ADDING LIFE
TO YEARS AND YEARS TO LIFE

Director of Public Health Report for Sheffield 2017

Sheffield
City Council

Contents

1. Introduction

Health is an essential part of everything we do, yet we are still tempted to think of it as being about "not being sick" and our automatic response is therefore to see "health" as the same as "health care services".

As I attempted to describe in my report last year, if we take an individual, community and population approach, health is the building block of personal fulfillment, prosperity, resilience and sustainable growth. That's why a loving family, a safe home, educational achievement, a decent income, a good job, friendly neighbours, clean air, and an environment that lets us all start, live and age well are all far more influential factors in securing good health outcomes than health and social care services alone.

Despite this universal truth, we continue to focus our attention in the health domain on health and social care services and how to reduce our expenditure on them. As I have blogged many times, prevention is the key to addressing growing expenditure on health and social care and until this is addressed robustly and improved outcomes secured, the issue of care costs will remain. This consideration is even more pressing given that the key indicators of a healthy population (life expectancy and healthy life expectancy) are beginning to tell a worrying story: one which should give us serious pause for thought.

The most recent data on average life expectancy for both men and women in the UK show that the rate of annual increase has been slowing down over the last few years.

Figures 1 & 2: Trends in Male and Female Life Expectancy 2001-03 to 2013-15 (Sheffield & England)

Life Expectancy at Birth: **Males, Sheffield and England**

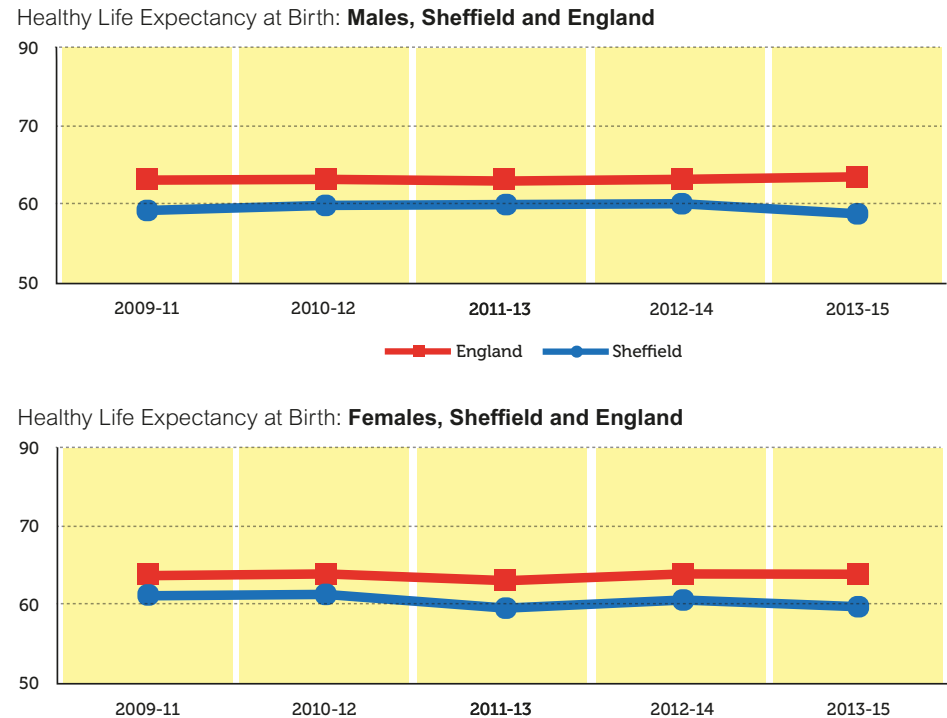Life Expectancy at Birth: **Females, Sheffield and England**
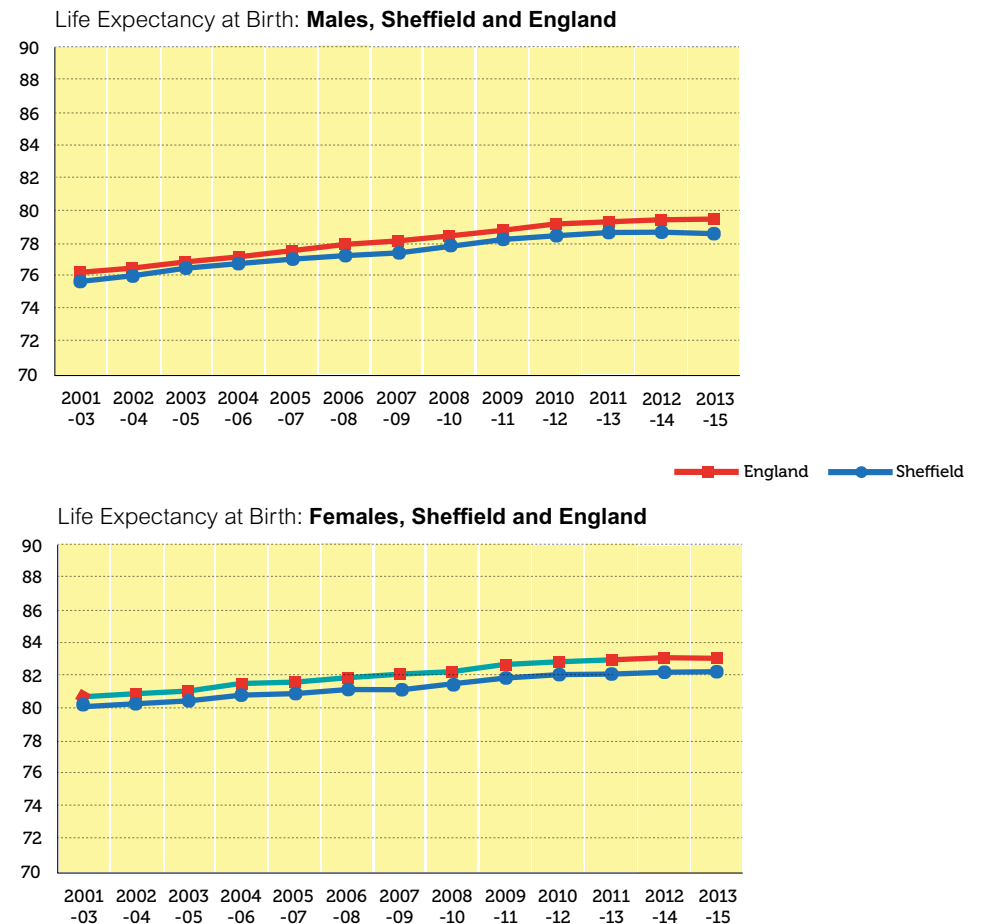
In Sheffield we have noted very little improvement in women's life expectancy over the last 10 to 15 years. For men, we have seen a decrease in average life expectancy from 78.8 years in 2012-2014 to 78.7 years for the most recent period of 2013-2015. This is deeply concerning. There are many theories to explain this stall in improvement, but the direct and indirect impact of continuing austerity ranks highest among these.

