Sheffield City Council

DRAFT Public Health Strategy

5 Sept 2016

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Suggested foreword and intro

JM & or Cllr McDonald.

Executive Summary

Why this strategy

Sheffield City Council has made a commitment to becoming a public health organisation. This strategy aims to state the level of ambition contained within this commitment and set out a vision for the Council as an organisation focused on improving health outcomes and reducing inequalities.

The “aim” of public health has often been framed as something quite narrowly defined as “something the health sector does”. This is not the case in Sheffield. The aim of “public health” is to allow and enable people to be as healthy as they can because it is the right approach; because it will slow the rate of cost growth in the health and care sector and importantly – though often missed – as a healthy population is a core infrastructure investment for a vibrant economy.

This strategy is a statement of intent and is deliberately not voluminous. It is not intended to replace existing plans and strategies, but to boost their implementation, to signal opportunities to further enhance progress against our priorities, and a tool to provoke debate on where more ambitious/radical approaches need exploring. This strategy should also be a tool to change the debate about “health” to something that is considerably wider than “health services” and considerably further upstream than the current debate.

Focus of the strategy

The focus is on giving people in Sheffield **the best start in life** to **maximise their life chances**; considering the health dividend across all our work; and considering how we can best support people in Sheffield to live **longer and healthier lives, with an explicit focus on inequalities.**

Aim of the strategy

The aim of this strategy is to increase healthy life expectancy by 1 year over the next 10 years, explicitly focused on improving fastest in those with lowest healthy life expectancy. If achieved this equates to 560,000 person years of illness and disability avoided. The benefits of this in terms of care costs avoided are obvious. It also equates to an impact on the productivity of the economy.

Objectives

There are 4 objectives. The objectives reflect some substantial areas where we would like to see some progress. We will use the skills, expertise and resources we have to enable these outcomes to be delivered.

Objective 1 – **refresh and revise our approach to health inequalities**.

Objective 2– Optimise **health outcomes as an output of public service reform**, integrate health and well being as a **core consideration in all SCC policies and processes**; and **upgrading our approach to prevention** across the totality of SCC.

Objective 3 – Maintain and develop a **robust system to protect the population** from preventable infections and environmental hazards.

Objective 4 – Develop ambitious **policy and service based approaches to healthy lifestyles** to support people be as healthy as they can.

Areas of early focus

There isn't a single big thing that will resolve the challenges of the city in this area. An approach based on a range of interventions including education, service provision, regulation and structural or policy initiatives will be needed.

The commitment in this strategy is to moving the direction of the resource commitment towards prevention being the norm and focused effort across the council on achieving the aim of the strategy – that being improving healthy life expectancy and reduction of the gap between best and worst.

We have not set out all the areas for detailed work on interventions beyond the headlines below. The identified early priorities below are a combination of easy wins, big gain areas and strategically important issues.

Who has what responsibility

Ultimately the Heath and Well Being Board is best placed to lead this agenda. The role of the DPH should be holding Sheffield City Council to account for delivery of improved healthy life expectancy and reduced inequalities, and providing support where this is needed. If the role of the finance director is to ensure an organisation stays within budget, the role of the DPH is to ensure health and wellbeing outcomes are achieved.

The challenge is on of maximising the health dividend of all activities of SCC across the totality of resource deployment, to link activities together and to develop whole system and cross sector approaches to “health” problems. Thus the key question is whether the resources used in the city address or are detrimental to the vision and aims, and the challenge is therefore to optimise the use of its £1.4bn budget, and associated purchasing power, to best improve health and address inequality.

Three key messages

This agenda stretches far beyond “health services” and interacts with almost all aspects of SCC. The agenda is considerably broader than “service provision”, policies and supportive environments can enable health.

Investment to achieve improvements in healthy life expectany are just that, an investment. That investment will have positive consequences on down stream health and care costs, and broader economic impacts.

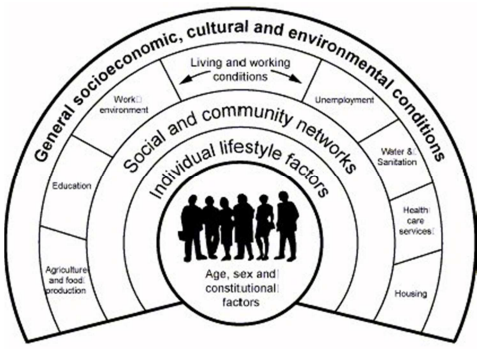
The critical challenge is how we deploy the resources of the city to address improvements in healthy life expectancy and health inequalities.

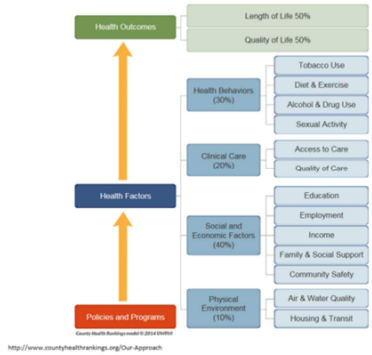
1 Introduction

Our approach to health and well being

Health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, as per the WHO definition. This is a broad an expansive definition and is taken to incorporate broader notions of “well being”. Importantly it a definition that requires a wider response than “health services”.

