HEALTH AND WELLBEING BOARD PAPER

STRATEGY MEETING

Report of:	Greg Fell
Date:	27th July 2017
Subject:	Public Health Strategy
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Summary:

Sheffield CC Cabinet have agreed a Public Health Strategy, which aims to describe the ambition of SCC to redress the 25 year difference in healthy life expectancy through the totality of SCC's functions (not just the Public Health Grant). A key feature of the strategy is focused on the concept of Health in All Policies, which considers how to maximise the health gain from policies and service areas that are not traditionally considered as "health" related. The acid test of adoption of a principle of Health in All Policies will be that all areas of decision making and resource commitment systematically consider health and wellbeing outcomes, and inequalities, across all decision making processes. To truly deliver a Health in All Policies approach it will be necessary to change the way the organisation thinks and does its business. The Committee are asked to consider how this approach can best be further developed.

Questions for the Health and Wellbeing Board:

- Are the priority areas identified in the strategy the right areas to be focusing on, and are there any of these that are of more immediate interest?
- Are there other areas we should be looking at too?
- What role could the Health & Wellbeing Board play in maximising the impact of the strategy?
- How could the Health and Wellbeing system in Sheffield build upon this direction to improve wellbeing in the city?
- How could the Health & Wellbeing Board work with the Council's Scrutiny function to support the delivery of the Strategy?

Background Papers:

Public Health Strategy

PUBLIC HEALTH STRATEGY

1. Introduction/Context

1.1. On 15th March Sheffield City Council's Cabinet agreed a Public Health Strategy.

1.2. In developing this, the original ask of the Leader of the Council and Chief Executive was to describe what SCC as a "public health organization" would look like, to transform 'public health' from an NHS facing model to a local government facing one, and to set out a strategy that described the ambition of SCC to redress the 25 year difference in healthy life expectancy between the most and least deprived areas of the city, through the totality of SCC's functions (not just the Public Health Grant).

1.3. The strategy is now agreed and published. Some further work will be done to turn this into a public facing document. As a Council Strategy, this paper principally describes the intended impact on SCC, but also highlights the potential for enacting this approach across the whole health and wellbeing system in Sheffield.

1.4. SCC is clear that the scope of "public health" is not confined to the services and activities funded from the Public Health Grant.

1.5. The approach taken in the strategy is, deliberately, tipped away from an NHS centric model of public health, though the importance of the NHS is not underestimated. This is an effort to redress the balance in approach to "public health", while being mindful of the large gravitational pull of the NHS and the potential in terms of the staff that work in it. The strategy therefore makes a concerted effect to shift the balance of the discussion and narrative on health away from healthcare and more towards other issues.

1.6. A key feature of the strategy is a focus on the concept of Health in All Policies. Health in All Policies is a mechanism to 1) make explicit, and 2) increase (rather than describe the current), health gain from policies and service areas that are not traditionally considered as "health" related. One of the aims is to ensure the health and inequalities impact is on the balance sheet in a visible and tangible way , in order to challenge the way existing resources are committed. The point of such approaches is to challenge existing resource commitments with a view to delivering more health return with them than is currently the case. Many of the processes in place will continue to happen; the challenge and opportunity is to maximise the wellbeing generated by those processes above what might have otherwise been the case.

1.7. In this way the intention is to seek to create health & wellbeing, something at least as sensible and as practical as simply avoiding disease.

1.8. Health in All Policies is not the only feature of the strategy, there is still an expectation that business as usual will continue – the services funded through the PH Grant, a focus on

lifestyles and a focus on health protection. In addition the first aim is to continually refresh our approach to health inequalities, arguably the hardest challenge of all.

2. Implementation

2.1. There is no intention to write a detailed action plan; indeed a detailed action plan may actually be a barrier to success, opportunism is likely to be strategy critical element of a successful approach. Implementing Health in All Policies will take many forms and there isn't a single idea or policy option that will achieve the goal.

