.4	96.4	99.6
32	96.5	98.7	99.4

Data Source: CYPF

2.21 The increase in survival over time is apparent. It has been particularly marked for younger age groups, although survival figures at more mature ages increased marginally. The increasing survival rates of premature babies in the City is clear, and although the percentage increase is small in the more mature ages, numerically the increase in survivors, particularly at the lower gestational ages (e.g. 2.7% at 23 weeks in 1996 to 34.3% in 2008-10, 79.7% at 28 weeks in 1996 to 97.5% in 2008-10) is significant.

2.22 One in every thousand new babies dies as a result of Sudden Unexpected Death in Infancy (SUDI). Whilst the overall numbers of SUDI are low, this is more than double the national average. **SUDI has been highlighted in the Infant Mortality Strategy as an area requiring specific concerted action.**[74]

2.23 It is widely accepted that the health of a baby is crucially affected by the health of its mother[75]. The following risk factors are identified in our Infant Mortality Strategy as priorities for Sheffield:[74]

- Maternal obesity is a factor in around 30% of still births or neonatal deaths (and approximately 35% of maternal deaths). The trend in the proportion of Sheffield women who are obese or morbidly obese is almost 22% and is increasing.

- The percentage of Sheffield mothers smoking at delivery was lowest in 2009-2010 (13.6% equivalent to around 860 mothers). Over the last three years this has increased to 14.1% (just over 900 mothers). This increase runs counter to the national trend.

- Sheffield's teenage pregnancy rate has reduced significantly over the last few years and now stands at 35.2 per 1,000 births in girls aged 15-17 years (2011). It has been consistently the lowest of the Core Cities but in the latest period is third and remains above the national average of 30.7.

- Breastfeeding significantly increases a child's chances of being healthy throughout life as well as conferring health benefits on the mother. In 2012/13 the percentage of mothers initiating breastfeeding was 77.7% however, by 6-8 weeks after birth, only 50.8% of babies were continuing to be breastfed.

[74] Sheffield Infant Mortality Strategy and Delivery Plan, NHS Sheffield, 2011.
[75] The Marmot Review: 'Fair Society Healthy Lives, UCL Institute of Health Equity, 2010

- The incidence of infant mortality (2009/2010) in the Asian & Asian British ethnic group (13.4 per 1,000 live births) in Sheffield is more than double the incidence for the White ethnic group (5.5 per 1,000 live births) and the rate in the Black and Black British group (10.9 per 1,000 live births) is almost double that for the White ethnic group[76].

Interventions that will have the greatest impact on reducing infant mortality will focus on reducing maternal obesity, smoking at delivery, teenage pregnancies and increasing breastfeeding.

Healthy lifestyles

2.24 Certain lifestyles and behaviours, linked to the way we live our lives, are leading to a rise in the incidence of diseases such as cardiovascular disease, diabetes, liver disease and cancer. Unhealthy or risky lifestyles put people at greater risk of suffering from acute and chronic disease, leading to increasing need for health and social care and poorer health and wellbeing outcomes including premature death. Sheffield is not immune to this trend and there are significant and in some cases increasing, levels of need in our population. **Primary prevention interventions that promote healthy lifestyles and provide help and support to individuals and communities are critical to efforts to reduce mortality and morbidity from chronic conditions**

2.25 **Smoking**

Smoking remains the largest, reversible cause of ill health and early death in Sheffield. It is estimated that smoking related illness costs Sheffield up to £151.5m every year[77] and overall accounts for approximately 900 deaths in the City each year; around almost 84% of all deaths from lung cancer; 86% from COPD; and 15% from cardiovascular disease. [78] It is estimated that currently 21.5% of the adult population (aged 18 years and over) smoke, which is slightly higher than the England average, (20.7%) but the second lowest among the Core Cities (range 21.3% - 27.8%). Smoking prevalence varies by occupation and by area. For example, in 2009/10, the estimated smoking prevalence in routine and manual workers (32.7%) was significantly higher than that in the population as a whole (23.4%). Smoking is also estimated to range from around 40% of the adult population in the most deprived areas of Sheffield to just under 13% in the least deprived areas.[79]

[76] Sheffield Child Death Overview Panel 2009 and 2010

[77] The cost of local tobacco control. ASH (2012)

[78] Sheffield Tobacco Control Strategy, 2009/10.

[79] Data based on local modelling, SCC public Health intelligence Team.

2.26 For several years now, approaches to reducing smoking in the adult population have centered on the Department of Health's four-week quit target. As a result over 90% of resources available for tobacco control have been focused on the provision of stop smoking services[80]. Whilst there is evidence that these services offer value for money, rates of stopping smoking in Sheffield are the lowest in the region, although compare favourably alongside the national average[81]. The underlying level of smoking in Sheffield however remains virtually unchanged. It is therefore becoming clear that a comprehensive Tobacco Control Programme is now the only effective way to achieve further and greater reductions in smoking prevalence[82]. Across South Yorkshire work has been undertaken with the University of Sheffield to help determine the correct balance of funding for a local Tobacco Control Programme in order to achieve optimum improvement in health within available resources. **The results of this work should be used to inform the Sheffield tobacco control commissioning plans.**

2.27 **Alcohol**

Alcohol consumption is linked to over 60 different medical conditions including liver disease, mouth, throat and other cancers, neurological conditions (including dementia), poor mental health, reduction in fertility, as well as acute conditions resulting from accidents, self-harm and violent assault. In Sheffield, 85.8% of people aged over 16 years are estimated to drink alcohol, higher than the national average of 84.5% and the other Core Cities. Sheffield has an estimated 51,000 'high risk' drinkers[83] and around 6,500 people are admitted to hospital each year due to alcohol-attributable conditions. Whilst the number of adults accessing local community alcohol treatment increased by 6% between the years 2011-12 and 2012-13, given the prevalence of high risk drinkers in Sheffield, efforts to increase the number of people accessing alcohol treatment year on year will be essential[84]. **Our alcohol strategy should continue to focus on a range of approaches for tackling this issue, notably promoting screening and identification of people with alcohol related problems, including those from specific population groups (such as 18-25 year olds, Lesbian, Gay, Bisexual and Transgender people and people in the criminal justice system) to increase the number of individuals engaging with alcohol treatment alongside reducing the accessibility of alcohol, in line with government guidelines.** [85]

[80] All Party Parliamentary Group Report – Inquiry into the effectiveness and cost effectiveness of tobacco control (2010)

[81] NHS Stop Smoking statistics (Dept of Health) 2012-13

[82] http://www.who.int/tobacco/mpower/en/ - such programmes would include protecting people from exposure to second hand smoke, reducing the availability and supply of illegal tobacco products and help for those who want to quit.

[83] 'High risk drinkers' – with an average weekly alcohol consumption of more than 50 units for men or 35 units for women

[84] Sheffield Drug and Alcohol Commissioning Team (DACT) data on access to community treatment (SEAP and structured treatment)

[85] Sheffield Alcohol Strategy 2010-14 - http://www.sheffielddact.org.uk/Professionals/StrategicDocuments.aspx

2.28 Drug misuse

Drug misusers often suffer from multiple vulnerabilities including poor physical and mental health, offending behaviour, homelessness or inadequate housing, lack of education and unemployment. The latest data show there has been a reduction in the prevalence of people using opiates/crack cocaine in Sheffield (the second lowest rate of the core cities) with around 4,000 problematic opiate and/or crack drug users in the City (15-64 years)[86]. In 2012-13 over 2,200 opiate users accessed structured drug treatment and over 300 individuals accessed treatment for non-opiate drug misuse. This represents a decrease of 4.7% between 2011/12 and 2012/13 and is larger than the 2% national average decrease[87]. The emphasis on maintaining the numbers accessing drug treatment is therefore increasingly centred on the engagement of individuals using non-opiate drugs with treatment, particularly those using steroids, cannabis and the new psychoactive substances. **A specific focus on certain population groups (i.e. young people, Lesbian, Gay, Bisexual and Transgender people) is required both in terms of recognising when drug use has become problematic and to ensure drug treatment services are accessible.**

2.29 Drug treatment

The Public Health Outcomes Framework (2012) shows that Sheffield compares favourably with the England average for those successfully complete drug treatment in a year and do not re-present to treatment services within 6 months of completing their treatment. In 2011 8.5% of opiate users and 38.8% of non-opiate users in Sheffield achieved this outcome compared with 8.6% and 39.5% in England[88]. Local activity has however decreased in 2012/13 to 7.2% (opiate) and 38.8% (non-opiate) **[89].** The number of young people accessing drug and alcohol treatment has also declined from 155 (rolling 12 months) in April 2012 to 107 in March 2013[90]. These services however have a high level of planned discharges from substance misuse interventions, at 88% in Sheffield compared with 79% nationally[91]. **Overall, completions from drug treatment must remain an area of focus.**

2.30 Drug related mortality

In the past drug misusers were at high risk of death from an overdose. More recently however there has been a shift in the pattern of cause of death towards people dying of long term conditions such as Hepatitis C or venous disease due to their substance misuse. The number of people screened for blood borne viruses continues to increase with 94% of all new people arriving into structured treatment offered a Hepatitis B vaccination and 94% of injecting or previous injectors recorded as receiving a Hepatitis C test[92]. **Harm reduction must remain a priority, particularly in relation to increasing the numbers screened, tested and referred for blood borne virus treatment.**

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[86] Hay, G., Anderson, R. and Millar, T. (2013) Estimates of the prevalence of opiate and /or crack cocaine use (2010-11)

[87] Sheffield Drug and Alcohol Commissioning Team data

[88] Public Health Outcomes Framework (2012) – Public Health England

[89] Diagnostic Outcomes Monitoring Executive Summary – Sheffield. Public Health England (May 2013)

[90] National Drug Treatment Monitoring System (NDTMS) May 2013

[91] Successful completion rates/planned exits are not comparable with the measure for adults. The direct comparison is that 41% of all drug treatment episodes are successful in adult treatment services in Sheffield compared with 43% nationally. Green reports for young people, adults and England. Public Health England May 2013.

[92] Sheffield Drug and Alcohol Commissioning Team (DACT)data.

2.31 **Obesity**

Obesity, poor diet and increasingly sedentary behaviour are associated with higher risk of hypertension, heart disease, diabetes and certain cancers. By 2015 it is estimated that obesity will cost Sheffield £165m per year. In terms of childhood obesity, in 2010/11, 22.7% of 4-5 year olds and 34.7% of 10-11 year olds were classed as overweight or obese[93]. Overweight and obesity levels for both of these age groups have increased over the last four years, in line with most other areas of the country. In terms of people aged 16 years and over in Sheffield 23.7% are estimated to be overweight or obese[94]. This is slightly lower than the national average of 24.2% but the 4th highest out of the eight Core Cities. Although reflective of the national picture, Sheffield's rising trend in both adult and childhood obesity is worrying and poses a major risk to health.

2.32 Obesity is typically caused by unhealthy food choices and sedentary behaviour. Sheffield has poor levels of diet and nutrition and it is estimated that only 25% of Sheffield adults eat five or more portions of fruit or vegetables a day, lower than the national average of 28%. Estimates suggest that around 580 deaths in Sheffield a year could be prevented if diets complied with national nutritional guidelines. In Sheffield around 18.7% of adults were estimated to be physically active in 2005/06 rising to 21.6% in 2011/12[95]. **Lower than average levels of healthy eating are key to Sheffield's increasing prevalence of obesity and although Sheffield has slightly higher than average levels of physical activity, the level is still too low and there is considerable room for improvement.**

2.33 **Sexual health**

The consequences of poor sexual health include unplanned pregnancy, avoidable illness and mortality from Sexually Transmitted Infections (STIs) and HIV/AIDS. Sheffield is ranked 83 out of 326 local authorities[96] in England for rates of STIs in 2011. 4,350 acute STIs were diagnosed in Sheffield residents, a rate of 783.1 per 100,000 residents of which 70% were 15-24 year olds[97]. The burden of sexual ill health is not equally distributed in the population but concentrated amongst the most vulnerable including men who have sex with men, young people and BME groups.

[93] National Child weighing and measuring programme, 2010-2011.