Twenty per cent of health outcomes, here measured by life expectancy and healthy life expectancy, are attributed to health care. The determinants of health also include health behaviours, social & economic factors, access to services and the environment, as illustrated below:





Accordingly, SCC has agreed to adopt a social model of health[1] [2]. This focuses the attention and locus on the upstream social and economic determinants of health. Within this there are a number of balances to be struck between different approaches, for example: the balance between areas of activity, for example the balances between

- social issues (jobs and poverty) and lifestyle issues (tobacco and physical activity),
- service provision and structural / policy solutions
- “treatment of here and now issues” and “prevention by going upstream”

A medically- and a socially-focused approach to health are not mutually exclusive, and different stakeholders may put different emphasis on one approach or the other. Different approaches are effective for achieving goals over different timeframes. These balances require constant attention, especially given that there isn’t a single intervention that will address the overall health and wellbeing challenge in its entirety.

There is also a tension inherent in the language of inequalities that may lead some to consider that “inequalities are not their business; its only about the 20%”. Health, and other inequalities, are a population level issue and are inextricably linked, as demonstrated by Marmot, Pickett, Piketty and many others.

What is “Public Health”

Here “public health” is defined as the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.

The “aim” of public health has often been framed as something quite narrowly defined as “something the health sector does”. This is not the case in Sheffield. The aim of “public health” is to allow and enable people to be as healthy as they can because it is the right approach; because it will slow the rate of cost growth in the health and care sector and importantly – though often missed – as a healthy population is a core infrastructure investment for a vibrant economy. Recent research[3] has highlighted that one in eight people are too ill or disabled to work by state pension age. This is obviously important from a wide range of viewpoints, it is also a redressable problem.

Background to this strategy

The Director of Public Health Report 2015[4] , the Joint Strategic Needs Assessment[5], the recommendations of the Fairness Commission[6], the State of Sheffield[7], the PHE Local Authority Health Profile[8], the Marmot Indicators[9], the locally produced lifestyle and mortality quilts and the Public Health Outcomes Framework[10] tell a consistent story about the key themes for health priorities. More recently SCC undertook an online survey to identify the key priorities as perceived by local stakeholders. In 2015, the Kings Fund supported a review of public health in Sheffield. This was set against their resource for local government focused public health[11]. This review identified a number of themes, with some detailed suggestions where we could adopt good practice from elsewhere.

What is the aim of this strategy? Why now?

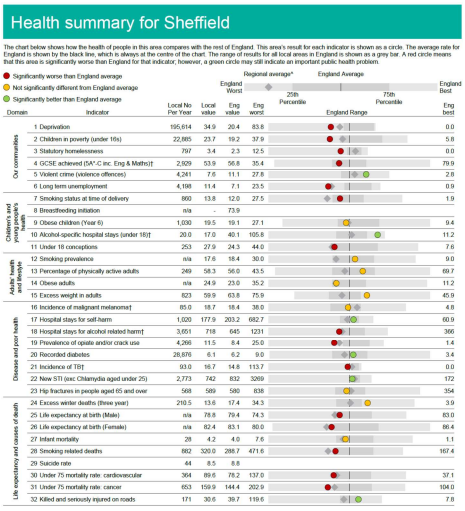
Sheffield City Council has made a commitment to becoming a public health organisation. This strategy aims to state the level of ambition contained within this commitment and set out a vision for the Council as an organisation focused on improving health outcomes and reducing inequalities. SCC has also made a commitment to becoming an organisation oriented around Prevention, this is a commitment in our developing Strategic Business Plan

This strategy is therefore a statement of intent, setting out what being “a public health organisation” looks like. It is deliberately not voluminous. It is not intended to replace existing plans and strategies, but to boost their implementation, to signal opportunities to further enhance progress against our priorities, and provoke debate on where more ambitious/radical approaches need exploring. It does, however, commit SCC to a number of specific and high impact interventions or broad directions of travel that should serve to institutionalise the focus on health outcomes and health inequalities.

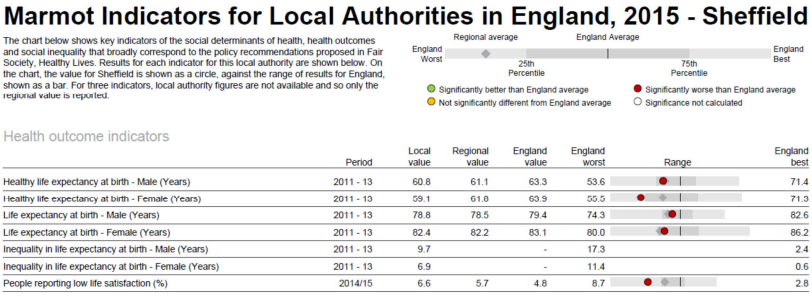
The development of the Sustainability and Transformation Plan, the Sheffield Place Based Plan and the SCC commitment to upgrading prevention combine to provide an opportune moment to define our approach to “public health” and set out some high level aspirations.

The health of the people that live in the city. The problem to solve.

The actions set out in the strategy are clearly focused on a clearly stated issue of avoidable illness and early death, and the consequences of both in terms of lost quality of life, lost economically productive years and pressure on health and social care services. Good health and well being is obviously important in its own right as a fundamental human need. The Public Health Outcomes Framework gives a snapshot of indicators of health and well being. The PHE Public Health Outcome Framework profile for Sheffield is below:



The 2015 Marmot Profile for Sheffield gives high level indicators on the wider determinants of health, health improvement, health protection, premature mortality.