2.2. The specific 10 areas highlighted in the strategy are one place to start, and focused on obvious opportunities, easy wins – in terms of where health gains can be made with limited changes to existing arrangements, and areas with significant gain potential. SCC expects to refresh or revise our strategy in these areas over the coming years. These are listed below:

1. **Best Start** – pre birth to primary school education (The first 1001 days);
2. A comprehensive **Work and Health** strategy;
3. The potential for **sustainable economic growth** to improve better health outcomes and redresses inequalities.
4. The **City for All Ages Strategy** and a refreshed approach to healthy ageing.
5. Optimising the health & wellbeing opportunities around **land use planning; population density and mix, transport planning including active travel**;
6. Development of an **Air Quality Strategy** for Sheffield.
7. Supporting the **NHS with the reform and transformation** agenda as articulated in the Sheffield Place Based Plan.
8. Reviewing and redeveloping the **Sheffield strategy for open space and green space,** bringing together our approach to the **Outdoor City, parks, Move More** and other agendas;
9. Maximising the health and wellbeing opportunities in our **housing strategy**, and development in the housing sector more broadly;
10. Developing a strategy for **mental wellbeing,** building on, and complementing the Mental Health Strategy.

Some of these target areas are wholly within the purview of SCC, but all would at a minimum benefit from a wider system view, some would be significantly enhanced by involvement from the wider system, and some are explicitly cross-organisational.

2.2. As per above, it should be emphasised these are only areas of obvious opportunity. Obviously where opportunities naturally arise on account of external or internal events these will be taken; it may also be possible to engineer opportunities. ‘Policy windows’ may only be open for a short time and may revolve on an unexpected crisis, budget process, and community demands, so an opportunistic approach will be important. Continued austerity represents a threat to progress for a number of reasons.

2.3. Gaining traction on the way that large resource commitments influence long term wellbeing and inequality outcomes, in the face of immediate demand led pressures, and reconsideration of core statutory duties is the key resource challenge. There may also be a belief gap to address.

2.4. There is a need to ensure the right machinery to make change happen. Arguably that may become a little bureaucratic but without machinery the strategy may never get beyond bold words. Eight ideas to develop implementation where it may be possible to demonstrate progress through a Health in All Policies approach are set out below:

- **Build health impact assessment into planning processes and developments in a practical way**, based on best practice. Linked to this, develop common monitoring and evaluation tools.
- **Ownership** – it only matters if others share the vision and general approach. Ownership of challenges by a large group of stakeholders matters. Persistence and presence across all parts of organisations will be needed, and potentially between organisations.
- **There may be merit in reconsidering the purpose of "commissioning" in some areas,** including what outcomes are desired and whether there are more strategic uses of resources to get those outcomes.
- **Be clear about expectations** - should key policy or service areas set and publish health and wellbeing objectives, take reasonable steps to meet objectives, and write an annual statement in which if objectives are not met reasons are given.
- **In some areas it may be necessary to change how success is measured in big systems, how Return On Investment is considered and what lessons can be learned from elsewhere in the world or other relevant sectors**. An example of this might be reconsidering how “success” is measured in transport policy, and the incorporation of health impact into economic success measures and evaluation models. A second example would be the consideration of the long term health impact of economic policies. The RSA Inclusive Growth report (among others) has noted that a healthy population is core to economic productivity, but is often missing from calculations.

- **Engaging citizens in this agenda is important, and could be done better.** There is a need to think through how to better engage individuals in the factors that influence their health. Health is NOT solely the product of our own choices, but individuals can influence these decisions as voters, consumers, employees and shareholders if they understand the problem. How can citizens be equipped to be just as (or perhaps more?) prepared to lobby their politicians over the levels of nitrous oxides on their local streets or the lack of street level activity in their housing estates, as the closure of an A&E department?
- **Supporting community based co-design to define and solve "problems". Starting with the problems as defined by communities themselves, rather than the problem as perceived by the authorities.** The five a day message will have little traction in a food desert: improving access to health services for depression and anxiety is necessary but if for instance, the root cause of people's anxiety is lack of housing security, a pill or talking therapies isn't going to solve it.
- **Aligning wider policies with improving health**. There is consensus that the decisions that influence job supply, housing quality, or the ability for people to lead active lives are going to have more impact on health than whether services fund a new treatment or build a new hospital.

