Transforming Public Health: Director of Public Health Report for Sheffield 2015

Sheffield DPH Report
Sheffield City Council
Town Hall
Pinstone Street
Sheffield
S1 2HH

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1 Introduction:

This is my first annual report as Interim Director of Public Health for Sheffield. It is a great privilege to have the opportunity to contribute to improving health and wellbeing in the City which has a long and distinguished history of working to reduce health inequalities and promote an environment which helps everybody to improve their own quality of life.

The report this year has the main theme of Transforming Public Health with the emphasis of looking at where we are at the present time in Sheffield. There are a number of basic statistics on how we look at health and assess what progress has been made. These are covered in Section 2.

The 2015 health profile for Sheffield and the Public Health Outcomes Framework provide detailed information on the health status of the population of Sheffield. Broadly speaking we have not reduced health inequalities and although life expectancy for both women and men has improved it is still below that for England. When we look at broader determinants of health we have too many children living in poverty, we need to improve school readiness and reduce school pupil absence. In addition we need to reduce teenage unemployment. In relation to health improvement we have too many people smoking, and almost 60% of the adult population is overweight or obese. We are making some progress on increasing exercise in the City but we need to become much fitter and we still drink too much alcohol.

The report then looks at how we can improve this situation by applying good Public Health principles. We need to bring all the resources of the Council not just the small Public Health Grant to bear on improving this situation and we have some creative initiatives already underway to improve the position. These are outlined in more detail in Section 3.

I believe that although Sheffield has made progress in improving health when comparing itself with other Core Cities (as shown in Table 1) now is the time to be much more ambitious and consider how we compare with England as a whole. Our aim should be to improve health and wellbeing in Sheffield to be amongst the best in the Country. Given the move regarding devolution to City Regions it may be appropriate to explore the development of a Public Health Deal for Sheffield with Public Health England to take this aspiration forward.

Table 1: Comparison of Sheffield with other Core Cities

	England	Sheffield	Birmingham	Bristol	Leeds	Liverpool	Manchester	Newcastle	Nottingham	Sheffield rank*
Male Life Expectancy 2011-2013	79.4	78.8	77.6	78.2	78.3	76.2	75.5	78.2	77	1
Female Life Expectancy 2011-2013	83.1	82.4	82.2	82.8	82.1	80.5	80.0	81.8	81.7	2
Male Healthy Life Expectancy 2011-2013	63.3	60.8	58.8	63.0	60.6	57.2	58.0	57.8	58.8	2
Female Healthy Life Expectancy 2011-2013	63.9	59.1	60.5	62.6	62.5	59.6	56.8	59.9	59.8	7
Under 18 Conception rate, 2013, per 1000	24.3	27.9	25.9	25.7	31.6	34.1	36.5	26.8	37.5	4
New Cases of TB, 2011-2013, per 100,000	14.8	16.7	38.1	20.6	13.8	9.3	37.2	14.4	20.3	4
Mortality from Cancer < 75, 2011-2013, per 100,000	144.4	159.9	163.1	156.9	163.5	195.2	198.9	173.6	177.2	2
Mortality from Cardiovascular Disease < 75, 2011-2013, per 100,000	78.2	89.6	101.0	88.8	91.1	108.8	137.0	96.9	108.0	2
Mortality from Respiratory Disease < 75, 2011-2013, per 100,000	33.2	33.0	44.9	39.8	41.6	65.2	74.0	43.8	54.9	1
Mortality from Liver Disease < 75, 2011-2013 per 100,000	17.9	18.1	23.4	20.1	19.6	33.9	35.7	24.0	28.6	1

*1 = best, 8= worst

Source: Public Health Outcomes Framework

There are a number of Priorities for Action outlined in the report and I would expect to see these taken forward and included in action plans but I have specifically only identified three which I would recommend the Council actively supports in 2016-2017.

1. Establish a local baseline measure of wellbeing for the City and use this to track change over time and variation across the different communities in Sheffield.

2. The Council should provide products which assist residents to reduce the cost of their home energy and the amount they use by:

   - Progressing the business case for a local Energy Service Company to present opportunities to generate local energy, create lower priced energy and address the inequalities balance in fuel poverty – for example by providing prepayment meters with electricity at an uninflated price

   - Assist residents to improve their homes thermally by delivering more attractive financial products than the current ECO and Green Deal, for example by offering a revolving loan scheme.

3. It is everyone's responsibility to engage with the Move More message; from creating environments which make being physically active the easiest choice to the individual responsibility of building physical activity into daily lives and just moving more! The Health and Wellbeing Board should ensure schools in Sheffield give all children the opportunity to participate in appropriate exercise.

Stephen Horsley, Interim Director of Public Health
Sheffield City Council

Acknowledgements

Reports such as this are always the result of many people's work. I am grateful this year to the following contributors: Magda Boo, Anna Brook, Ruth Granger, Dawn Lockley, Chris Nield, Bethan Plant, Chris Shaw, Janet Southworth, Julia Thompson, Dawn Walton and Jessica Wilson. Thanks are also due to John Skinner, Louise Brewins and Olufunke Adedeji for their work in editing the text and Ann Richardson for data analysis. Final responsibility for the content rests with me.

2 A picture of health

Introduction

In each DPH report we look at a number of national and local indicators to provide an update on health in Sheffield. This year we have based this overview on a national set of indicators produced by Public Health England (PHE) covering various aspects of health at local authority level, known as the Public Health Outcomes Framework (PHOF). [1]

The PHOF concentrates on a number of high level outcomes (related to life expectancy) and then groups further indicators into four domains that cover the spectrum of public health work in the Council: the wider determinants of health, health improvement, health protection and preventable mortality. Taken together, these indicators provide a detailed picture of how long people live and how healthy they are at all stages of life.

In addition to the PHOF, Public Health England produces an annual summary profile of health for each local authority in the Country. We therefore start our overview of health and wellbeing in the City by considering what the most recent profile for Sheffield tells us.[2]

2.1 Profile of health and wellbeing in Sheffield

Summary profiles of health for each local authority in England have been produced annually since 2006, with the latest profiles published in 2015. A total of thirty two health outcomes are now included in the profile although only 16 remain directly comparable over this 10 year history. Looking at these 16 outcomes, Sheffield's position relative to the rest of the Country has remained virtually unchanged over the period 2006 to 2015. That is to say although we have seen often quite large improvements on all of the outcomes considered, our position is no better or worse than the England average now than it was 10 years ago except in relation to infant mortality and road traffic injuries and deaths, where our position relative to the England average is better than it was. For the majority of outcomes, Sheffield's health remains significantly below average. These outcomes are considered in more depth in the subsequent sections.

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[1] You can browse the indicators and data for all local authority areas in England at the following Public Health England website: http://www.phoutcomes.info/

[2] http://www.apho.org.uk/resource/view.aspx?RID=50215®ION=50152&SPEAR=

In relation to the latest position, the Public Health England health profile for 2015 shows that there are 15 indicators where Sheffield remains significantly worse than the England average, as summarised in Table 2.

Table 2: Health indicators from PHE Health Profiles 2015 where Sheffield is worse than England [3]

Outcome Indicator	Sheffield	England	Sheffield rank amongst Core Cities*
Deprivation - % of people in the area living in 20% most deprived areas in England (2013)	34.9%	20.4%	n/a
Children in poverty - % of children under 16 in families receiving means tested benefits and low incomes (2012) PHOF 1.01(ii)	23.7%	19.2%	3
Statutory homelessness – crude rate per 1000 households (2013/14) PHOF 1.5(i)	3.4	2.3	6
GCSE achievement - % GCSE achievement (5A*-C including English and Maths) 2013-14	53.9%	56.8%	n/a
Long term unemployment – crude rate per 1000 population aged 16-64 (2014)	11.4	7.1	n/a
% of women smoking at time of delivery (2013/14) PHOF 2.03	13.8%	12%	5
Under 18 conception rate per 1000 girls aged 15-17 (2013) PHOF 2.04	27.9	24.3	4
Hospital stays for alcohol related harm – directly age standardised rate per 100,000 population (2013/14) PHOF 2.18	718	645	3
Prevalence of opiate and/or crack use – crude rate per 1000 population aged 15-64 (2011/12)	11.5	8.4	n/a
Incidence of TB – crude rate per 100,000 population (2011-2013) PHOF 3.05(ii)	16.7	14.8	4
Life expectancy at birth in years – Males (2011-13) PHOF 0.1(ii)	78.8	79.4	1
Life expectancy at birth in years – Females (2011-13) PHOF 0.1(ii)	82.4	83.1	2
Smoking related deaths – directly age standardised rate per 100,000 population aged 35 or more (2011-13)	320	288.7	n/a
Under 75 mortality from cardiovascular disease – directly age standardised rate per 100,000 population (2011-13) PHOF 4.04(i)	89.6	78.2	2
Under 75 mortality from cancer – directly age standardised rate per 100,000 population (2011-13) PHOF 4.05(i)	159.9	144.4	2

*Where 1= best and 8= worst

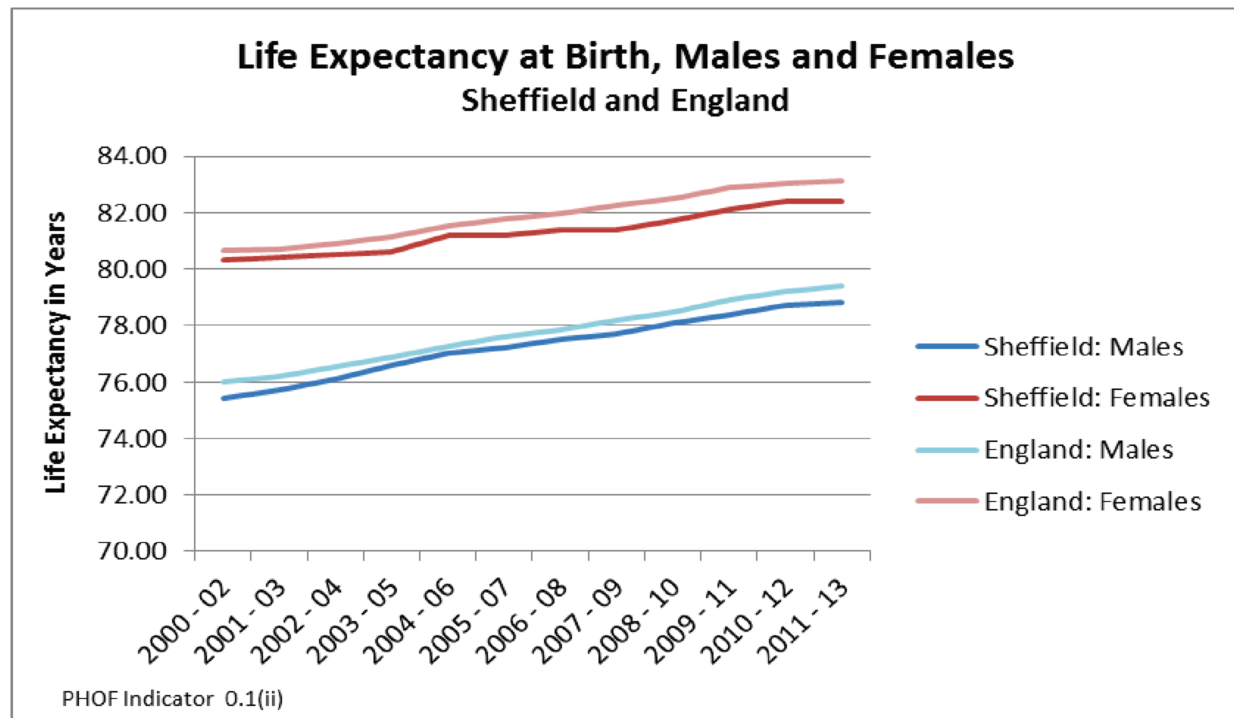
[3] Public Health England Health Profiles http://www.apho.org.uk/default.aspx?QN=HP_FINDSEARCH2012 The table shows which indicators are also included in the PHOF indicator set.

2.2 Life expectancy and healthy life expectancy

2.2.1 Life expectancy

Life expectancy for both men and women in Sheffield is improving year on year and the gender gap is narrowing. For men (in the three years 2011-2013) average life expectancy at birth was 78.8 years and 82.4 years for women. As the graph in Figure 1 shows however, life expectancy in Sheffield still falls short of the England average of 79.4 years for men and 83.1 years for women.

Figure 1



When we compare ourselves with the other major cities in England however, as shown in Figures 2 and 3, life expectancy for both men and women in Sheffield is amongst the best.