Marmot Indicators for Local Authorities in England, 2015 - Sheffield

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that broadly correspond to the policy recommendations proposed in Fair Society, Healthy Lives. Results for each indicator for this local authority are shown below. On the chart, the value for Sheffield is shown as a circle, against the range of results for England, shown as a bar. For three indicators, local authority figures are not available and so only the regional value is reported.

Regional average
England Average
England Worst
England Best
25th Percentile
75th Percentile
Significantly better than England average
Not significantly different from England average
Significantly worse than England average
Significance not calculated

Health outcome indicators

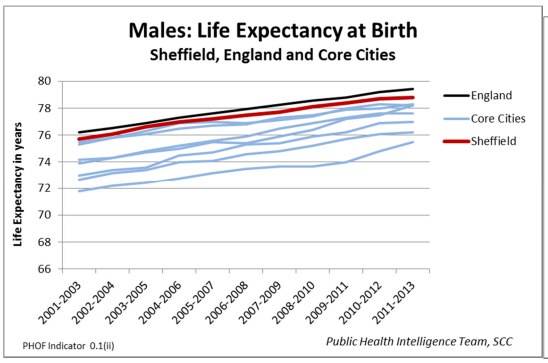
	Period	Local value	Regional value	England value	England worst	Range	England best
Healthy life expectancy at birth - Male (Years)	2011 - 13	60.8	61.1	63.3	53.6		71.4
Healthy life expectancy at birth - Female (Years)	2011 - 13	59.1	61.6	63.9	55.5		71.3
Life expectancy at birth - Male (Years)	2011 - 13	78.8	78.5	79.4	74.3		82.6
Life expectancy at birth - Female (Years)	2011 - 13	82.4	82.2	83.1	80.0		86.2
Inequality in life expectancy at birth - Male (Years)	2011 - 13	9.7		-	17.3		2.4
Inequality in life expectancy at birth - Female (Years)	2011 - 13	6.9		-	11.4		0.6
People reporting low life satisfaction (%)	2014/15	6.6	5.7	4.8	8.7		2.8

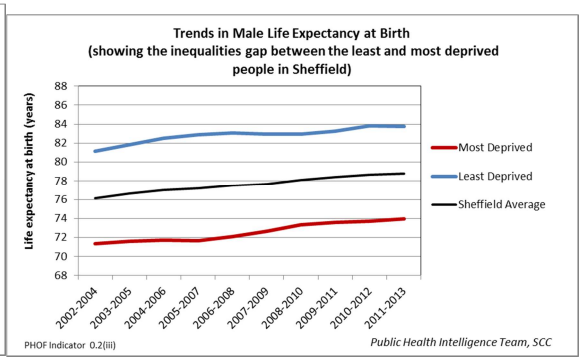
There are subsets of indicators in a number of domains – best start in life, enabling children and adults to have maximum control, fair employment and good work for all, healthy standard of living for all, and healthy & sustainable communities.

The Sheffield Joint Strategic Needs Assessment also sets this out in some detail with a range of specific data products.

Life expectancy

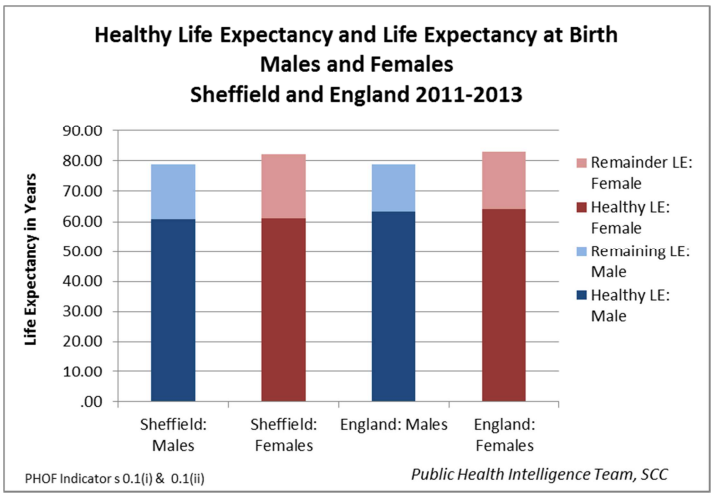
Life expectancy is increasing in Sheffield and compares well to core cities. Male life expectancy is shown here, female life expectancy data shows a similar picture. However there are still inequalities in life expectancy between the most and least deprived populations.





Healthy life expectancy is a more useful metric

Healthy Life Expectancy is a metric that incorporates the length of life, but also the number of years lived with poor health. For example, the graph below shows that for women in Sheffield average life expectancy is 82, but approximately 20 of those years are lived with poorer than optimal health.



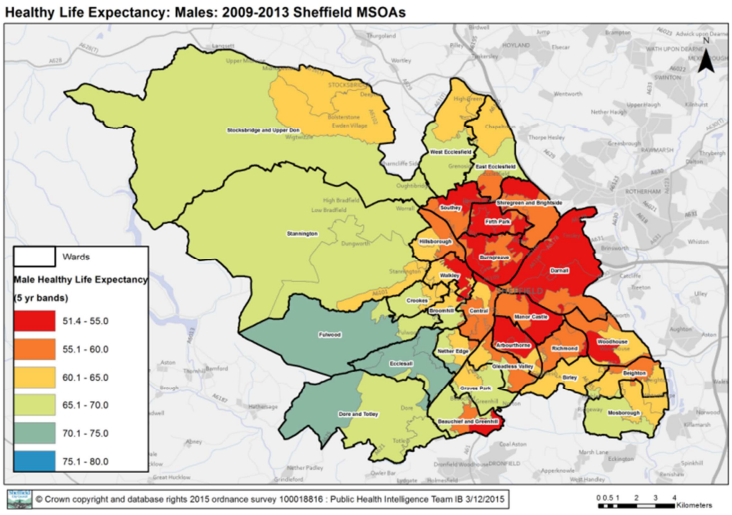
Healthy Life Expectancy is not improving and inequality persists

Healthy life expectancy is not increasing – this is a key challenge. As is often reported this avoidable illness and early death is not equitably distributed in any population. Considering the proportion of people with multiple conditions, at age 50-54 18.3% of the population have

more than one condition morbidity in least deprived populations compared to 36.8% in most deprived. Unlike life expectancy, healthy life expectancy is not increasing in Sheffield.

