HEALTH AND WELLBEING BOARD PAPER

Report of:	Chris Gibbons

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Subject:	Update of Joint Strategic Needs Assessment

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Summary:

The JSNA provides a high level overview of health need in Sheffield and has served as one of the core pieces of evidence on which the Health and Well Being Strategy is based.

The production of the JSNA is a requirement of the HWBB. This paper describes the update and details the high level summary section of the JSNA, which forms one part of the four part JSNA. The JSNA for Sheffield is structure in four key parts. The first, the attached document (draft), provides a high-level overview of the key health indicators, places these in the context of recovery from the Covid-19 pandemic, and outlines some of the strategic priorities for the city's health and wellbeing.

The second is the data available on our Local Insight Platform. This web tool gives the latest data and analysis for communities and services, with up-to-date open data matched to the areas multiple sectors and organisations work in. It combines the ability to map data at MSOA level and produce custom dashboards to compare and rank areas within the city, the region, other Core Cities and nationally.

The third is the Picture of Health Toolkit which replaces much of the statistical analysis and infographics contained in the current Sheffield JSNA website with a more user-friendly interface based on PowerBI.

The fourth part is an updated A-Z web page which provides definitions and links to key strategies, data sources and other documents grouped by topic. This will be going live in January 2023.

Update of The Joint Strategic Needs Assessment

1.0 SUMMARY

1.1 The JSNA provides a high level overview of health need in Sheffield and has served as one of the core pieces of evidence on which the Health and Well Being Strategy is based.

1.2 The production of both is a requirement of the HWBB. This paper describes the update of both and gives some summary headlines of the JSNA.

2.0 Update of the Joint Strategic Needs Assessment

2.1 The production of the Joint Strategic Needs Assessment (JSNA) is a statutory requirement of the Health and Well Being Board (HWBB). This has been led by the PH Intelligence team within SCC. Over the course of the pandemic capacity has been exceptionally constrained for anything other than covid epidemiology and surveillance.

2.2 The [Sheffield JSNA](#) is well established and has historically been a very well regarded piece of work by all that use it.

2.3 **The structure of the Sheffield JSNA** aims to provide over-arching information on the current and future health and wellbeing needs of Sheffield people. It provides the evidence base for the joint health and wellbeing strategy and the context for all other health needs assessment for the City. The online site contains a range of specific pieces of public health analysis, an overview of health at neighbourhood and ward level, DPH reports. It is split broadly into 7 chapters (population, communities of interest, economic, social and environmental impact on health, maternal, child and young people's health, disease and disability, commercial determinants of health).

2.4 **Maintaining the JSNA** in that form with the current demands on the intelligence team's time is problematic and it is increasingly out of date. As we update it, the JSNA has become shorter, punchier (and perhaps more widely read and used), makes more use of third-party tools and products to reduce duplication of effort and, critically, easier for the team to produce. This will free up more time to do more detailed needs assessment work where required to answer more bespoke questions.

2.5 **The update** is described here:

- Finalisation of a slimmed down summary of the JSNA.
- Production of a simple A-Z of all public health intelligence and insight tools on the JSNA website and elsewhere
- Using the Picture of Health tool to replace the need for an update of the specific chapters on the current JSNA website.
- More emphasis given to the local insight tool [Sheffield Local Insight website](#) to point users to data for specific geographies.
- Greater link to the [Public Health Outcome Framework](#) the [fingertips](#) tools. We will be framing this as the health and wellbeing outcome framework for the city. From these users can get readily accessible outcomes data on many topics across a number of domains (NHS and Care, health improvement, wider determinants, health protection, headline indicators).

SHEFFIELD JSNA

Part One – Strategic Summary

JSNA for Sheffield

A Joint Strategic Needs Assessment (JSNA) is a comprehensive analysis undertaken by local authorities and health partners to identify the current and future health and social care needs of a population. JSNAs involve collating data on demographic trends, health outcomes, and social determinants. This assessment aims to provide a holistic understanding of the community's well-being, helping policymakers prioritize resources, plan services, and address specific health inequalities. JSNAs play a crucial role in informed decision-making, fostering collaboration between various stakeholders, and ensuring that health and social care services are tailored to meet the unique needs of the population.

The JSNA for Sheffield is structure in four key parts. The first, this document, provides a high-level overview of the key health indicators, places these in the context of recovery from the Covid-19 pandemic, and outlines some of the strategic priorities for the city's health and wellbeing.

The second is the data available on our Local Insight Platform. This web tool gives the latest data and analysis for communities and services, with up-to-date open data matched to the areas multiple sectors and organisations work in. It combines the ability to map data at MSOA level and produce custom dashboards to compare and rank areas within the city, the region, other Core Cities and nationally.

The third is the Picture of Health Toolkit which replaces much of the statistical analysis and infographics contained in the current Sheffield JSNA website with a more user-friendly interface based on PowerBI.

The fourth part is an updated A-Z web page which provides definitions and links to key strategies, data sources and other documents grouped by topic. This will be going live in January 2023.

JSNA For Sheffield 2023- Strategic Summary

This section of the report gives a broad overview of health in Sheffield. More detail can be found in the Local Authority Health Profile produced by OHID at https://fingertips.phe.org.uk/ and on the Global Burden of Disease GBD Compare website athttps://vizhub.healthdata.org/gbd-compare/