Figure 2

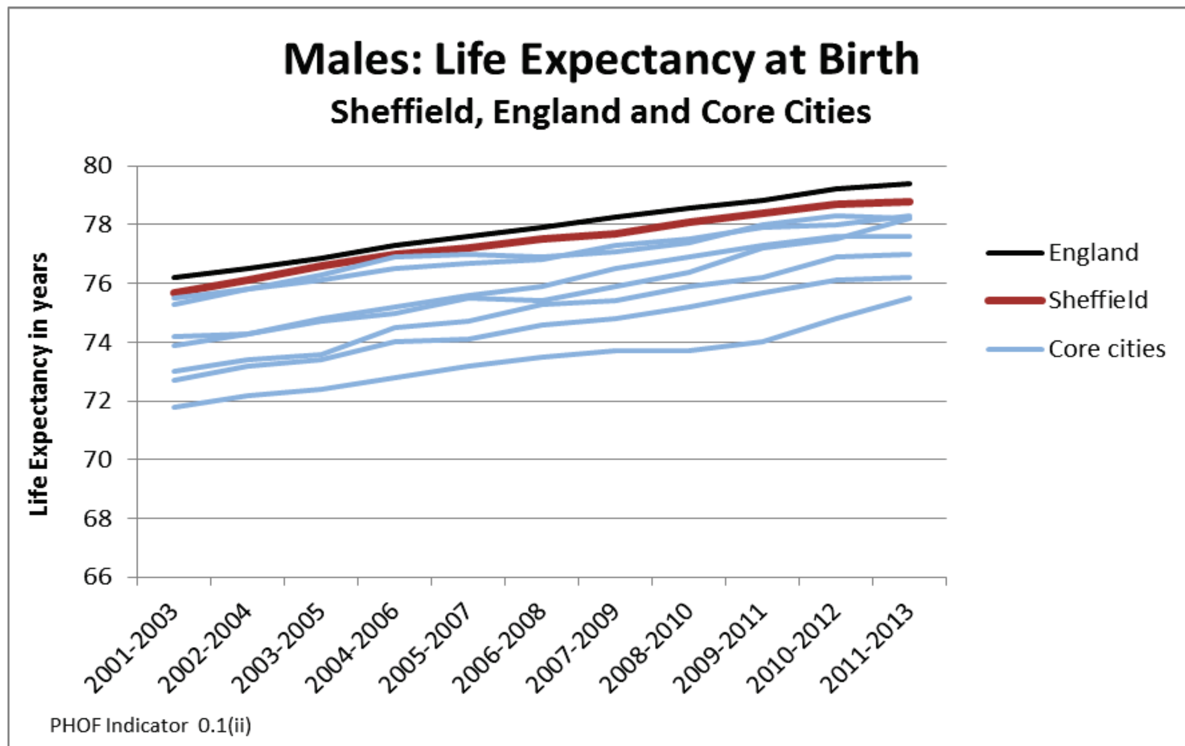
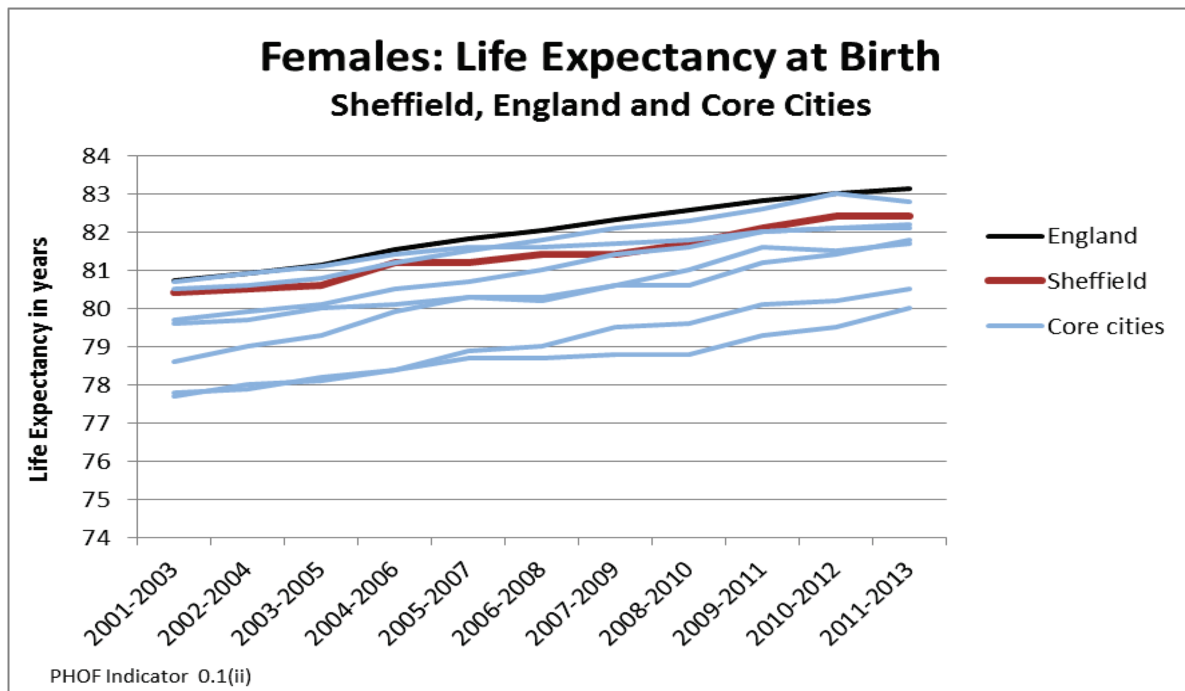


Figure 3



A different picture of health begins to emerge when we look at the gap (or inequality) in life expectancy between the most and least deprived people in Sheffield. This indicator is known as the 'slope index of inequality in life expectancy'. Figure 4 shows the gap in life expectancy between the most and least deprived men in Sheffield and Figure 5 the gap between the most and least deprived women. For men the gap has narrowed over the previous period and now stands at 9.8 years (2011-2013). For women, the gap has also narrowed over the previous period and currently stands at 6.9 years (2011-2013). Although the gap tends to widen or narrow from year to year, over the last ten years it has remained stubbornly unchanged for both men and women. In 2002-2004 for example, the gap was 9.8 years for men and 6.8 years for women.

Figure 4

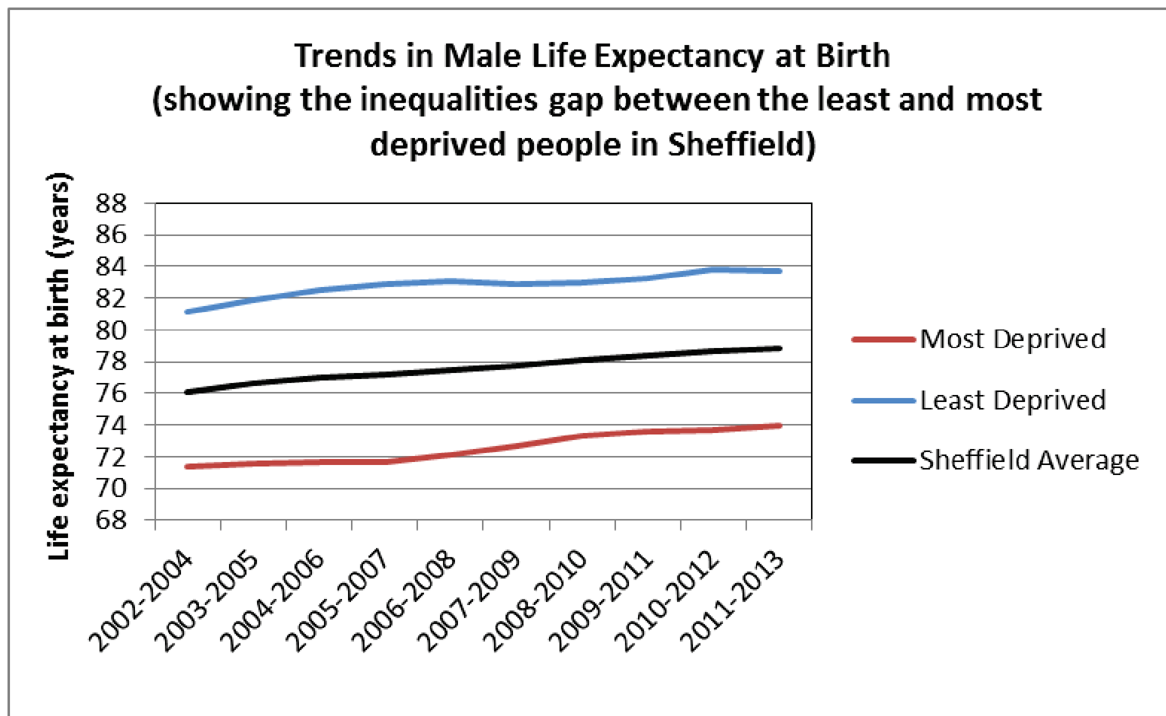
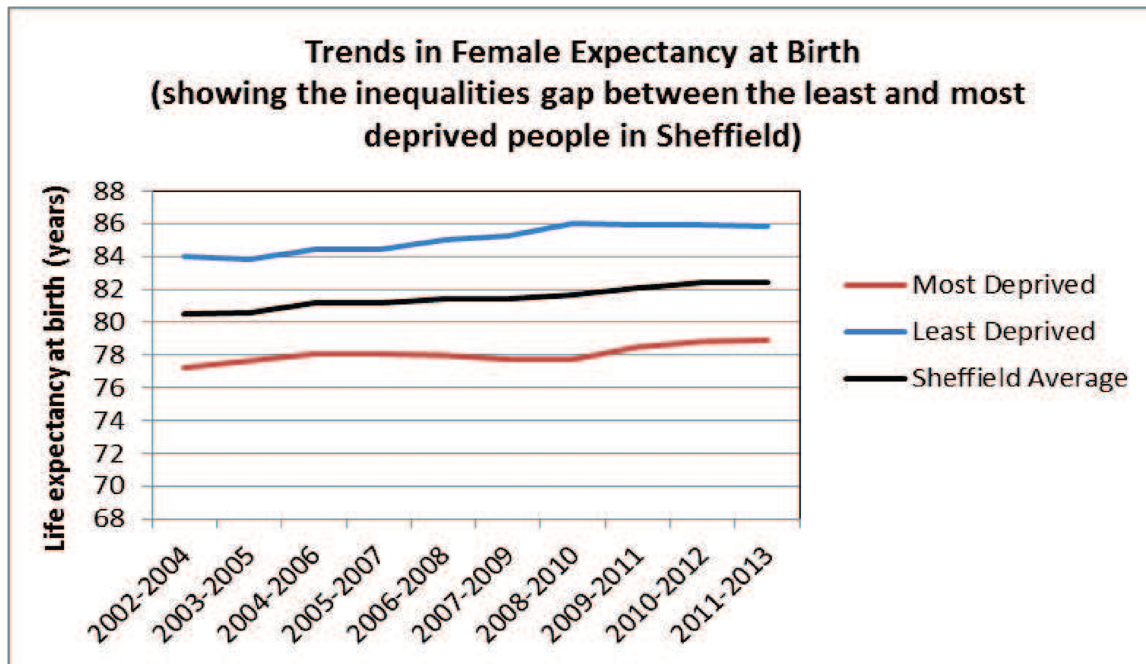


Figure 5



Sheffield, like the rest of the Country, is very unequal. Socioeconomic differences between different sectors of the population are the root cause of health inequalities. This is why Sheffield's Fairness Commission (2013), and the report it produced, is a key document for public health in the City. [4]

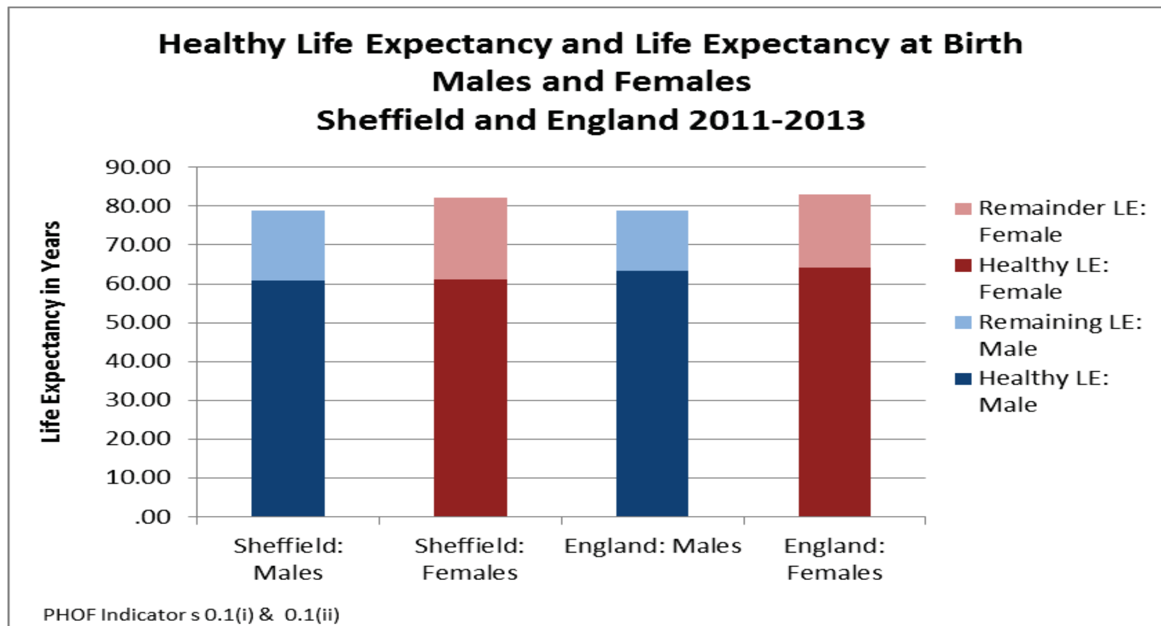
2.2.2 Healthy life expectancy

As well as looking at how long we live, we must also take account of how healthy it is. One way of doing this is to consider 'Healthy Life Expectancy'.