	Sheffield HLE Female	England HLE Female	Sheffield HLE Male	England HLE Male
2009-11	61.2	64.2	59.3	63.2
2010-12	61.4	64.1	60.6	63.4
2011-13	59.1	63.9	60.8	63.3

There is a c20-25 year gap between most and least deprived people in Healthy Life Expectancy, as indicated below.



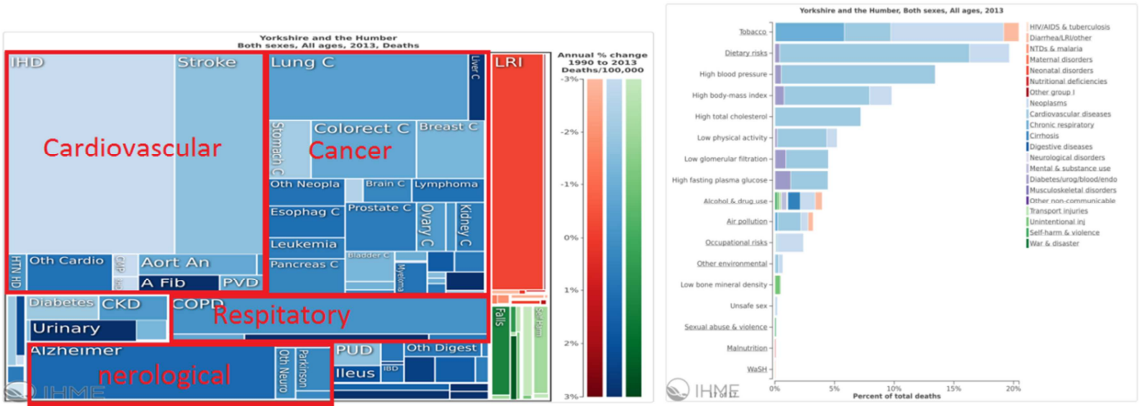
The data for female healthy life expectancy shows a similar pattern.

There are similar patterns in what is called multi mortbidity – or when people have multiple long term health conditions. We can see a 10 – 15 year difference in the age of onset of People living in the most deprived neighbourhood develop multiple morbidities 10-15 years before those in the least deprived. As many of the illnesses are preventable, this brings into question the “ageing population” issue and suggests that it is avoidable illness that causes problems, rather than age per se.

These gaps in life expectancy and healthy life expectancy do not just apply to geographically defined populations. There are also substantial differences in the life expectancy in other vulnerable groups including those with a learning disability or with a serious mental health problem, and other populations with multiple disadvantage, and the wider population.

Causes of death.

Most of the deaths in any population are attributed to cancer or cardiovascular disease, as is illustrated below alongside the immediate risk factors ranked:

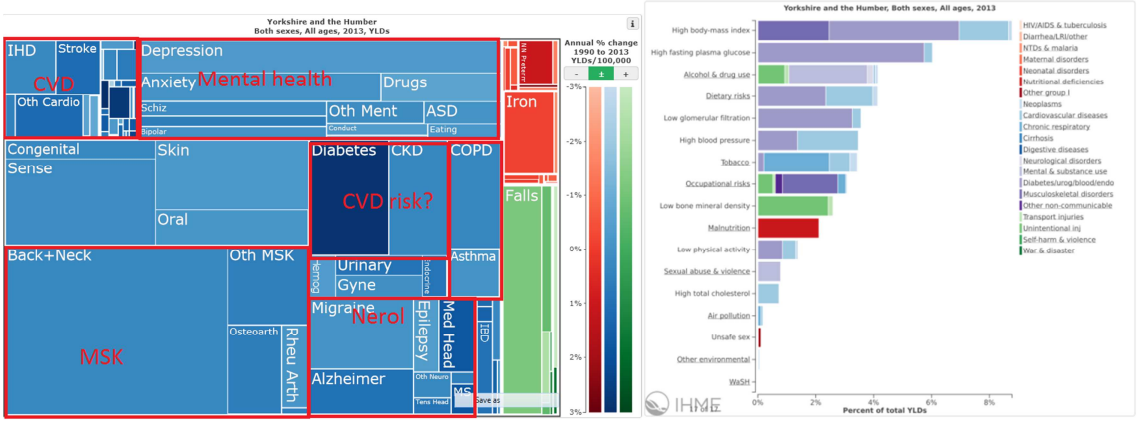


When considering early death (under 75), the same pattern holds true.

The immediate risk factors for those deaths are well documented and highlighted below:

Avoidable illnesses – Years Lived with Disability

The pattern of illness is different to causes of death; there are many things that lead to lost quality of life that don't actually kill us. This is illustrated below using the metric of Years Lived with Disability (YLD) to quantify, again alongside the immediate risk factors:



Accordingly, the immediate causes of those years lived with disability are different to causes of death.