3. What does this mean for the people of Sheffield?

3.1. The acid test of adoption of a principle of Health in All Policies will be that all areas of decision making and resource commitment systematically consider health and wellbeing outcomes, and inequalities, across all decision making processes.

3.2. For example, the expectation would be that transport policy and investments in this area will deliver health gain (and vice versa) and that should be led from within that part of the council.

3.3. Using this example further: developing a win/win approach is important. Success should be defined as both "how can health support successful transport policy" AND "how can transport policy deliver health outcomes". The language used may be important: the use of "health" language usually defaults to health care services, so we could consider using "wellbeing instead" as that is an outcome that is universally accepted.

3.4. Similarly the work of the planning or licensing committee should consider the possible health gain, or loss, associated with decision making. In this way "health" becomes business as usual for the council. This is a long term project and the difficulty shouldn't be under estimated. Success involves changing cultures, standard operating procedures for a city and challenging the status quo. There are obviously trade-offs and compromises are always necessary.

3.5. The focus of the strategy is on Council activity, but a Health in All Policies approach could clearly be applied beyond SCC; it is not hard to imagine that there is potential for significant

gains across the system in the context of the greater coordination involved in accountable care approaches. Irrespective of developments in this area, it should be expected that there will be opportunities for investing differently across the system to help deliver a healthier population.

3.6. It is of note that Government have attempted this in the past with a Cabinet Office led approach to health policy, but over time this defaulted to a DH led approach. Similar was seen in South Australia where "better health" was a prime concern of the Premier. Similarly here we should be mindful that the responsibility is organisational (and potentially multi-organisational), not solely that of the DPH.

4. Recent developments

4.1. Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee discussed the Public Health Strategy on 12th April. The Committee expressed strong support for the strategy and broad agreement for the ten early target areas outlined in the strategy, with some additional comments:

- There was a desire to see the strategy focus on young people of all ages, rather than just pre-school years;
- The Committee want to see consideration of sports clubs as a setting for health gain, looking beyond physical activity to linked social activities;
- The Committee were most interested in the following five priorities: Work and Health, Inclusive Growth, Healthy Planning, Air Quality, and Housing & Health;
- There was a suggestion that business cases for each of these be developed, covering: the range of outcomes to be achieved; how competing/conflicting outcomes are dealt with; and realistic estimates of what can and should be achieved (rather than hypothetical).

4.2. The Committee also reflected on the mechanisms for enacting a Health in All Policies approach. In relation to the Council's policy development processes, there was discussion that major reports and decisions should include consideration of impacts on health/health gain; this should not be a tick-box exercise, but an approach that ensures all policies, proposals etc. build 'public health' into their design.

4.3. In their discussions, the Scrutiny Committee recognized the potential impact they could have in this space, with appropriate training, development and awareness for the relevant members and officers. In particular they were supportive of the idea of calling in other portfolio areas (non-traditional health) to see what they are doing to maximise health gain. It was also noted that they are about to agree their work programme for 2017-18 so would want to consider relevant topics in this.

5. Questions for the Board

5.1. The Board is asked:

- Are the priority areas identified in the strategy the right areas to be focusing on, and are there any of these that are of more immediate interest?
- Are there other areas we should be looking at too?
- What role could the Health & Wellbeing Board play in maximising the impact of the strategy?
- How could the Health and Wellbeing system in Sheffield build upon this direction to improve wellbeing in the city?
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Appendix

Sheffield City Council

Public Health Strategy

April 2017 – March 2019

Suggested foreword

Responsibility for Public Health transferred from the NHS to local government in 2013. In reality responsibility for public health has rested with local government for over a century. Sheffield City Council has a stated aim of being a “public health organisation”, the aim of this strategy is to try to define what that actually means.