Healthy life expectancy is the average number of years that a person can expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. In Sheffield, healthy life expectancy for men indicates that on average they can expect to live in good health until approximately age 61. Overall life expectancy for men is almost 79 years. This means that men can expect to live the remaining 18 years of their life in poorer health – almost a quarter of their life. For women the figures are approximately 59 years for healthy life expectancy, and around 82 years for life expectancy overall. This means Sheffield women can expect to live the last 23 years of their life in poor health. Figure 6 illustrates these differences.

[4] The Fairness Commission's report (published in 2013) and the 2014 review report may be accessed from the Council's website at the following link: https://www.sheffield.gov.uk/your-city-council/policy--performance/fairness-commission.html

Figure 6



We are all too familiar with the differences in life expectancy that exist across the different communities in the City, but the differences in healthy life expectancy are significantly greater, more than double in fact. This means that not only do people from disadvantaged communities die earlier than those from better off backgrounds, but they experience a considerably longer period of poor health before dying.

2.3 Wider determinants

The wider determinants of health are concerned with the broader socio-economic factors that can influence health either negatively or positively. They include: poverty, educational attainment, employment, crime and safety, the physical environment and housing. Overall Sheffield is on a par with the England average across the range of wider determinants and is performing well in regard to housing for vulnerable groups of people including those with learning disabilities or mental health problems. There are a number of other areas however where we want to see further improvement.

2.3.1 Child poverty

Child poverty is defined as the proportion of children living in households where income is less than 60% of median household income, before housing costs. One of the conclusions of the Marmot Review (2010) was that childhood poverty leads to premature mortality and poor health and wellbeing

outcomes for adults.[5] In addition, the Joseph Rowntree Foundation (Money Matters 2013)[6] demonstrated the causal impact of low income on children's educational and wellbeing outcomes. In particular it identified how financial stress and diminishing family resources can impact adversely on the type of parenting support that is most helpful to child development as well as loss of enrichment activities.

The latest figures (2012) indicate that almost 23% of all Sheffield children live in poverty compared with 18.6% nationally. Although the local position is improving slightly, our level of childhood poverty remains significantly higher than the national average, and this gap is widening. Research undertaken by Sheffield Hallam University (2013) suggests the recent changes to welfare benefits will impact most severely on those already hardest hit (i.e. those on less than 60% median income), especially families with children.[7] This means Sheffield could experience an increase in childhood poverty over the next few years and this in turn could impact negatively on overall health and wellbeing outcomes in the City.

We have developed a new Tackling Poverty Strategy for Sheffield (2015-2018) to meet the growing need in our City in the context of welfare reforms, austerity, continuing difficult economic circumstances and Government cuts to public sector funding.[8] The key elements of the Strategy include how to make things better for children, young people and adults who are struggling and experiencing poverty now and what we can do to tackle some of the root causes of poverty to give our children and young people the best chance of a poverty-free future. We also acknowledge that we need to go further than the commitments we have made so far and have identified a number of areas for further development with our city-wide partners over the lifetime of the Strategy.

2.3.2 School readiness

School readiness is a key measure of early years development across a range of areas. One such area is the extent to which a child, at the end of its first year of formal education (Year 1: 5-6 year olds) is able to understand the sounds that letters and combinations of letters make. This is known as the phonics screening check. The latest figures for Sheffield (2013/14) show that 69.9% of eligible children in Year 1 achieved the required standard in the phonics screening check compared with 74.2% for England.

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[5] The Marmot Review (2010) Fair Society Healthy Lives. UCL Institute of Health Equity. London

[6] Cooper and Stewart (2013) Money Matters. Joseph Rowntree Foundation. York

[7] Beatty, C. and Fothergill, S. (2013) Hitting the poorest places hardest: The local and regional impact of welfare reform. Centre for Regional Economic and Social Research, Sheffield Hallam University.

[8] https://www.sheffield.gov.uk/your-city-council/policy--performance/what-we-want-to-achieve/corporate-plan/tackling-inequalities/tackling-poverty-strategy.html

Moreover, children with free school meal status achieved only 57.1% in Sheffield compared with 61.3% nationally. Children from poorer backgrounds are more at risk of poorer development and evidence shows that differences by social background emerge early in life and can persist into adulthood. Such differences clearly exist in Sheffield.

The period from conception through to the early years is a crucial phase of human development and is the time when focussed attention can bring rewards for society. Infants thrive when they feel safe, secure and loved. Therefore the foundations for children's communication, social and emotional development and nutrition lie in the quality of the parent-infant relationship, and the interactions they experience. Supporting parent-infant relationships is a priority for Sheffield and it is why efforts to ensure the best start in life represent such an important aspect of public health work for the Council.

2.3.3 Pupil absence

The proportion of half days missed (authorised and unauthorised) by primary and secondary school pupils in 2012/2013 was 5.87% in Sheffield compared with 5.26% in England. This represents a recent increase over what had been a steadily reducing trend, both locally and nationally.

Regular attendance at school (or otherwise) is clearly the first step in ensuring a child receives a suitable education. In turn, educational attainment is influenced both by the quality of education received and socio-economic background. Educational achievement can determine an individual's life chances in terms of employment, income and housing as well as other material resources. These factors are strongly related to health outcomes and health inequalities. Improving attendance at school therefore represents an important element of ensuring a child achieves its potential and in contributing to improving health and tackling health inequalities.

2.3.4 16-18 year olds not in education, employment or training

Young people who are not in employment, education or training are at greater risk of a range of negative outcomes including poor health, depression or early parenthood. Reducing the number can therefore make a lasting difference to individual lives.

6.6% of Sheffield's 16-18 year olds were not in education, employment or training ('NEETs') in 2013 compared with 5.3% nationally. Nevertheless, the proportion of NEETs is reducing year on year in

Sheffield and at a faster rate than nationally, such that the gap is narrowing. Along with a general need to tackle long term unemployment, youth unemployment is identified as a key priority in our Joint Health and Wellbeing Strategy (2013)[9] and recent local developments, such as the Sheffield Apprenticeship Programme and the new UTC (University Technical College) Sheffield, will make a positive contribution to continuing to improve outcomes in this regard.

2.3.5 Violent crime (including sexual violence)

The rate of emergency hospital admissions for violence is increasing in Sheffield, running counter to the trend for England. Currently the Sheffield rate stands at 66.8 per 100,000 population (2011/2012 to 2013/2014) compared with 52.4 for England. Nevertheless, Sheffield's rate is the second lowest of the eight core cities in England with Liverpool the highest at 148.2 per 100,000 population and Birmingham the lowest at 65.6.

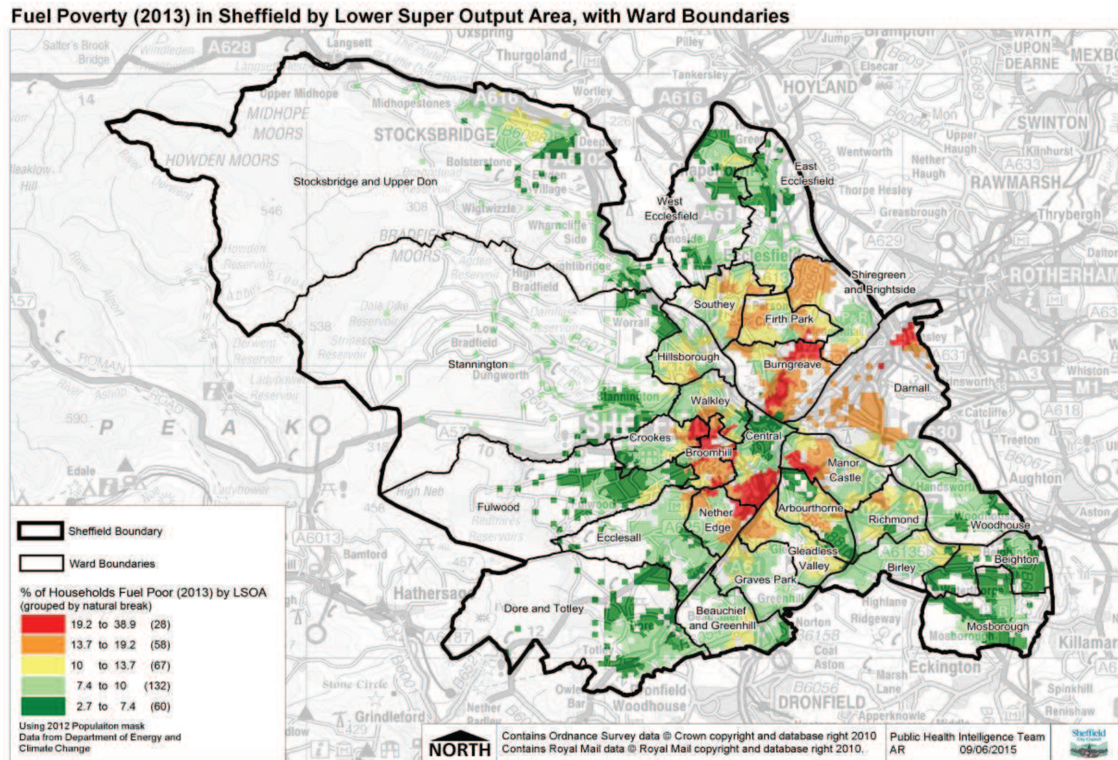
2.3.6 Fuel poverty

Fuel poverty is a real issue for the City and is directly linked to living at low temperatures in the home. Living in a cold home can damage people's health as well as being a potentially significant problem or risk factor in relation to winter deaths, children, young people and adults with chronic health conditions, and mental ill-health .The elderly, children and those with long term limiting conditions (which keep them at home a lot) are especially vulnerable. In 2012, 11.3% of households (26,604) in Sheffield experienced fuel poverty, compared with 10.4% in England. This varies considerably across the City and as the map in Figure 7 shows, represents a significant health inequality.

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

[9] https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html

Figure 7



2.4 Health improvement

Health improvement is concerned with healthy lifestyle choices and mental wellbeing across the key stages of life (i.e. birth, childhood, young people, working age adults and post retirement).

For most of the areas covered in this domain, Sheffield is achieving similar or slightly better than average outcomes than the rest of the Country. In relation to infants and children this includes higher breastfeeding rates and lower levels of childhood obesity. Nevertheless, the overall prevalence of childhood overweight and obesity in Sheffield is too high and there are still only around one in two babies being breastfed. There is a similar picture for adults which shows that although rates of smoking, physical inactivity and obesity are similar to the average for England, levels are much too high. We must ensure we achieve further dramatic improvement in healthy behaviours within the population given that these play such a crucial role in helping to prevent ill health and early death.

There are also a number of areas where Sheffield must take further improvement action.

2.4.1 Smoking during pregnancy

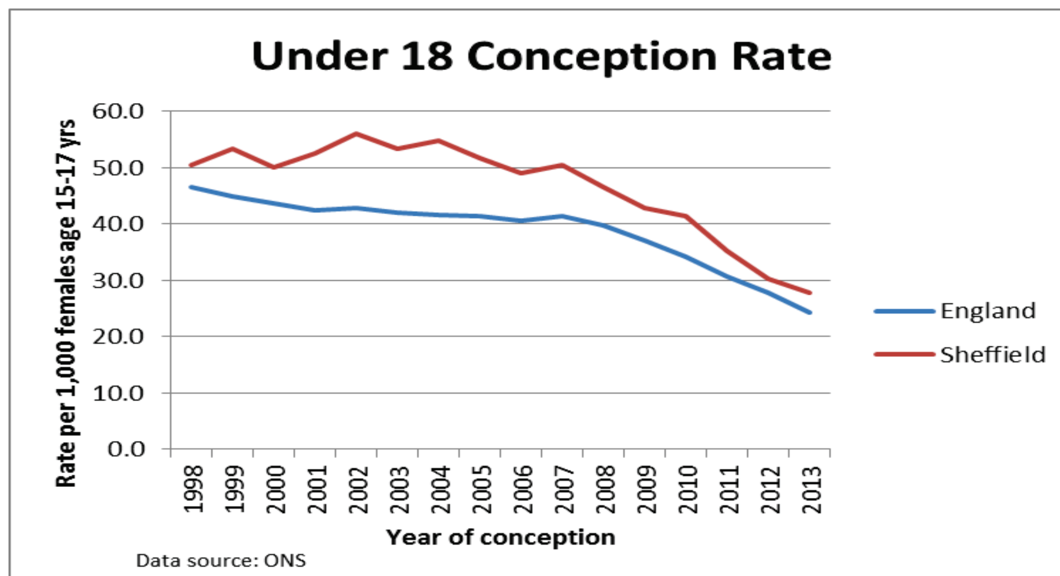
Smoking during pregnancy has well known adverse effects on the growth and development of the baby and on the health of the mother. On average, smokers experience more complications during pregnancy and labour and a greater risk of miscarriage, premature birth, still birth, low birth weight and sudden unexpected death in infancy.

The proportion of Sheffield mothers smoking at the time of the birth of their baby is consistently higher than the national average (12% in 2013-2014), and is currently 15.1% (2014/2015) which is the highest it has been for several years. Nationally comparable figures are not yet available for 2014/2015 so we cannot say whether this latest figure is part of a wider trend or local to Sheffield. Nevertheless, it is a significant concern and one that we will need to address, as part of our Tobacco Control Programme, as a matter of urgency.