[94] Public Health Outcomes Framework (2012) – Public Health England

[95] Sport England 'Active People' data

[96] *N.B first in the rank has the highest rates*

[97] Sexually transmitted infections epidemiology report, HPA Sheffield Local Authority, 2011

2.34 Evidence from our local health needs assessment indicates we should maintain focus on reducing teenage conceptions, unplanned pregnancies and prevalence of STIs/HIV through increasing access to contraception and STI/HIV testing, specifically for high risk groups, alongside a focus on health promotion and education (especially peer education[98]) to improve public awareness and encourage safer sexual behaviour. Key to achieving good sexual health outcomes is the commissioning of universal open access sexual health services via a 'hub and spoke' model which focuses on the development of community based outreach sexual health services.[97] Services need to be fully integrated to offer patients a single point of access, pathways between primary and secondary care services should be prioritised and organisations should work collaboratively to look at how new and existing services and interventions can meet the needs of our local population. **Sheffield's sexual health interventions must focus on reducing teenage conceptions, unplanned pregnancies and prevalence of STIs/HIV.**

2.35 **Oral health**

Tooth decay is the main oral health problem affecting children in Sheffield, and has significant impacts on the daily lives of children and their families including pain, sleepless nights and time missed from school and work. In 2007/8, the average number of decayed, missing and filled primary (baby) teeth for 5-year-old schoolchildren was 1.66, which was higher than the average for the Yorkshire and the Humber region (1.51) and for England (1.11). Of the 41% of children with experience of tooth decay, each child had an average of 3.8 affected teeth[99]. For 12-year-old Sheffield schoolchildren in 2008/9, the average number of decayed, missing and filled permanent teeth was 0.97. This was lower than the average for the region (1.07), but higher than the average for England (0.74). Of the 41% of children with experience of decay or its management, the average number of teeth affected was 2.4[100]. Within the City, there are inequalities in the distribution of tooth decay between wards. In 2011/12 for example, the average number of decayed teeth in some wards was eight times higher than in other less deprived wards of the City. The wards with the highest decay experience currently include Burngreave, Central, Southey and Darnall. **The main risk factors for tooth decay are diets high in sugars and lack of exposure to fluoride therefore tooth decay is largely preventable. Local data should continue to be used to inform oral health improvement strategies.**

2.36 We currently do not have comprehensive, good quality local data on lifestyles. In order to develop a more detailed understanding of how lifestyles vary and are changing across our population, we need a local population survey or access to the data held on GP clinical information systems. This would support an integrated and targeted approach to achieving improvements where they are needed most and support setting this work in the context of people's daily lives. **Comprehensive local data on lifestyles is needed if we are to have a detailed understanding of how they vary and are changing across our population.**

Mental health and wellbeing

2.37 People with good mental health and wellbeing tend to experience lower rates of physical and mental illness, recover more quickly when they do become ill (and for longer) and

[98] Our JSNA Events highlighted peer education in particular as a successful sexual health intervention

[99] NHS Dental Epidemiology Programme 2008

[100] NHS Dental Epidemiology Programme 2009

generally experience better physical and mental health outcomes. Good mental health and wellbeing also represents a significant asset in terms of underpinning broader outcomes such as educational attainment and employment opportunities.[101]

2.38 **Wellbeing**

In 2012 the Office for National Statistics carried out a national survey of subjective wellbeing or 'happiness index'. For Sheffield this confirmed pre-existing evidence that feelings of wellbeing are generally at their lowest in the working age population and higher among younger and older people. Looking at the four key indicators measured in the survey however, Sheffield's wellbeing is poorer than the average for England, and significantly so in terms of the percentage of people reporting low levels of feeling happy.[102]

Table 2: Estimates of subjective wellbeing

Indicator	Sheffield	England
% of respondents with a low score of satisfaction with life	26.1%	24.3%
% of respondents with low score of feeling that things they do are worthwhile	21.1%	20.1%
% of respondents with low score of feeling happy yesterday	31.3%	29.0%
% of respondents with high score of anxiety yesterday	42.3%	40.1%

Data Source: Annual Population Survey, April 2011 – March 2012, Office for National Statistics

2.39 Mental wellbeing can positively affect almost every area of a person's life – relationships, family, education and employment. It can help people achieve their potential, realise their ambitions, cope with adversity, work productively and contribute to their community and society. Improving mental wellbeing is supported through universal approaches to encourage understanding of the behaviours and interventions that can promote wellbeing and enhance resilience[103].

2.40 Those groups in the population most at risk of mental ill-health include: people who are at risk of being homeless; new and expectant mothers (e.g. post-natal depression); people misusing alcohol and other substances; people undergoing significant life stresses (such as debt or bereavement); people with a long term health problem or limiting illness; prisoners and people in contact with the criminal justice system; survivors of abuse or people who were in care as children; and asylum seekers and refugees.[104] **Clearly, if we are to promote improved mental health and wellbeing within the general population, we need to combine**

[101] HM Government: No health without mental health, a cross government mental health outcomes strategy for people of all ages. 2011. London:HM Government.

[102] Department of Health (2012) Improving outcomes and supporting transparency. Part 2: Summary technical specifications of public health indicators.

[103] New Economics Foundation & NHS Confederation (2011) Five Ways to Wellbeing – new applications, new ways of thinking. New Economics Foundation, London.

[104] Government Office for Science. Mental capital and wellbeing:making the most of ourselves in the 21st century – Foresight Report, 2008.

universal approaches which raise awareness and understanding and reduce the stigma around mental illness with the need to identify those people within our local population most at risk of developing mental health problems and to develop and target health promoting interventions directly to them.

2.41 Children's mental health

Half of adult mental health problems start before the age of 14. Early intervention to support children and young people with mental health and emotional wellbeing issues is vital and local authorities have a duty to co-operate to promote wellbeing among children and young people; Looked after Children are particularly at risk of developing mental health problems.[105] The main indicator used to measure emotional wellbeing in Looked After Children (aged between 4-16 years) is the total difficulties score. The average score for Sheffield's Looked After Children is 15.4% which is considerably higher than the average for England at 13.9% and is the second highest average score of the Core Cities.[106] **Early intervention to support children and young people with mental health and emotional wellbeing issues is vital and particular attention must be paid to Looked After Children, especially given Sheffield's high total difficulties score.**

2.42 Mental ill health

Mental health problems are common, with one in four people experiencing a mental health problem in their lifetime and around one in one hundred people suffering a severe mental health problem. [107] In relation to common mental health problems, such as depression and anxiety, around 12.27% of Sheffield adults are estimated to have depression compared with 11.68% in England. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for individuals, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. [108] In terms of severe mental illness (such as psychosis or severe depression) the latest figures for Sheffield (2011-12) suggest that the number of people with a psychosis (all ages) registered with a Sheffield GP practice was approximately 4,500. When considered as a percentage of all people registered with a Sheffield GP, this represents 0.80% which is on a par with the England average of 0.82%[109].

2.43 Excess mortality and morbidity

People with a severe mental illness have a threefold increased risk of premature death than those without such an illness and a reduced life expectancy of approximately 16 years for women and 20 years for men. Although suicide accounts for around 25% of these deaths, physical illnesses account for the other 75% with cardiovascular disease being the most common cause of premature death in people with mental ill health and diabetes the most

[105] No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages, HM Government, 2011

[106] Public Health Outcomes Framework 2013-2016, Public Health England.

[107] HM Government: No health without mental health, a cross government mental health outcomes strategy for people of all ages. 2011. London:HM Government.

[108] Community Mental Health Profiles (2012). www.nepho.org.uk/cmph

[109] The Information Centre for Health and Social Care: Compendium of Clinical and Health Indicators. http://indicators.ic.nhs.uk/webview/

significant cause of increased ill health.[110] Smoking rates in people with mental health problems are, on average, twice as high as those in the general population. As such, smoking related illness and early death is also greater[111]. In addition people with mental health problems have over three times the odds of losing their teeth than the general population. Contributory factors include lack of motivation/self-care, poor oral hygiene, fear, costs, problems accessing a dentists and side effects of many psychiatric drugs. Wider health risks may be exacerbated as poor oral health can be linked to physical health problems including stroke, cardiovascular disease and diabetes[112], [113].

2.44 The excess premature mortality rate in Sheffield people with a mental illness (988 per 100,000 population) is higher than that for England (921 per 100,000 population). The mortality rate from suicide and undetermined injury however, at 6.45 per 100,000 population (2009-2011) is much lower than the average for England (7.87 per 100,000 population)[114]. In the recent National Audit of Schizophrenia (2012) while Sheffield had the second best record nationally for avoiding prescribing more than one antipsychotic drug and the best for not exceeding recommended doses, it was ranked lowest in the sample of service users for having their weight monitored in the previous 12 months and was below the national average for checking blood pressure, smoking status and alcohol intake, and general physical health monitoring.[115] **There is therefore good national and local evidence to indicate that more can and should be done to promote better physical health and wellbeing in Sheffield people with mental health problems[116],[117].** This is why Sheffield's 'Right First Time' programme now includes a specific project on physical health and severe mental illness where the emphasis is firmly on reducing inequalities in mortality and morbidity among people with mental health problems.[118]

2.45 **Treatment**

Treatment and early intervention can help to minimise the impact of mental illness and improve overall wellbeing. The majority of treatment for mental ill health is delivered through general practice with more severe or enduring problems referred on to secondary health care. Admissions to hospital for a mental health condition should be avoided, where appropriate, through the use of early intervention for first episode of psychosis, assertive community based services and crisis teams. A high number of people in contact with mental health services may indicate a particularly high prevalence in the population, but it may also therefore reflect good

[110] De Hert M, Dekker JM,Wood D,et al. Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association, supported by the European Association for the Study of Diabetes and the European Society for Cardiology. *European Psychiatry*. 2009;24:412-24.

[111] Sheffield Tobacco Control Strategy 2009/10

[112] Chapple IL. The impact or oral disease upon systemic health – symposium overview. Journal of Dentistry 2009;37:S568-71

[113] Kiesley et al The British Journal of Psychiatry (2011) 199, 187-93.

[114] Public Health Outcomes Framework (2012) – Public Health England

[115] National Schizophrenia Audit (2012)

[116] Curtiss JH and Newall et al (2012) The heart of the matter: cardiometabolic care in youth with psychosis. Early Intervention in Psychiatry. 6(3) 347-53

[117] Lester H. Shires DE. Et al (2012) Positive Cardiometabolic Health Resource – an intervention framework for patients with psychosis on antipsychotic medication. Royal College of Psychiatrists. London.

[118] Right First Time – working together to transform Sheffield's health and social care services. www.sheffieldccg.nhs.uk

recognition and diagnosis of conditions and availability of appropriate treatment services in line with best practice in acute care and recovery pathways[119].

2.46 The hospital admission rate for mental ill health in Sheffield (2009-10 to 2011-12) is significantly higher than the England average at 388 per 100,000 population compared with 243 per 100,000. This is particularly the case for schizophrenia, schizotypal and delusional disorders. In addition, people from some BME communities are twice as likely to be admitted to in-patient mental health services and up to five times more likely to be compulsorily admitted under the Mental Health Act[120]. Conversely however, Sheffield has lower than average numbers of adults using mental health services; numbers on the Care Programme Approach[121]; and number of contacts with a Community Psychiatric Nurse.[122]

2.47 There is also evidence from our JSNA events to suggest that demand for medium to longer term community based counselling and therapy is increasing significantly at a time when both the public and voluntary sector provision is experiencing difficulties. Pilot funding in some parts of the country has been made available to extent 'Improving Access to Psychological Therapies' (IAPT) to those with major mental health problems. **These areas require more detailed analysis, particularly within the context of a refreshed mental health needs assessment and the 'Right First Time' programme.**

2.48 **Outcomes**

Improving outcomes is the aim of all mental health services in line with the NHS Mandate. There is little data available however about patients following their use of mental health services, although recovery rate following treatment by IAPT services is one such direct indicator. For existing IAPT services, Sheffield is on a par with England on this indicator with 46.6 per 1,000 of Sheffield adults referred into IAPT for mild to moderate mental health problems on the road to recovery in 2011-12 compared with the national average of 43.8 per 1,000. **Nevertheless, there is potential for this to be significantly better given that the best rate in the country is 65 per 1,000 [123] and this reinforces the need to improve measurement of post treatment outcomes and consider cross organisational and cross pathway data sharing on reducing mortality, improving quality of life, readmission rates and patient safety and experience measures.**

2.49 Taking the wider determinants of health into account, again outcomes for people with mental health problems are less good than the general population. For example, in 2011-12 while the proportion of people in contact with mental health services who live independently was steadily improving in Sheffield and better than average (73.5% in Sheffield compared with 66.8% in England) the proportion in employment remained stubbornly low at 7.7% compared with 9.5% nationally[124]. Similar to people with long term conditions or learning disability, low

[119] NICE Guideline – Psychosis and Schizophrenia in Adults (2013) Update – forthcoming.

[120] Mental Health Needs Assessment (2009) – NHS Sheffield and Sheffield City Council.

[121] The Care Programme Approach is a way of co-ordinating community mental health services for people with severe and enduring mental health problems. It involves carrying out a comprehensive assessment and producing a care plan for each patient

[122] Community Mental Health Profile for Sheffield (2012). www.nepho.org.uk/cmhp

[123] Community Mental Health Profile for Sheffield (2012). www.nepho.org.uk/cmhp

[124] The figures quoted are taken from the Public Health Outcomes Framework (2012). More recent local data suggest that the proportion in settled accommodation is 85.5% and just 5.5% for those in employment (Sheffield Health & Social Care Foundation Trust, March 2013)

level of employment remains a major cause of deprivation and inequality for this population group.

In summary

2.50 Sheffield average **life expectancy** at birth is 78.1 years for men and 81.8 years for women. Whilst this represents a longstanding trend of year on year improvements, both remain lower than the national average of 78.58 years for men and 82.57 years for women.

2.51 In terms of the major killers, **cancer and cardiovascular** disease account for around 60% of premature deaths in Sheffield, consistent with the national picture. For both the premature mortality rate from all cancers and cardiovascular disease, Sheffield has the lowest rates amongst the Core Cities but figures remain higher than the national average. We are detecting a worrying upward trend in both ill health and mortality linked to **liver disease**.

2.52 We currently have around 6,400 people living with **dementia** in the City, and this is expected to rise to over 7,300 by 2020 and over 9,300 by 2030. Early diagnosis and intervention improves quality of life and can delay or prevent premature and unnecessary admission to care homes.

2.53 The **infant mortality** rate in Sheffield is 5.2 per 1,000 live and still births (2011) compared with a national rate of 4.3 per 1,000. Infant mortality has been slowly rising, widening the gap with national outcomes.

2.54 **Smoking** remains the single largest, reversible cause of ill health and early death in Sheffield. Continued action is required here and across a range of unhealthy or risky lifestyle issues in Sheffield including alcohol consumption, drug use, levels of child and adult obesity, diet and nutrition, physical activity and sexual health.

2.55 1 in 4 people will experience a **mental health** problem at some point in their life. In terms of severe mental health problems, Sheffield has a higher excess premature mortality rate for people with a severe mental illness than England as a whole and may also experience poorer levels of wellbeing. Promoting mental health and wellbeing for all is crucial to achieving health and wellbeing outcomes across the board.