This strategy sets out an an ambitious agenda to reframe “public health” as a civic responsibility for local authorities, move away from some of the less successful approaches of the past and to influence the way a city works for health. The critical question is if we were redesigning a city for about 570,000 people where improved health and reduced inequality in health outcomes was a key criterion of success, what would this look like, and I had a budget of £14bn what would it look like.

Our strategy aims to take what could be defined as a healthy cities approach and implement this across the totality of responsibilities of the City Council. Our challenge is to institutionalise the focus across all our functions and decision making processes. Our view is the resources to be influence are the totality of the cities resources, not just “the public health grant”.

It is a two year strategy – April 2017 to March 2019. We are aware that many of the actions have a long term pay off. We also accept some of our ambition may be tempered by changes in national policy outside local control, but this doesn’t dampen our ambition. We will review progress in two years.

Cllr Cate McDonald, Cabinet Member for Health and Social Care.
John Mothersole, Chief Executive.

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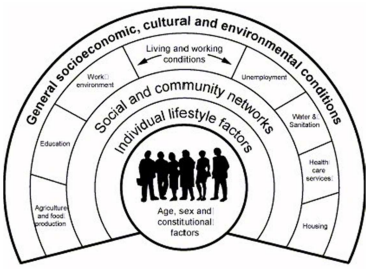
1 introduction

a) Our approach to health and well being, and inequalities in Sheffield.

SCC has agreed to adopt a social model of health[i] [ii]. This focuses the attention and locus on the upstream social and economic determinants of health.



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. 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"

Our approach is deliberately different to the health service model of public health of the recent past. This is not to say that the health service doesn't have an important role in improving the health of the public, however our approach reflects the responsibilities of local government.

Inequality and social injustice in itself is a risk to health. Inequality affects how you see those around you and your level of happiness. People in less equal societies are less likely to trust each other, less likely to engage in social or civic participation, and less likely to say they're happy. Living in an unequal society causes stress and status anxiety, which may damage health. In more equal societies people live longer, are less likely to be mentally ill or obese and there are lower rates of infant mortality[iii].

4. b) The health of the people that live in the city, what are the key issues in Sheffield.

A wide selection of data and feedback from the public tells us a consistent story about the key themes for public health priorities.

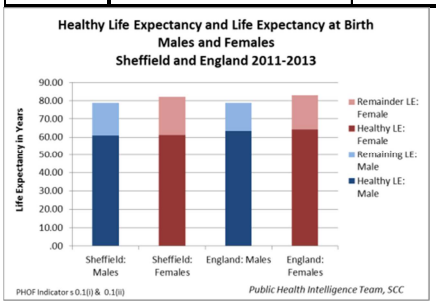
Good health and well being is obviously important in its own right as a fundamental human need. The Sheffield Joint Strategic Needs Assessment, the Public Health Outcomes Framework & the 2015 **Marmot Profile** for **Sheffield** gives good insight and high level indicators into some of the key issues, on the wider determinants of health, health improvement, health protection, premature mortality.

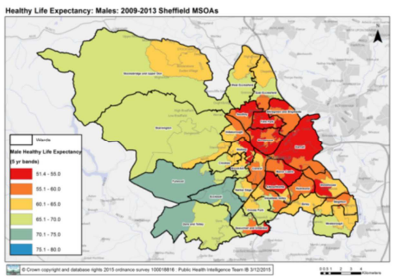
Our JSNA shows that the health priorities for Sheffield are largely the same as anywhere else; good mental health and wellbeing underpins all success; poor physical health is linked to lifestyle behaviours; health inequalities result from social and income inequality; healthier futures are built on good employment and decent homes. But the way these priorities distribute across our population is more unusual than many other similar large and diverse cities. Sheffield is characterised by extremes in the population; in terms of socio-economic status, health outcomes, environment and economic prosperity. But these extremes are often masked when we look at averages, meaning that the Public Health Outcomes for Sheffield can seem on a par with the rest of England when for large parts of the City the reality is significantly and enduringly worse. It's why we have to maintain a focus on small area variation in outcomes and develop our indicators and targets accordingly (see the ward and neighbourhood quilts[iv].