2.4.2 Teenage conceptions

As a result of continued implementation of Sheffield's Teenage Pregnancy Action Plan, the City has seen a substantial and sustained reduction in the rate of conceptions in girls under the age of 18 years from 52.6 per 1000 girls aged 15-17 years in 2001 to 27.9 per 1000 in 2013, as Figure 8 shows.
Despite this progress, Sheffield's rate remains significantly higher than the national average (24.3 per 1000). Moreover, the rate varies significantly across Sheffield's wards with around 6.5 per 1000 in Ecclesall to 59.9 per 1000 in Manor Castle. It is important therefore that this remains a priority area for health improvement and tackling health inequality in the City.

Figure 8



2.4.3 Successful completion of drug treatment

The percentage of opiate drug (i.e. heroin or other opiate drugs) users aged 18-75 years that left drug treatment successfully who did not re-present to treatment within six months has reduced in Sheffield for the second year in a row and now stands at 5.8% compared with 7.8% for England (2013). It should be noted however that successful completion of treatment for non-opiate drug users is much greater at 35.3% (37.7% nationally).

Although the local trend mirrors the national one, it is nevertheless a concern given that successful treatment represents significant potential for improved health outcomes including: better physical and mental health, longer life expectancy, improved parenting skills and reduced transmission of blood-borne viruses. It is also strongly linked with reductions in offending behaviour. Nevertheless, local treatment services have around 2,000 people engaged in opiate treatment at the current time, many of whom will be experiencing the improved health outcomes of being successfully engaged in treatment, before having been successfully discharged from the service.

2.4.4 Alcohol related admissions to hospital

Alcohol misuse is linked to over sixty different medical conditions including liver disease, mouth, throat and other cancers, neurological conditions (including dementia), poor mental health, reduction in fertility, as well as acute conditions resulting from accidents, self-harm and violent assault.

One indicator used to measure the extent to which alcohol misuse and related harm may be a problem is hospital admissions that involve an alcohol related primary diagnosis or an alcohol related cause. In Sheffield the number of alcohol related hospital admissions per 100,000 population is increasing and in 2012/2013 was 706 per 100,000 population, significantly higher than the England rate of 637. Nevertheless, Sheffield's rate was the third lowest of the eight English core cities after Leeds (683 per 100,000) and Birmingham (691 per 100,000).

A Sheffield Alcohol Strategy (2015-2019) is currently being written and will be consulted on widely before a final version is agreed later in the year. This strategy will address these issues specifically and action plan to reduce alcohol related hospital admissions and the harms caused by alcohol use and misuse.

2.4.5 New born blood spot screening

There are a number of health screening programmes in the UK that are undertaken at different stages of life that can have a significant impact on health and wellbeing of the population. One of these is the new born blood spot screening programme (also known as the 'heel prick test') which is used to identify babies (under 17 days) who may have rare but serious conditions that respond to early treatment, such as cystic fibrosis or sickle cell disease.

The benefits of screening may only be realised however if coverage rates are maintained at high enough levels. In Sheffield the coverage rate for new born blood spot screening was 83% in 2013/2014. This was significantly lower than the average for England at 93.5%. Improvements have been put in place to address this however and more recent local data indicate that our performance is now consistently over 90%, which represents a significant improvement.

2.4.6 Health checks

The national 'Health Checks' programme aims to prevent heart disease, stroke, diabetes and kidney disease by inviting everyone aged between 40 and 74 years, who does not already have one of these diseases, to have their risk of developing such diseases assessed and to be referred on to appropriate services as required. The two indicators in the PHOF related to this area measure the cumulative proportion of the eligible population offered a health check, and the cumulative proportion of those who receive it.

In 2013/2014, 17.3% of the eligible population were offered a health check (compared with 18.4% nationally) and 46.9% received it (49% nationally). This means we are currently identified as being significantly below the national average on both indicators although our position relative to England has improved since the programme commenced in Sheffield in July 2012.

2.5 Health protection

The third domain of the Public Health Outcomes Framework is concerned with protecting the population's health from major communicable diseases and environmental threats to health. The majority of this domain is concerned with the childhood vaccination and immunisation programme, which provides protection against serious infections such as hepatitis, mumps and meningitis. Sheffield consistently achieves better than average coverage rates for virtually all areas of the programme. There are however two aspects of health protection, largely related to adults, where further improvement action is required.

2.5.1 Late presentation of HIV

The proportion of people presenting with HIV at a late stage of infection is included as an indicator within the PHOF as a measure of avoidable disease and the effectiveness of sexual health promotion and treatment services. Just over half of all patients newly diagnosed with HIV in Sheffield are diagnosed late (51%), which is significantly higher than the figure nationally (45%).

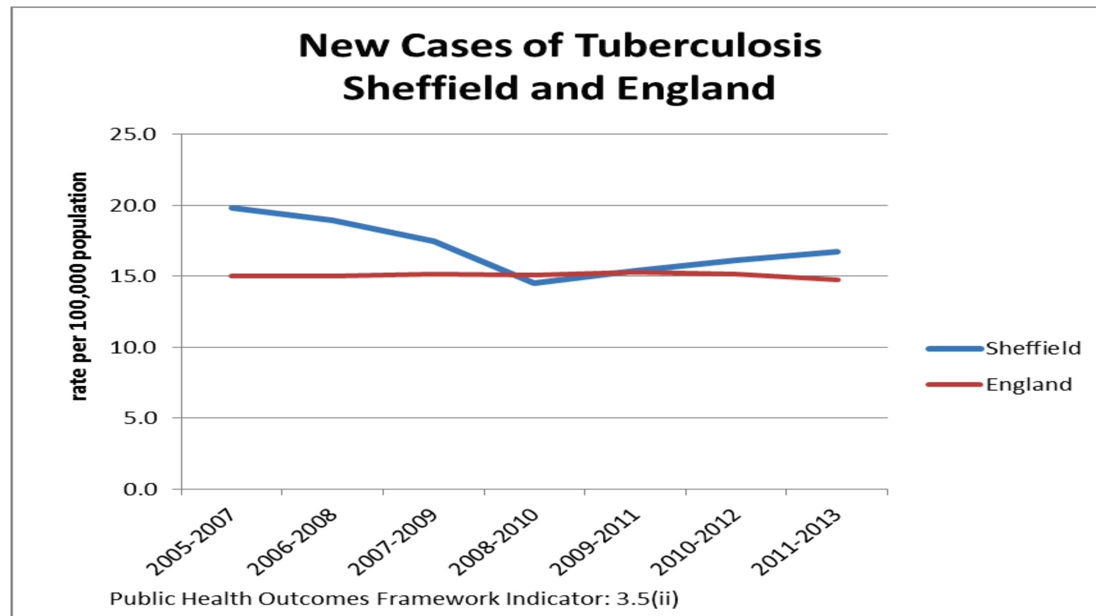
Approximately 90% of deaths among HIV positive individuals within one year of diagnosis are among those diagnosed late. Late diagnosis can lead for the individual patient to higher risk of death in the short term and poorer health in the longer term, as well as the risk of onward transmission (thus further avoidable cases of HIV) and higher healthcare costs.

2.5.2 Tuberculosis

Perhaps thought of as a disease of the past, Tuberculosis (TB) has re-emerged as a serious public health problem over the last two decades, both nationally and locally. The incidence of TB in Sheffield has increased from 10.5 new cases per 100,000 population in the early 1980s to 16.7 per 100,000 in 2011-2013 (approximately 90 new cases per year). This is significantly higher than the average rate for England which currently stands at 14.8 per 100,000 population. As Figure 9 shows, the TB rate reduced

over the period 2005-2010 in Sheffield but more recent data show the disease is on the rise again. This is a dynamic situation that could change significantly in the future. For example in 2010 10% of our TB cases were accounted for by university students who have previously been considered a low risk group.

Figure 9



TB is a bacterial infection that is slow to develop and it usually takes several months for symptoms to appear. Left undiagnosed, a person with infectious TB can infect between 10-15 other close individuals over a 12 month period. Timely and fully completed TB treatment is therefore crucial to saving lives and preventing long-term ill health as well as reducing new infections and drug-resistance. In terms of the percentage of people completing TB treatment within 12 months, the current standard is 85%. In Sheffield we achieved 74.7% in 2012 compared with 83.3% nationally so it is clear we have some way to go. A new national TB strategy has recently been published[10] and in response, Sheffield is seeking to develop a city-wide latent TB screening programme to help reduce the rate of active TB disease in the area.

2.6 Preventable mortality

The fourth and final domain of the PHOF focuses on the various aspects of mortality (death) and morbidity (ill health) and related healthcare activity that are considered preventable. Sheffield is on a

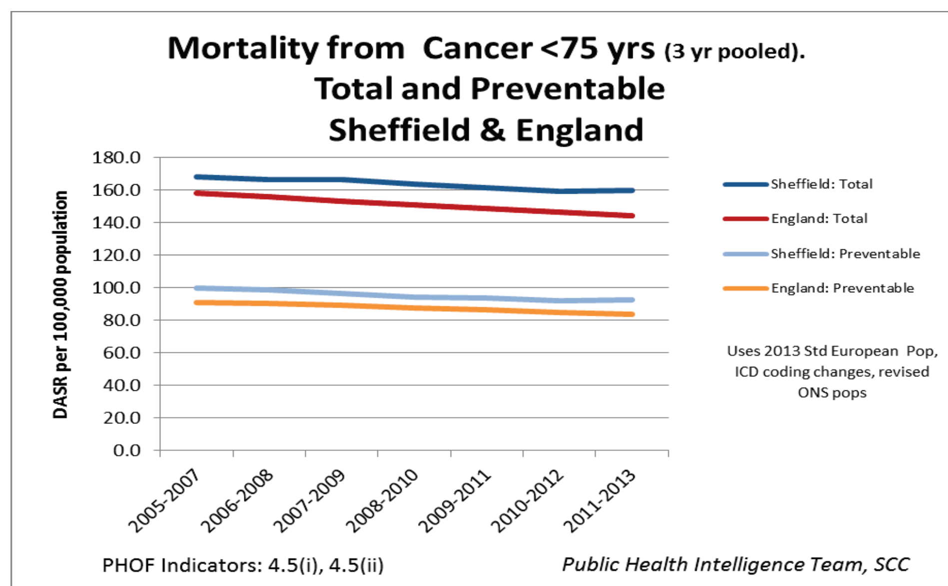
[10] Collaborative Tuberculosis Strategy for England 2015 to 2020. January 2015 https://www.gov.uk/government/publications/collaborative-tuberculosis-strategy-for-england

par with the rest of England in terms of indicators related to preventable healthcare activity and recording of key aspects of preventable ill health, but does less well in terms of reducing preventable premature mortality (deaths in people under the age of 75 years) from cancer, cardiovascular disease (CVD), respiratory disease and liver disease. In addition, there is an aspect of preventable healthcare activity (emergency readmissions to hospital) where further improvement is required.

2.6.1 <u>Preventable mortality from cancer</u>

Each year, almost 42% of all premature deaths in the City are caused by cancer. This makes it the leading cause of death in people under 75, as is also the case nationally. Moreover, despite a reduction over the last 10-20 years, Sheffield's premature mortality rate from cancer at 159.9 per 100,000 population (2011-2013) remains significantly higher than the national average (144.4 per 100,000 population) as Figure 10 illustrates.

Figure 10

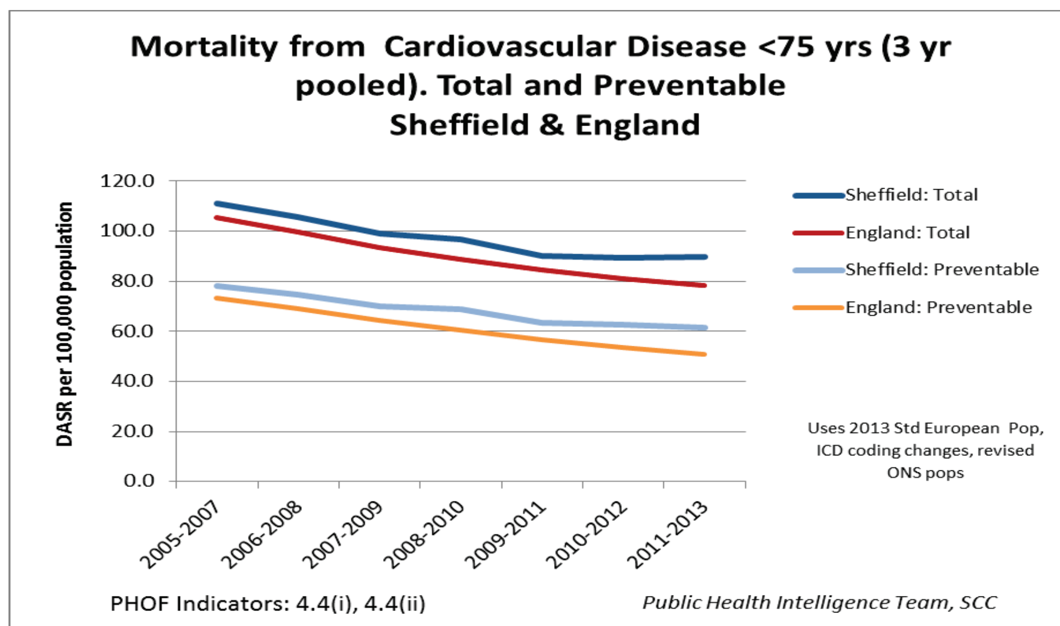


Approximately 58% of all premature deaths from cancer in Sheffield are considered preventable, which would equate to almost 380 deaths a year. This is higher than the proportion nationally that are considered preventable, also shown in Figure 10. Common causes of cancer are smoking, poor diet and physical inactivity. A large number of cancer deaths before age 75 could therefore be prevented by changes in lifestyle, maintaining good coverage of the three cancer screening programmes (breast, bowel and cervical) and earlier detection and treatment.