But the story doesn't end there. We are also seeing a similar problem emerging with how long we can expect to live in good health ('healthy life expectancy'), although we do not have reliable data going back as far as we do for life expectancy.

Latest figures for Sheffield show that average healthy life expectancy for women decreased from 61.5 years in 2009-11 to 59.9 years in 2013-15. The decrease in men's healthy life expectancy has been less sharp over the same period, reducing from 59.3 years to 59 years. It should also be noted that Sheffield's figures, for both life expectancy and healthy life expectancy, are worse than for England and for Yorkshire and Humber. This means more people in poor health at a (slightly) younger age than previously.

We are currently updating our Joint Strategic Needs Assessment and, in so doing, taking a much more in-depth look at health and wellbeing in the city. This has included for example, examining our progress across all the 159 indicators in the national Public

Figures 3 & 4: Trends in Male and Female Healthy Life Expectancy 2009-11 to 2013-15 (Sheffield & England)

Healthy Life Expectancy at Birth: **Males, Sheffield and England**

Healthy Life Expectancy at Birth: **Females, Sheffield and England**

Source: https://www.ons.gov.uk/releases/healthstatelifeexpectanciesuk2013to2015

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Health Outcomes Framework[1]. Together with the latest data on life expectancy and healthy life expectancy, this work is pointing to the need to focus on a number of areas as a priority.

In this year's report, I draw attention to three particularly important priorities for the health of our city. They are not the only priorities, but they are three that warrant careful consideration.

Adverse childhood experiences (ACEs)

There is increasing evidence that both positive and negative childhood experiences have a tremendous impact on future violence (victimisation and perpetration) and lifelong health and life chances. Moreover, early childhood development programmes targeted towards the most vulnerable show good rates of return on investment across many social outcomes, albeit over the long term. Sheffield is no exception to the effects of ACEs but it is also well placed to respond. This section of the report therefore considers why ACEs matter so much to longer term health outcomes and sets out some of the work already taking place in the City to address the adverse effects.

Mental wellbeing for life

Good mental wellbeing is essential for a healthy and prosperous society and it is just as important as good physical health. But it is all too easy to focus on what happens when someone becomes mentally ill and how specialist services respond to that rather than

how to stay well in the first place, prevent problems from arising, intervene early if problems do emerge, and help people to manage and look forward with their lives. In this second section of the report I therefore look at some of the key determinants of mental health and wellbeing and what we can do locally to ensure there is no health without mental health.