Priorities:

4. **Mental wellbeing:** Sheffield experiences poorer levels of mental wellbeing than the national average. We need a more comprehensive understanding of the specific factors that contribute to wellbeing if we are to improve it.

5. **Focus on the leading causes of mortality and morbidity:** Long terms conditions (such as coronary heart disease and cancer) are among the leading causes of premature death in Sheffield and **dementia** a significant factor in increasing morbidity**.** This will have significant implications for health and social care services including acute hospital services, residential care and end of life care. These must be a priority for health and social care commissioners for the foreseeable future

6. **Smoking** remains the largest, reversible cause of ill health and early death in Sheffield. Evidence places increasing importance on implementation of a comprehensive tobacco control programme as the key means by which to prevalence of smoking in the future.

3 Health inequalities

Health and Wellbeing Strategy Outcome 3: Health inequalities are reducing

What does the Health and Wellbeing Strategy say?
"This outcome is about focusing on those people and communities who experience the poorest health and wellbeing. People in the most deprived parts of Sheffield still experience a greater burden of ill health and early death. If we are to address some of the major health and wellbeing issues affecting Sheffield today, we need to focus on those people and communities who experience the poorest health and wellbeing.**"**

The **key measures** that the Health and Wellbeing Board have identified for this outcome are:

- Reducing health inequalities
- Improved access to health for different groups
- Improved outcomes for disadvantaged groups
- Improved environment for different geographical areas

What is the issue?

3.1 Sheffield is characterised by stark inequalities between different groups of people and between different geographical communities. People in the most deprived parts of the City still experience a greater burden of ill-health and early death than people in less deprived areas, demonstrating that inequalities in health and wellbeing are linked to wider social, cultural and economic issues. It is acknowledged that putting additional support into the most disadvantaged areas and raising standards there will have a beneficial effect on the whole community.[125] Currently however we do not know the extent to which the distribution of resources is linked to the distribution of need.

3.2 However the concept of the inverse care law presented by Tudor Hart in 1971[126] is relevant in a system likely to be affected more prominently by market forces such as the system that currently exists. This concern is re-iterated in the Fairness Commission recommendation which states '*Health and Wellbeing Board partners from the Clinical Commissioning Group and Sheffield City Council must ensure that health spending across the City is more fairly utilised based on the relative needs of the communities. This includes making services more accessible and appropriate to groups who currently underuse services*'. **The Health and Wellbeing Board needs to establish if health-spend across the City is following the clearly identifiable health inequalities.**

3.3 Whilst we have good data on inequality by geography, we do not have it by group. Groups such as 'Looked After Children', children with learning difficulties and disabilities, some BME communities, migrant and asylum communities, homeless people, victims of domestic and sexual abuse, carers and lesbian, gay, bisexual and transgender people, are all reported nationally to have below average health, but local data are lacking. These 'communities of interest' are not all contained within the geographical inequalities already identified, although there is a strong enough correlation for us to deal

[125] Clustering of unhealthy behaviours over time: Implications for policy and practice, King's Fund, 2012.

[126] Hart, J. T. (1971) The Inverse Care Law. The Lancet. i. 405-12

predominantly with the geographical perspective within this chapter.

This chapter analyses health inequalities. We will focus on: geographical inequalities in terms of life expectancy, morbidity, children's health, the wider determinants and service access.

What do we know?

3.4 Overall, the health of the City continues to improve and people in all parts of the City are living longer. However, whilst it is easy to think of Sheffield as a whole, there are many differences within the City and health inequalities are a persistent problem.

Life expectancy

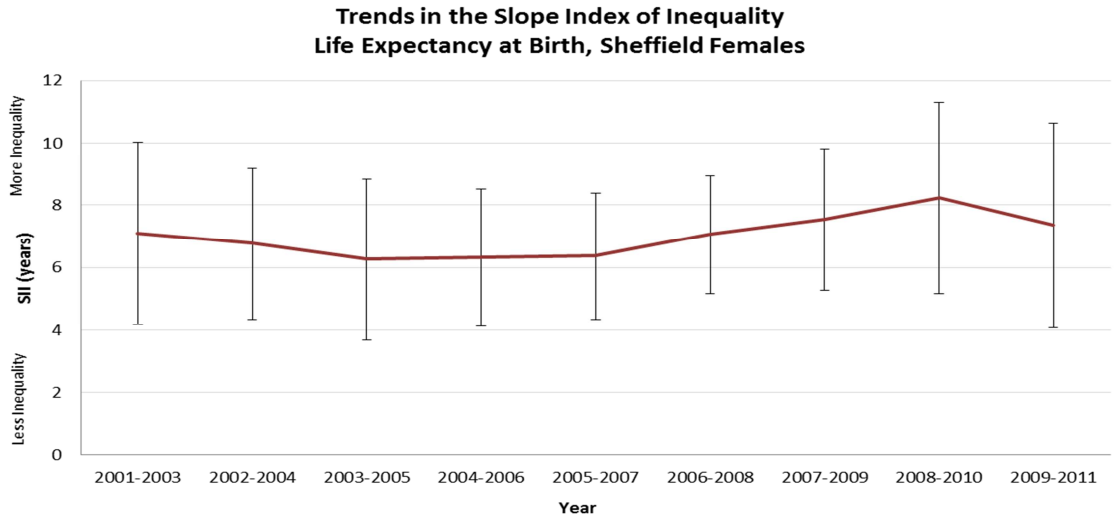
3.5 **Inequalities in life expectancy by area**

The 'Slope Index of Inequality in Life Expectancy' measures the gap (in years) in life expectancy between the most and least deprived people in the area. The gap in life expectancy between the most and least deprived people in Sheffield is 8.6 years for men (2008-10) and 8.2 years for women (2008-10).

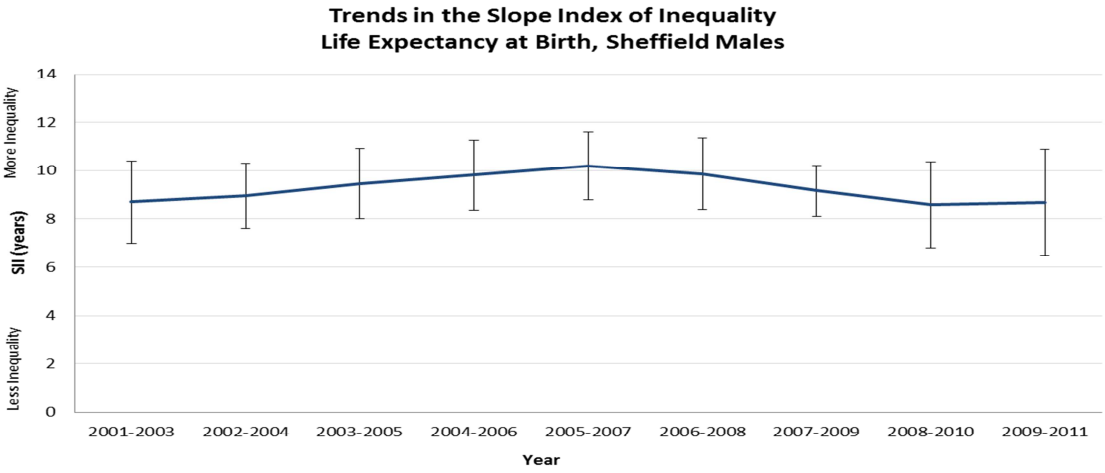
3.6 **Inequalities in life expectancy over time**

Sheffield trends in the gap in life expectancy for the period 2001-2003 to 2008-2010 are shown separately for men and women in Figure 6. The overall trend is one of the gap in life expectancy narrowing for men and widening for women. Possible explanations for this gender difference include changes in occupational patterns, smoking behaviour, alcohol consumption and the prevalence of obesity. **Whilst the narrowing of the gap in life expectancy for men is encouraging, the increasing inequality in women's life expectancy is of concern and should be prioritised.**

Figure 6: Changes in the inequalities in life expectancy



Source: Sheffield Director of Public Health Report 2011, Public Health Intelligence Team

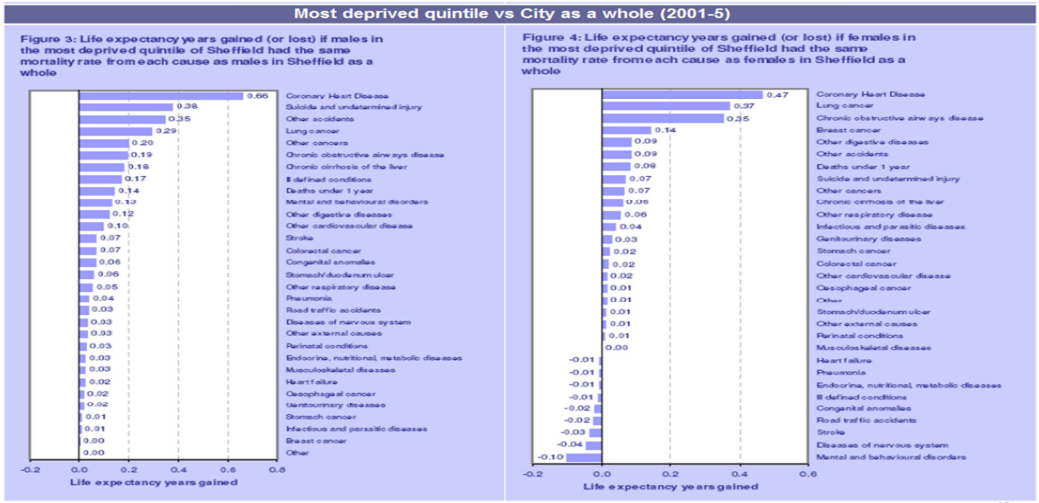


Source: Sheffield Director of Public Health Report 2011, Public Health Intelligence Team

Mortality and morbidity

3.7 We know, both from local data such as the 'Sheffield Health and Illness Prevalence' surveys, as well as from elsewhere, that inequality in morbidity across the City is every bit as great as inequality in mortality.[127] Although this source of information is now dated and there is a need for a more recent assessment, we know that generally speaking, if we were to map the distribution of a range of health conditions, such as coronary heart disease or preventable cancers, the inequalities in outcomes would replicate those of life expectancy. In particular, we have looked at the potential gains in male and female life expectancy that could be achieved if men and women in the most deprived parts of the City experienced the same level of mortality as men and women in the rest of the City. As the two charts in Figure 7 illustrate, the top three greatest gains in life expectancy for the poorest men in Sheffield are to be made in improving outcomes in relation to coronary heart disease, suicide and undetermined injury, and other accidents. For the poorest women, the top three gains are in improving outcomes in relation to coronary heart disease, lung cancer and chronic obstructive pulmonary disease[128].

Figure 7: Life expectancy gains



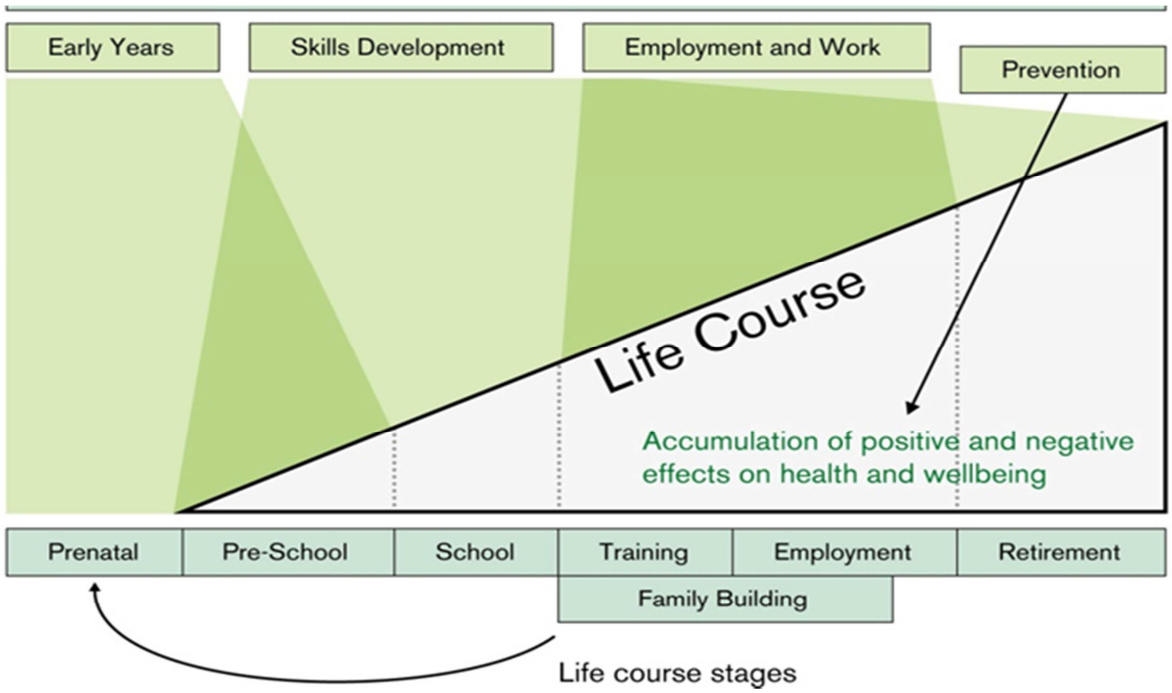
[127] Sheffield Health and Illness Prevalence Survey (2002) www.sheffield.nhs.uk/healthdata/resources/shaips2.pdf

[128] Public Health Intelligence Team (Sheffield City Council) based on methodology developed by the Department of Health

Children's health

3.8 There is a wealth of evidence that shows health inequalities start very early on in life and then accumulate throughout the life course.[129] Giving every child the best start in life is therefore crucial to reducing health inequalities across the life course. Whilst children and young people growing up in Sheffield today are generally healthier than ever, there are wide variations across the City. Two examples, infant mortality and obesity, are highlighted.