Indicator	Period	Sheffield Recent Trend	Sheffield Count	Sheffield Value	Region Value	England Value	England Worst	England Range	England Best
Life expectancy and causes of death									
Life expectancy at birth (Male, 3 year range)	2018 - 20	−	-	78.6	78.4	79.4	74.1	●	
Life expectancy at birth (Male, 1 year range)	2021	−	-	78.9	78.0	78.7	72.3	●	82.9
Life expectancy at birth (Female, 3 year range)	2018 - 20	−	-	82.4	82.2	83.1	79.0	●	
Life expectancy at birth (Female, 1 year range)	2021	−	-	82.0	82.0	82.8	78.6	●	86.0
Under 75 mortality rate from all causes	2021	−	1,705	380.5	394.9	363.4	625.1	●	205.7
Under 75 mortality rate from all cardiovascular diseases	2021	−	368	83.2	86.8	76.0	133.9	●	39.6
Under 75 mortality rate from cancer	2021	−	561	126.6	131.0	121.5	189.8	●	75.8
Suicide rate	2019 - 21	−	168	11.0	12.5	10.4	19.8	●	4.8
Killed and seriously injured (KSI) casualties on England's roads	2021	➡	235	148.6*	110.8*	95.6*	469.8	●	31.2
Emergency Hospital Admissions for Intentional Self-Harm	2021/22	−	825	143.3	146.7	163.9	425.7	●	47.9
Hip fractures in people aged 65 and over	2021/22	−	540	546	546	551	741	●	
Injuries and ill health									
Percentage of cancers diagnosed at stages 1 and 2	2020	➡	806	53.6%	50.6%	52.3%	43.7%	●	%
Estimated diabetes diagnosis rate	2018	−	-	77.3%	81.9%	78.0%	54.3%	●	95%
Estimated dementia diagnosis rate (aged 65 and over)	2022	➡	4,507	70.3%	63.1%	62.0%	50.3%	●	
Admission episodes for alcohol-specific conditions - Under 18s	2018/19 - 20/21	−	60	17.0	27.2	29.3	83.8	●	7.7
Admission episodes for alcohol-related conditions (Narrow)	2021/22	−	2,842	562	533	494	840	●	251
Smoking Prevalence in adults (18+) - current smokers (APS)	2021	−	-	13.3%	14.1%	13.0%	22.0%	●	6.6%
Behavioural risk factors									
Percentage of physically active adults	2020/21	−	-	68.1%	65.2%	65.9%	48.8%	●	76.5%
Percentage of adults (aged 18 plus) classified as overweight or obese	2020/21	−	-	63.9%	66.5%	63.5%	76.3%	●	
Under 18s conception rate / 1,000	2020	➡	133	14.8	16.5	13.0	30.4	●	2.7
Smoking status at time of delivery	2021/22	↓	-	9.4%	12.0%	9.1%	21.1%	●	3.1%
Baby's first feed breastmilk (previous method)	2018/19	−	-	71.7%	56.4%	67.4%	43.6%	●	
Child health									
Infant mortality rate	2019 - 21	−	61	3.5	4.4	3.9	7.5	●	1.2
Year 6: Prevalence of obesity (including severe obesity)	2021/22	↑	1,570	25.3%	24.9%	23.4%	34.0%	●	
Deprivation score (IMD 2019)	2019	−	-	27.1	26.0	21.7	45.0	●	5.8
Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)	2020	−	-	19.9%	25.5%	24.5%	42.1%	●	
Inequality in life expectancy at birth (Male)	2018 - 20	−	-	10.9	10.7	9.7	17.0	●	
Inequalities									
Inequality in life expectancy at birth (Female)	2018 - 20	−	-	8.7	8.8	7.9	13.9	●	
Children in relative low income families (under 16s)	2020/21	↑	28,029	26.4%	25.2%	18.5%	42.4%	●	6.2%
Children in absolute low income families (under 16s)	2020/21	↑	24,060	22.7%	21.5%	15.1%	39.2%	●	5.2%
Average Attainment 8 score	2021/22	−	265,585	46.1	46.9	48.7	39.2	○	
Wider determinants of health									
Percentage of people in employment	2021/22	➡	290,200	75.8%	74.3%	75.4%	62.9%	●	91%
Homelessness: households owed a duty under the Homelessness Reduction Act	2021/22	−	3,403	13.8	12.0	11.7	29.9	●	4.4
Violent crime - hospital admissions for violence (including sexual violence)	2018/19 - 20/21	−	890	45.7	47.3	41.9	116.8	●	12.0
Excess winter deaths index	Aug 2019 - Jul 2020	−	250	15.7%	16.6%	17.4%	50.2%	●	0.7%
New STI diagnoses (excluding chlamydia aged under 25) per 100,000	2021	↓	-	193	285	394	2,634	●	103
TB incidence (three year average) **New data**	2018 - 20	−	130	7.4	5.9	8.0	43.1	●	0.6

The health of people in Sheffield is varied compared with the England average. Sheffield is one of the 20% most deprived districts/unitary authorities in England and about 23.2% (23,095) children live in low income families. Life expectancy for women is lower than the England average.

Life expectancy is 9.6 years lower for men and 8.8 years lower for women in the most deprived areas of Sheffield than in the least deprived areas.

In Year 6, 21.6% (1,334) of children are classified as obese, worse than the average for England. The rate for alcohol-specific hospital admissions among those under 18 is 16 per 100,000, better than the average for England. This represents 18 admissions per year. Levels of GCSE attainment (average attainment 8 score) and smoking in pregnancy are worse than the England average. Levels of breastfeeding are better than the England average.

The rate for alcohol-related harm hospital admissions is 736 per 100,000, worse than the average for England. This represents 3,816 admissions per year. The rate for self-harm hospital admissions is 167 per 100,000, better than the average for England. This represents 1,010 admissions per year. Estimated levels of physically active adults (aged 19+) are better than the England average. The rate of new sexually transmitted infections is better than the England average. The rate of killed and seriously injured on roads is worse than the England average. The rates of statutory homelessness, violent crime (hospital admissions for violence) and under 75 mortality rate from cardiovascular diseases are worse than the England average.

The major causes of death and disability are detailed in the Global Burden of Disease data for Sheffield, the most recent data available are from 2019. It is important to note, a very large proportion of these deaths and causes of illness and disability are preventable or at worst delayable.