Multiple morbidity (ill health and disability)

The practice of hospital based medicine is highly specialised with specific conditions treated individually and usually in isolation from each other as well as from the lived context of the person with the condition. The reality however is that we are seeing more and more people with two or more long term conditions at a time – known as multi morbidity. In this third and final section of the report I suggest it is this expansion of multi morbidity, both in terms of overall numbers and at earlier ages, that is not only impacting adversely on healthy life expectancy but is also the key factor driving the increase in the demand for health and social care services, rather than the ageing of the population.

For each of the three areas covered in the report I identify a number of priorities for action over the short, medium and longer term. This year I am also making the following three recommendations for further research:

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1 Access the Public Health Outcomes Framework here: http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000049/pat/6/par/E12000003/ati/102/are/E08000019

The Council and the CCG should request Public Health England to co-ordinate further research on identifying and describing the long term return on investment of tackling ACEs and effective primary and secondary prevention models.

The Council and the CCG should review the Sheffield strategy and evaluate the city's approach to mental health and wellbeing against the current evidence base for high impact/high value interventions, including the economic case for investment in good mental health.

The Council and the CCG should commission more in-depth epidemiological analysis of changes in multi morbidity and enhance their approach to healthy ageing, including care of people who have multiple illnesses.

The report also includes a progress report on the recommendations I made in last year's report and provides details on how to access further information about health and wellbeing in Sheffield.

Greg Fell
Director of Public Health for Sheffield

2.

Adverse Childhood Experiences

Why ACEs matter

There is a growing body of evidence showing the profoundly damaging impact that adverse childhood experiences (ACEs) can have on a child's future outcomes across many areas including health and wellbeing, and these effects can last a lifetime.

ACEs are stressful experiences occurring during childhood that directly harm a child or affect the environment in which they live and grow up. It is estimated that almost as many as 50% of adults may have been exposed to at least one adverse experience during their childhood (indeed some studies have put this higher at around two thirds of all adults).

Types of ACEs include child abuse (which includes emotional, physical or sexual abuse), neglect (both physical and emotional) and household challenges such as growing up in a household
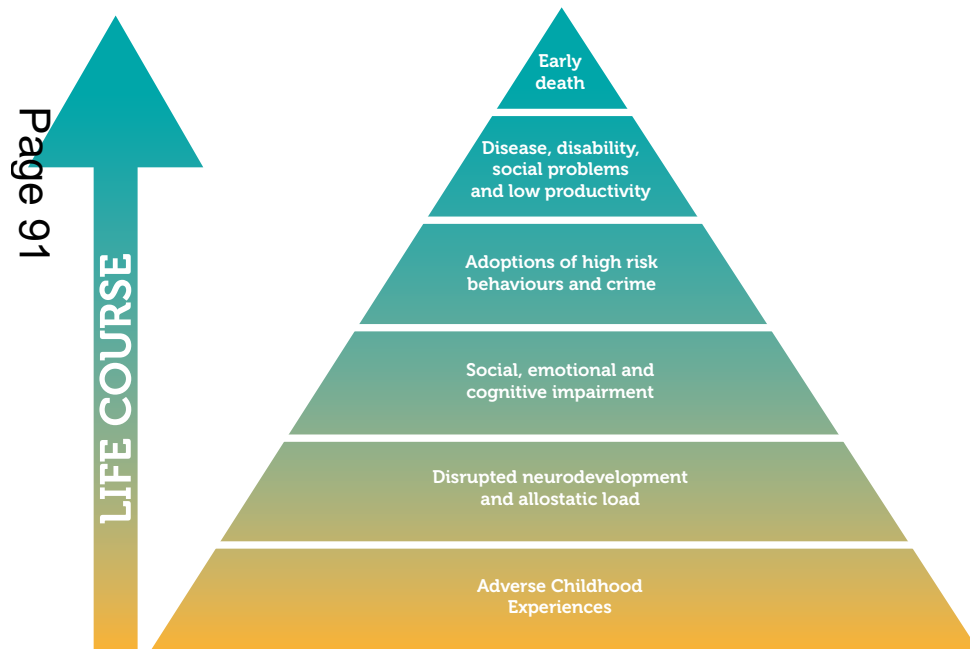
where there is substance misuse, mental illness, domestic violence, parent separation/divorce or where a member of the household is sent to prison. Evidence shows there is a strong graded relationship between the number and category of childhood exposures and the risk of developing emotional and physical health problems in later life.

Children who experience ACEs are more likely to become parents who raise their children in family environments where these risk factors are more common. This can result in a cycle of disadvantage and poor health outcomes. By preventing or reducing the impact of ACEs there is a real opportunity to break these destructive cycles and reduce the impact on future health and wellbeing outcomes.