Healthy life expectancy is not improving and inequality persists

Healthy Life Expectancy is a metric that incorporates the length of life, but also the number of years lived with illness. 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. Recent research[v] 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 solvable problem. There is a 20-25 year gap between most and least deprived people in Healthy Life Expectancy, as indicated below, this is not just a geographic phenomena.

	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 are worrying signals that the long term, historic trend in the improvement of life expectancy has slowed significantly in recent years. This is happening in England and in Sheffield. The reasons for this are not yet known, but it is a significant issue that warrants significant attention.

5.

6. **2 Aims and objectives**

a) Why this strategy

Sheffield City Council has made a commitment to becoming an organisation oriented around prevention and to be a public health organisation. The challenge is therefore to optimise the use of its budget, associated purchasing power, and policy making process to improve health and address inequality.

This is a strategy for Sheffield City Council. It is intended to enable the public to hold the council to account in it's commitment to becoming a public health organisation. The **purpose of this strategy is to define the role of SCC as "a public health organisation" to set out a statement of ambition and to establish some priority areas** and strategically important issues.

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 strategy 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 will 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. There is an obvious interface with other plans, including the Health and Well Being Strategy, the 2014 Health Inequalities strategy, the

Sheffield Place Based 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 strategy is considerably broader than “service provision”, and includes policies and supportive environments can enable health. Large chunks of NHS and social care resource are used “buying back” health that we've already lost via policy choices in other policy spaces. Over time we may move away from “services” towards investments and outcomes.

b) Aim – what outcome are we seeking to change

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

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. This will equate to significant number of years of illness and disability avoided. The benefits of this in terms of care costs avoided are obvious. It will also equate to making an impact on the productivity of the economy, and contribute to a broader social justice agenda.

Our focus is on giving people in Sheffield **the best start in life** to maximise their life chances, and taking a life course approach. We will consider 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.**

A healthy population is seen as an investment for vibrant and just society and economy not a cost to health and social care system. That investment will have positive consequences on downstream health and care costs, and broader social and economic impacts. For each of these interactions there is a two way relationship, The identified early priorities below are a combination of easy wins, big gain areas and strategically important issues.

The obvious challenge is being explicit about “well being” on the balance sheet and ensuring it is being considered with the same gravity as finance and economic growth. We will work towards quantifying the gain from changed life trajectories from past and current investments and policy decisions. ..

c) Objectives

We have set 4 objectives – focusing our attention on **health inequalities**, **health in all policies**, **health protection** and **healthy lifestyles**. 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.

Objective 1- we will refresh and revise the Sheffield approach to health inequalities.

Sheffield City Council accepts this as one of its most important priorities. It also accepts there are no simple easy solutions. Through the Health & Well Being Board, the council has agreed five areas of focus reflect a need for interventions with a short and long term return and has agreed to refresh the city’s strategy for health inequalities with initial priorities:

- **Continued commitment to a community development based approach** to health and well being. We don’t underestimate the difficulty of this in an era of shrinking resources. We will build on and reflect the strengths which communities have, developing resilience and promoting greater community spirit.
- **Continued investment in and commitment to community and primary care, especially in the most disadvantaged parts of the city.** In particular we should focus on targeted cardiovascular risk management and an approach to healthy

lifestyles as part of treatment and prevention. We will also focus developing the model of, and maximising the impact of social prescribing.