Figure 8: Accumulation of positive and negative effects of health and wellbeing over the life course



Source: Marmot Report 2010

3.9 **Infant mortality**

Sheffield's infant mortality rate currently stands at 5.2 per 1,000 live and still births (as discussed in chapter two). However, there is much variation within the City. Between the 'best' and 'worst' wards there is a four-fold difference in infant mortality rates. Although, the slope index of inequality shows that inequalities in the infant mortality rate have reduced over the last 10 years, the current inequality gap remains large. As noted in Chapter 2, there is a strong relationship between infant mortality, deprivation and ethnicity[130].

3.10 The differences in infant mortality are, in large part, reflective of varying maternal lifestyle behaviours. For example, the proportion of mothers breastfeeding in Sheffield varies significantly with as few as 42% of mothers in some areas breastfeeding compared with over 90% in other parts of the City. Similarly, in terms of smoking, there is a seven

[129] The Marmot Review: 'Fair Society Healthy Lives, UCL Institute of Health Equity, 2010

[130] Public Health Outcomes Framework (2012) – Public Health England

fold difference at Community Assembly level in the proportion of women who are smoking 'at delivery'[131]. **Tackling the four fold difference in infant mortality rates between the best and worst wards in the City should be a priority. The focus should be on changing maternal behaviours in the more deprived areas.**

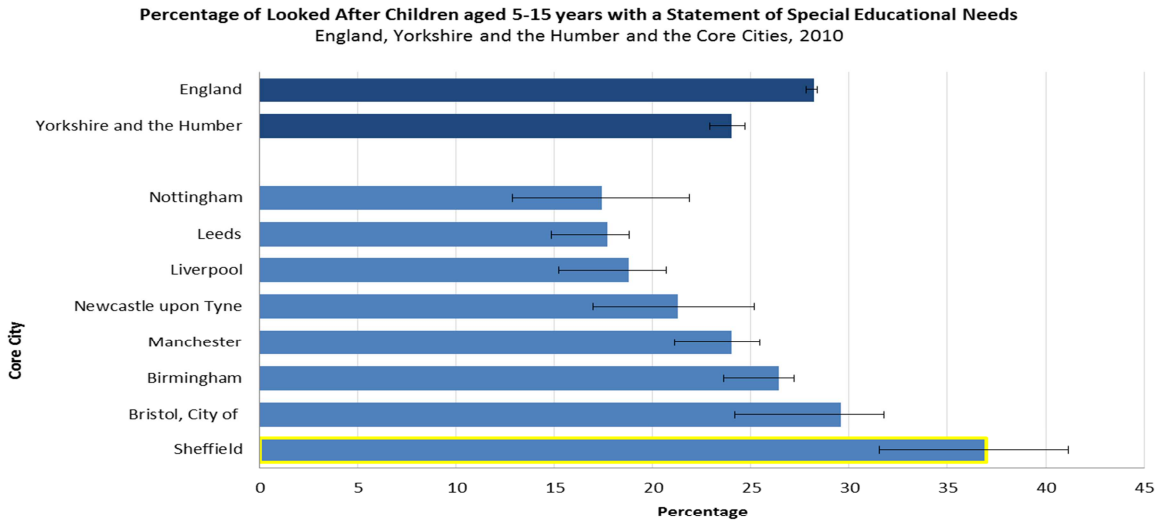
3.11 Obesity

For those aged 4-5 years (2009-10 and 2011-12), there is an inequalities gap of 9.5% in overweight and obesity prevalence between the most (25.8%) and least (16.2%) deprived children in Sheffield. The Slope Index of Inequality pooled over three years shows that approximately 82.1% of variation in overweight and obesity prevalence may be explained by the level of deprivation. For children aged 10-11 years (2009-10 and 2011-12), there is an inequalities gap of 15.1% overweight and obesity prevalence between the most (41.4%) and least (26.3%) deprived in Sheffield. The Slope Index of Inequality for Year 6 data pooled over three years shows that approximately 84.9% of variation in overweight and obesity prevalence may be explained by deprivation[132]. **Interventions focused on reducing childhood obesity must recognise the clear and significant relationship between deprivation and obesity**

3.12 Looked After Children

One specific group of children who experience inequalities, and warrant particular attention, are Looked After Children. Looked After Children are a priority group in Sheffield as Figures 9 and 10 show. Given this evidence, it would seem apparent that Looked After Children will continue to require significant support from health, social care and educational support services.

Figure 9: Percentage of Looked After Children (5-15 years) with a statement of SEN

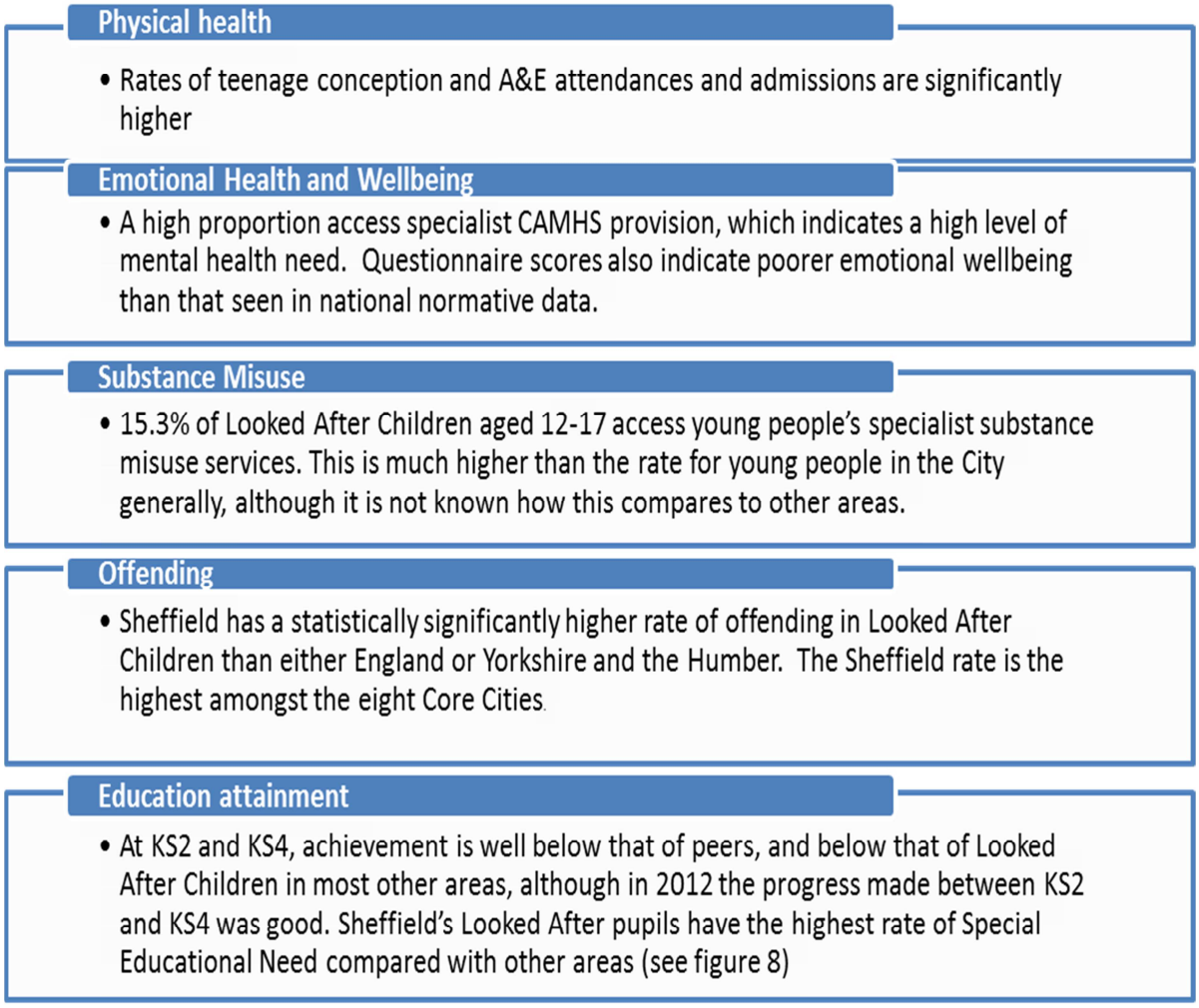


Source: LAC Statistical Returns. Notes: Based on children looked after continuously for at least twelve months at 31 March 2010. Includes pupils attending primary, secondary and special schools, pupil referral units and in alternative provision. Excludes children in respite care and those who could not be matched to pupil records in School Census, Alternative Provision Census or Pupil Referral Census.

[131] Sheffield Infant Mortality Strategy and Delivery Plan. NHS Sheffield (2011)

[132] Public Health Intelligence Team (Sheffield City Council) using data from the National Child Weighing and Measuring Programme for Sheffield.

Figure 10 A health needs assessment of Looked After Children



The wider determinants

3.13 People in the most deprived parts of Sheffield still experience a greater burden of ill-health and early death. This demonstrates that inequalities in health and wellbeing are linked to inequalities in the wider social, cultural and economic context, also known as the wider determinants of health. Whilst we discussed the wider determinants in chapter one, we did not analyse the inequalities within these.

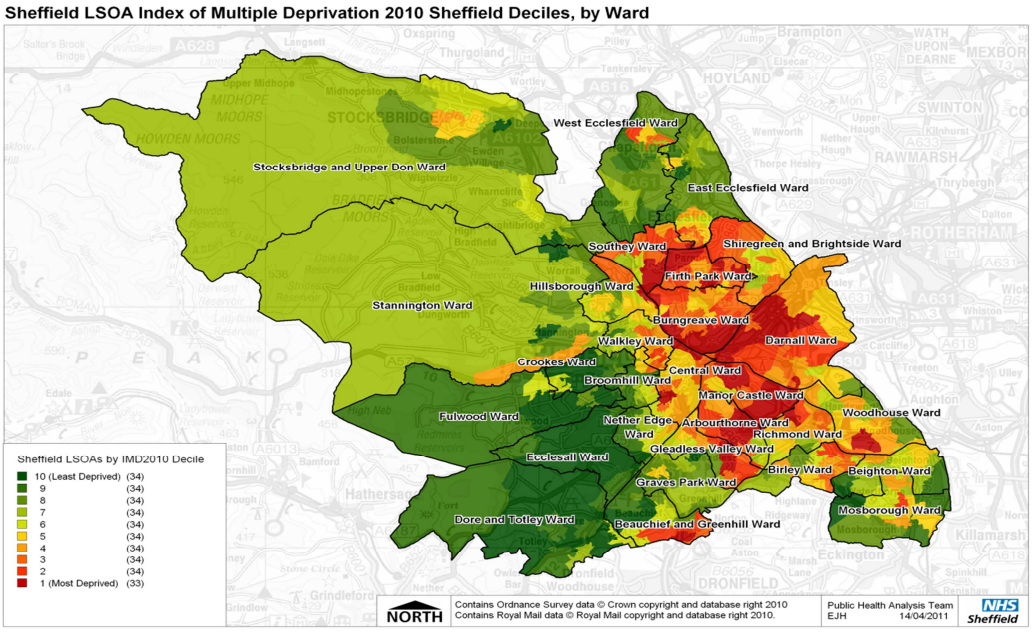
3.14 **Deprivation within Sheffield - overall Index of Multiple Deprivation (IMD)**

The IMD is probably the best measure of inequalities in the wider determinants. It is made up of seven indices of deprivation that are grouped together and weighted to produce the overall index of multiple deprivation. These seven indices cover a number of domains, these being: income; employment; health and disability; education, skills and training; barriers to housing and services; crime; and living environment. As the map in Figure 11 shows, there are clear geographical inequalities in the wider determinants of health. The main trends within Sheffield for the IMD measure are that:

- Sheffield has within it great deprivation inequality.

- Overall the North East and East Community Assemblies stand out as being more deprived than the Sheffield average; South West Community Assembly is the least deprived.
- There are pockets of deprivation within non-deprived surroundings.
- The crude gap in deprivation between best and worst Lower Super Output Areas in Sheffield has widened.[133]

Figure 11: The geography of deprivation in Sheffield



3.15 **<u>Deprivation within Sheffield – Index of Multiple Deprivation domains</u>**

It is also worth breaking the IMD down further to highlight some of the key trends in the domains that sit beneath the IMD. In particular:

- **Income:** Geographically, most people with lower income deprivation are located to the East of the City.
- **Employment:** deprivation is highest in the East of the City but there are pockets of high deprivation to be found in most parts of Sheffield, with the exception of the South West which is generally much less deprived. There is substantial intra-ward variation in employment.
- **Educations, skills and training:** The South West of Sheffield is much less deprived than the East, which has large areas within the worst decile. Education inequalities across Sheffield are the most extreme.
- **Barriers to housing and services:** There is a distinct lack of extreme deciles for this domain. Unlike the other domains, relatively high deprivation is not confined to the eastern areas, and low deprivation is not confined to the South West; deprivation is more evenly distributed.

[133] A Lower Super Output Area (LSOA) is a small geographical area that typically contains around 1,600 people (although this can vary considerably). There are 339 LSOAs in Sheffield.

- **Crime:** There is a high concentration of relatively high crime in Southey, Firth Park, Shiregreen and Brightside wards, and in wards including and surrounding Arbourthorne.
- **Living environment:** There is a lack of extremes in deprivation for this domain and most areas are classed within the average deprivation deciles. Relatively high deprivation is concentrated in the Central ward, with levels of deprivation generally improving further out from the city centre. In wards outside the city centre, relative deprivation is worst in the North East, and as with Barriers to Housing and Services, there is also relatively more living environment deprivation in the rural, western areas of the City.
- **Deprivation and disability:** relatively higher deprivation is more common across the City than lower deprivation. There is a relative absence of people within the best decile.