Abuse Neglect Domestic violence Mental illness Substance misuse Incarceration Homelessness Parental separation/divorce

Impact on healthy life expectancy

Figure 5: Model of ACE impacts across the life course

Source: Public Health Wales NHS Trust (2015). Adverse Childhood Experiences - and their impact on health harming behaviours in the Welsh adult population. Page 7

The 'Great Start in Life' Best Start strategy[2] describes Sheffield's ambition that every child, young person and family achieves their full potential. We aim to do this by providing families and communities with the capacity, resources and support that will enable young children to flourish. Exposure to ACEs can have a direct negative effect on these aspirations.

We are increasing our understanding of the biology of ACEs, their social and physical causes and what we can do to respond. Recent evidence for example, shows that chronic traumatic stress in early life alters how a child's brain develops as well as changing the development of their immune and hormonal systems. Such changes can have a detrimental impact on a child's capacity to learn, and on their physical health, increasing the risk of illnesses such as cancer and heart disease. The combination of these factors may lead to mental health problems and a greater likelihood of adopting harmful behaviours in adulthood, such as smoking, poor diet, substance misuse and early sexual activity. By understanding ACEs and developing interventions that reduce the risk factors in vulnerable families we have an opportunity to:

• improve health outcomes and prevent disease across the life course

• improve individuals' mental and emotional wellbeing

• increase economic productivity

• reduce costs to the health and welfare system.

Breaking the cycle

We know children's earliest experiences are the key to their success in adulthood. Significant developments have been made over the last few years to improve Early Years provision in Sheffield and deliver interventions from pregnancy through to early childhood that promote bonding and attachment, and protect babies' brain development.

Joint working is key and partnerships involving statutory organisations, the voluntary sector and local communities are using a range of evidence-based programmes to provide universal and targeted support, which also offer opportunities to identify families at risk or in need of greater support. This activity has been supported by the delivery of skills development and training to over 3,000 practitioners on attunement[3], regulation and its critical importance in infancy.

The new Family Centres, which build on the role that Children's Centres played in prevention and early intervention, offer an extensive range of early help services across Sheffield. These can be tailored around the needs of individual families with children from pre-birth up to 19 years, and include input from partners in health, education and the wider community. Provision includes support with physical and emotional health, practical advice on keeping children safe, support with education and learning, support with parenting, home, money, work, training, and volunteering.

Whilst action to address ACEs is not currently an explicit feature of this work, existing activities provide an excellent foundation for greater understanding and awareness. They also offer the opportunity for further collaborative action to support prevention, early intervention and to mitigate the impact of ACEs.

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3 "Attunement" describes how reactive a person is to another's emotional needs and moods. A person who is well attuned will respond with appropriate language and behaviours based on another person's emotional state.

Priorities and recommendation

Growing knowledge and understanding of the effect that ACEs have in early life and their damaging consequences for lifelong outcomes cannot be ignored. Tackling their presence and impact is important for reducing inequalities across the community.

We will work with our Children's Health and Wellbeing Transformation Board[4] to agree a plan that provides a detailed programme of work on ACEs for Sheffield, based on our priorities for action. This plan will include a simple framework that identifies innovative ways to build a systematic approach to ACEs into our early years' delivery model, including prevention and harm reduction. The work will complement the city's Tackling Poverty Strategy[5] and the work of the Fairness Commission[6].

We want every child to grow up free from ACEs and reach their full potential. The social and economic benefits of taking forward this approach are compelling - the costs of not doing so are far greater.

Recommendation: The Council and the CCG should request Public Health England to co-ordinate further research on identifying and describing the long term return on investment of tackling ACEs and effective primary and secondary prevention models.

Priorities for action

- Increase public awareness of ACEs and their lifelong consequences in childhood, and gain political and organisational commitment for a coherent programme of work to prevent ACEs.

- Identify what can be done at individual, family and community level to put in place effective interventions in the pre-natal period and first 3 years after birth for the most disadvantaged children and families.

- Explore how we can incorporate our response to ACEs into our Early Years' delivery model, its pathways and services. This model provides an ideal basis for identifying vulnerable children and families, and providing appropriate and timely support.

- Equip Early Years' practitioners with a full understanding of ACEs, the importance of promoting bonding and attachment for good parent-child relationships and secure emotional attachment, and also promoting positive maternal, family and emotional health and resilience.

4 http://www.sheffield.gov.uk/home/public-health/children-health-wellbeing
5 http://democracy.sheffield.gov.uk/ieDecisionDetails.aspx?AIId=10078
6 http://www.sheffield.gov.uk/home/your-city-council/fairness-commission

3.
Wellbeing for life

No health without mental health

The statement "no health without mental health" and the underlying meaning of parity of esteem between physical and mental health is widely accepted, but achieving this aspiration in practice is more challenging: the fact remains that much more needs to be done to secure good mental wellbeing and emotional resilience in both children and adults. This means going further upstream to prevent illness and promote positive health.