2 What is the vision, aim and objectives

The overall vision is to improve healthy life expectancy, and to reduce inequality in healthy life expectancy between best and worst.

The focus is on giving people in Sheffield **the best start in life** to maximise their life chances; considering the health dividend across all our work; and considering how we can best support people in Sheffield to live **longer and healthier lives, with an explicit focus on inequalities.**

Aim – what outcome are we seeking to change

The outcomes this strategy is most focused on are healthy life expectancy and the inequalities between best and worst.

We will aim to increase healthy life expectancy by 1 year over the next 10 years, explicitly focused on improving fastest in those with lowest healthy life expectancy.

If achieved this equates to 560,000 person years of illness and disability avoided. The benefits of this in terms of care costs avoided are obvious. It also equates to an impact on the productivity of the economy.

Objectives of the SCC Public Health Strategy

There are 4 objectives. The objectives reflect some substantial areas where we would like to see some progress:

We will use the skills, expertise and resources we have to enable these outcomes to be delivered.

Objective 1 – **refresh and revise our approach to health inequalities**.

Objective 2– Optimise **health outcomes as an output of public service reform**, integrate health and well being as a **core consideration in all SCC policies and processes**; and **upgrading our approach to prevention** across the totality of SCC.

Objective 3 – Maintain and develop a **robust system to protect the population** from preventable infections and environmental hazards.

Objective 4 – Develop ambitious **policy and service based approaches to healthy lifestyles** to support people be as healthy as they can.

3 The underpinning principles of the public health strategy for SCC

The principles that underpin implementation are:

The following principles will underpin implementation of this strategy:

- A **balance is needed across people focused services & policy approaches.**
- We should actively seek to encourage **an environment that is as healthy as it can be, to support the healthy choice being the easiest or default** option.
- **At every turn and every decision we will push upstream;** we should examine all our activity to determine whether an upstream approach could have achieved better outcomes more efficiently.
- **Interventions should be balanced across a short, medium and long term pay off**.
- All interventions should be aiming to **reduce demand for downstream services.**
- **Proactive interventions in early years, and with families, represents the best value investment for improving the health of future generations, and achieving short term gains.** Ignoring this sets up future demand and avoidable poor outcomes. We should seek to optimise the potential in the first 1001 days. This is the "best start in life is the best value" principle.
- **We should challenge investments that have little evidence of effectiveness or value for money**, but we will **support evaluation of innovations** where there is little or no evidence.
- **We will systematically consider health and well being outcomes, and inequalities across all of our major processes and functions.**
- SCC will look to **work with people and communities by using a co-production approach** wherever possible.
- We will look to **build on existing assets and strengths in individual people and communities**.
- We will **work with people and communities based on an understanding of their individual context** and starting position.
- We will aim to **increase community engagement and empower individuals and communities**.
- We are actively changing the way we do business, **seeking to treat adults as responsible citizens.**
- We **encourage new partnerships and new stakeholders** to be involved in the pursuit of improved health and wellbeing in the city that may not have been explicitly involved in the past. These include, but are obviously not limited to, the fire service, the police, trade unions, business leaders, better incorporating the knowledge that rests within the universities and higher education sectors.

4 Areas of early focus

There isn't a single big thing that will resolve the challenges of the city in this area. An approach based on a range of interventions including education, service provision, regulation and structural or policy initiatives will be needed.

The commitment in this strategy is to moving the direction of the resource commitment towards prevention being the norm and focused effort across the council on achieving the aim of the strategy – that being improving healthy life expectancy and reduction of the gap between best and worst.

We have not set out all the areas for detailed work on interventions beyond the headlines below. The identified early priorities below are a combination of easy wins, big gain areas and strategically important issues.

Objective 1- refresh and revise our approach to health inequalities.

- **Develop a revised approach to health inequalities. Agree, develop and begin to implement a refreshed approach to health inequalities.** This should be led and owned by the HWBB, with a role to holding the system to account not for the "activity" but for the outcomes.
- Where new resources are available they should be unequivocally focused on what will make most progress on health inequalities. New resources, as and where they are available, should be focused on where the need is greatest. The Health and Well Being Board have agreed a **principle of implementing effort and change where greatest need is identified.** There is intent to see the **distribution of primary care and GP services to match needs** and levels of disadvantage across the city.
- **Develop policy and structural approaches to lifestyle and lifestyle factors** (as opposed to individual level interventions)
- Ensure a **community development based approach**, building on the strengths which communities have, developing resilience and promoting greater community spirit.
- In particular there should be an **early focus on targeted cardiovascular risk management** as something with a short term return.
- Ensure focused effort on the **employment and purchasing power of SCC the NHS** and other large organisations for optimising social value and addressing inequalities. This obviously incorporates the work around ethical procurement.

Objective 2 –Optimise health outcomes as an output of public service reform, integrate health and well being as a core consideration in all SCC policies and processes; and upgrading our approach to prevention across the totality of SCC.