2.6.2 Preventable mortality from cardiovascular disease (CVD)

Widespread changes in lifestyle, systematic identification of people at risk, and better treatment for cardiovascular disease (heart attacks and strokes) has resulted in the premature mortality rate falling year on year in Sheffield, and at a faster pace than nationally. Currently CVD accounts for around a quarter of all premature deaths in Sheffield. Although the gap between Sheffield and rest of the Country has narrowed, our rate at 89.6 per 100,000 population (2011-2013) remains significantly higher than the average for England (78.2 per 100,000 population), as shown in Figure 11.

Figure 11



Over two thirds of premature mortality associated with CVD in Sheffield is considered preventable, as shown in Figure 11. This equates to almost 250 premature deaths per year. The lifestyle factors that contribute to cancer are also key contributors to CVD. As already noted in relation to the role of the 'Health Checks' programme, together with the range of other actions we are taking to ensure timely prevention and early intervention in relation to chronic disease, we anticipate further improvements in this area over the next few years.

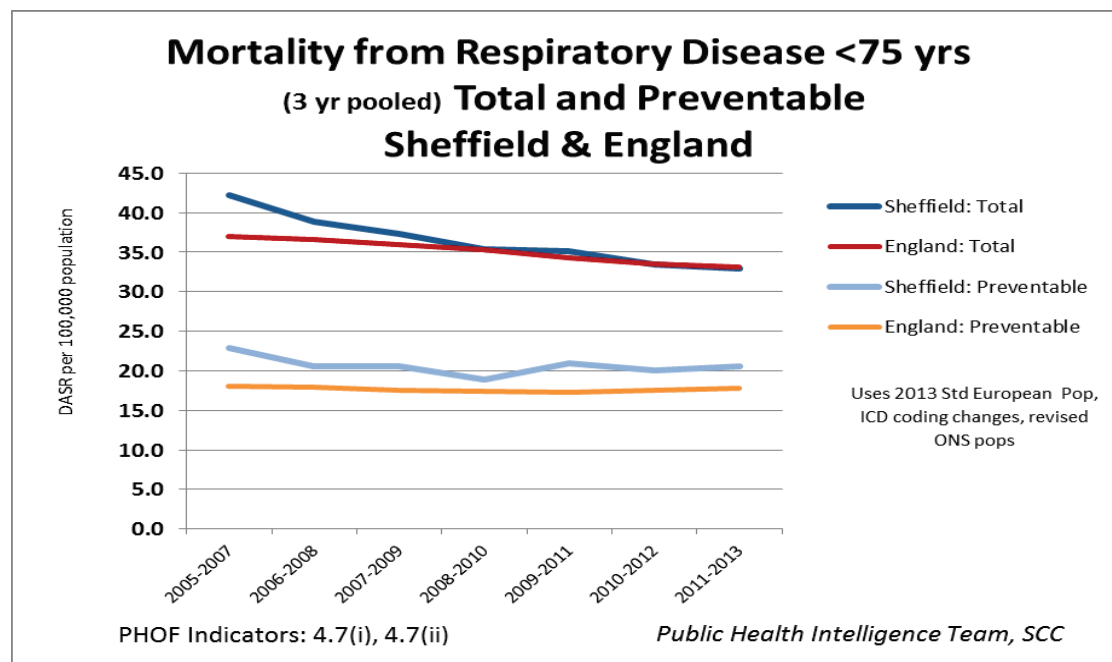
2.6.3 Preventable mortality from respiratory disease

Respiratory disease is a general term used to cover a range of lung conditions including asthma and chronic obstructive pulmonary disease (COPD). Respiratory disease is the third leading cause of

premature death in Sheffield (after cancer and cardiovascular disease) and COPD the main cause of respiratory mortality.

The premature mortality rate from respiratory disease is reducing in Sheffield and at a faster rate than nationally, as illustrated in Figure 12. Currently (2011-2013) Sheffield's rate is 33 per 100,000 population compared with 33.2 for England. COPD is a progressive yet largely preventable disease, with around 85% of cases being caused by smoking. In Sheffield, approximately 70 respiratory deaths in people under the age of 75 could be avoided each year if the prevalence of smoking reduced to among the lowest levels in the Country.

Figure 12



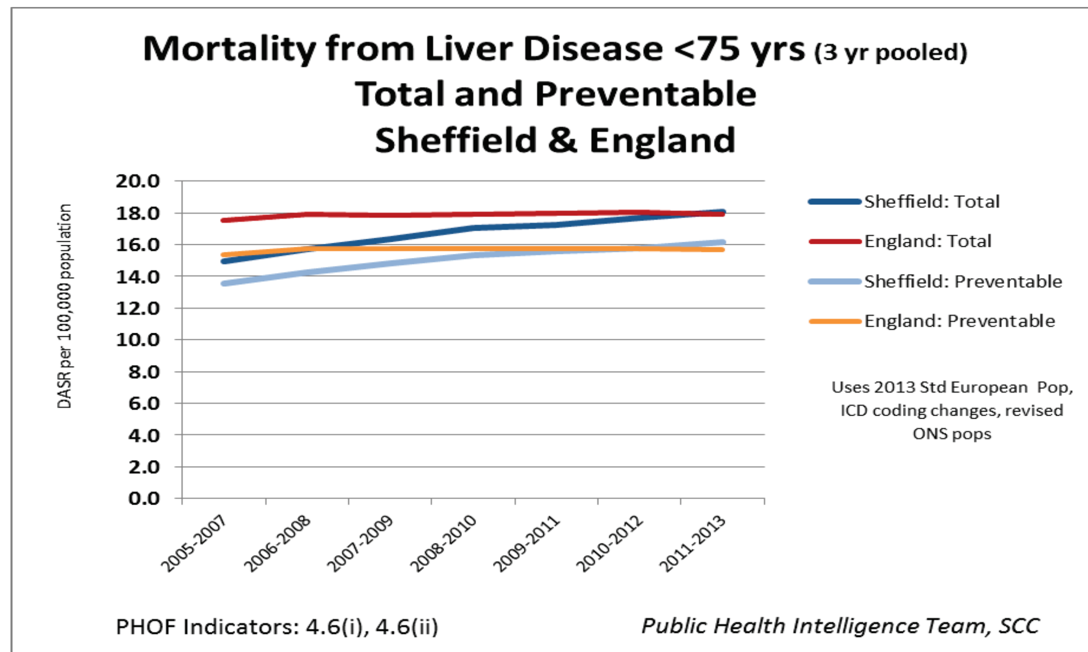
2.6.4 Preventable mortality from liver disease

Liver disease is the only major cause of premature death for which the rate is increasing (locally and nationally) although it has recently begun to level off, as shown in Figure 13. People are also dying from it at younger ages.

Premature mortality from liver disease in Sheffield now accounts for almost 80 deaths per year in people under the age of 75 years. Over 90% of these deaths are considered preventable. The common avoidable causes of liver disease are alcohol consumption and obesity, both of which are amenable to

public health interventions. The Sheffield Alcohol Strategy (2015-2019) will directly address liver disease prevalence and mortality in Sheffield.

Figure 13



2.6.5 <u>Emergency readmissions to hospital</u>

Emergency readmissions to any hospital within 30 days of previous discharge are an important indicator of how well health and social care interventions, designed to help people recover from illness and remain independent, are working. Services such as rehabilitation, recuperation and re-ablement play a significant role in supporting people, especially older people, to return home after a period of time in hospital and to regain their independence, thus avoiding crisis in the short term.

In Sheffield the percentage of people readmitted to hospital after 30 days following discharge has been increasing year on year for the past 10 years from 10.6% in 2002/2003 to 12.5% in 2011/12. This is now higher than the national average of 11.8% although this has not always been the case. This is a key priority identified in our Joint Health and Wellbeing Strategy (2013) and more recently in our ambitious 'Better Care Fund' health and social care improvement programme.

Conclusion

Although public health outcomes in Sheffield are improving on the whole, it is clear there are a number of areas where a step change in improvement will be required if we are to achieve a long-held ambition of being one of the healthiest cities in the Country and reduce the health inequalities that continue to blight our City.

Since the implementation of the 2012 Health and Social Care Act it is now the Council's responsibility to take the necessary steps to improve health and wellbeing in the population. Through using the full range of skills, resources and influence that a local authority can bring to bear on these issues, we have identified a number of developments, as part of our Corporate Plan (2015-2018), that we believe will enable us to achieve this step change in key public health outcomes in the City.[11] These are considered in more detail in the next section.

[11] https://www.sheffield.gov.uk/your-city-council/policy--performance/what-we-want-to-achieve/corporate-plan.html

3 Transforming public health

The opportunities offered by public health in local authorities have the greatest potential to impact on public health outcomes.[12] We are therefore seeking to use the full breadth and reach of the Council to make lasting improvements in health and wellbeing in Sheffield. As part of our Corporate Plan (2015-2018) we have identified a number of public health programmes and initiatives that we believe have the potential to transform health and wellbeing in the City and for which there is strong and clear evidence that local authorities can have a major impact on health.[13] For each area we set out why the area is so important to health and wellbeing, what, as a local authority, we can do about it and the likely impact on a range of public health outcomes.

3.1 More children ready for learning and life

3.1.1 What is this about?

Children's experiences from conception make a significant difference to their lifelong health, wellbeing and life chances. From birth to age 18 months connections in the brain are created at a rate of one million per second. Earliest experiences shape a baby's brain development, and have a lifelong impact on the baby's mental and emotional health, and capacity for learning. Investment during this period has considerable benefits in terms of potential health gains.[14]

The preschool years involve children undertaking a number of important developmental tasks relating to their physical development, social and emotional development and language and cognitive development. In these early years, children are laying down the foundations for higher mental processes, including the cognitive skills which optimise learning – such things as the ability to focus, be motivated, have self-belief, flexibility in thinking, working memory, logical thinking and empathy (known as Executive Function Skills). Alongside self-regulation these are the key skills children need to access learning, enjoy fulfilling relationships and maximise their life chances.

If babies experience significant adversity and their stress response systems are chronically over activated this can profoundly affect their responses to stress in later life. Early stress can come from the

[12] Due North: Report of the inquiry on health equity in the north. University of Liverpool and Centre for Local Economic Strategies (September 2014)
[13] Buck, A. and Gregory, S. (2014) Improving the Public's Health: A resource for local authorities. King's Fund. London
[14] The 1001 Critical Days. 'The Importance of the Conception to Age Two Period' All Parliamentary Group Report 2015

primary caregiver who may be experiencing a range of problems such as poverty, mental health problems, domestic violence or substance/alcohol dependency. [15] Attachment is the bond between baby and its caregiver. There is long standing evidence that a baby's social and emotional development is strongly affected by the quality of their attachment. Children growing up in healthy, stable and nurturing family environments are more likely to be better prepared for school and life and to experience better outcomes.

International studies show that when a baby's development falls behind the norm during the first year of life, it is more likely to fall even further behind in subsequent years, than to catch up with those who have a better start. At least one loving, sensitive and responsive relationship with an adult caregiver can protect the baby's developing brain and reduce the risk of long term problems in learning, behaviour and mental health.

Parenting is the key factor influencing children's social and emotional development and there is a clear link between parenting practice and anti-social behaviour. [16] Positive parenting in particular is associated with high child self-esteem and social and academic competence and is protective against later disruptive behaviour and substance misuse. Parental sensitivity, engagement and verbal stimulation in interaction has been shown to be important in terms of early speech, language and learning.

3.1.2 What are we doing about it?

There are 33,600 children under the age of 5 in Sheffield and of these about 70% will thrive with support from universal services. 30% (around 10,000 children) however, are more vulnerable and need additional, tailored help to achieve good outcomes.

The Best Start Sheffield Strategy 2015-2017 has been developed by the Council and Sheffield Clinical Commissioning Group to provide a city wide vision for early years and identifies further collaborative action to improve existing provision. Whilst it is designed to support all families with children under the age of 5, its focus is on tackling inequalities linked to social disadvantage. The strategy includes the following eight priorities:

[15] Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays
[16] Best Start Sheffield 'A strategy for a great start in life' May 2015

- Improve access to and coordination of health and wellbeing initiatives for children and families
- Empower parents, families and carers to provide healthy, stable and nurturing family environments in order to reduce the risk of child maltreatment and promote secure attachment
- Improve prevention, early identification and early intervention for vulnerable children and families
- Engage families in local communities to influence and play a positive role in shaping activities and services
- Reach into our communities and ensure service provision is accountable to local communities and responsive to community need and demand
- Provide accessible, flexible and high quality effective early learning and childcare for all children
- Narrow the attainment gap especially for children in the most deprived areas
- Support organisations and child-minders across the sector to work together to ensure the early years' workforce has the knowledge, skills and support that will enable children to reach their full potential.

A Best Start Delivery Board has been established to recommend key decisions, advise on programme progress, highlight risks and issues and influence other strategies. The Board has wide representation from partners which include health, private, voluntary, independent and community sectors, social care and safeguarding. It will steer the content of the Strategy and develop the action plan. Three workstream pathways have been established to take forward actions in relation to the agreed priorities. The pathways are: Enhanced Attainment, Vulnerable Care and Social Mobility. The Board will monitor and review progress and feed into the Children's Health and Wellbeing Board.