Many people prefer the term "mental wellbeing" to "mental health" as the latter can focus attention on psychiatric conditions and related specialist mental health care services. This can lead us to assume that good mental wellbeing outcomes can only be achieved through better mental health services. Good service provision is necessary but it is not sufficient for achieving mental wellbeing. Good mental wellbeing is about feeling good and functioning well, comprising an individual's experience of their life and a comparison of life circumstances with social norms and values. It also means increasing the focus and emphasis on population and community level resilience and risk factors without losing focus on the need to continue to improve services for those who are ill. A social and economic environment that supports good mental wellbeing is as important as high quality specialist services.

The economic case for good mental wellbeing is also increasingly well evidenced. For example, it has been estimated that doubling the number of people offered good quality employment would cost approximately £54 million but could generate savings to the NHS alone of £100 million in under two years with significant additional savings for other parts of the public sector, not to mention the impact on individual and family incomes.

Blending the social and medical models to promote good mental wellbeing is critical to achieving our aspiration of no health without mental health. On the whole we have good clinical services including both pharmacological and psychological treatments and support. However, if we focus only on the service response we miss the opportunity to prevent poor mental wellbeing and secure longer term positive outcomes.

The determinants of mental wellbeing

The determinants of mental wellbeing can be thought of as both protective of and risk factors for mental health outcomes, and operate at individual, family, community and population levels. Traditionally our focus has been on how we treat and support severe mental illness rather than how we promote and protect wellbeing.

Evidence relating to the detrimental impact of poverty, financial and housing insecurity and the ongoing consequences of austerity on mental health and wellbeing is growing. Whilst there may be little that we can do to change national policy, there is still considerable potential to achieve positive change at the local level, and Sheffield already has a strong offer in this regard. It is worth noting, for example, that ensuring timely, effective and appropriate access to the £126 billion social welfare system represents a significant priority for local action.

However, these factors and responses are primarily focussed on adults, at least at the first point of contact. If we are determined to prevent poor mental wellbeing we need to go further upstream and start much earlier.

Risk factors

Housing insecurity, homelessness and fuel/food poverty

Debt problems, financial insecurity and exclusion

Low wages, insecure employment and long term unemployment

Welfare rights and ongoing consequences of welfare reform and austerity

Bereavement, family breakdown, social isolation

Protective (local) services

Housing Plus (covering Council Homes) and homelessness support services

Financial inclusion strategy

Help for people with mental health problems back into work

Sheffield Citizens' Advice Bureau

Voluntary, Community and Faith (VCF) sector services supporting community based asset development and resilience

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Starting early

Promoting, protecting and improving our children and young people's mental health and wellbeing are national and local priorities. Experiences in childhood have a profound effect on our adult lives. Many mental health conditions in adulthood show their first signs in childhood and, if left untreated, can develop into conditions that need regular care. Indeed, it is estimated that 75% of mental health illnesses (excluding dementia) emerge before the age of 18.

Our local priorities and actions for improving children's emotional health and wellbeing are set out in our 'Future in Mind' plan[7]. This plan has enabled us to access an additional £1.3 million per year of national funding from 2015-16. We are using this in a number of ways including:

- improving access to and reducing waiting times for therapeutic services
- improving support for our most vulnerable children and young people, including those living in care, those involved in the Youth Justice System and children in need
- providing the Sheffield workforce with the training and development it needs to support the emotional wellbeing and mental health needs of children and young people
- providing help and support to young people experiencing low level mental health problems at the earliest opportunity in schools and other settings

- redesigning child and adolescent mental health pathways, suicide prevention and crisis response.

A whole system approach to improving children and young people's emotional wellbeing and mental health promotes protective factors at all levels:

- **Individual:** balanced nutrition, regular physical activity, sufficient sleep
- **Family:** things are spoken about and someone listens, feeling safe and loved, free from harm
- **School:** personal, social and health education (PSHE), sense of belonging, feeling safe, positive relationships with teachers and peers, achievement
- **Community:** good places to spend time, trusting people and feeling safe

7 https://www.sheffield.gov.uk/home/public-health/children-health-wellbeing

Priorities and recommendation

As part of our JSNA we have undertaken in-depth analysis of mental health needs in Sheffield including a health needs assessment (HNA) for children and young people (2014) and for adults (2015)[8]. These HNAs continue to help shape and structure our approach to mental health and wellbeing in the City. Based on what these tell us, the main priorities for mental health across the life course are:

Promoting wellbeing - a good and positive state

Promoting psychosocial resilience - skills to cope with stressors and life's problems

• Preventing ill health - spotting signs, intervening early with basic interventions

• Addressing and recovering from mental ill health - coping, functioning and best possible recovery.