Figure 1 GBD treemap of causes of death, both sexes, all age, rate per 100,000 2019, Sheffield

Figure 2 Disability Adjusted Life Years (DALYS) for major causes of morbidity, all ages, both sexes, Sheffield 2019

The tree maps shown in Figs 1&2 detail the major causes of death and morbidity which have remained broadly constant since 1990, with significant progress made on smoking, diet and lipid modification as well as some advances in diagnosis meaning that CVD and some cancers have seen a drop in rates for both mortality and morbidity. Worsening trends for Sheffield are shown in darker shades, and are consistent with the findings of the Lancet Commission which explored the changing health needs of the UK population. Figure 3 sets out how some of those key burdens of illness have changed for men and women over a 20 year time period for the UK, despite risk factors remaining relatively constant (Fig 4).
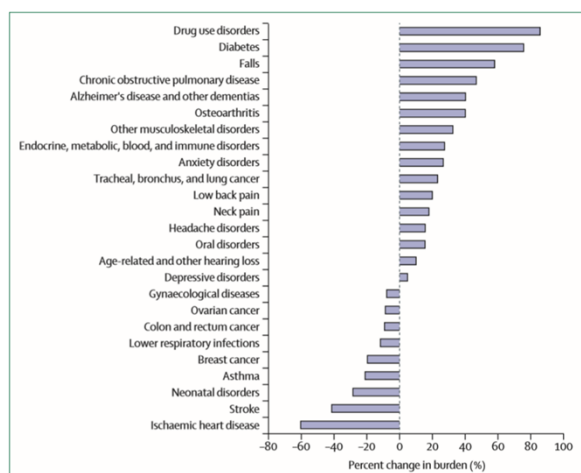
Figure 5: Percentage change in burden due to the top 25 causes of DALYs in women in the UK, 1990–2019
Source: Global Burden of Disease. DALY=disability-adjusted life year.
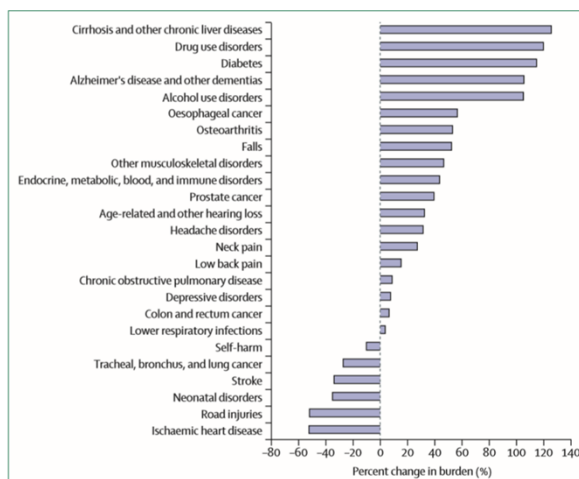
Figure 6: Percentage change in burden due to the top 25 causes of DALYs in men in the UK, 1990–2019
Source: Global Burden of Disease. DALY=disability-adjusted life year.

Figure 3 McKee et al. 2023 Lancet Comission

It should be noted that for some changes the % change is from a low baseline (for example Drug Use Disorders) and for others, whilst the percentage change is not as large, the magnitude in epidemiological terms is enormous (for example diabetes). Another important hidden issue in the data is that there is a growing burden on working age people, with the percentage change evident in chronic liver diseases in men for example being indicative of this phenomena. There is also interaction between risk factors and health outcomes are often a result of the cumulative effect of multiple and overlapping risk factors. Tobacco consumption is a risk factor for cancer and cardiovascular diseases, and high blood-pressure a risk for heart disease and stroke, but tobacco consumption also causes and worsens high blood pressure, for example.

The data shown in the charts in figure 4 further emphasises that ill health and its main drivers are amenable to prevention and intervention. There is a temptation to view this data and reduce the risk factors and the burden of ill health to a simplistic and false narrative about poor individual choice and a lack of 'personal responsibility' for health. Commercial actors and media outlets sympathetic to this narrative encourage policy to be shaped around the individual and education to make 'informed decisions' about commodities that are addictive, harmful, and heavily promoted. This detracts from investment in upstream interventions which have much greater benefit to population health (see Defining and conceptualising the commercial determinants of health - The Lancet 2023 for more detail). Of particular concern is the rising trend in Type 2 diabetes, which remains a substantial public health issue. Type 2 diabetes, which makes up the bulk of diabetes cases, is largely preventable and, in some cases, potentially reversible if identified and managed early in the disease course. However, all evidence indicates that diabetes prevalence is increasing, primarily due to a rise in obesity caused by multiple factors. Preventing and controlling type 2 diabetes remains an ongoing challenge. It is essential to better understand disparities in risk factor profiles and diabetes burden across populations, to inform strategies to successfully control diabetes risk factors within the context of