Ultimately, any attempt to tackle health inequalities must tackle the inequalities in the wider determinants of health as these are the 'causes of the causes' of ill health.

Service access

3.16 Inequality and unfairness in health can also be due to inequity in access to services and inequity in the quality of services available. The *inverse care law* refers to a particular relationship between need for healthcare and actual take up of health services[134] which means that those people who are most in need of health services are often least likely to receive or access them.

3.17 The Fairness Commission received evidence which suggested that particular communities in Sheffield, for example BME communities and asylum seekers, could not access the health and wellbeing services they needed, potentially delaying or preventing the treatment of health problems. In addition, we know that people living in more deprived communities are more likely to need emergency hospital admission for health problems such as cancer and coronary heart disease than other areas of the City and are also more likely to visit Accident and Emergency (A&E). This supports evidence that people living in more deprived areas are less likely to report their health concerns, delaying early diagnosis and treatment and potentially leading to more serious conditions. Paragraph 3.2 also refers to this issue.

3.18 Ultimately, we do not have good enough data on inequalities in service access and usage and this represents an area for further research. **In particular, we need to establish geographical health spend distribution and map this against geographical health outcome if we are to ensure this reflects our aspiration to reduce health inequalities.**

[134] The Inverse Care Law, The Lancet (1: 405–12), 1971.

3.19 In terms of interventions, there is evidence that suggests those with the best health and wellbeing tend to adopt healthier lifestyle behaviours, and that the overall health and wellbeing of the population improves as a result. However, those with greatest health needs, often living in poverty, with low levels of educational attainment and low aspirations, benefit the least. This simply widens inequalities in health and adds avoidable pressure on the NHS and all other health and social care services[135]. **Interventions should be specifically targeted towards those with the greatest health needs and this is particularly the case in relation to the nine 'protected characteristics' covered by the Equality Act (2010).**

3.20 The Equality Act offers protection to the following nine characteristics: age; race; sex; gender reassignment status; disability; religion or belief; sexual orientation; marriage and civil partnership status; and pregnancy and maternity. The law also protects people who are at risk of discrimination by association or perception. This could include, for example, a carer who looks after a disabled person. **It is important that in the future we develop, where reasonably practicable, our joint assessment of need within the context of the Equality Act.**

In summary

3.21 **Health inequalities** remain a problem for the City.

3.22 There are large inequalities in **life expectancy**. For males, the gap between the lowest and highest life expectancy is 8.6 years, whereas for females, the gap is 8.2 years. These gaps in life expectancy have not remained static. Whilst inequality in life expectancy has decreased for males, it has increased for females.

3.23 Whilst **children and young people** growing up in Sheffield today are generally healthier than ever, there are wide variations. For example, between the most and least deprived wards in the City there is a four-fold difference in **infant mortality** rates. Health and wellbeing outcomes for **Looked After Children** require particular attention.

3.24 Any attempt to tackle health inequalities must tackle the inequalities in the **wider determinants of health**.

3.25 The people who are most in need of health services are often less likely to receive or access them. Ultimately we do not have good enough data on inequalities in this regard. In particular we need to establish geographical **health spend distribution** and this against health outcomes if we are to ensure this reflects our aspiration to reduce health inequalities.

[135] Clustering of unhealthy behaviours over time: Implications for policy and practice, King's Fund, 2012.

Priorities:

7. **Identify geographical health spend:** Establish a geographical health expenditure distribution and map this against geographical health outcomes. Ensure this reflects our aspiration to reduce health inequalities.

8. **Develop better measures about health inequalities and ethnicity:** We know how health varies by area but we do not have good enough data on how health varies by ethnicity and this represents a major gap in our understanding.

9. **Map assets:** If we are to reduce health inequalities in the City, it is not enough to know only about need, we also need to know where our assets lie so that we can build on these.

4 Health, housing, children's and social care services

This chapter incorporates the two service–focussed Health and Wellbeing Strategy outcomes. These are:

Health and Wellbeing Strategy Outcome 4: "People can get health, social care, children's and housing services when they need them, and they're the sort of services they need and feel is right for them"

What does the Health and Wellbeing Strategy say? "This outcome is about how people of all ages should experience health, social care, children's and housing services in Sheffield. This means Sheffield's health and wellbeing system working better based on the needs of people in the City and to support the achievement of outcomes 1, 2, and 3.**"**

The key measures that the Health and Wellbeing Board have identified for this outcome are:
- Increased satisfaction with GPs
- Increased satisfaction with provider services
- Reduced emergency admissions
- Improved outcomes for those in need of help and support
- Maintaining access

Health and Wellbeing Strategy Outcome 5: "Services are innovative, affordable, and deliver value for money"

What does the Health and Wellbeing Strategy say? "This outcome is about how Sheffield's commissioners and service providers will deliver health, social care, children's and housing services. As with Outcome 4, this outcome intends to make changes to the way the health and wellbeing system works in Sheffield; making it sustainable and affordable in the long term."

The **key measures** that the Health and Wellbeing Board have identified for this outcome are:
- Improved sustainability and value for money
- Increased spend on preventative services

What is the issue?

4.1 The City's population is rising as a result of an increasing birth rate, inward migration and people living longer. Over the next 10 to 20 years there will be an increase in the number of older people in Sheffield alongside increasing numbers of children and working age adults with disabilities and complex needs. We know that this population change is likely to place a significant and increasing demand on health, social care, children's and housing resources.

4.2 In Sheffield we have developed an 'investment profile' of the City's NHS and Council budgets using a commissioning landscape model that apportions budgets to the following categories: promoting lifelong health and wellbeing; early, short-term or one-off interventions designed to promote recovery and independence (community based care and acute or specialist care); and medium to long term support focused on stability and maintaining quality of life (community based and acute/specialist). This profile indicates that around 80% of all the money invested in health and wellbeing services in Sheffield in 2012/13 went into acute hospital care and medium to long term care and support services. **The growth in our population and the current economic situation mean that this balance of investment is unsustainable and greater emphasis should be placed on promoting lifelong health and wellbeing and recovery and independence.**

4.3 When the Joint Health and Wellbeing Strategy talks about 'people getting the help and support that they need and feel is right for them', it is important to focus not only on outcomes, but to consider people's knowledge of, access to and experience of services. Currently, these are not all accurately measured but are important and must be given greater emphasis.

This chapter focuses on services. We will look at: service demand, GPs, hospitals, social care services, children's services, housing services and voluntary sector services.

What do we know?

Service demand

4.4 Sheffield's changing demographics are central to the planning and delivery of services across the City. The 2011 Census revealed that Sheffield has a population of 552,700, which represents a 7.7% increase since the 2001 Census[136]. Sheffield's growing population results from an increase in the number of births, higher net inward migration and longer life expectancy.

4.5 Births to Sheffield residents rose from 5,715 in 2001 to 6,916 in 2012, and are projected to rise to 7,000 in 2015 and 7,700 in 2020[137]. Although children and young people growing up in Sheffield today are generally healthier than ever, there are some key trends around obesity and exercise that need attention. In addition, there has been almost a 40% increase in the number of children and young people with a learning disability over the last 10 years[138]. Given the increasing number of children in the City and the increasing number of children with complex needs and disabilities in particular, the investment profile for relevant services should be examined closely.

[136] 2011 Census: Office for National Statistics (ONS) 2012

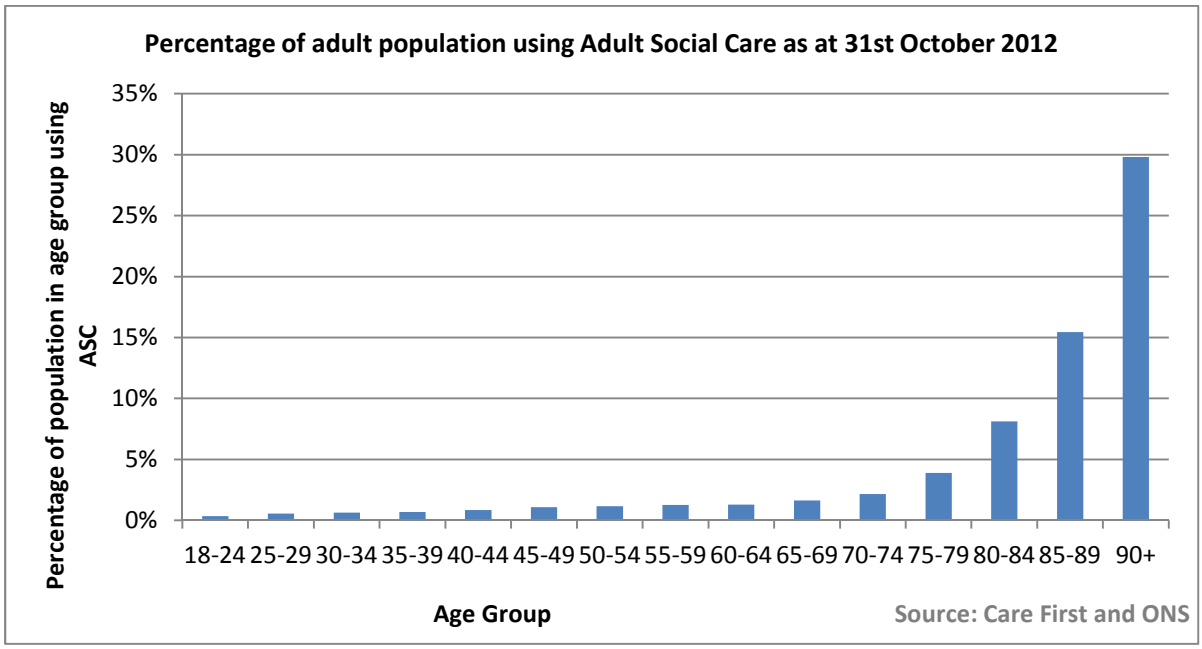
[137] Public Health Births: Office for National Statistics (ONS) – uses 2006 base for projections

[138] Sheffield Case Register (2003 to 2013)

4.6 Net inward migration has also increased and Sheffield now has a large and growing BME population. Not only has there been an increase in the number of people from BME backgrounds from almost 9% of the total population 2001 to 16% in 2011[139], there has also been an increase in the number of different BME groups and more than 128 languages are now spoken by Sheffield's school children. Commissioners must consider the specific health needs of the City's large, diverse and growing BME population and ensure that services are culturally sensitive.

4.7 Over the last ten years, the City has also experienced an increase in people aged over 65 years and in particular has experienced almost an 11% increase in people over the age of 85 years, although it should be noted that this increase is lower than the national trend[140]. This increase has translated into increased demands on services, given that older people are major users of health and care services. As the graph in Figure 12 highlights, in the case of adult social care, service usage increases with age. **The commissioning of services must reflect the increasing numbers of older people and greater emphasis should therefore be placed on prevention and early intervention.**

Figure 12: Percentage of adult population using adult social care



[139] 2011 Census: Office for National Statistics (ONS) 2012

[140] 2011 Census. Office for National Statistics (ONS) 2012

4.8 Looking to the future, Sheffield's population is projected to rise further, with an increase of 6.8%, or 38,000 people, between 2011 and 2021[141]. 30% of Sheffield's population increase will be in those aged 65 years and over. There are currently 11,800 people in the 85+ age group, but by 2020 this will have increased to 15,000 and by 2030 it will be around 20,000. Currently around 9,000 people aged 65 years and over (12% of all in the City) receive some adult social care support but as the numbers of older people increase, there will be increased demand on social care services. At present, it is estimated that nearly 7% of people aged over 65 years are living with some form of dementia, but the increases projected in the City's population means that by 2020 there will be an increase of around 1,000 more older people living with dementia and by 2030 there may be an additional 3,000 people living with this illness. **The growing number of older people and the associated increased demand placed on services will present clear challenges to the health and wellbeing system.**

4.9 The increase in the number of people with severe or complex needs will be particularly marked in children, young people and younger adult age groups. **Children's services, particularly those that deal with children with severe or complex needs, must explore options for responding to this increasing demand.** The ethnic profile of the City will also continue to change and local estimates suggest that the BME population could grow to around 23% by 2020 assuming that trends in arrivals and births remain constant[142]. **Services must be culturally sensitive so they are accessible and relevant to different communities.**

GPs

4.10 The GP patient survey[143] asks patients about their experience of using GP services. Some of the key findings in terms of access and experience are highlighted in Table 3.

Table 3: GP access and experience data

Access:	Experience:
- 74% found it 'very' or 'fairly' easy to get through to someone at the GP Surgery on the phone, although 22% said it was not very or not at all easy.	- 87% had 'very' or 'fairly' good experience of their GP Surgery.
- 73% were able to get an appointment or see or speak to someone, 13% had to call back closer to the day they wanted and 11% not able to get an appointment or see/speak to someone.	- 93% 'definitely' or 'to some extent' had trust and confidence in their GP
- 76% felt their GP was open at times convenient to them, however, 17% felt it was not.	- 89% felt GP was 'very' good or 'good' at listening.
- 41% of people did not know how to contact an out of hours GP.	- 87% said their GP was 'very' good or 'good' at giving them enough time. - 33% felt that the out of hours GP service took too long.

Data Source: GP Patient Survey

[141] ONS Interim 2011 based Population Projections
[142] Estimates from the Public Health Register (PHR)
[143] GP Patient Survey, NHS England, 2012.