Ensuring we have the right mix of asset based community development, primary care, early intervention, treatment & support and recovery is an ongoing challenge. We should not abandon difficult future challenges in the face of overwhelming immediate pressures. The approach we develop should include population and individual level interventions (risks, assets and protective factors) and connect services that deliver care and support with the "determinants" of mental health.

Recommendation: The Council and the CCG should review the Sheffield strategy and evaluate the city's approach to mental health and wellbeing against the current evidence base for high impact/ high value interventions, including the economic case for investment in good mental health.

8 https://data.sheffield.gov.uk/stories/s/Sheffield-Health-Needs-Assessments/hb5c-7389

Ten ways to improve mental wellbeing

1	Promote mental wellbeing as something everyone can improve on, not just those using mental health services
2	Tackle the things that impact on mental wellbeing such as bullying, financial stress, abuse and social isolation
3	Fight mental health stigma with positive social marketing and personal 'real life' stories
4	Design campaigns and initiatives in collaboration with target audiences
5	Support mental wellbeing and resilience in schools and tackle bullying as a priority
6	Encourage employers to take ownership of their employee's mental wellbeing, and offer support and training
7	Recognise healthy lifestyle choices as being both a cause and effect of mental wellbeing
8	Treat social isolation as a threat to mental and physical health and work to link people up with their community
9	Consider the effect of public policy on mental health and wellbeing
10	Ensure everyone has access to timely support - waiting lists and restricted access are a false economy

4.

Multiple morbidity

What drives demand for health and social care?

The most popular answer to this question is "the ageing population". Evidence derived from Sheffield and across the UK clearly shows this is the wrong answer to the question and that it is to the issue of multiple morbidity (people with many illnesses) that we should look for our answer.

We know that healthy life expectancy is not improving. This means we are developing long term illnesses earlier in our lives and therefore living longer in poor health. GP records show that almost 40% of the Sheffield population (all ages) has at least one long term condition and all the indications suggest this percentage is not likely to decrease anytime soon. This leads to more 'unhealthy person years' in a fixed capacity system that is designed to respond to single diseases and acute health problems. Moreover, the 'unhealthy person years' are not evenly spread across the population with the burden falling disproportionately on poorer people.

Contrary to conventional wisdom, while the number of older people in Sheffield and nationally (people age 65 and over) is rising, the basic age structure of the population isn't changing very much. If the ageing population was the key driver for increasing demand for health and care services, we would expect to see this changing impact reflected in increases in hospital admissions for selected one-year periods. However, when we look at national hospital admission data for 1994-1995, 2004-2005, and 2014-2015, for example, the proportion of increase that can be attributed to ageing factors are

0.33%, 0.63%, and 0.80%, respectively. Demand for health and social care in England is currently increasing by about 4% per year, far faster than the ageing population. Moreover, there is now consistent evidence from a macro perspective that the key drivers of cost growth are: disease incidence (prevention); lack of attention to primary care, high cost technology (manufacturer pressure & patient expectation); and over diagnosis (clinical culture and system pressure)[9 10 11 12].

Figure 6: Prevalence of multi morbidity by age and deprivation
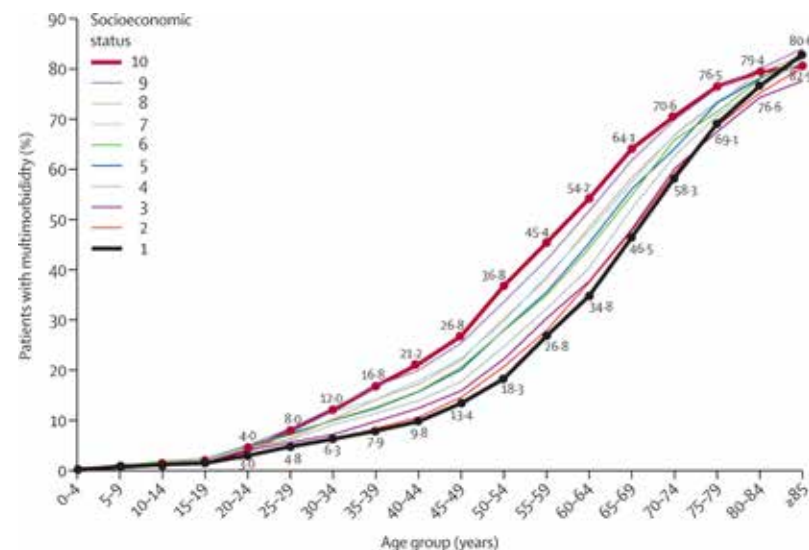
Source: Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012) Epidemiology of multi morbidity and implications for health care, research and medical education: a cross-sectional study. The Lancet 2012 Jul7; 380 (9836): 37-43.