multiple and complex drivers. Much of this will depend on better regulation of the food system, particularly food choice architecture, advertising, and lobbying by national government.
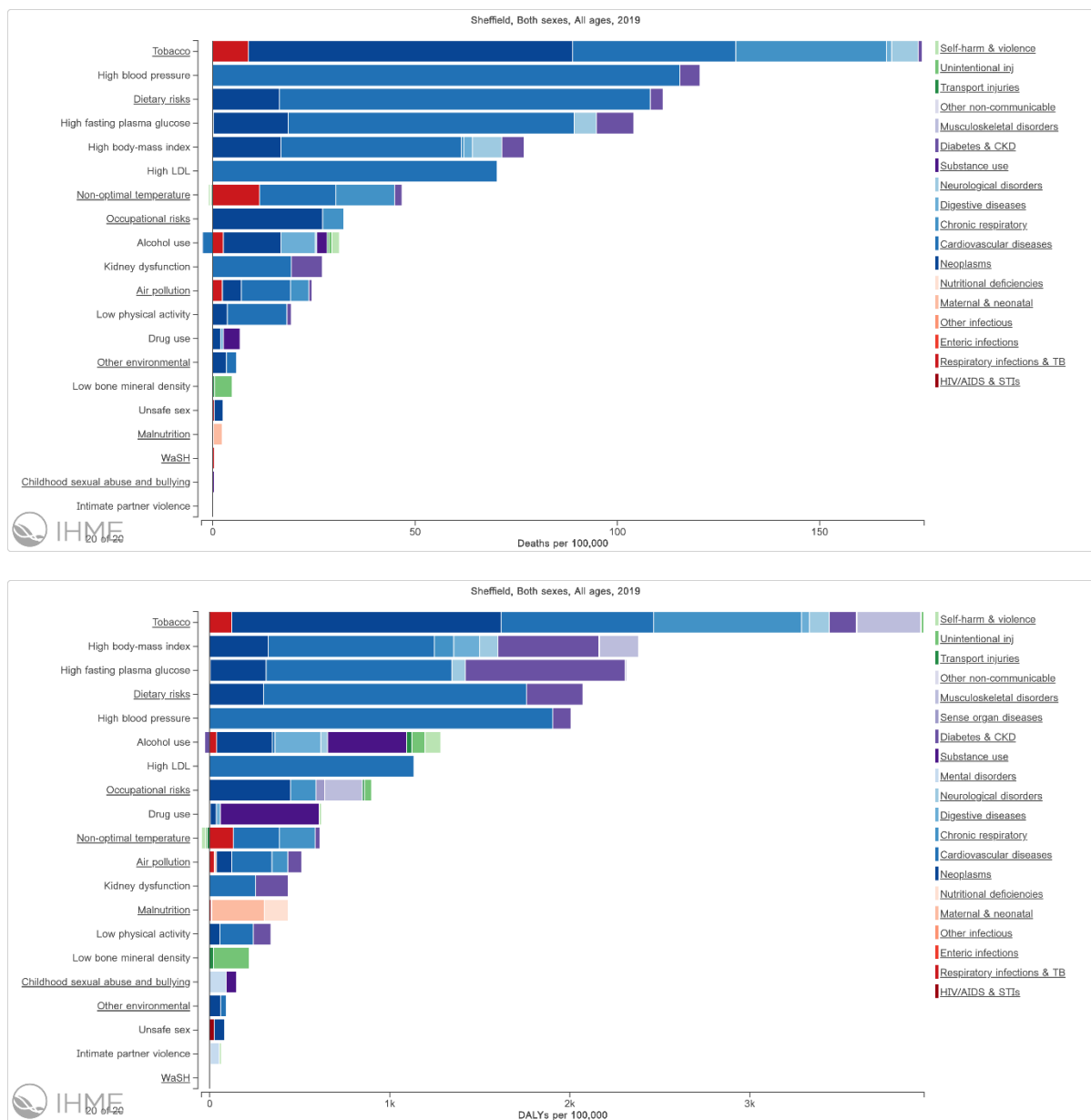

Figure 4 Risk factors for death (top) and morbidity (bottom), all ages, both sexes, Sheffield 2019

Since 2011, increases in life expectancy slowed after decades of steady improvement. In 2020, the Covid-19 pandemic caused a sharp fall in life expectancy larger than at any time since the Second World War. Health measures such as childhood immunisations, the introduction of universal health care, medical advances in treating adult diseases such as heart disease and cancer, and lifestyle changes including a decline in smoking had increased life expectancy over many years. Healthy life expectancy has also increased over time but to a lesser degree than life expectancy, so for many people more years are spent in poor health. Recent data for both life expectancy (LE) and healthy life expectancy (HLE) suggest that for much of the population historic gains are slowing down, and for those living in the most deprived areas the trend is worsening. Around 30%

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of the life expectancy differences between the richest and poorest areas are due to differences in the prevalence of cardiovascular and respiratory diseases, which are preventable conditions.
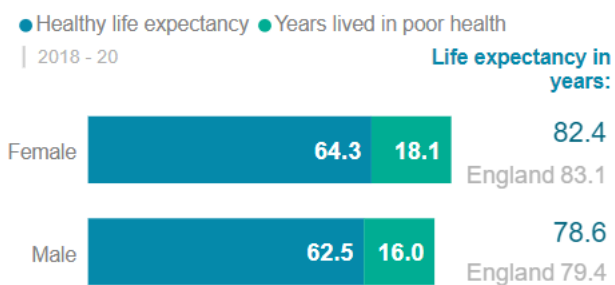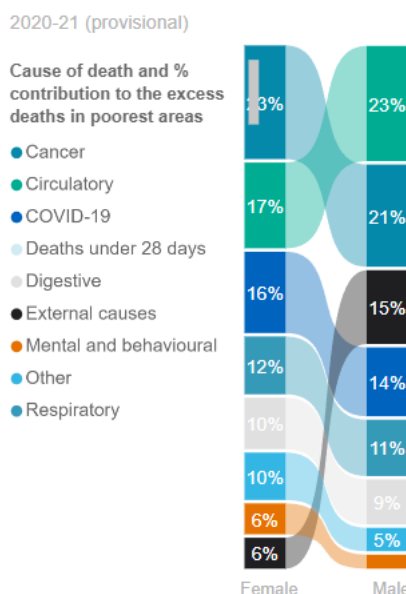
In Sheffield, life expectancy and healthy life expectancy direction of travel are a similar shape to the national data but the numbers are worse relative to England. What is particularly concerning is that the overall data masks considerable inequality at a local level, with people living in the most deprived areas of this city experiencing both shorter lives but a greater proportion of their lifetime in poor health relative to people in the least deprived neighbourhoods (Fig 5). A baby born in Firth Park can expect to live a third of a shorter life with poor health, with a large proportion of that in working age. A baby born in Carterknowle and Millhouses will live a seventh of a longer life with poor health.
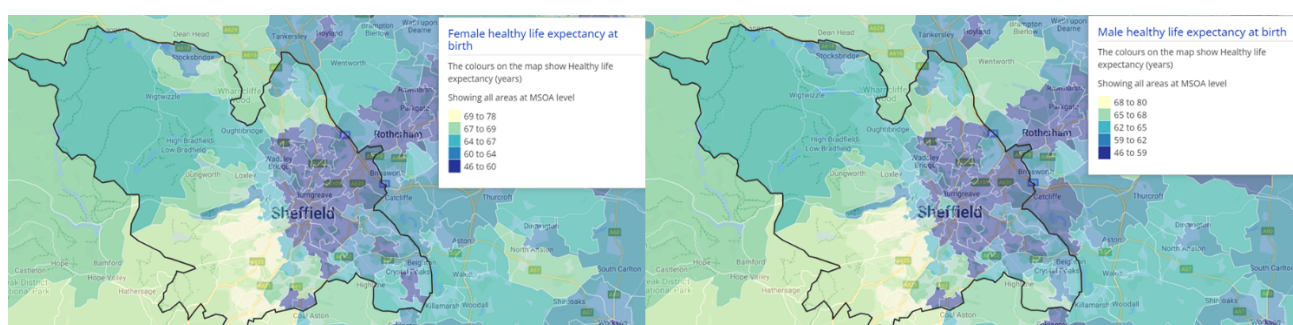