4.11 Anecdotal evidence from our JSNA events echoed that GP experience was good but that GPs are not accessible enough, especially for people who work. Problems included not being able to get through to the surgery on the telephone, waiting too long for an appointment and not being able to see their GP on a weekend. Visiting the Accident and Emergency department (A&E) may therefore become the next best option for too many people.[144] There also seemed little understanding of the 'Out of Hours' service at our JSNA events. Overall, Sheffield scores well in terms of GP user experience, although the time taken to see an out of hours GP service appears to be an area of concern. **Whilst GP experience appears to be good, according to the national GP survey, the local evidence about access arrangements should be explored in more depth.**

4.12 With some exceptions, practices that perform poorly on both clinical outcome measures and patient experience are more likely to be located in more deprived areas. **We do not currently have information on GP user experience by area but this is an issue that warrants further investigation.**

Hospitals

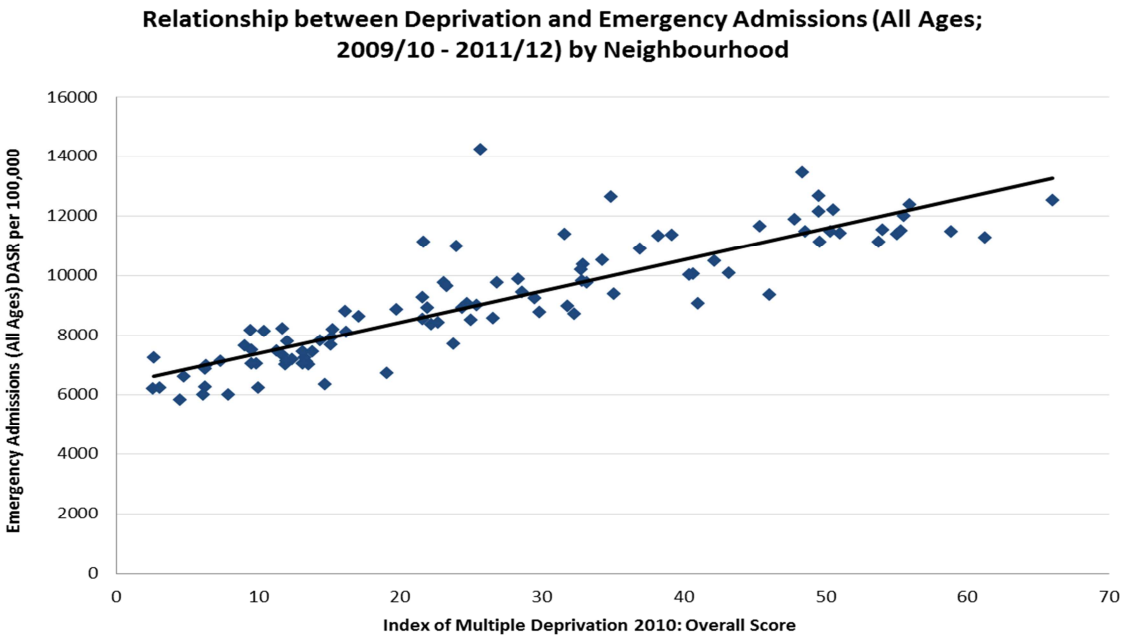
4.13 **Hospital admissions**

The Sheffield rate of 94.6 emergency hospital admissions per 1,000 population 2011/12 is just a little over the England average rate of 94.4. However, there is currently high use of children's emergency care and Sheffield benchmarks very poorly against the national and Core City averages for A&E attendances and emergency admissions for the under-fives. For example the attendance rate at A&E for children under the age of 5 years has increased in Sheffield from 78,961 per 100,000 population in 2008/9 to 80,306 in 2010/11[145]. These rates are almost double the national average. We also know that emergency hospital admissions in Sheffield are strongly correlated with deprivation, which is reflective of the national picture. A&E usage (across all age groups) is nearly double the rate in the more deprived neighbourhoods when compared with the least deprived (Figure 13). **Whilst Sheffield's rate of emergency hospital admission is only slightly over the national average, the rate of emergency hospital admissions and A&E attendances for children is much higher than the national average and this should be followed up as a priority.**

[144] Sheffield City Council JSNA Event Reports, 2013.

[145] Child, Adolescent and Maternal Health Profile – www.chimat.org.uk

Figure13: Relationship between deprivation and emergency hospital admissions



Source: Public Health Intelligence Team Neighbourhood Indicator Tool

4.14 Quality measures

The **Dr Foster Report** showed that the Sheffield Teaching Hospitals NHS Foundation Trust is one of the top performing large acute hospitals in the country and achieves better than average survival rates from surgery, low infection rates and high quality care[146]. However, there are still some areas of concern. For example, the Trust struggled to meet the four-hour target to treat, admit or discharge A&E patients over the last two winter periods (2011 and 2012), although Sheffield's performance is reflective of the national picture[147].

4.15 Length of stay

The length of time people stay in hospital in Sheffield is perhaps the biggest concern. The average length of stay in hospital following an emergency admission in Sheffield is 6.4 days which is 28% higher than the national average and is the joint highest nationally. Unnecessary admission and unnecessarily long length of stays are particularly a problem for older people.[148] **The length of stay in hospital in Sheffield is too high and this is an issue particularly for older people. Bringing the length of stay in line with the national average must be a priority.**

In an audit in Sheffield in 2010, of a sample of people aged over 75 who were admitted to hospital in an emergency, 49% did not meet the criteria for admission and could have been managed through either Home Care, sub-acute rehabilitation, a lower level of care or managed as an outpatient.
Source: Sheffield Teaching Hospitals Annual Report 2011-12.

[146] Fit for the future? The Dr Foster Hospital Guide 2012. Dr Foster, 2012.

[147] Sheffield Teaching Hospitals NHS Foundation Trust data

[148] 2012 quality account, Sheffield Primary Care Trust, 2012.

4.16 **Patient experience**

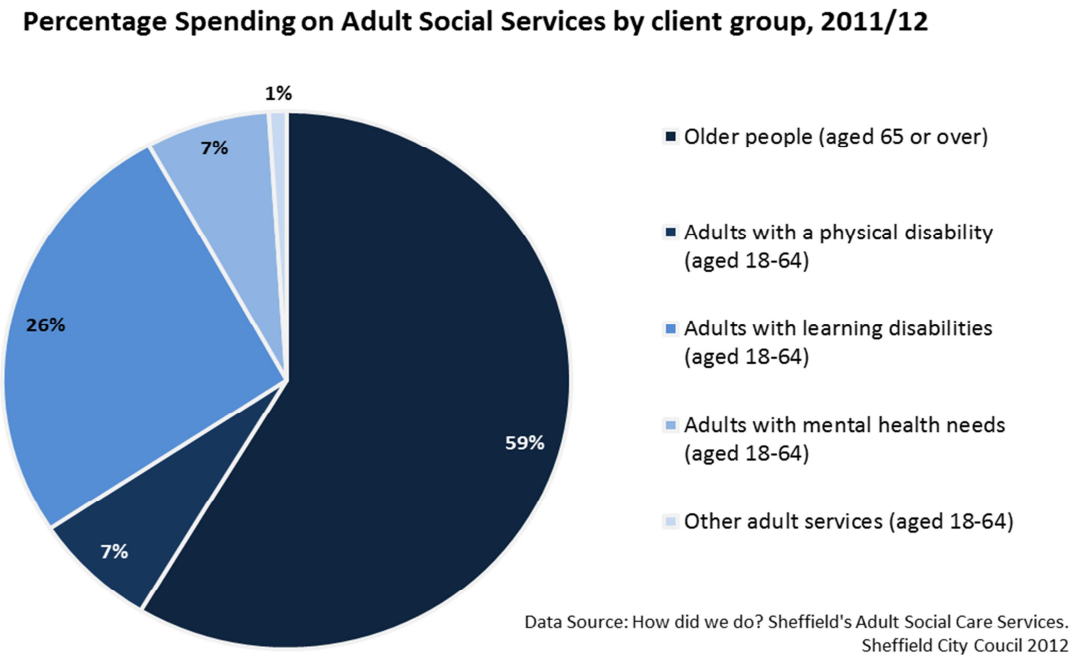
We do not have good data on patient experience and this represents a major gap in our knowledge. At our JSNA events however, we heard evidence about excessive costs of TV and parking at hospitals; over-use of medical jargon by doctors which was confusing and intimidating; and cases of individuals or a family members being shown a basic lack of care. The recent Francis Report into the care provided by Mid Staffordshire NHS Foundation Trust, which concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes, is a warning about the fundamental responsibility hospitals have to provide safe care and the consequences when this is overlooked. Patient experience is a critical measure of performance and will be of increasing importance in the future. **The importance of data on patient experience is being 56nalyzing56 and more emphasis should be placed on collecting, 56nalyzing and interpreting this.**

Social care services

4.17 **Social care spend**

As the chart in Figure 14 shows more than half of Sheffield's adult social care spending is on older people (59%), in line with other councils. Overall Sheffield spends slightly more on adults with a learning disability and slightly less on adults with a physical disability, compared with other councils. As shown previously, the use of adult social care increases steadily with age. Increasing numbers of older people, along with the predicted increases in children and adults with complex needs will mean increased demand for adult social care services.

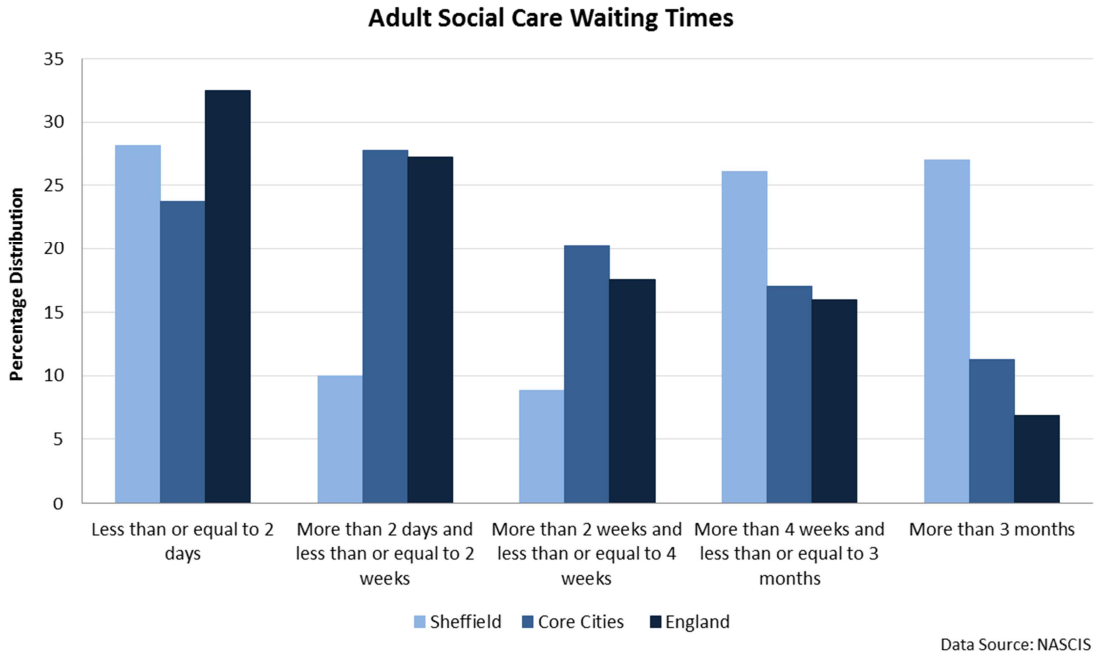
Figure 14: Percentage of spending on adult social services by client group



4.18 **Waiting times**

Sheffield performs poorly in terms of its adult social care waiting times. In 2011/12 26% of people waited between four weeks and three months and 27% waited over three months.[149] These figures are higher than the Core Cities and the national average. Given Sheffield's longer than average adult social care waiting times, reducing these must be a priority.

Figure 15: Adult social care waiting times



4.19 **Quality of life**

When we asked people who receive social care services about their quality of life, Sheffield's survey results were not quite as good as the national results or the results across similar big cities[150]. Whilst about a third of people said their quality of life was 'ok', less than half of respondents (49%) thought that their quality of life was good, very good or so good it couldn't be better compared with 58% nationally and 54% across similar big cities. 10% felt their quality of life was bad and a further 5% said it was either very bad or so bad it couldn't be worse. **The self-reported quality of life of people receiving adult social care in Sheffield is poor, both in the figures themselves and compared with other parts of the Country. This is clearly an area which requires greater attention.**

[149] National Adult Social Care Intelligence Service (part of the National Information Centre for Health and Social Care).

[150] How Did We Do? Adult Social Care Outcomes Survey (2012) – a national survey

4.20 **Control over daily lives**

Similarly, in terms of how much control social care clients felt they had over their daily lives, over a third (34%) of respondents felt they had as much control over their daily life as they wanted and a further 40% felt they had adequate control. However 19% said that they did not have enough control and 6% felt they had no control[151]. In terms of how much control users of adult social care had over their daily lives, Sheffield's results are more or less identical to national results and similar big cities.