3.1.3 What difference will it make?

Sheffield's Best Start Strategy is designed to impact on a range of outcomes and key performance indicators across the early years. These are summarised in Table 3.

Table 3: Best Start Strategy Outcomes

Key Indicator	Impact of effective early years services
Reducing conceptions in under 18s by 14% by 2018 (reporting in 2020) from baseline in 2009 to achieve a rate of 37.1/1000 by 2020	Can be reduced, e.g. health visitors supporting teenage mothers to take up contraception and avoid future pregnancies
Reduce the City's infant mortality rate below the national average by 2020, and reducing inequalities across localities in the City	Can be improved through antenatal work with mothers to support quitting smoking and substance misuse and maintaining a healthy weight. Safe sleep advice eLearning package included a feature of all early years staff induction.
Reducing the rate of smoking in pregnancy year on year to achieve a rate of 8% by 2020 with a maximum rate of 14% in any community area	Can be improved through antenatal work with mothers to support quitting smoking
Increasing the rate of breastfeeding at 6-8 weeks with the lowest rates to be a minimum of 70% by 2020	Can be increased through antenatal and postnatal support and by early identification and responsiveness to a mother's concerns. Non-breastfeeding mothers targeted to encourage and support breastfeeding of second and subsequent children. Vulnerability information collated to inform targeting.
Reduce the number of children aged 5 with one or more decayed, missing or filled teeth	Can be reduced through encouraging breastfeeding and healthy weaning in line with the guidelines, as well as healthy family nutrition. Working with dentistry to target patterns of decay and identify key interventions.
Reduce the percentage of children who are obese or overweight (in Reception) aged 4-5 years across all wards	Can be improved through encouraging breastfeeding and healthy weaning in line with the guidelines, as well as healthy family nutrition.
Reduce inequality gap in achievement across the early years goals to achieve the national average by 2016	Can be supported through the delivery of evidence-based parenting programmes and close working with Children's Centres and Best Start Early Years teams.
Increase availability of flexible accessible childcare (based on number of provisions registered)	Improve accessibility to flexible childcare available at point of need. Include toddler groups and child minding.
Increase average attainment of pupils in the lowest 20% at the end of the Foundation Stage	High quality early learning provision and effective and consistent transition arrangements in schools and the private sector.
Increase take up of Free Early Learning for 2, 3 and 4 year olds	Implementation of a city wide training programme for the delivery of free early learning to be made available to all sectors

As part of the Best Start strategy an integrated performance framework is being developed to support monitoring of these outcomes, in particular to give a better overall assessment of performance across care pathways and organisational boundaries and to focus commissioner/provider dialogue on overall system wide improvements.

3.1.4 Priorities for action

We have identified the following three actions as priorities for the next 12 months:

(i) Developing a focused approach to delivering evidenced based maternal mental health interventions including:

- Early assessment of perinatal mental health to identify those at risk
- A strategic approach to families who are not engaged
- Local information sharing agreement to target support effectively

(ii) Establishing local integrated teams based on:

- Agreed framework for local screening and triage
- Streamlined support at a local level for domestic abuse
- Integrated approach to data and information analysis

(iii) Ensuring timely access to quality early learning and childcare for all those eligible for free childcare and for those wishing to enter employment or training including:

- Proactively encouraging those eligible for provision to take-up local places
- Increasing take-up of 2 year old provision
- Introducing employment advice in all early years settings
- Introducing an Early Years quality framework and auditing tool.

3.2 Improved mental and emotional wellbeing

3.2.1 What is this about?

The term 'emotional' wellbeing is often used interchangeably with 'mental' wellbeing. Some people prefer this use of language as the term 'mental' often makes people think of psychiatric conditions. To experience emotional wellbeing is to feel positive about today and to have hope about the future, to feel reasonably confident about being able to manage life's stresses and problems, and that mostly life is fulfilled and rewarding.

The concept of wellbeing comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity and engagement are characteristic of someone who has a positive experience of their life. Equally important for wellbeing is our functioning in the world. Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing.[17]

Resilience is strongly connected with mental wellbeing and both are significant factors to protect and increase. Resilience refers to an individual's, or a community's, ability to cope with the ups and downs of life, with challenging circumstances, and to recover from difficulties. We can help develop resilience by: promoting wellbeing; building social capital; and developing individual psychological coping strategies. The ability to be resilient can be built up during life, especially during infancy and childhood but it can also be lost if not protected.[18]

Emotional wellbeing is a valuable resource for individuals, families, communities and the City as a whole. Improved wellbeing is associated with better physical and mental health, reduced inequalities, improved social relationships and healthier lifestyles. It can help people of all ages achieve their potential, realise ambitions, cope with adversity, work productively and contribute to their community and society. Therefore this work is important in the context of the health inequalities evident in Sheffield, including those in respect of mental illness. For example, the Disability Rights Commission has reported on serious inequalities experienced by people with serious mental ill health. Evidence suggests

[17] Huppert F (2008) *Psychological well-being: evidence regarding its causes and its consequences* (London: Foresight. Mental Capital and Wellbeing Project 2008).
[18] Foresight Reports (2008) Mental Capital through Life: future challenges; Wellbeing and Work: future challenges. Final Project Reports. www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/ProjectOutputs.asp

that people with serious mental ill health die between 15 and 25 years earlier than the average for the general population.[19]

The foundations of emotional wellbeing develop in early childhood, and multiple social, psychological, health, material and situational factors determine a person's mental health and wellbeing at any point in time. Risk, vulnerability and protective factors all impact on emotional wellbeing. A wide range of factors such as creative opportunities, cultural, lifelong learning, leisure and physical activities, housing and jobs play a key role in protecting and promoting mental wellbeing. A number of plans are already in action across Sheffield to influence these factors.

The adverse impact of risk factors for emotional wellbeing is most significant in more unequal societies, when people are made to feel of no account, and the stark inequalities undermine social cohesion and the quality of civic society. It is also acknowledged that we are currently living through difficult economic times which pose additional challenges for the health and wellbeing of individuals, families and communities.

Our mental and physical wellbeing are interconnected. There is strong evidence that investment in the protection and promotion of mental wellbeing improves quality of life, life expectancy, educational achievement, productivity and economic outcomes, and reduces violence, antisocial behaviour and crime. This can result in significant economic savings in health, social care, criminal justice and other public sectors.[20]

Currently we do not have good information on emotional wellbeing in Sheffield. This is true nationally. The Office for National Statistics (ONS) has undertaken a national survey on adult self-reported wellbeing in 2011 and 2014. Four of the questions from this survey are included in the Public Health Outcomes Framework and cover satisfaction with life; how worthwhile life feels; feelings of happiness; and feeling anxious. Unfortunately the results of the survey, and specifically, the responses to these four questions, are only available at a sub-regional level which in Sheffield's case equates to South Yorkshire. The results show a highly mixed picture making it difficult to draw any practical conclusions. Overall the

[19] The PHOF indicator for excess mortality in people with serious mental ill health shows that there is an inequality both nationally and in Sheffield.
[20] Joint Commissioning Panel for Mental Health (2012) Guidance for Commissioning Public Health Mental Health Services. www.jcpmhm.info

figures suggest that wellbeing in South Yorkshire (and therefore probably Sheffield) is not as good as it could or should be.

3.2.2 What are we doing about it?

Mental wellbeing is enhanced the more people, families and communities have a sense of control over the things that matter to them. Promoting mental wellbeing and resilience in the whole population is central to Sheffield's Joint Health and Wellbeing Strategy's mission to ensure the health and wellbeing of the people of Sheffield is improving and that health inequalities are reducing. The key way in which we are seeking to take this forward is through a city-wide approach known as the **5 ways to wellbeing**. The national centre for well-being (New Economics Foundation)[21] was commissioned by the Government to develop a set of evidence-based actions to improve personal well-being. A whole range of factors determine an individual's level of personal well-being but evidence indicates that the things we do and the way we think can have the greatest impact. A generic set of actions, the **5 ways to wellbeing**, was established as a result.

Connect...

Be active...

Take notice...

Keep learning...

Give...

The **5 ways to wellbeing** supports an asset-based approach which focuses on the skills, talents, strengths and aspirations of individuals and communities, rather than simply on their needs. Our aim is to promote understanding of a range of actions, appropriate for all ages, offering options to suit different people at different times. Understanding the **5 ways to wellbeing** offers people an additional tool to look after themselves, a bit like eating your 5 a day.

Although designed for individuals, the **5 ways to wellbeing** can also be used as a framework for strategic planning, service design and commissioning. In this way we aim to maximise the opportunities to support action which promotes and protects mental wellbeing, and supports healthy lifestyles, an empowering approach and the development of social capital.

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[21] www.neweconomics.org

Our **5 ways to wellbeing** approach in Sheffield will continue to focus on developing a range of universal and targeted approaches across the lifespan. This includes;

- Pilot work in three sets of schools to deliver emotional wellbeing services through a locality hub model. These will include promoting resilience and improving emotional wellbeing, preventing mental health problems from arising and providing early support where they do. Evidence shows that a whole school approach to wellbeing can have a positive impact on both physical and mental health outcomes.
- A training programme around emotional wellbeing for universal staff in children's and young people's services
- Running campaigns to raise awareness of the **5 ways to wellbeing** with Council staff
- Incorporating **5 ways to wellbeing** thinking in our approach to commissioning, for example when we develop specifications for carers' services or drug and alcohol services
- Continued development of our Community Wellbeing Programme, supporting the growth of social capital through a community development approach in our more deprived neighbourhoods
- Collaboration with library services as community hubs
- Using **5 ways to wellbeing** as part of our plans to train the wider Council workforce in public health approaches
- Supporting our voluntary sector partners in rolling out **5 ways to wellbeing** understanding and approaches
- Additional capacity to deliver Mental Health First Aid training in collaboration with the Sheffield Health and Social Care Foundation Trust, Sheffield Hallam University and the Voluntary sector. To date we have trained around 1,300 Mental Health First Aiders
- Develop links through our Lifelong Learning and Skills team, with the Community Adult Learning Sector, with the aim of increasing access to and normalising opportunities to learn about emotional wellbeing and skills
- Aiming to increase access to social prescribing, developing from the examples of good practice in the City.

Our role within the Council has offered opportunities to develop this approach, but we need our partners alongside, to influence and bring about change on a much wider scale. It is critical to the

potential success of this approach, that we influence our strategic leaders in understanding the value of growing emotional wellbeing as a resource for individuals, families and communities. We have started this discussion at the Health and Wellbeing Board, and will continue to develop the narrative.

3.2.3 What difference will it make?

Given that emotional and mental wellbeing underpins good health throughout life, we would expect our approach to impact across a number of Public Health Outcomes, especially those concerned with life expectancy and healthy life expectancy, preventing premature death (including excess mortality in people with serious mental ill health) and illness and improved mental health. In addition, we are working with our two local universities to develop tools that will help us to identify, measure, and track progress of the wellbeing impact of our approach on both individuals and communities. This will cover impacts such as social capital and community resilience.

3.2.4 Priorities for action

We have identified the following three actions as priorities for the next 12 months:

(i) Embed the development of mental wellbeing and emotional resilience in the commissioning and delivery of services

(ii) Facilitate the engagement of a range of partners in promoting **5 ways to wellbeing** and identify the ways in which they can contribute to taking it forward

(iii) Establish a local baseline measure of wellbeing for the City and use this to track change over time, and variation across the different communities in Sheffield.

3.3 Better housing conditions

3.3.1 What is this about?

Poor housing costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes. The Kings Fund[22] describes three aspects of housing that can have a significant impact on improving health:

Preventing accidents in the home among children – Home accidents are the most common cause of death in children over the age of 1 year. More than 1 million children under the age of 15 experience accidents in and around the home every year that result in a visit to A&E, with children aged 0–4 years at highest risk.[23] Figures suggest there are between 800-1000 admissions of this type per year in children aged 0-14 years in Sheffield (lower than average).

Making homes warmer - Each winter in England and Wales between 25,000 and 30,000 more people die in winter than in the summer.[24] There is quite wide variation from year to year in terms of the number of excess winter deaths in Sheffield ranging from around 150 to 350 – but the key point is that these are largely preventable, particularly in those over the age of 65 years. Much of this is due to living in a cold house with an increased risk of cardiovascular disease, respiratory illnesses and stroke. Just under 2.4 million homes were considered 'fuel poor' in England in 2011.[25] Warmth and energy improvements in poorer households with children can reduce respiratory problems and even improve mental health. Although the graph in Figure 14 indicates a recent reduction in fuel poverty, there are those who suggest the Government's recent change in definition has had a lessening effect on the numbers. 11.3% of Sheffield's households experience Fuel Poverty[26], this is well above the UK average of 10.4% and is the fourth worst in Yorkshire and Humberside.