Figure 5 HLE for men and women, Sheffield

The gap in healthy life expectancy matters to both the NHS & social care, with rising demand largely from preventable non-communicable diseases (NCDs) and long term conditions (LTCs)with earlier onset in some populations. It also matters to the economy because of lost productivity on account of poor health at earlier ages. It is also, fundamentally, an issue of social justice.

Underpinning this variation is the growing problem of multimorbidity (MM). This was first well documented in Scotland (Barnett on multi morbidity in Scotland. Lancet 2012) but similar work has been done in many

places in England over recent years (Somerset, Sheffield, Bradford) and the story is broadly the same. The key metric is a 10-15 yr difference in onset of MM between most and least deprived areas. Or at any given age 15% difference in prevalence of MM across that spectrum of inequality.
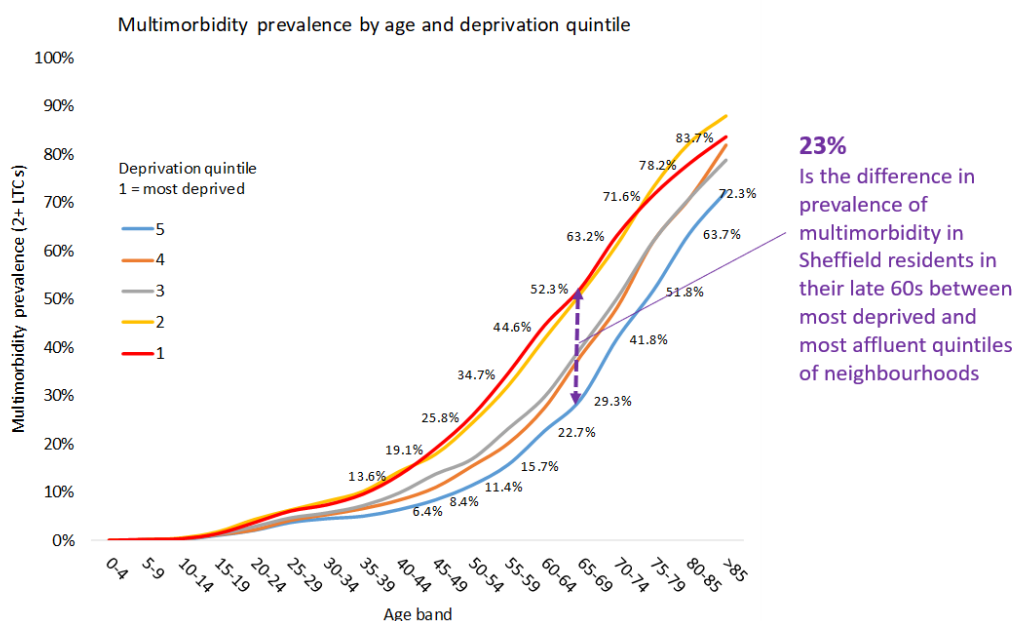
The principal impact of socioeconomic deprivation on the development of LTCs is to bring forward the age at which they develop and accumulate. There is an approximate doubling of the prevalence of multimorbidity in most deprived relative to most affluent neighbourhoods. And this is true at all ages following the onset of LTCs. This is where NHS and social care demand comes from and represents the biggest single shift in epidemiology of non-communicable diseases in the last 3 decades. Ever more efficient systems to address demand will not address this problem. Multi morbidity or frailty is not "inevitable". It's constituent parts are largely preventable. From the Lancet Commission paper on health need: **"Meeting the challenges of the future will require an increased focus on health promotion & disease prevention, involving a more concerted effort to tackle the multiple social, environmental, and economic factors that lie at the heart of health inequalities"** – and are driving the increase in MM and declining HLE.

Despite the growing recognition of multimorbidity's importance in driving demand for healthcare services, there is evidence that resource allocation in the healthcare system has not caught up with an increasingly complex, multimorbid population. Data from the Lancet shows that funding for single specialty consultants rose considerably compared with that allocated to GPs in the ten years from 2008-2018 with the latter actually falling over the same period.

The Covid 19 Pandemic

COVID has had a significant impact on the health and wellbeing of the Sheffield population. The severity of this impact, and its unequal nature, are inseparable from the health of the city population in the years prior. The trend of flatlining life expectancy and healthy life expectancy his was well documented in Marmot 10 years on (Feb 2020), by Barr documenting the Impact of LA spending cuts on Life Expectancy (and by definition HLE), and by Bambra writing on the long term trends in life expectancy over 2 decades . In addition to the short term hit from covid LE is now decreasing in many places. As of 27th October 2023, over two-