4.21 **Support to find employment**

Most 'working age' adults with ongoing care and support needs would like paid employment, but face significant barriers finding and maintaining a job. The rate of employment measures the effectiveness of the City's supported employment strategies and services in helping vulnerable people prepare themselves for employment, find jobs and succeed. For those with a learning disability in Sheffield, 5.9% are in paid employment compared with 6.6% nationally whereas for those with a mental health problem, only 7.7% in Sheffield are in paid work compared with 9.5% nationally[152]. **Sheffield is doing poorly when it comes to getting working age adults with ongoing care and support needs into paid employment and this should be emphasised as an area of concern within relevant employment strategies and action plans.**

4.22 **Move to Self Directed Support**

Sheffield has made significant progress with the personalisation of Adult Social Care. Over the last three years there has been a major roll out of Self Directed Support, helping as many people as possible who are eligible for care and support to have choice and control over the support they receive through Personal Budgets and Direct Payments. As at 31 March 2013, 68% of people who use adult social care services in Sheffield were receiving a Personal Budget[153]. **We should continue to roll out Personal Budgets as a key part of our work to make sure we help people achieve independence, choice and control.**

Children's services

4.23 **Paediatric Speech and Language Therapy (SLT)**

The Bercow Report on services to children with Speech, Language and Communication Needs (SLCN) stated that nationally*: "Although there are some skilled professionals and good facilities, the overall position in terms of speech, language and communication services is highly unsatisfactory. Access to information and services is often poor, services themselves are very mixed, continuity across the age range is lacking, effective joint working between the health and education services is rare and there is something of a postcode lottery across the country. Above all, local commissioners attach a low priority to the subject…this must change".*

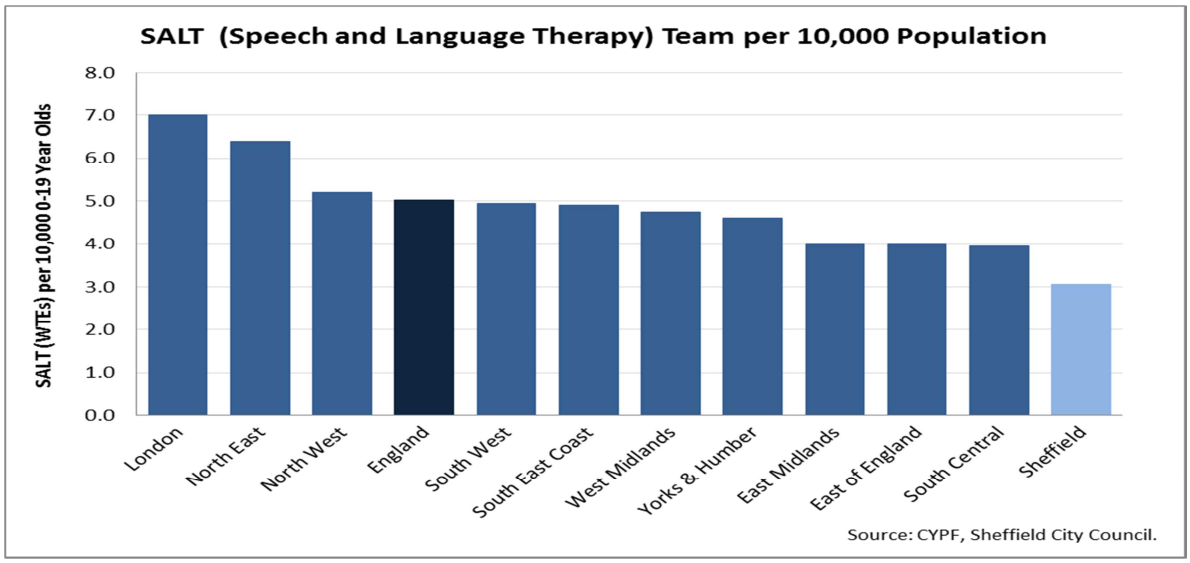
[151] How Did We Do? Adult Social Care Outcomes Survey (2012) – a national survey

[152] Public Health Outcomes Framework (2012) – Public Health England

[153] Sheffield City Council – Adult Social Care Service performance data (2012/13)

4.24 The evidence indicates that this is a fairly accurate description of the current position of SLCN services in Sheffield. Of particular concern is Sheffield's Speech and Language Therapy (SLT) workforce. As the graph in Figure 16 shows, the SLCN workforce is significantly smaller than any other regional average and is around 40% smaller than the national average.

Figure 16: Speech and language therapy team per 10,000 population



4.25 We also know that the number of children with SLCN has increased, at a faster rate than nationally. In 2012, 34.1% of children with a Special Educational Needs (SEN) statement had speech, language and communication as a primary need, compared with 29.1% nationally[154]. **Given this increase in need and the City's weak position in relation to the gap between the lowest performers and their peers at the end of the Foundation Stage, SLT should be addressed as a matter of priority.**

4.26 **<u>Neonatal care</u>**

Table 4 highlights neonatal activity at the Jessop Wing, part of the Sheffield Teaching Hospitals NHS Foundation Trust. The figures for intensive care include a substantial amount of activity from other hospitals, but the figures for the other categories will be for Sheffield children predominantly. The increased survival rates of preterm babies have been noted in Chapter 2 and as the table shows there has been a clear increase in use of neonatal care over time in Sheffield. It is expected that this increase will continue over the next 5 to 10 years. **Due to the continuing, increasing use of neonatal services, it is crucial that this area receives adequate attention.**

[154] Sheffield City Council: Children, Young People and Families performance data.

Table 4: Neonatal activity (bed days) at the Jessop Wing, Sheffield.

Year	Intensive Care	High Dependency Care	Special Care	Transitional Care	Total
2005	2005	1826	5457	369	**9657**
2006	2943	1892	5072	1485	**11392**
2007	2541	2088	5894	1919	**12442**
2008	2774	2126	5767	1660	**12327**
2009	3317	2515	5320	1793	**12945**
2010	3737	2790	6396	1728	**14651**
2011	4407	2786	6481	1551	**15225**
2012	4288	2806	6809	1693	**15595**

Data Source: CYPF

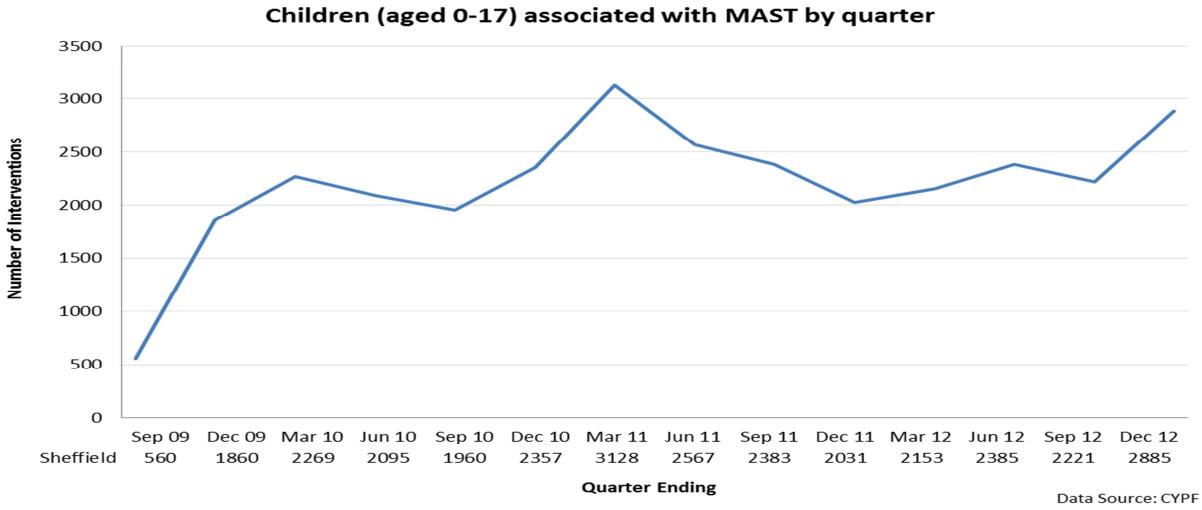
4.27 **Childhood and Adolescent Mental Health Service (CAMHS)**

Waiting times in the Childhood and Adolescent Mental Health Service increased significantly in the 2010/11 financial year and over a third of children were waiting longer than the 18 weeks deadline in the second quarter of 2012-13. Targeted improvement work, the deployment of primary mental health workers, and the operation of early intervention and prevention services (see paragraph 4.29 below) has largely rectified this problem, but a continuing issue is the lack of a clear service offer for 16/17 year olds[155]. Sheffield's is the only specialist service in the North of England that does not fully provide for children and young people up to the age of 18 years. This means that 16/17 years olds are too young to qualify for Adult Mental Health Services support but too old for the current CAMHS service. Given the lack of mental health support available to 16/17 year olds, integrating this age group into CAMHS must be a priority.

4.28 **Children in Need**

The prevalence of Children in Need in Sheffield stood at 288 per 10,000 in 2012, which is below the national average of 326. The Sheffield rate has fallen markedly in recent years, from a peak of 407 in 2010, which was higher than the national average of 341. Whilst the Children in Need rate has fallen, the number of cases being dealt with by the Multi Agency Support Teams (MAST) has risen.

Figure 17: Number of cases being dealt with by the Multi Agency Support Teams



Data Source: CYPF

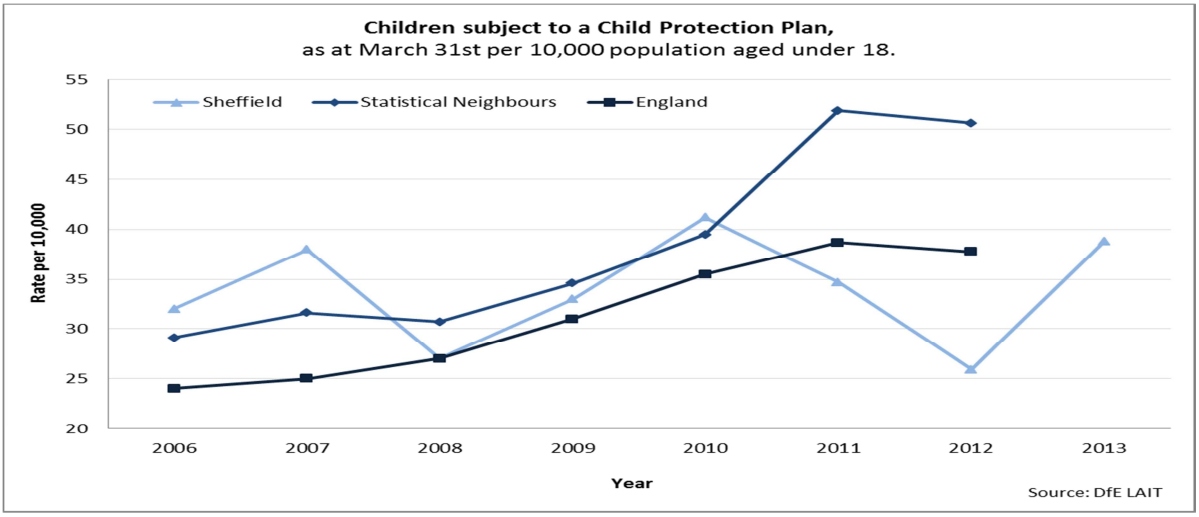
[155] Sheffield City Council – Children, Young People and Families performance data.

There is good evidence that the operation of Sheffield's early intervention and prevention services has had an impact on the number of children and families who require a service from statutory social care services and this model of working should continue to be supported.

4.29 **Children's social care**

Referrals to Children's Social Care in Sheffield have been lower than comparable areas but higher than the national average since 2008. The proportion of referrals going on to initial assessment has been significantly higher in Sheffield than elsewhere since 2009 and this coincides with the implementation locally of the Multi-Agency Allocation Meeting (MAAM) system. The Sheffield trend in the rate of children becoming subject to a Child Protection Plan (CPP) has run counter to that seen elsewhere over the last 2 years, although the most recent data show a rise[156].

Figure 18: Children subject to a child protection plan



The high 'conversion rate' of cases that are referred to social care to those that receive an assessment indicates a good level of multi-agency working and case management at the 'threshold' between preventative support and statutory intervention. This model of working should continue to be supported.

Housing services

4.30 **Homelessness**

Presentations to the homeless service that involve families with children have remained steady, at approximately 30% between 2009 and 2011 but there was an increase from 47% to 58% in homelessness acceptances. The increase in homelessness acceptances that involve families with children suggests more families with children are reaching the required thresholds for services[157].

[156] Sheffield City Council – Children, Young People and Families performance data

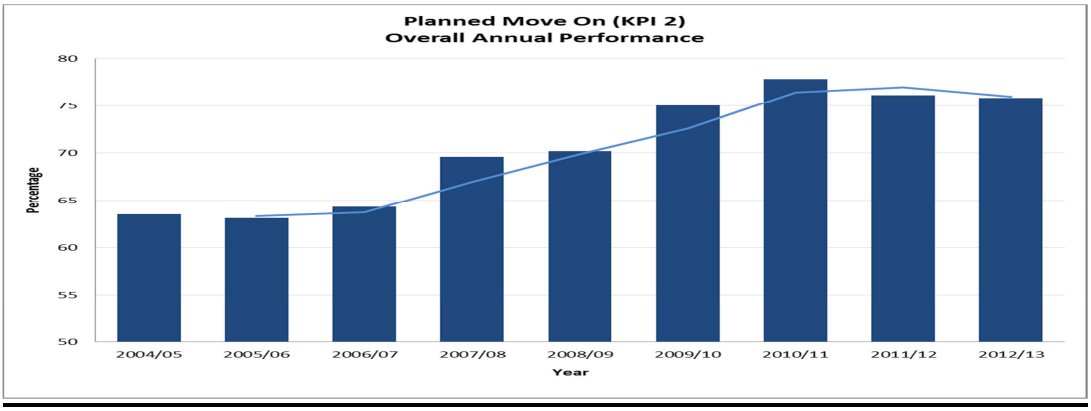
[157] Sheffield City Council – Housing Independence Service performance data

4.31 **Housing related support**

Housing related support services deliver preventative and personalised support to a wide range of people who are at risk of losing their home or their ability to live independently for a variety of reasons. Most adults who require housing related support have multiple needs. The 'Supporting People' outcomes framework measures 17 potential areas of need which individuals might have[158]. In 2009/10 each service user in housing support services had on average 35.9% of the 17 specified needs. There has been a steady increase in the level of need that people in services have over the last three years. In particular the areas of need that have increased are: managing debt, establishing contact with services, groups, families and friends, managing mental health, managing self harm and obtaining and maintaining accommodation. **The increase in the level of need of people accessing housing related support services is a concern**[159].