9 NHS Greater Glasgow and Clyde http://www.gla.ac.uk/media/media_443695_en.pdf & http://www.gla.ac.uk/media/media_443697_en.pdf

10 Office for Budget Responsibility http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf

Prevalance of multi morbidity in Sheffield

Information derived from GP practice medical registers shows that in 2017, 94,110 people in Sheffield had been diagnosed with two or more long term conditions. The most common conditions are hypertension (high blood pressure), depression and diabetes.

In terms of age distribution, multi morbidity is most common in people aged 70 to 79 years followed by 60-69 year olds and then people aged 80-89 years. Overall, there are more people under the age of 70 with two or more long term conditions in Sheffield than there are over the age of 70.

If we focus only on the ageing population, the wrong response becomes more likely. So, for example, if we think the increase in demand for health and social care services is an inevitable consequence of more, older people, we may prepare for this incorrectly by building bigger hospitals and increasing the number of hospital beds provided to cope with this demand. But as we can see, it is multi morbidity that drives demand.

The response should therefore be about prevention, early identification and management of these conditions within primary care. We are in danger of losing our focus on healthy life expectancy by fixating on something we can't control (people getting older) rather than on something we can control (preventing onset of ill health).

Table 1: Prevalence of individual conditions in Sheffield people having two or more physical and/or mental health long term conditions

Condition	Number	Proportion
Hypertension	54,906	58.3%
Depression	37,711	40.1%
Diabetes	25,658	27.3%
Asthma	25,053	26.6%
Chronic kidney disease	18,924	20.1%
Coronary heart disease	18,028	19.2%
Hypothyroidism	15,471	16.4%
Cancer history	13,581	14.4%
Stroke or transient ischaemic attack	10,608	11.3%
Chronic obstructive pulmonary disease	10,499	11.2%
Atrial fibrillation	9,718	10.3%
Heart failure	6,080	6.5%
Epilepsy	4,532	4.8%
Dementia	4,468	4.7%
Serious mental illness	3,907	4.2%
Peripheral vascular disease	3,659	3.9%
Learning disability	2,226	2.4%

The table is based on the 94,110 people in Sheffield who have two or more long term conditions. 54,906 (or 58.3%) of these people have hypertension as one of these long term conditions

Source: Sheffield GP Practice Registers (June 2017).

11 Nuffield Trust http://www.nuffieldtrust.org.uk/blog/nhs-financially-sustainable
12 Centre for Health Economics (University of York) http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP127_medical_spending_hospital_inpatient_England.pdf

Shifting the curve

Our overall aspiration should be to move the whole multi morbidity curve downwards such that, instead of developing your first long term condition in your late fifties, you develop it in your sixties instead, as well as having fewer long term conditions overall.

Local analysis demonstrates the tangible financial savings that can be achieved by delaying the onset of multiple illnesses. As Figure 7 shows, a one year delay in onset and development of complexity overall could yield savings of approximately £4 million per year in NHS hospital costs in Sheffield alone. In addition to the financial saving there is a tangible improvement in health and wellbeing outcomes and, for those of working age, a clear economic benefit as well.

Work on shifting the curve will need to focus on inequalities. There is already a 15 year gap in onset of multiple illnesses between the most and least deprived people in Sheffield. For example, approximately 18% of the least deprived people in Sheffield have developed a long term condition by their fifties whereas as many as 40% of the most deprived 50 year olds have developed one or more chronic conditions.

This will mean shifting our health and social care system away from treating individual diseases on an episodic basis towards providing help for people with a number of different conditions, earlier on and in their own communities.

Figure 7: Impact of delaying onset of multiple illness in adults on hospital care expenditure in Sheffield
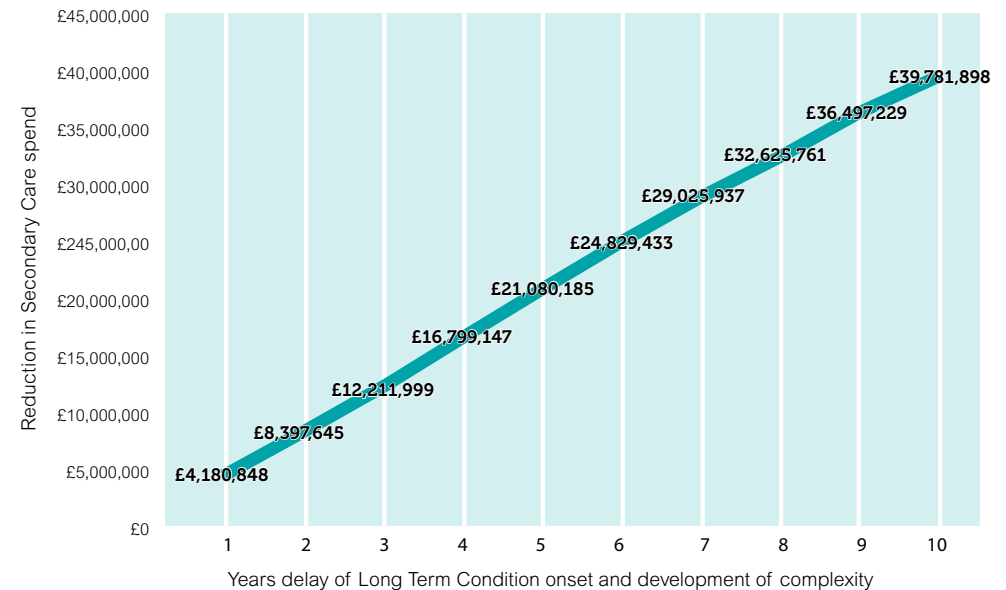
Source: Sheffield GP Practice Records