thousand deaths have been recorded with Covid-19 mentioned on the death certificate as a cause. In 2020-2021 Covid-19 was responsible for around 15% of the gap in life expectancy between the most and least deprived areas of the city (Fig. 6).
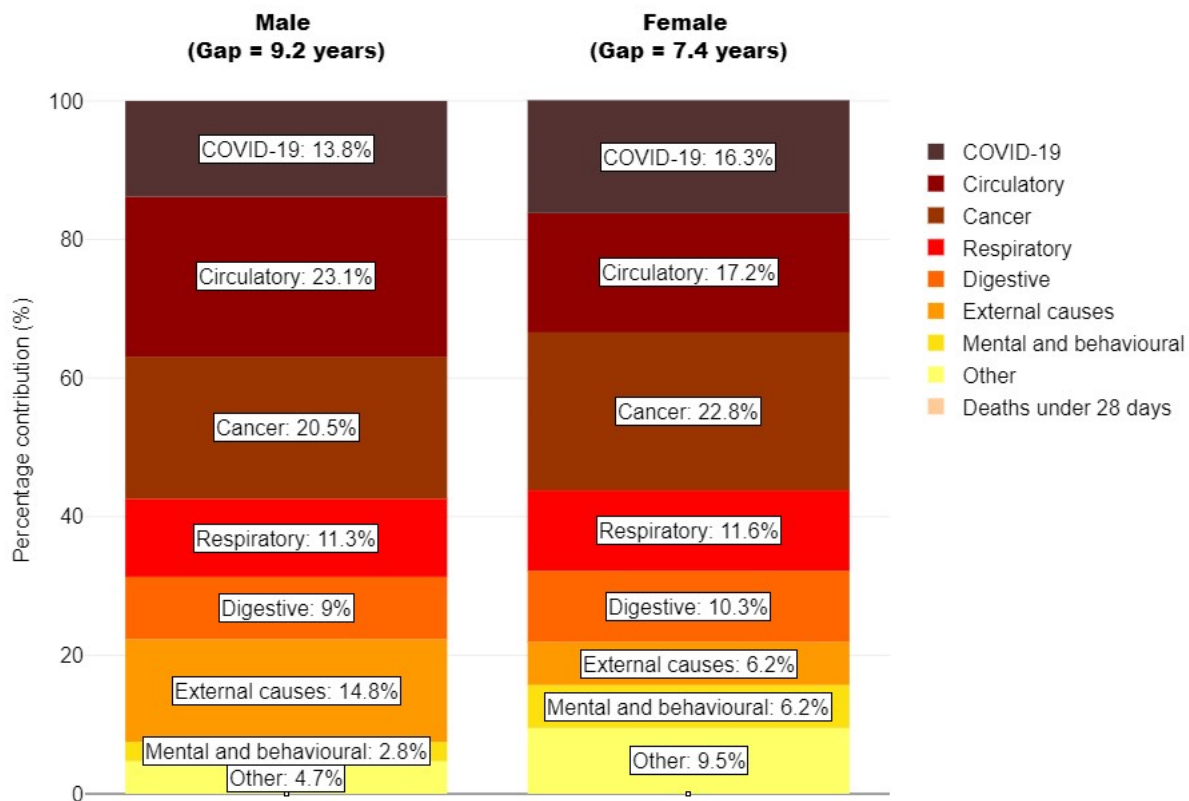

Figure 6 Breakdown of the life expectancy gap between the most and least deprived quintiles of Sheffield by cause of death, 2020 to 2021. Source: Office for Health Improvement and Disparities based on ONS death registration data and 2020 mid year population estimates, and Department for Levelling Up, Housing and Communities Index of Multiple Deprivation, 2019

The PH team published the **covid rapid health impact assessment** in 2021. The numbers will have shifted but the broad story has not.

Again and again, conversations on health come back to being about or framed in the National Health Service (NHS) or framed in NHS at the centre and then worked out from that focal point. It is the wrong starting point. The starting point should be the whole of government, and the structural determinants and environment, not individual behaviour and personal responsibility. This point probably cannot be underscored enough. The cycle of ever increasing spend on health care, (mostly the high technology variety where the incremental marginal benefit is low relative to cost), comes with the opportunity cost of less health, as investments with a much higher value in health terms get crowded out. The opportunity cost of more medicine is less health. Illich wrote about this at least five decades ago.

The data shown in the charts in Figure 4 further emphasises that ill health and its main drivers are amenable to prevention and intervention. There is a temptation to view this data and reduce the risk factors and the burden of ill health to a simplistic and false narrative, about poor individual choice and a lack of 'personal responsibility' for health. Commercial actors and media outlets sympathetic to this narrative encourage policy to be shaped around the individual and education to make 'informed decisions' about commodities

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that are addictive, harmful, and heavily promoted. This detracts from investment in upstream interventions which have much greater benefit to population health (see Defining and conceptualising the commercial determinants of health - The Lancet 2023 for more detail).

Why does this matter in the context of a pandemic?

The overall story on health is of a stalled improvement based on historical trends. The underlying health of a population matters enormously to individuals and to society. However, it also mattered to the spread of Covid-19 and its impact on Sheffield particularly with reference to the inequitable nature of that impact.

The illness profile is largely made up of what is known as non-communicable disease (NCD), preventable illness. Not really a function of "lifestyle choices" but a function of social, commercial, and other determinants of our health.

Sheffield in 2020 had broadly well understood and stable causes of ill health in the population. There were concerning trends in LE and HLE which were indicative of worsening inequalities in some areas and were underpinned by the growing problem of multimorbidity. When Covid-19 arrived in Sheffield, its impacts were overlaid on top of those existing inequalities.

Multimorbidity is a defining feature and single biggest shift in epidemiology in the last three decades. It is caused by multiple, often preventable, or delayable illness and is not simply a function of an ageing population. Multimorbidity and frailty are not inevitable. The inequality in the prevalence of multimorbidity and frailty was a major contributor to the unequal impacts of the pandemic.

The underlying health status of a population, particularly the unequal nature of it, when combined with underpinning inequality in differences in social and economic factors (overcrowded housing, the financial inability to be able to afford isolation, the type and nature of some roles meaning they cannot be undertaken remotely) explain a large proportion of inequality in exposure to the virus, overall infection force and outcomes from the virus.

The pandemic was marked by a series of phases characterised by the dominant strain of Covid-19 circulating at the time, the non-pharmaceutical interventions deployed by the government to mitigate against it, and the numbers of cases, hospitalisations, and deaths.

In terms of pandemic recovery, which the city still finds itself in and will do so for years to come, the Marmot recommendations detailed in Build Back Fairer: The COVID-19 Marmot Review (December 2020) are all highly relevant to Sheffield. These are:

•	Communities and places (providing more resources for more deprived areas and communities by redistributing existing assets and seeking greater investment from business and Central Government), housing.