- **Continued commitment to the principle of implementing effort and change where greatest need is identified**; this is building on the key recommendation of Professor Sir Michael Marmot of proportionate universality – a universal offer for all, but focused approaches where need is highest. Though this will require further debate there is a case to consider the concept of disproportionate universality.
- **Refocused effort on the link between employment and health**, through the development of a comprehensive strategy for work and health. This will focus on finding new ways to help people get back into work, and stay healthy at work.
- **When we are looking at the issue of healthy lifestyles we need to focus on the environment and make the healthy choice the easiest and default choice**. This may need some difficult conversations about policies and a shift away from "lifestyles" being about individual level actions and services.

We also agree that specific population groups required additional focus, for example children and young people, BME groups, those with learning and physical disabilities and those experiencing mental health problems. The **advantage of a double and layered approach is that it will allow for multiple inequalities to be handled at the same time.** The Council accepts these five issues aren't the only answer to the difficult issue of health inequalities, they are the issues we will focus on first. The council will also will also facilitate a number of public engagement events on this issue as a way of developing a broader debate.

Objective 2 – We will adopt a principle of Health in All Policies & systematically consider health and well being outcomes, and inequalities across all of the decisions we make

There is renewed interest in the concept of Health in All Policies, and there is currently an openness to new ways of working and innovative approaches. This gives us an opportunity to prioritise health and wellbeing across the totality of SCC resource commitments and areas of policy responsibility.

A Health in All Policies (HiAP) approach is strongly advocated by WHO and is being adopted worldwide. We will seek to work across sectors and systematically takes into account the health implications of decisions, seek synergies, and avoids harmful health impacts in order to improve population health and health equity.

Health in All Policies is mechanism to make explicit, **and increase** (*rather than describe* the current), the health gain from policies and programme areas that have not been considered as "health" related. One of the aims is to ensure the health and inequalities impact is on the balance sheet in a visible and tangible way. In this way we will challenge the way the existing resources are committed.

For example the expectation would be that transport policy and investments in this area will deliver health gain and that should be led from within that part of the council. The same may be said about licencing process, or the build environment planning process. In this way "health" becomes business as usual for the council.

The challenge remains to build this into the fabric of the organisation and the standard operating protocol so it is considered unconsciously. We will pursue an approach based on, but more ambitious than, the healthy cities model.

Objective 3 – we will 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 continue to ensure we have strong health protection arrangements 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.
- **We will continue to 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 – we will develop ambitious policy and service based approaches to promote healthy lifestyles.

Reflecting that "healthy lifestyles" are in the context of the environment in which we live and make choices we will 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, using both behaviour change & behavioural insight techniques and policy focused approaches.

We will publish and implement detailed cross council and city strategies around

- **food – with a specific focus on sugar, salt and the fast food environment; food poverty, the local food economy.**
- **tobacco;**
- **alcohol and drugs**
- **physical activity;**

These strategies will link to other strategies focusing on public health priority areas for example oral health as an obvious inequalities challenge.
We will develop a "Heart of Sheffield" project to coordinate work in this area.

3 Implementation

It is not our intention to write a long action plan at this stage. Our aim is to use this strategy to influence the way the organisation works. Within our four broad objectives, there are ten areas of early focus where we would focus our attention first.

a) areas of early focus

We have not set out all the areas for detailed work on interventions beyond the headlines areas set out. The identified early priorities below are a combination of easy wins, big gain areas and strategically important issues where we feel we can make quick impacts. There are many other areas that are not included here, that remain important. There isn't a single big intervention 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 and policy initiatives will be needed. Also we will seek to balance initiatives with a short, medium and long term pay off but all focused on reducing demand for downstream services.

There are a number of specific areas we propose to prioritise initially. These are set out below.