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[22] Buck, A. and Gregory, S. (2014) Improving the Public's Health: A resource for local authorities. King's Fund. London

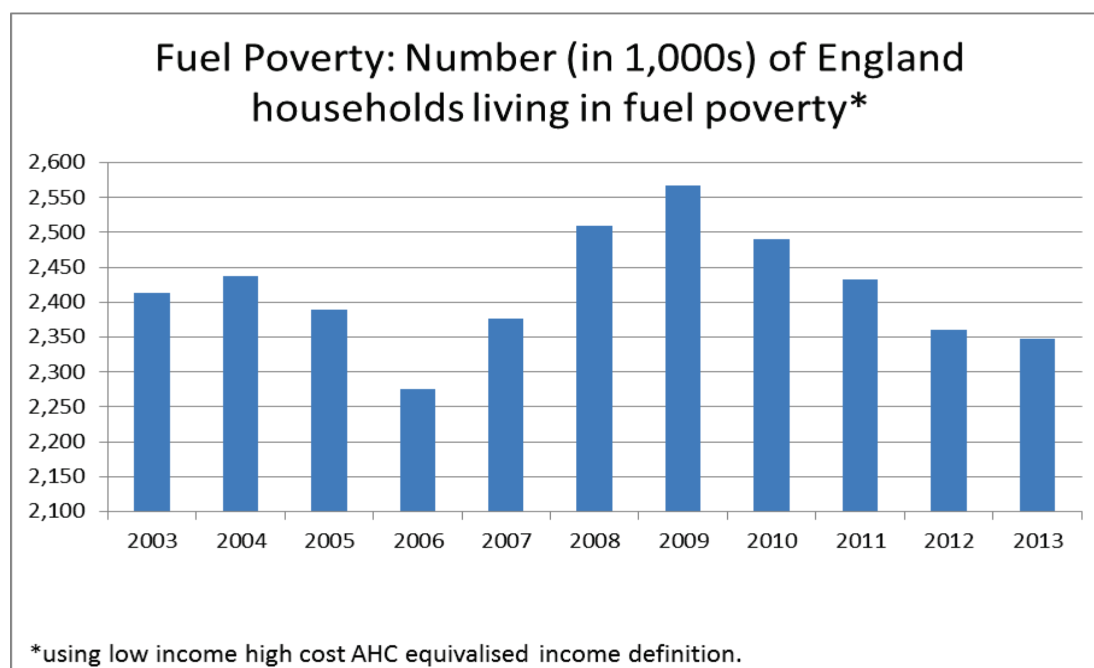
[23] RoSPA (2013) Facts and Figures, http://www.rospa.com/home-safety/advice/general/facts-and-figures/

[24] Department of Health 2013; Office for National Statistics 2013

[25] Department of Energy & Climate Change 2013

[26] Department of Energy and Climate Change, 2012 statistics https://www.gov.uk/government/collections/fuel-poverty-sub-regional-statistics

Figure 14



Source: data from https://www.gov.uk/government/statistics/fuel-poverty-trends-2003-2013 Table 1

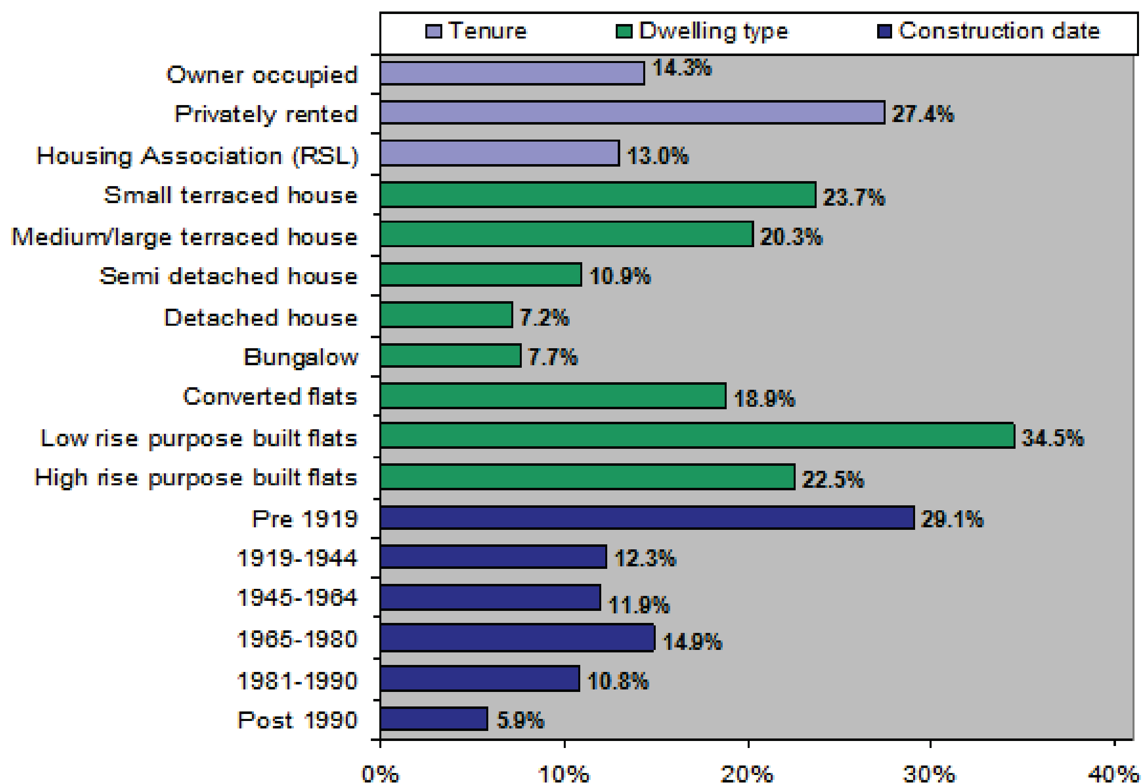
Preventing falls among older people - The nearest thing to a measure of this in Sheffield is the Public Health Outcome Framework indicator concerned with hospital admission rate for injuries due to falls in people aged 65 years and over. The rate (expressed as the number per 100,000 population) has increased in Sheffield and tends to be much higher in the older age groups (i.e. 80+) but is consistently lower than the England average. Clearly not all of these injuries will have occurred in the home but the issue is that they lead to hospital admissions and potentially subsequent loss of independence and decrease in quality of life for older people and yet, in large part, are preventable. As part of their social care responsibilities, local authorities have a role to play in making homes safer. More than one in five homes pose risks to the people living in them. Adaptations and mobility or other aids help people live independently for longer, yet only 2% of owner-occupied homes have been adapted to meet people's needs. About a quarter of people with a serious medical condition living in rented accommodation say their homes are unsuitable for their needs.[27]

In Sheffield all three of these issues are of relevance, but looking at current performance and cost benefit analysis from the King's Fund[28] we have identified making homes warmer as critical to

[27] Adams, S. and Ellison, M. (2009), Time to Adapt, Nottingham Care and Repair
[28] Buck, A. and Gregory, S. (2014) Improving the Public's Health: A resource for local authorities. King's Fund. London

supporting improved health outcomes and reducing health inequalities. This creates particular emphases; for example, there is an increasing reliance on private rented sector properties for poorer residents changing from socially rented 20 years ago. Although not all private rented stock has poor thermal efficiency, a significant proportion does. In Sheffield the sector has more than doubled in size between 2001 and 2011 and makes up 16% of our housing stock, accommodating some 35,670 households in the City, the majority of which (91%) rent from a private landlord or letting agency.[29] According to recent projections, buy to let landlords will continue to drive the growth of the private rented sector in coming decades. Some estimates predict the rate of homeownership will fall from the current rate of 65% (April 2015) to 50% by 2032 while the rate of private sector renting will increase from 17% to 35% over the same period. The chart in Figure 15 shows the proportion of various property types in Sheffield that fall below a set 'thermal comfort' standard.

Figure 15



Source: Private Sector House Condition Survey, Sheffield City Council, 2009

[29] Sheffield Housing Market Bulletin Supplement January-June 2014

There are a number of other factors that we need to take into account:

- The increasing use of prepayment meters in private rented and owner occupied properties is increasing the inequality of fuel poverty
- An increasing number of the worst off individuals and families are spending an increasing proportion of their income on heating or sacrificing it (usually for food) and risking cold related illness, thus exacerbating health inequalities
- There are no really effective drivers of high energy efficiency standards in the private rented sector; this is often attributed to the 'split incentive' in that the landlord sees no benefit in reducing energy costs for the tenant and the tenant is not motivated to invest in measures to improve the landlord's property
- The energy market is substantially deregulated and tariffs are confusing, leading to some households spending more than they need to on energy. Currently there are over 1,000 tariffs and over 12 suppliers
- The new energy efficiency grants and loans system is very complex, and not all have been viewed as highly successful
- Reducing local authority budgets have affected regulatory control of cold homes in the private rented sector. The Housing Health and Safety Rating System has the potential to address fuel poverty in the private rented sector in England and Wales if action and enforcement could be more widely applied. However, financial constraints on local authorities have meant that use of this mechanism has been minimal

3.3.2 What are we doing about it?

Public Health in the Council is currently seeking to address this across three fronts:

- **Helping those currently affected:** by funding organisations to identify those in fuel poverty and assist them with their bills, their tariff, the efficiency of their property and the operation of their heating system (e.g. by Health Champions in communities or through organisations with expertise in energy such as the South Yorkshire Energy Centre)
- **Influencing other organisations to consider the issue and help them address it***:* by collaborating with other organisations and departments to influence their operation and delivery e.g. the Council's own Warm Homes Team, Shelter, etc. to ensure fuel poverty is addressed in their overall operating model

- **By working to develop new models of energy provision to reduce the numbers affected and re- balance the unfair burden of energy costs on those least able to pay:** by working with colleagues to develop new ways of providing energy through locally owned energy service companies. We are currently trying to develop a collaboration with energy companies and community business organisations to develop local, affordable energy production. We will also produce a Fuel Poverty Strategy in 2015 and develop Sheffield's response to the NICE guidance on 'Excess Winter Deaths and Cold Related Illness'.[30]

As a Council we will also need to make sure landlords and tenants are aware of their rights and responsibilities under the Energy Efficiency (Private Rented Property) Regulations 2015. These regulations force landlords (within reason) to bring their properties up to a certain standard. We must also continue to find ways of reducing the cost of energy and increasing ability to pay (both bills and for insulation) for the most vulnerable in the City, be they owners or tenants.

There is also an important role that the NHS can play. While senior management in both the primary healthcare and public health sectors can be highly committed to reducing excess winter deaths and tackling fuel poverty, this commitment is not yet being translated into action by frontline staff such as District Nurses who have access to some of the most vulnerable members of our society. In part this is due to the health sector linking excess winter deaths and fuel poverty to extreme cold weather conditions which are then interpreted as a public health crisis requiring a reactive response. As a result, the link between health and housing disappears from the health sector's radar outside of severe cold snaps. Whilst senior management may understand that energy efficiency interventions can improve public health, and in the long-term make their patients more resilient to extreme cold weather events, frontline staff have yet to integrate this understanding into their day-to-day working practices and energy efficiency is perceived to be a housing specialisation beyond the remit of the health profession.

3.3.3 What difference will it make?

In the short term our aim is to identify and impact on 200 households who are worst affected by March 2016. In the longer term our aim is to ensure every resident lives in a house which they can afford to heat; where they understand and can operate its controls effectively; and is on a tariff system that does not disadvantage less well households.

[30] http://www.nice.org.uk/guidance/ng6

3.3.4 Priorities for action

We have identified the following three actions as priorities for the next 12 months:

(i) Implementing NICE guidance on excess winter deaths and morbidity and the health risks associated with cold homes including (but not exclusively):

- A single point of contact health and housing referral service for individuals and families living in cold homes
- Tailored solutions via the single point of contact health and housing referral service for all people living in cold homes
- Identifying people of all ages at risk of ill health from living in a cold home
- Making every contact count by assessing the heating needs of individuals and families who use primary health and home care services
- Non-health and social care workers who visit children, young people and adults at home should assess their heating needs
- Discharging vulnerable children, young people and adults from health or social care settings to a warm home
- Train health and social care practitioners to help people of all ages whose homes may be too cold.

(ii) Providing products which assist residents to reduce the cost of their energy and the amount they use by:

- Progressing the business case for a local Energy Service Company to present opportunities to generate local energy, create lower priced energy and address the inequalities balance in fuel poverty – for example by providing prepayment meters with electricity at an uninflated price
- Assist residents to improve their homes thermally by delivering more attractive financial products than the current ECO and Green Deal, for example by offering a revolving loan scheme.

(iii) Taking every reasonable opportunity to reduce the number of landlords who fail to ensure their properties have affordable heating.

3.4 Tackling the underlying causes of health inequalities

3.4.1 What is this about?

Inequalities are a major feature of the health and social care landscape in Sheffield. The Council's Corporate Plan (2015-2018), the Fairness Commission (2013) and the Joint Health and Wellbeing Strategy for Sheffield (2013) all recognise this and the need to prioritise actions to address them. Health inequalities are a matter of life and death and are fundamentally rooted in social inequality. Lifestyles are shaped by socio-economic conditions; in order to influence these wider conditions, it is important to engage children, young people and adults from disadvantaged backgrounds in the planning and delivery of community interventions designed to improve their health and wellbeing. In addition, we must do all we can within our local control to tackle the structural barriers faced by those experiencing poverty and disadvantage. The health and social care 'offer' also needs to be re-focussed so that there is greater support for self-care and links with community interventions and promoting wellbeing.

When there are inequalities in society, we all suffer. "*For each of eleven different health and social problems; physical health, mental health, drug abuse, education, imprisonment, obesity, social mobility, trust and community life, violence, teenage pregnancy and child wellbeing, outcomes are significantly worse in more unequal rich countries*" (Picket and Wilkinson, 2010).[31] In other words, nobody benefits from inequality and it is therefore in all our interests to tackle the inequalities that exist in Sheffield.