•	Transport and the environment ('healthy living' standards for housing, environment and employment. Addressing overcrowded housing, and damp, cold and mouldy homes which are a risk for respiratory health. Providing guaranteed training and support for young people).

•	Early years, children and young people (prioritising future generations – with no young person without employment, education or training after they leave school. Providing additional support for mental health in schools and workplaces and more mental health service provision for young people).

- Income, poverty and debt (advocating nationally for a minimum income level to be the benchmark for wages and welfare payments).

- Work and unemployment (a stronger role for business in achieving social goals, including reducing health and social inequalities, by being good employers, having 'equitable' supply chains, investing in / contributing to communities, investments to be sustainable and healthy, and providing beneficial products and services).

In terms of the role of the healthcare system in recovery, there are other specific actions that it can take.

- Covid-19 has seen unprecedented growth of elective care waiting lists. The prioritisation of reducing these should be biased towards unmet need in underserved, more deprived communities. As part of this effort, there is a need to re-emphasise the "Make every contact count" effort on smoking, alcohol, exercise, debt management and others at every opportunity.

- The healthcare system needs to take concrete steps towards addressing multimorbidity and resourcing primary care and generalists with that goal in mind. Improving technical efficiency in single disease specialties will not address this fundamental demand pressure. Given the resource constraints, and the problems of allocative inefficiency which are making inequalities worse in some areas, the healthcare system needs to work with and if necessary, fund partners/allied sectors. Given the challenges of multimorbidity and increasing complexity, primary care needs to be able to fulfil the generalist role best suited to meeting these challenges – with funding commensurate to that task. This may require a rethink of current funding models.

- Population Health Management is still very much a concept rather than actual practice and there is a risk that if the focus of it is, as a result of where data is most complete and comprehensive, disease and clinical risk stratification it will lead many to conclude that resources should be moved towards precisely the wrong things. Diagnostic screening, increasing medicalisation of social ills, and a medical system that will design services and patient care based on data that is about the conditions people have and does not give equal importance to the conditions people live in. This will miss an opportunity to use this data to resource, empower and develop communities recovering in the wake of one of the most significant societal emergencies of our lifetimes.

Poverty

Poverty is intricately linked to public health outcomes, creating a web of challenges that affect individuals and communities. The impact of poverty on public health is pervasive, influencing factors such as access to healthcare, nutrition, education, and living conditions. Limited financial resources often lead to inadequate nutrition, increasing the prevalence of malnutrition and associated health issues. In impoverished communities, access to quality healthcare is often restricted, exacerbating the burden of preventable diseases.

Poverty also contributes to the perpetuation of morbidity, with crowded living conditions making infectious diseases more likely to spread while damp and mould can cause and worsen respiratory conditions like asthma. Moreover, individuals in poverty may face heightened stress and limited mental health resilience, further impacting overall well-being. Lack of education and employment opportunities can hinder the effectiveness of measures designed to improve of health and reduce risk.

Addressing poverty is essential for promoting public health equity. By implementing policies that alleviate economic disparities, communities can break the cycle of poor health outcomes. Initiatives aimed at improving education, housing, and income security contribute not only to poverty reduction but also to the enhancement of overall public health. Recognizing the interconnectedness of poverty and health is crucial for developing comprehensive strategies to create healthier, more equitable societies. However, austerity measures in the UK introduced after 2010 had profound implications on trends in poverty and health. Reductions in public spending, strained the NHS, leading to longer waiting times, staff shortages, and limited access to vital services. Mental health and Social Care services, both for adults and children, also faced cutbacks, exacerbating the burden on an already stretched system. Austerity widened social inequalities and exacerbated health disparities, with marginalized communities experiencing poorer health outcomes. Public health initiatives suffered, impacting disease prevention efforts. Critics argue that the austerity-driven health policies disproportionately affected the most vulnerable, widening health inequalities and leaving a lasting imprint on the overall well-being of the population. In the same way that Shefield found itself in a vulnerable position in terms of population health and well-being prior to the pandemic, the city was not best placed to absorb the enormous economic shock either.
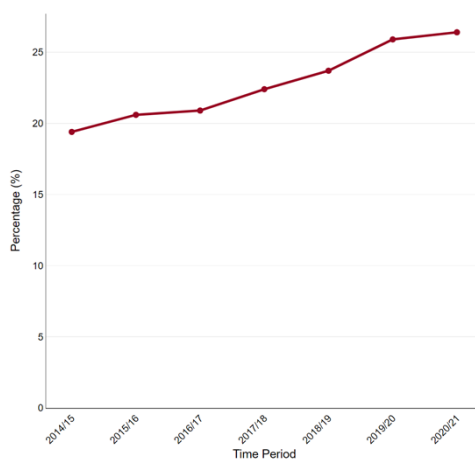

Figure 7 This indicator shows the percentage of children (<16) in Sheffield, living in relative low income families. A family is defined as a single adult; or a married or cohabitating couple; or a Civil Partnership; and any dependent children. Source: Public Health Outcomes Framework
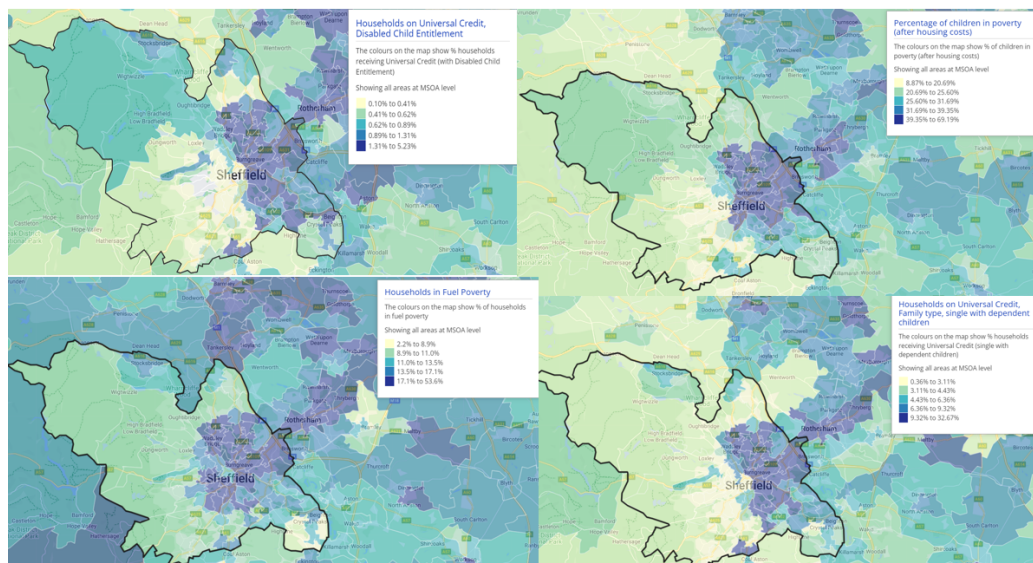