11. **We will renew and increase SCC's commitment to best start – pre birth to primary school education. The first 1001 days.** Building on this we will refocus our effort on Adverse Childhood Experiences and inequalities in educational attainment as a determinant of health. We will also refocus our approach to healthy schools agenda. This is underpinned by the evidence that proactive early 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.
12. **We will develop a comprehensive work and health strategy, focusing on delivery of interventions to optimise the health of those not in work due to ill health.** There are multiple other strands to this that need to be brought together into a coherent strategy; it also includes interventions to optimise the well being of those in work. This obviously reflects the two way relationship between health and the economy. We will also ensure that the skills system is a part of this work
13. **We will seek to maximise the potential for sustainable economic growth to improve better health outcomes and redresses inequalities**. There are many opportunities here around economic growth, the public and the social economy and inclusive growth to address health directly, but also the determinants of health such as poverty.
14. **We will refresh and redevelop the City for All Ages Strategy and refresh our approach to healthy ageing**.
15. **We will optimise the health & well being opportunities around land use planning; population density and mix, transport planning including active travel by adopting a healthy town framework**. We will seek to build health impact assessment into planning processes and developments in a way that is practical, pragmatic and supportive. There may be significant opportunities to learn from other European Cities on spatial planning.
16. **We will redevelop an Air Quality Strategy for Sheffield**. This will reflect the emerging evidence base about effective and cost effective interventions. Linked to this, **ensure that the developing Transport strategy fully engages with the opportunities to improve health and redress health inequality**. This will need to encompass the Streets Ahead programme but also incorporate close links with public transport planning and other aspects of transport.

17. **We will support the NHS with the reform and transformation agenda as articulated in the Sheffield Place Based Plan.** This will particularly focus on achieving the radical upgrade in prevention and the transformation of the delivery model to move the health and care system towards a place based population focused model based around "wellness". In addition we will focus on supporting the development of primary care, person centred care and capitalising on the potential of up scaling the implementation of behaviour change techniques.

18. **We will review and redevelop the Sheffield strategy for open space and green space, bringing together our approach to the Outdoor City, parks, Move More and other agendas**

19. **We will maximise the health and well being opportunities though the our housing strategy, and development in the housing sector more broadly.** This will include issues picked out in the Housing Hazard Rating System NICE Guidance 6, including - fuel poverty, slips and fall hazards, housing quality, supported housing, social housing and standards for new build and environmental hazards in homes.

20. **We will develop a strategy for mental well being**, building on, and complementing the mental health strategy.

b) Risks and enablers

Realising a health in all policies approach is dependent on a number of factors; **and success will happen if the approach is institutionalised. To truly deliver a health in all policies approach it will be necessary to change the way the organization thinks and does its business.**

This is a long term project and the difficulty shouldn't be under estimated. It involves changing cultures, standard operating procedures for a city and challenging the status quo. Gaining traction in the way that large resource commitments influence long term well being and inequality outcomes, in the face of immediate demand led pressures, and reconsideration of core statutory duties is the key resource challenge. 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, as history has demonstrated in both the NHS and Social Care.

We will seek to build health impact assessment into planning processes and developments in a practical way, based on best practice. This will be prospective and undertaken in a way so as to influence policy at an early stage, not retrospectively measuring when a decision has been made. There is a danger that this becomes a technical diversion away from the real decision making process, we will assess that on a case by case basis.

On occasion asking challenging questions of what we commission and relook at the purpose of commissioning. We may consider the question of the purpose of "commissioning", what outcomes do we want to achieve and whether there are more strategic uses of resources to get the outcomes we want.

In some areas it may be necessary to change how success is measured in big systems, how ROI is considered and what lessons can be learned from elsewhere in the world or other relevant sectors. An example of this might be reconsidering how "success" is measured in transport policy, and the incorporation of health impact into

success measures and evaluation models. A second example would be the consideration of the long term health impact of economic policies.
We acknowledge that we need to continue the current path of establishing community and neighbourhood approaches as the key delivery mechanism; especially focused on an explicit community development approach. We will seek to work with people and communities by using a co-production approach wherever possible. And focus on building on existing assets and strengths in individual people and communities.
We also acknowledge we need to maximise the potential of citizen contact with public services to improve health through making every contact count and similar approaches. We have a strong training and development function both for SCC staff and within our communities that enables this to happen.