4.32 The percentage of service users who leave services in a planned way is an important measure of service performance. Since the introduction of Supporting People and its quality and monitoring framework there has been a continual increase in performance on planned move on. However, this started to decline in 2011-12 when the budget ring fence was removed from Supporting People and other external economic factors started to impact on service users. **The more recent downward trend in 'planned moved on' is discouraging and it is anticipated that this will continue**[160].

Figure 19: Planned move on levels in housing related support services



4.33 In terms of demand, a 2013/14 assessment of need for housing related support in Sheffield indicates an undersupply of 3,202 units of support across all client groups with short term needs of which, 559 are adults with mental health problems and 555 with substance misuse problems.[161]. We know that our client base is clustered geographically in areas of deprivation and our clients face multiple disadvantages. A number of trends have emerged over the past three years which show the level of need within services increases at the same time as public expenditure on housing support is decreasing. **Our assumption is that need will continue to increase in complexity and extent as the economic pressures increase and that this will impact negatively on individuals and high level health, care and community safety budgets.**

[158] Supporting People is a national programme helping vulnerable people in England live independently and keep their social housing tenancies. It is run by local authorities and provided by the voluntary sector. It was launched on 1 April 2003

[159] HGO Consultancy – Housing Needs Assessment Tool for Sheffield

[160] Sheffield City Council – Housing Independence Service performance data

[161] HGO Consultancy – Housing Needs Assessment Tool for Sheffield

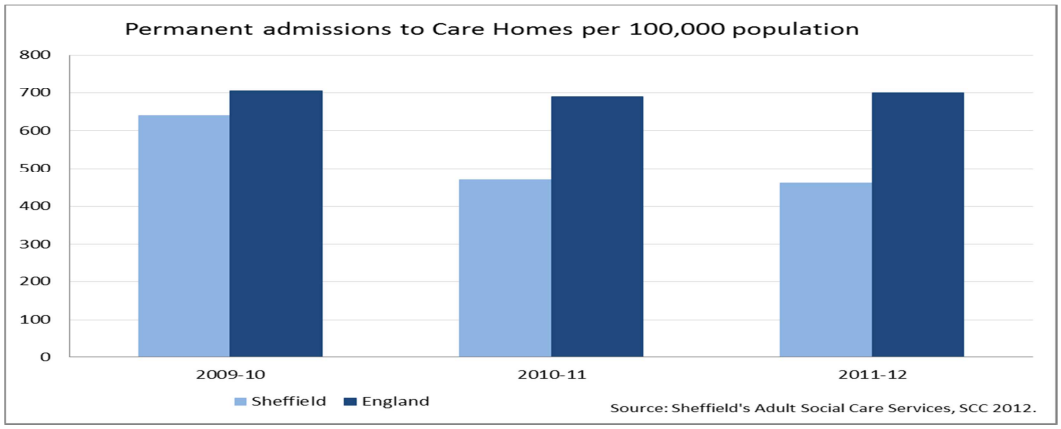
4.34 **Reablement and rehabilitation programmes**

People who have been in hospital sometimes need extra help to prepare them for returning home. Reablement and rehabilitation programmes aim to enable people to live independently and the success of these services is measured by checking how many older people are still living at home 91 days after being discharged from hospital into such service. In 2011/12 over 86% of older people (65 years and over) in Sheffield were still at home[162]. This is slightly higher than the national average of 82.7%. **Although it is encouraging that Sheffield is above the national average for helping people to stay living at home, emphasis should be placed on continuing this.**

4.35 **Admissions to care homes**

Most people want to stay living in their own home for as long as they can and it is far more cost effective to provide care in the home than it is for residential care. In 2012-13, it cost £397.48 (gross) per person per week to care for someone in a residential or nursing home compared with £137.53 (gross) per person per week to care for someone in their own home[163]. We must ensure that people have the support to stay in their own home. Some people eventually have to move into a care home but ideally this would be as few as possible. If we check how many people are making a permanent move into residential or nursing home, it is clear that Sheffield has reduced permanent admissions to residential and nursing care at a faster rate than the national average. **Whilst Sheffield's fall in the number of permanent admissions to care homes should be commended, further emphasis should be placed on this area so as to ensure this trend continues in the future.**

Figure 20: The number of permanent admissions to care homes per 100,000 population



[162] Adult Social Care Outcomes Framework (2012) National Adult Social Care Intelligence Service, part of the National Health & Social Care Information Centre

[163] Sheffield City Council – Adult Social Care Services financial system

4.36 **Joined up services**

There is a need to make better connections between housing and health services. For example, the connection between asthma and damp housing is well known but partnerships between healthcare and housing services are piecemeal and not well supported. The growth of poor quality private rented sector housing in some areas of the City also creates a pressing need to improve this relationship and the City's Fairness Commission have also commented on this issue. **Stronger joint working between housing and health services should be encouraged to support improving health and wellbeing.**

Changing services

4.37 As The King's Fund research shows, services have struggled to keep pace with demographic pressures, the changing burden of disease, and rising patient and public expectations. Fundamental change to the delivery system is needed. Changes to existing models of care will not be sufficient in addressing these challenges; a much bolder approach is needed. Here we provide some evidence to highlight why and how services need to change.

4.38 **Avoidable or inappropriate use of high end or 'acute' services**

Overall, there is clear evidence that avoidable or inappropriate use of high end or 'acute' services (such as avoidable hospital admission) leads to poorer outcomes for people and higher levels of dependency. For example, older people with dementia face more chance of living in a care home following a stay in hospital, rather than returning to their own homes. Voice evidence from one of our JSNA events suggested that people generally agreed that there was a need to reduce reliance and spending on hospitals, but that the increased spend in prevention, early intervention and community services must come before any reductions in hospital spend. Avoidable usage of acute services is not only bad for the patient, but is an expensive and inefficient use of resources.

4.39 **Prevention and early intervention**

The King's Fund has shown that too much care is still provided in hospitals and care homes, and that treatment services continue to receive higher priority than prevention. It is well known that hospitals are under pressure from the rising numbers of A&E attendances and emergency admissions and a greater emphasis on prevention and early intervention is needed.[164] **Trying to prevent problems from arising and intervening early is much better than the traditional reactive approach and more schemes that emphasise prevention and early action are needed.**

4.40 **Joined up working**

Lack of integration with social care and community services is contributing to the pressure on NHS hospitals. The traditional dividing lines between GPs and hospital-based specialists, hospital and community-based services, and mental and physical health services, mean that care is often fragmented and integrated care is the exception rather than the rule. One example of positive working is Sheffield's 'Right First Time' programme[165].

[164] Dr Foster Report, 2012

[165] Right First Time – Working together to transform Sheffield's health and social care service. www.sheffieldccg.nhs.uk RFT is designed to reduce avoidable hospital admission, length of stay and use of residential care by promoting healthier lives, and supporting people in their local community by joined up, high quality, responsive, health and social care services and by supporting nonpaid carers.

4.41 **Community working**

Workers based in the community often have a detailed knowledge of that community and can provide appropriate, local support. There is good evidence in Sheffield of the effectiveness of such schemes and the 'Healthy Communities' Programme is one such example[166].

4.42 At our JSNA events voluntary sector organisations told us that cuts in funding meant their capacity to respond to problems was increasingly limited and that demand was beginning to outstrip supply. Rather than being overly critical, many organisations understood the difficult environment in which the public sector was currently operating in, but felt more could be done to facilitate knowledge sharing and forging closer links between organisations. While the NHS implements the current reforms, it will be important to ensure that community-based work can flourish. Whilst this is likely to present some challenges, it is important that the invaluable contribution made by local voluntary sector organisations is not forgotten. **Despite the current economic constraints, dedicated commitment, time and resource should be made available to support the local voluntary sector.**

In summary

4.43 Around 80% of all the money invested in health and wellbeing services in Sheffield is in acute hospital services, and in medium to long term care and support services. The growth in our population and the current economic situation mean this is **unsustainable**.

4.44 We have little data in Sheffield on people's knowledge of and **access** to health services, and have only limited data on **experience.** It is crucial that more emphasis is placed on collecting, analysing and interpreting experience data.

4.45 Whilst the level of **emergency hospital admissions** in Sheffield is broadly in line with the national and regional averages, the **average length of stay** in hospital following an emergency admission in Sheffield is 28% higher than the national average and the joint highest nationally.

4.46 Sheffield has longer times for **social care assessments** than the national average, performs poorly in terms of the **self-reported quality of life** of people receiving adult social care, and its record on **helping working age adults with on-going care and support needs into paid employment** is weak.

4.47 Services for **children** with **speech, language and communication needs**, new-borns, and 16/17 year olds with **mental health needs** require attention and particular consideration should be given to the ability of services in the City to meet the needs of these three groups.

4.48 Sheffield is just above the national average for helping people to stay **living at home** but has reduced **permanent admissions to residential and nursing care homes** at a faster rate than the national average.

[166] http://www.sheffield.gov.uk/SCC-Home/caresupport/health/healthy-communities

4.49 Trying to prevent problems from arising and intervening early is much better than the traditional reactive approach and more schemes that emphasise **prevention and early action** are needed. Health care needs to be better **integrated** with social and community care if we are to reduce dependency on hospitals and provide higher quality care.

4.50 While the NHS implements the current reforms, it will be important to ensure that community-based work can flourish and dedicated commitment, time and resource should be made available to support the **Voluntary, Community and Faith sector**.

Priorities

10. **Service access and experience:** Greater emphasis must be placed on collecting, analysing and interpreting service access and experience data. Without this, it is impossible to measure the extent to which "people get the help and support they need and is right for them".

11. **Changing demand:** The growth and changes in our population and balance of our investment profile means that the current service model is unsustainable. We must therefore find new ways of responding to need which places a premium on prevention, early intervention, integrated working and care in the community. Although there is a move to do this, there is still a long way to go.

12. **Spending cuts:** Cuts to the NHS, local government and the voluntary sector cannot be overlooked and are beginning to impact on service provision. It is important to question how realistic the outcomes of the Joint Health and Wellbeing Strategy are in light of these funding changes.

5 Next steps

The evidence base for the Joint Health and Wellbeing Strategy

This Joint Strategic Needs Assessment document presents an overview of health and wellbeing needs in Sheffield. It attempts to set out our assessment of the key health and wellbeing priorities for the City and the actions that will be required to help us respond to these over the coming years. This document, together with the more detailed assessments and data that underpin it, provides the evidence base for the City's Joint Health and Wellbeing Strategy. This evidence, together with the public consultation that is currently taking place, will be used to prepare and agree the final version of the strategy in September 2013.

An evolving document

The JSNA is not, nor should be, a static document. We will be constantly reviewing health and wellbeing issues in the City and updating our JSNA to reflect major changes. For example, we have already identified a number of areas in which we will undertake more comprehensive needs assessments and areas where there are gaps in our information. This includes: autism, children with complex needs, neurological conditions, speech and language in children, sensory impairment, mental ill health, and care homes. If the JSNA is to be of real use, it must be kept up to date. We will work hard to ensure that this is the case and will be developing a programme of work for the next 12-18 months to help us meet these requirements. Details will be published on our website at: www.sheffield.gov.uk/jsna

A comprehensive online information resource

The JSNA is not intended to be an exhaustive list of need in the City. Instead it highlights what we have found to be the key issues. The data that we have used to produce this JSNA, as well as some of the information that we hold but may not have been able to include here, will be held in our JSNA online information resource. This will bring together in one place all of the intelligence that we have on health and wellbeing in Sheffield and will make gathering and sharing data much easier. Although this is a longer term ambition, it is one which we are committed to fulfilling.

Regular updates

We will publish updates on the JSNA on our website at: www.sheffield.gov.uk/jsna and through the Health and Wellbeing Board's monthly e-bulletin 'The Pulse'. If you would like to be added to the mailing list for The Pulse, please contact: healthandwellbeingboard@sheffield.gov.uk

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of Life Initiative, Expert Elders, Heeley City Farm, Hesley Group, Home Care Direct, Home Start Sheffield, Homegroup, Housing 21, Huntington's Disease Association, ISRACC, Jubilee Food Bank, Learn to Re-create, Leonard Cheshire Disability, LinK, Lloyds Pharmacy, Macmillan Cancer Support, Manor and Castle Development Trust, Mercury Create, Metropolitan Care & Support Motor Neurone Disease Association, MS Society, Neighbours can help Ltd, NHS Sheffield, Partners for Inclusion, Places for People, SAFE@LAST, Safeguarding Children's Service, Sanctuary Housing, Sheffield City Council, Share Psychotherapy, Sharrow Sure Start, Sheffield 50+, Sheffield Alcohol Support Service, Sheffield Carers Centre, Sheffield Children's NHS, Sheffield International Venues, Sheffield First Partnership, Sheffield Hallam University, Sheffield Health & Social Care Trust, Sheffield Homes, Sheffield Local Pharmaceutical Committee, Sheffield Mind, ,Sheffield Parent Carer Forum, Sheffield Rape and Sexual Abuse Counselling Service, Sheffield Royal Society of the Blind, Sheffield Teaching Hospitals NHS Foundation Trust, SOAR, South Yorkshire Fire and Rescue, South Yorkshire Housing Association, South Yorkshire Probation Trust, Special Olympics Sheffield, SSCAT Foundation, Stocksbridge Community Health Forum, Stroke Association, Survivors of Depression, SYHA, TARA, Tourettes Action, University of Sheffield, the Wildlife Trust for Sheffield & Rotherham, and Zest.

Any questions?

If you have any questions concerning this document, please contact us at the following email address: SheffieldJSNA@sheffield.gov.uk

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