Figure 8 Clockwise from top left: Households on universal credit disabled child entitlement, Percentage of children in poverty after housing costs, Households in fuel poverty, and Households on universal credit with single parents with dependent children.

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Poverty in Sheffield is highly correlated (R² > 0.7): with health outcomes including: Deaths from causes considered preventable, under 75 years; prevalence of obesity (including severe obesity) in Year 6; deaths from all causes, under 75 years; prevalence of overweight (including obesity) in Year 6; low birth weight of live babies; deaths from all cancer, under 75 years; life expectancy for both men and women and healthy life expectancy for both men and women.

Conclusions

We also know covid will cast a long shadow on the health of the population. We know that structural issues in society were more impactful in the spread of covid and infection rates and thus outcomes. We know there was more covid in some communities than others, and on account of underlying morbidity there were more serious consequences). We can expect there will be more long covid in those communities. There are lots of worrying indicators on the indirect impact of covid (frailer, more drinking, less activity, obesity in children, mental illness, all of which will be unequally spread. The social and economic impact will affect the health of the population for many years (maybe decades) to come. Impact of pandemic has accelerated (significantly) fundamental flaws in the local state funding position

The impact of long covid on population health is as yet uncertain. ONS have the best estimates with their [ongoing tracking](). As with all health need this will not only be an NHS and care demand issue, it will also become an issue of poverty (inability to work thus earn), benefit demand, economic productivity and social justice issue. This is yet to be well quantified.

The gap in healthy life expectancy matters beyond just NHS and care. It matters to the NHS & social care (demand largely from preventable NCDs with earlier onset in some populations) and the economy (lost productivity on account of poor health at earlier ages). It is obviously also a social justice issue.

The factors that contribute to HLE are well beyond only more or better health and social care, though that does matter enormously… but that whole life span, whole of society perspective for interventions, across every dept in govt, local and national, and well beyond govt.

The ability to impact at the margin is greater in those with lower starting point vs those at the top, those at the bottom have more to gain and those at the top less (diminishing marginal returns). This has **obvious implications in terms of NHS and social care demand, is also has huge implications in terms of overall economic productivity (health is a constraint to economic growth) and obviously social justice.**

The main risks for non communicable diseases (NCD) are largely preventable (tobacco, obesity, alcohol, diet, lack of activity, these things then lead to NCD. This then often accumulates into what we know as multi morbidity). When "health" is considered more broadly, the core deterimnants of health are well established, and our Health and Well Being Strategy is based on those determinants – factors upstream of lifestyle risks.

A lot of demand is preventable. Someone needs to prevent it. It doesn't happen by itself. Long term decline in smoking (and CVD and lung cancer hasn't happened by magic). It isn't a project, it is about orientation, purpose and mission.

A test for all discussions will be the extent to which in any area we are seeking to enable a shift to a more preventive model.

The ageing population is usually held as the core issue determining ever increasing NHS and social care demand. This is a fallacy and the reality is considerably more complex, as has been set out in this comprehensive [Health Foundation analysis](#) amongst others. All the available analysis points towards preventable illness, and wider living standards not ageing per se. The absolute number of people aged >65 is increasing, but the overall age structure is not changing that quickly. Thus there are more "person years" in the population. Multi morbidity and the stalling life expectancy and HLE improvement are the main drivers of the unsustainable yet largely preventable growth in demand for health and social care services. This basically leads to more "unhealthy person years" in a fixed capacity system.

Multi morbidity or frailty is not "inevitable". The things that make up are all largely preventable. For many of the core issues within the existing burden of disease we haven't achieved any level of meaningful disease prevention. From the Lancet Commission paper on health need: "Meeting the challenges of the future will require an increased focus on health promo & disease prevention, involving a more concerted effort to tackle the multiple social, environmental, and economic factors that lie at the heart of health inequalities."

No single person or body is accountable for health. Often our machinery asks for financial balance and service delivery metric improvement, not outcomes. Given the wide ranging nature of what contributes to good health outcomes, no single body is accountable for it all. Nobody is held accountable for the gap in healthy life expectancy between most and least affluent or those with a learning disability and those without. Maybe something about setting up a 2 way conversation on accountability for outcomes. A once a year exercise? Open and transparent.

All risk factors / demand and outcomes are unequally spread. There are many very helpful sets of policy recommendations on health inequalities (notably the [2021 Marmot recommendations for Greater Manchester](#)). These provide and excellent basis on which to regresh out Health and Well Being Strategy. Addressing this needs a shift in purpose, not a "project". There are some core fundamentals (the basic Marmot principles – proportionate universalism, shift to preventive model, early years focus, focus on community level capacity and capability). There may be many opportunities to push this through both levelling up and the DHSC approach to health disparities.

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6   QUESTIONS FOR THE BOARD

The board is asked

1. **To approve the process for updating the JSNA and PNA, both to be completed by Oct 2022 alongside the DPH report.**
2. **To consider, as we come out of covid and thus have more capacity, what broad or specific intelligence questions members would wish to focus analytic attention to.**
3. **To note the high level points set out summarising the high level picture on health need.**