Priorities and recommendation

To shift the curve, reduce demand for hospital care and ultimately improve healthy life expectancy there are a number of key actions and approaches we need to pursue, although fundamentally increasing emphasis must be given to preventing illness and better management of complications in those who are ill. No developed healthcare system is particularly good at this, so we shouldn't underestimate the level of challenge we face. Our main focus should be on:

Preventing illness and supporting healthier ageing in the widest possible sense

- Altering the balance of investment and provision in community and hospital based care. Broadly we need to double the level of investment in primary and community based care and ensure this investment is allocated according to where multi morbidity is prevalent and investment is matched to need

- Developing the generalist workforce (rather than specialist healthcare staff) and reviewing the type and combination of hospital bed provision within the City

- Developing a 'person centred' city approach. The aim would be to develop a shared culture and ethos that recognises the value of a person and a community centred approach in how the local health and social care system operates and the range of capabilities and opportunities that are vested within people. We should strive to create conditions for people to achieve the life they have reason to value, whatever their starting point may be, and for services to be tailored to this range of abilities and starting points.

Recommendation: The Council and the CCG should commission more in-depth epidemiological analysis of changes in multi morbidity and enhance their approach to healthy ageing, including care of people who have multiple illnesses.

5.
Progress on last year's recommend -ations

Creating the environment for living well

Each year the Director of Public Health report makes a set of recommendations for improving health and tackling health inequalities within the local population. Here we summarise the progress made on the recommendations from last year's report.

Recommendation	Progress
The Health and Wellbeing Board should take forward a series of learning events / appreciative enquiry on different approaches to health and wellbeing to explore what optimising "health and wellbeing" could look like in a number of key policy areas.	The Health and Wellbeing Board has reviewed how it works and committed to consider how it uses engagement events in the development of its thinking. This work is still in progress and learning events will be built into the future programme of Board meetings.
The Council, as part of Public Sector Reform, should consider a healthy population and minimising health inequalities as a core infrastructure investment for a prosperous economy.	The Council is developing its approach to inclusive growth and redefining its understanding of "the economy" and the relationship between economic, health and social policy. It is also seeking to develop a citywide strategy for work and health. The Sheffield City Partnership Board is due to discuss the link between health and the economy in September 2017 and this will be developed further in the 2018 State of Sheffield report, feeding into the wider inclusive and sustainable growth focus. Nevertheless, ongoing austerity and cuts to public services mean this work operates in a highly challenging context.
The Council and the CCG should explore the development of a 'Heart of Sheffield' structural model to coordinate and shape a policy approach to improving living well options (such as increasing physical activity and reducing smoking) in the City.	The Council and the CCG developed the Sheffield 'Healthy Lives' Programme, agreed by the Health and Wellbeing Board in January 2017. The programme is part of the Sheffield Place Based Plan. There are three components: hospital-led smoking cessation and alcohol brief interventions; CCG-led cardiovascular disease risk factor management; and Council-led healthy public policies for tobacco, alcohol, sugar and food.
The Council and the CCG should develop a joint neighbourhood delivery system with a broad model of primary care as the main delivery mechanism for services.	Primary care neighbourhoods have been set up across the City based on federations of GP practices and community, social care and third sector services. A Programme Board oversees this, covering the Council, CCG, housing and voluntary sector organisations and is part of the 'People Keeping Well' partnership. The SCC Libraries and Communities Service is working with Voluntary Action Sheffield to enhance capacity and capability of the VCF sector to support this.

Further information

For more information on health and wellbeing outcomes in Sheffield you can access various data, maps and graphs, in-depth health needs assessments and other resources from our online JSNA resource, although please be aware this is still a work in progress and there will be many more topics to be added over the rest of the year:

https://data.sheffield.gov.uk/stories/s/fs4w-cygv

You can download a copy of this report here:

https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report.html

We're keen to hear your views on this report and in particular on the themes and issues we've raised. Please complete our online feedback sheet available from our website at

https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report.html

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