Public service reform is a high priority for the public sector as a whole in Sheffield, and across the country as a whole. There exists currently an openness to new ways of working and innovative approaches; this represents an opportunity to prioritise health and wellbeing with these. To this end we should seek to:

- Across groups of indicators within the Public Health Outcomes Framework develop a **short briefing setting out the evidence base for the main interventions that will improve that outcome, and the state of implementation**. This would focus on what investments leads to maximum impact, maximum return on investment. This will include learning from elsewhere in the UK and across the world. This should address the question of the evidence base to whether our current (and future) priorities and investments will achieve the impact and outcomes we want.
- **For each major area of SCC service delivery, policy or strategy, establish a review – re-asking (given the evidence) are we implementing the right set of interventions to maximise <u>health</u> and return on investment.** Consider a whole system approach[12] to these areas – for example poverty, mental well being, housing, transport, employment and skills, healthy ageing, economic development. Consider the **establishment of a series of learning events from other places and other cities and industries exploring different perspectives and approaches to well being.** This will include seminars with leading academic thinkers. For example there may be significant opportunities to learn from other European Cities on spatial planning. This may be under the auspice of the HWBB or the Sheffield Partnership Board.
- **Ensure long term health and well being is a core feature of the redevelopment of the Sheffield plan and economic policy**. Build **health impact assessment into planning processes and developments** in a way that is practical, pragmatic and supportive, learning from other places both in the UK and in Europe.
- Consider the merits of a **health in all policies approach** across SCC. This may involve consideration of **health outcomes on the "organisational balance sheet"** in the same way as financial outcomes are considered. Consider the merit of appointing an **officer to lead on "healthy urban planning"** to coordinate work in this area.
- **Optimise the health and wellbeing potential of business rate localisation and devolution**, possibly through further devolution of powers and responsibilities from central government.

- Through PSR and other means s**upport the establishment of a substantial "prevention" structural fund**, using this to support moving commissioning decisions away from demand management towards improving health and reducing inequalities.
- **Support the NHS to give prevention a radical upgrade** and **transform the Health delivery mode**l to move the health and care system towards a place based population focused model based around "wellness".
- Maximise the **potential of citizen contact with public services to improve health through making every contact count and similar approaches.**
- Have a **strong training and development function both for SCC staff and within our communities** that enables the above to happen. Maximise potential within customer contacts to reinforce health and well being messages
- Continue the current path of **establishing community and neighbourhood approaches** as the key delivery mechanism; especially focused on an explicit community development approach. Continue to provide training to community members where necessary to enable this to happen.
- Maximise the health and well being opportunities though the development of the **private rented sector housing strategy, and the housing sector more broadly**, both planning for future need and in terms of housing quality.
- Develop a **coherent and strategic work and health strategy** to bring together multiple strands around employment and health.

Early wins in this space are suggested as the work and health agenda, the licencing process and regulatory system, transport planning and air quality – especially active travel, and the work SCC has committed to around streamlining prevention.

Objective 3 – Maintain and develop a robust system to protect the population from preventable infections and environmental hazards

Protecting the population of Sheffield from preventable infections and environmental hazards remains a critical aspect of preventative work. We will deliver this by:
Working through the Health Protection Committee to provide leadership and strengthen assurance arrangements for preventing and responding to health protection incidents and communicable disease outbreaks.
Reduce risks to the health of the population through vaccination and screening programmes and seek opportunities through targeted work to protect the health of those most at risk of infections and environmental hazards, including TB, sexually transmitted infections and HIV.

Objective 4 – Develop ambitious policy and service based approaches to healthy lifestyles.

There is a need for both policy level interventions and services to support individuals. Community engagement and outreach are often a vital component of behaviour change interventions and support from peers who share similar life experiences can be a powerful tool for improving and maintaining health. Behaviours are determined by a number of factors, particularly commercial, social and economic influences; in acknowledging this we should:

Review and refresh our strategies around food, tobacco, move more, and alcohol.

Increase the emphasis given to **policy level approaches as a free tool for behaviour change is more efficient and more equitable**.

Develop a "heart of Sheffield" project to coordinate work in this area.

5 Outcomes and indicators

As set out above the desired outcome is a 1 year improvement in healthy life expectancy over the next decade. This can be achieved by increasing the population average, it can also be achieved by focusing on inequality and areas or populations where healthy life expectancy is unacceptably low.

Being outcomes focused

Being outcomes-based means starting any process with the outcomes we want to achieve and working back from there to determine activity, not starting with the "what do we do now". If we want to achieve improvements in life expectancy and health inequality, we shouldn't start an improvement process by considering small chunks of discrete areas. In some areas the response is about developing an analysis or a narrative, in others it may be about developing service models, ensuring high and equitable coverage of high value interventions, developing health enabling policies or designing evaluations and cost benefit approaches. What matters most is the outcome that is achieved, the method – whether this be policy development, regulatory issues, or service delivery is secondary to the outcome.

Indicators of success, measurement and targets.

Within this there are indicators that may be most important and moveable. The public health outcome framework, and the Marmot indicators will be used in the main. Both the absolute position of an indicator relative to others and the trajectory is important.

The areas where it is recommended early focus is given include:

- a 10% population prevalence in smoking over the next 10 years (currently 17%) with a reduction in gap between highest and lowest of 50%.
- a 15% of the population being inactive (currently 30%) with a 50% reduction in the gap.
- Aim to improve school readiness at the end of Reception and entry into Year 1 at four: 66% > 75%
- Increased the number of people who are currently long-term unemployed moving into economic activity or meaningful occupation by x,000 people by 2021
- Reduce the number of young people Not in Employment, Education or Training (NEET) by x%pts by 2021
- Reduce the prevalence of cold related illness by x% pts. Reduce to zero the number of people discharged into a cold home when the cold increases the risk of readmission; Reduce Fuel Poverty from 10.9% to the national average of 10.4%
- Aim to achieve 10 conceptions / 1000 girls aged 15-17 by 2020

Note – targets may be needed around other areas / may keep / may ditch

6 The role of Sheffield City Council in improving public health

Public health "function" and "services" and "public health"

The Health Select Committee have recently reviewed the transfer of public health responsibility to Local Government[13]. The report highlighted many strengths and positives resulting from this transfer. Arguably the report did over focus on "the public health grant" and a narrowly defined set of functions. This is not the approach being taken in Sheffield.