c) Indicators

Inequalities in healthy life expectancy is the key indicator of the success of this strategy. Obviously this is not something that is easy to see change in, or easy to change. As set out above the desired outcome is a 1 year improvement in healthy life expectancy over the next decade. This will be achieved achieved by focusing on inequality and areas or populations where healthy life expectancy is lowest.
We will use the established health and well being board indicator framework to measure progress; and we each programme and project will have its own indicator framework.
If successful we will see a changed 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.

d) Involving other stakeholders

Improving the health of the public is far from only being the business of “public health”. 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 communities, the fire service, the police, trade unions, business leaders, better incorporating the knowledge that rests within the universities and higher education sectors.
This is a strategy for SCC. Sheffield city council cant, by itself, solve the problem of health inequalities. Our ambition is to engage a wider set of stakeholders into “public health”. We will obviously reflect the ambition for 'public health' across the totality of the system, there should be contributions from the NHS, VCS, Public Health England, the universities both as major employers and in terms of knowledge transfer, schools and many others.

We will also invite expertise from outside Sheffield to help us think through difficult problems from a range of new perspectives.

7. **e) Resources**. **The “public health budget”.**

Public health is an organisational responsibility not a line in a budget. 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.
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".

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.

f) Who has what responsibility and accountability

Leadership of public health is currently a shared responsibility with a number of individuals and groups playing a part. There isn't a hierarchy, one concept isn't subservient to another. Improving health and well being is a key function of all aspects of the councils business.

Councillors have a role to set the policy direction, provide political leadership and engage communities in understanding and addressing challenges, and taking opportunities when they arise.

The Council also has a significant role in terms of wider influence outside Sheffield, for example in Sheffield City Region and advocating for where we want to see change at a national policy level through influencing government.

Where change requires a national legislative or policy change there is an important role of **SCC Members in advocacy for national change**.

SCC Cabinet has a responsibility for agreeing the overall strategy and detailed implementation plans and to realise the vision.

It is important to be clear that the council can't direct and control all aspects of this agenda, nor should they try to. Similarly the council 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.

The Health and Well Being Board has a critical role for the city in improving the health of residents and tackling inequality, and the council will work though the Board to influence agendas it cannot influence alone.

Scrutiny also has an important role In developing rounded policy and scrutinising implementation.

The role of the DPH should be to champion new ideas, to influence resource commitments so they better improve well being and health inequalities and support the council to achieve its potential. The Annual DPH report will consider progress in implementation of this strategy.

Implementing Health in All Policies requires a level of technical skill and sustained committed leadership. The LGA guidance[1] made a number of helpful suggestions about "backbone staff". The Council will consider how best to enable this through the skill sets we have and what we need to develop. Despite immediate budget pressures the support staff to enable strategic change to happen are not seen as an expensive luxury.

4 Conclusion

The task and ambition of this strategy is one of helping, supporting, injecting new ideas and fresh approaches to core SCC business 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.

The realisation of a "health in all policies" approach, and the challenge for this strategy is that it must change the way we commit mainstream resources. The point of such approaches is using such frameworks to challenge resource commitments and improve

outcomes with a view to delivering more health return with them than is currently the case. The difficulty of moving some of these debates forward is not underestimated.
This is an ambitious agenda to reframe “public health” as a civic responsibility for local authorities, move away from some of the less successful approaches of the past and to influence the way a city works for health. We accept some of our ambition may be tempered by changes in national policy outside local control, but this doesn’t dampen our ambition. We will review progress in two years.

[i] http://sheffielddemocracy.moderngov.co.uk/Data/Cabinet/20120125/Agenda/11%20New%20Arrangements%20for%20Public%20Health%20in%20Sheffield.pdf
[ii] http://sheffielddemocracy.moderngov.co.uk/documents/s9992/Social%20Model%20of%20Public%20Health.pdf
[iii] https://www.equalitytrust.org.uk/about-inequality/impacts
[iv] https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report.html
[v] https://www.tuc.org.uk/equality-issues/age-equality/one-eight-people-are-too-ill-or-disabled-work-state-pension-age-says