"Public Health staff" don't have a monopoly on "public health", it is a collective responsibility for the council as a whole, and beyond this – a social movement rather than a group of funded services or expertise.

Many staff will have a part to play in the delivery of this strategy, including the specialist public health workforce (defined here as those posts currently funded by the public health grant).

The distributed model of public health expertise in SCC

Responsibility for public health rests with Local Government; this has always been the case. It is clear there is a great deal of good work happening. The transfer of some functions from the NHS in April 2013, gives added impetus for addressing the challenge. The aim of this strategy is to accelerate this work and ensure the "health dividend" of SCC is fully realised – especially linking agendas together and testing / challenging whether current resource deployments are focused on prevention as best they can.

Public health is the responsibility of the whole of Sheffield City Council, and other organisations beyond this; therefore we do not have a centralised public health department but have deliberately embedded public health expertise across the organisation to work alongside and seamlessly with all functions. We have adopted a similar approach in our support to and interaction with the VCS, the NHS, PHE and other organisations.

This embedded model only works if the organisation responds to the challenge of improving healthy life expectancy. Services or staff funded by the public health grant will not by themselves meet the challenge. The responsibility of public health expertise is to apply a systematic methodology to test whether the totality of a service or sector is achieving a desired objective.

Public Health Services

Public health funding is used to provide or commission some services, such as stop smoking, weight management or sexual health services; these are often considered "public

health". However, other services also make a substantial contribution to the health of the public, for example general practice, cardiology, housing support or welfare benefits advice. Services funded through the public health grant are far from the only services that have an impact on health and well being outcomes.

The "public health approach"

A key contribution of public health specialists is in the application of a skill set to an issue. The skill sets that are applied to these areas have been published many times[14]; these are best summarised as:

- **Epidemiology** – a short hand term for the methods used to describe "need", "demand" or both. This covers what do we know about a given problem, how frequently it occurs, in which groups, how it is changing, what causes it and what outcomes it leads to.
- **Evidence and evidence based policy and practice** – given a particular health and well being problem, what does the available evidence tell us is the best way to prevent this problem or to meet this need as efficiently and equitably as possible.
- **Economic analysis** – what is the most cost effective way of addressing a problem, that will lead to the optimal return on any investment of money, time or human resource. Economic analysis will also enable a better understanding of where costs and benefits fall.
- **Evaluation** – the use of a range of skills and techniques to test whether a service, programme or policy is achieving the expected goals.
- **Ethics** – given all we know, what is the "right" thing to do to optimise the health of the population as a whole, and to minimise inequality.

The role of the specialist public health workforce is moving from one of provision and/or commissioning of 'public health' services and one of using public health skills to strategically support the whole council (and other organisations) to have maximum impact on the health and wellbeing of the population through the totality of the city's resources. Implementation of this strategy should move us significantly in that direction.

The key contribution of public health staff is the application of this set of skills and methods to an issue or problem. The approach can be applied from areas as diverse as "tacking poverty" to "planning for hyper acute stroke care". A key role of public health staff is to apply the methodology systematically to immediate and more upstream determinants of the health of the people of Sheffield.
The Public Health task is therefore one of helping, supporting, injecting new ideas and fresh approaches to enable each and all of those systems to give us better health and wellbeing outcomes. This may, however, imply using expertise to ask challenging questions of current

models and testing whether current commitments really deliver improved outcomes and value. There is also a role to connect systems together in a way they may not have been historically connected.

Leadership of "public health"

Leadership of public health is currently a shared responsibility with a number of individuals and groups playing a part. The Health and Wellbeing Board is the body best placed to lead the development of the public health as a whole. Recent research commissioned by the Local Government Association[15] has shown that Health and Well Being Boards considered to be operating effectively count "clarity of purpose" as a key factor in their development.

The role of the Director of Public Health

The DPH is the lead officer holding Sheffield City Council to account for delivery of improved healthy life expectancy and reduced inequalities. This role should provide challenge where necessary and support with technical skills where needed, develop skills and competencies within SCC and other organisations, develop positive and productive relationships, and bring innovative new ideas to the fore.

If the role of the finance director is to ensure an organisation stays within budget, the role of the DPH is to ensure health and wellbeing outcomes are achieved.

A key task for the Director of Public Health is to transform public health delivery by achieving true integration of public health staff into all areas of the organisation. This is intended to enable SCC as a whole to develop new partnerships, be entrepreneurial with policy and develop new thinking to impact existing areas of interest as well as health and wellbeing outcomes.

It is important to be clear that the Director of Public Health can't direct and control all aspects of this agenda, nor should they try to. Similarly the Director of Public Health doesn't have "the answer" to the problem; the role is to set a framework and a culture and to orchestrate the right response to the challenge, so that "the answer" is generated by the Council as a whole.

The "public health grant"

The Public Health Grant cannot by itself address the public health challenges of the city. The purpose of the public health grant is to leverage change and to enable fresh and challenging approaches to be tested and applied.

The "public health budget"

The way in which the public sector, the private sector and the voluntary and community sector broadly pursues its business will have a substantial impact on the determinants of health; for example, the way we plan the city from a built environment and transport

perspective, the way we shape the economy, or the way we try to redress poverty with evidence based interventions.

Sheffield City Council has set out its ambition to be a public health organisation, so the challenge is therefore to optimise the use of its £1.4bn budget, and associated purchasing power, to best improve health and address inequality. This is best framed as not about "new resources" but as about maximising benefits from existing commitments, and then changing the nature and shape of those commitments over time to optimise outcomes. Thus the question on "the public health budget" is best framed as "is SCC using its power to best improve the trajectory of health and wellbeing indicators, to redress health inequality and to optimise the health dividend (or the health return on investment) through the right interventions".

It is true that resources hang over all other issues, this is inescapable. The key consideration is making optimal use with the resources we DO have rather than what we don't have; and being mindful of impact on health and inequalities where there is a need to reduce resource commitments. In an era of shrinking resources we need to consider the resources that are already in the system and whether they are contributing to the desired outcome.

The approach to reform should be wide ranging and consider health in its broadest possible sense, with the key question being whether the £1.4bn of SCC resource commitment, the £4.3bn of public spend in Sheffield, or the totality of the economy of Sheffield, is optimally spent to maximise outcomes and minimise inequality.

The task is one of reimagining health in a city, setting out from a health perspective what sort of city we want in 1, 2, 5, 10 and 20 years, and what investments and changes we need to make now to achieve this.

Interfaces with other strategies and processes

There is an obvious interface with other plans, including the Health and Well Being Strategy, the 2014 Health Inequalities strategy, the NHS Sustainability and Transformation plan, the SCC Corporate Plan, the Best Start Strategy and existing service plans in many services and portfolios that will contain significant services and policy areas that impact on health.

The challenge we set ourselves is to be bold and specific about the impact we are seeking to have; linking agendas together where they have not been historically linked, asking ourselves challenging questions to enable the willing to do the right thing; to stretch ourselves to go further than others and to include both short and long term actions and institutionalise our focus.

Other stakeholders

This is a strategy for SCC. Our ambition is to engage a wider set of stakeholders into “public health”. We should obviously reflect the ambition for 'public health' across the totality of the system, there should be contributions from the NHS, VCS, the universities both as major employers and in terms of knowledge transfer, schools and many others.

7 Risks to the delivery of the intentions in this strategy

The key question is whether the deployment of resources across SCC contribute or are to the detriment of the aim of increased healthy life expectancy and inequality. It is accepted trade offs are often necessary. Often the execution of “public health” has been about challenging vested interests and as ever the demands of the short term thinking dominates agendas and resources. These are not easy challenges.

Challenging the language of “public health” as something that is only about “lifestyles and health care” is an issue that requires constant attention; as does the narrative that “health” is equivalent to “NHS”. Lifestyles, and care is important; life chances are more important.

Health and well being remains one of the core objectives of SCC. This strategy will support the achievement of that objective. It is a challenging agenda in difficult times. To achieve it we need to pay more than occasional attention to “public health” and be considerably more expansive than “the public health budget”. Essentially we need to achieve the full integration of a way of thinking and doing business into the whole of SCC. Most of those that “do” the activity of “public health” do not have public health in their job titles, nor should they.

The process of business rate localization, and the potential loss of the ring fence on the public health grant presents significantly more opportunities than threats; as does the NHS STP process.

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[1] http://sheffielddemocracy.moderngov.co.uk/Data/Cabinet/20120125/Agenda/11%20New%20Arrangements%20for%20Public%20Health%20in%20Sheffield.pdf
[2] http://sheffielddemocracy.moderngov.co.uk/documents/s9992/Social%20Model%20of%20Public%20Health.pdf
[3] https://www.tuc.org.uk/equality-issues/age-equality/one-eight-people-are-too-ill-or-disabled-work-state-pension-age-says
[4] https://www.sheffield.gov.uk/dms/scc/management/corporate-communications/documents/social-care-health/public-health/Director-of-Public-Health-Report-2015/Director%20of%20Public%20Health%20Report%202015.pdf
[5] https://www.sheffield.gov.uk/dms/scc/management/corporate-communications/documents/social-care-health/health-wellbeing-board/JSNA-2013-Report/JSNA%202013%20Report.pdf
[6] https://www.sheffield.gov.uk/dms/scc/management/corporate-communications/documents/legal-justice-rights/fairness-commission/Fairness-Commission-Report/Fairness%20Commission%20Report.pdf
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[9] www.lho.org.uk/LHO.../Marmot/MarmotIndicators2014.aspx
[10] http://www.phoutcomes.info/
[11] http://www.kingsfund.org.uk/publications/improving-publics-health
[12] For example in mental health - https://jimmcmanus.wordpress.com/2016/01/08/a-whole-system-approach-for-mental-health/
[13] http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news-parliament-20151/public-health-report-published-16-17/
[14] the Faculty of Public Health sets out the broad skill base that a person registered (UK PH register or GMC register) public health specialist should have - http://www.fph.org.uk/curriculum_2015 /
Skills For Health sets out a knowledge and skills framework more broadly https://www.healthcareers.nhs.uk/about/resources/public-health-skills-and-knowledge-framework
[15] http://www.local.gov.uk/web/guest/health-and-wellbeing-boards/-/journal_content/56/10180/7788025/ARTICLE

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