The WHO European review of social determinants[32] recommends strengthening the capabilities and assets of communities to support empowerment. Building community and individual resilience can also contribute to the development of integrated health and social care and local devolution as well as reduce inequalities, promote wellbeing and encourage economic development.

There is now a widely understood need for new solutions that focus on reducing demand for services as opposed to reducing costs. A community asset based approach is particularly pertinent as demands for services rise while grants from Government fall. In the context of an ageing population and a corresponding increase in demand for services it makes sense to invest in community led, co-produced

[31] Picket, K. and Wilkinson, R. G. (2010) The Spirit Level: Why equality is better for everyone. Penguin. London.
[32] UCL Institute of Health Equity, 2013, Review of social determinants and the health divide in the WHO European Region, Copenhagen: WHO http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/review-of-social-determinants-and-the-health-divide-in-the-who-european-region.-executive-summary Accessed August 19 2014

solutions that serve to create more engaged and active communities. The shift to a focus on demand reduction as well as optimising supply allows us to potentially build sustainable longer term solutions, improve quality and availability of services and enhance impact on those who need them most.

Communities therefore have a vital contribution to make to improving health and wellbeing and tackling the underlying causes of health inequalities. The importance of work to engage individuals and families with and through their communities in improving the health of the population is also recognised in the NHS Five Year Forward View (2014)[33] which notes that:

- We are unlikely to narrow the health gap in England without actively involving those most affected by inequalities
- The assets within communities, such as skills, knowledge and social networks, are the building blocks for good health and cannot continue to be ignored
- Health behaviours are determined by a complex web of factors including influences from those around us
- Community engagement and outreach are often a vital component of behaviour change interventions and the support from peers who share similar life experiences can be a powerful tool for improving and maintaining health
- Social isolation and loneliness is a major public health issue, associated with higher risks of mortality and morbidity but people can 'recover' from loneliness through improved social connections
- Wellbeing is a key concept for a functioning and flourishing society and community life, social connections, and active citizenship are all factors that enhance wellbeing
- A flow of new ideas and intelligence from local communities is needed to give a full picture of what works and what is needed.

Communities who can play a part in tackling some of the root causes of ill health and keeping people out of care are an effective way of making the public health pound go further and creating sustainable solutions to some of the key issues arising through inequalities and poverty.

[33] http://www.england.nhs.uk/ourwork/futurenhs/

3.4.2 What are we doing about it?

The transfer of Public Health to the Council provided a significant opportunity to develop our community based approach to improving health and wellbeing and tackling health inequalities. Specifically the Community Wellbeing Programme and the Best Start Sheffield Programme work with the most deprived communities in the City to reduce inequalities by focussing on resilience, social capital and emotional and mental wellbeing[34]. We have also created a companion programme to develop the public health knowledge, skills and competencies of both communities and the Council's workforce. These key areas of work involve working closely with the voluntary, community and faith (VCF) sector, valuing this sector's expertise in working with communities.

The main elements of the Community Wellbeing Programme include Health Trainers, Health Champions, Community Development and Health Programme and the Public Health Workforce Development Programme. This involves a partnership approach including work with locality teams, libraries, housing, and social care providers leading to a holistic community approach. The Best Start Programme is described in more detail in section 3.1 above. Table 4 summarises the key elements of the Community Wellbeing Programme.

The Sheffield First Partnership[35] has also led a collaborative process aimed at understanding how organisations in Sheffield can work together in relation to communities. This process has resulted in the production of a set of principles focussed on strengthening the resilience of communities. The Community Wellbeing Programme is using these principles to structure its work with other partners and to develop community resilience further. In addition the Community Wellbeing Programme forms an integral part of the City's ambitious integrated health and social care programme (Better Care Fund) which seeks to place people's wellbeing at the centre.[36] A core work stream of the Better Care Fund – Keeping People Well Closer to Home, is focussed on mobilising the community to improve health and wellbeing and reduce demand on services.

[34] These programmes are being developed alongside a number of other programmes designed to provide a comprehensive approach to tackling poverty and inequality in Sheffield; this section focuses on those programmes focussed on social capital and resilience.

[35] https://www.sheffieldfirst.com/ An organisation concerned with the regeneration of the City, set up to bring together the public, private and not-for-profit sectors to work together to make Sheffield a better place to live and work.

[36] The Better Care Fund is a national programme set up to facilitate a transformation in integrating health and social care services in local areas.

Table 4: Summary of the Community Wellbeing Programme and Related Programmes

Community Wellbeing Programme	Community Development & Health Training
There are 14 Community Wellbeing Programmes covering 41 of the most deprived neighbourhoods in the City. The Programme uses an asset based approach to reduce health inequalities and improve health and wellbeing by increasing social capital. It provides a framework for the other community initiatives to ensure a holistic approach within the community. It aims to tackle the wider determinants of health, remove barriers to making healthier lifestyles choices and increase appropriate access to services. Key outcomes are increased skills and capacity and employability of individuals. There is a ripple effect on family, friends and the wider community. In 2014-2015 there were 21,258 beneficiaries and 68,173 points of contact	The existing transformational learning programme training has been in place for many years and has empowered over 1000 participants benefitting more than 10,000 people. The approach involves community based learning which enables participants to gain confidence, build on their strengths and resilience. Participants complete the training with critical awareness and motivation to take action and instigate changes in their neighbourhood. As part of this programme, an Asset Based Community Development project has commenced with initial work in two communities facing high levels of poverty - Winn Gardens and High Green. This represents an acknowledged mechanism for garnering the involvement of local people using "what they bring" as a starting point.
Health Champions	**Practice Champions**
These are volunteers recruited from disadvantaged communities. They draw on their own local knowledge and life experience to undertake community interventions or provide one to one support to improve health, wellbeing and social connectedness**.** These activities are organised and delivered in their own communities, giving local people the opportunity to make a difference amongst their families, friends and neighbours. The experience of being a Health Champion gives volunteers transferable skills which many use to gain employment. Between 2009-2013 the total number of Health Champions was 500 supporting over 19,500 people.	These are patients and community members who work with GP practices to improve access and uptake of services in the area. They support patients with non-clinical needs to access community services and establish new activities such as self-help groups. Four GP practices have engaged in the first phase of the programme. The GP practices and voluntary organisations jointly recruited and trained 160 volunteers. Our aim is to extend the programme to more practices in 2015-2016. GPs involved report that this programme has changed the relationship with their communities.

Health Trainers	Workforce Development
Health Trainers support people to improve their health and wellbeing and manage long term conditions by building confidence and skills. Enabling people to access appropriate clinical and community services reduces unscheduled (emergency) care. Other outcomes include more appropriate use of NHS services, less visits to GPs, less use of medication and discontinuation of use of anti-depressants. The Health Trainers national data base indicates that the Sheffield Programme performs at a higher level than other programmes in England. In 2014-2015 Health Trainers supported over 1,200 people. Health Trainers are employed by voluntary sector organisations.	This programme involves working with colleagues across the Council to develop brief training interventions that will provide staff with an understanding of how health and wellbeing is influenced by wider determinants and the role they can play in addressing this. Our aim is to roll out the training to all front line staff and to develop wider public health training for all staff as part of a core training offer so that contacts the Council has with the people of Sheffield act to promote their wellbeing.

3.4.3 What difference will it make?

The over-arching indicator for this area of public health is the slope index of inequality in life expectancy at birth. This measures the gap (in years) in life expectancy between the most and least deprived people in the City. Although the figures fluctuate from year to year, long term trends show that the gap in Sheffield is little changed for both men and women. The picture is similar for healthy life expectancy although the gap between the most and least deprived people is wider. These are the gaps we are aiming to narrow through our community based asset approach and wider strategies to reduce inequalities and poverty.

3.4.4 Priorities for action

We have identified the following three actions as priorities for the next 12 months:

(i) Continuing to strengthen and develop the Community Wellbeing Programme and related infrastructure in the most disadvantaged communities, co-ordinated between different workforces, agencies and local citizens

(ii) Ensuring reducing health inequalities and an asset based community development approach is explicitly embedded in transformational programmes such as the Integrated Commissioning Programme, strengthening the role of Health Trainers, Health Champions, Practice Champions and lay workers as a key workforce to support this

(iii) Equipping the wider public health workforce with the knowledge, skills and competence to address community-level factors and for the public health knowledge and intelligence workforce to strengthen the voice of communities and citizens in public health evidence and intelligence.

3.5 Helping people who face barriers to get a job

3.5.1 <u>What is this about</u>?

It is widely acknowledged that appropriate work is generally good for young people and adults, and that unemployment can often have a negative impact on health.[37] There is strong evidence that access to work and meaningful activity has a therapeutic value, especially for people with severe and enduring mental health conditions [38] and of a positive association between work and good health, including mental health. At the same time, it is acknowledged that work should be appropriate to the individual, in relation to qualifications, skills and experience, health and (dis)ability. By failing to ensure we provide appropriate employment opportunities we are contributing to health inequalities and if we could change this, we will help to reduce health inequalities.

Currently there is a wide gap between the health and employment systems which leaves those with a disability or health condition caught between the two with the health system doing little to help them secure appropriate employment and the employment system providing little assistance to remove the health barriers or to assist entry into or prompt return to work if health and disability barriers exist. This places a drain on the health system (as unemployment can often lead to other poor health outcomes), a drain on the welfare system, almost requiring people to prove their incapability in order to receive

[37] Waddell, G. and Burton, A. (2006), Is work good for your health? DWP
[38] McLean, C. and Carmona, C. (2005), Worklessness and health – what do we know about the causal relationship, Evidence Summary Review, Health Development Agency

welfare support, and a person losing confidence, capability and inclination to be productive and potentially entering a downward spiral of poor health.

With the NHS under pressure and the austerity measures impacting on the most disadvantaged this is an important point to address. Equally with the devolution proposals likely to include a more localised approach to this long standing problem, it is important that Public Health provides evidence on what works and a link into the wider health system and seeks to be at the centre of a system change and bridging the gap between the employment and health systems. The diagram in Figure 16 illustrates the problem

Figure 16

Source: Presentation of "Health at Work – an independent review of sickness absence" [39]

3.5.2 <u>What are we doing about it</u>?

In June 2015 there were over 25,000 people in Sheffield claiming Employment Support Allowance (ESA) who were unemployed due to a health condition - in the main common mental health issues such as anxiety or depression.

[39] Black, C. and Frost, D. (2011), presentation slides from Health at work – an independent review of sickness absence, https://www.gov.uk/government/publications/review-of-the-sickness-absence-system-in-great-britain

The national employment rate for people with learning disabilities is 6.7%. This is 65.1% below the rate of the overall population [40] At the same time we know about 70% of people with learning disabilities actually want to work, but the system is actually depriving them of that opportunity. The gap is 65-70 % in Sheffield for people with a learning disability or a moderate to severe mental health condition so their employment rates are around 3-7 %.

There are a number of organisations commissioning ' employment' support within Sheffield, from a variety of different perspectives, with varied levels of success, but performance across the City is below the Region average and getting worse.

We are addressing the issue on five different levels:

- Delivering (jointly with Job Centre Plus and the Council's Employment and Skills team in the Children, Young People and Families portfolio) a £400,000 pilot project aiming to bring people on employment support allowance back into employment by removing the health barriers
- Working to develop a pathway into employment from the Health system (particularly GP surgeries) where GPs can refer patients into a pathway which will move them into, or towards employment and improve the communication and data sharing between the health and employment systems
- Reviewing locally commissioned Supported Employment provision to make sure it is effective, and is connected to both local and national health and employment provision, so that people and organisations know how to access the support and increase progression of people receiving employment support, to enable them to move into mainstream employment provision whenever possible
- Encouraging employers to provide 'good work' for the City's population, for example paying a living wage reduces zero hours provision where possible and keeps employees healthy, (both physically and mentally) to reduce absenteeism and the 'in work – out of work ' cycle
- Working with colleagues across the City, the City Region and the Core Cities to ensure the employment and disability barriers are addressed in any devolution proposals for the welfare/ employment system.

[40] Bill Gunnyeon Medical Officer DWP 2013 ' Health, Work and Wellbeing 2012 and Beyond' Health Work and Wellbeing Conference Birmingham 2012

3.5.3 What difference will it make?

By 2018 we aim to support 7,000 people into sustained employment by developing a local 'Progress to Work' programme that works with communities, employers and employees to support those facing the greatest barriers to find work. We want this support to double the number of disabled people and those with mental health conditions moving into employment.

Although this may only be an increase of 2-300 people with those specific conditions or disabilities, the wider aim is to create an employment/ health infrastructure which makes it easier for people who want to work to be able to work. Within the social model of public health we believe this will in turn enable people to make choices which have a positive impact on their health and wellbeing and impact across a far wider range of public health measures. It is important to recognise the fact that the unemployment issue in Sheffield, as in the rest of the UK is disproportionately affecting young people, and therefore focussing opportunities on young people not in employment, education or training (NEETs) is obviously key within this. It will also ensure that the devolution proposals address the issue at Local Economic Partnership [41] level and increase productivity and reduce the welfare costs across the Region. We will ensure the public health contribution to this is delivered.

3.5.4 Priorities for action

We have identified the following three actions as priorities for the next 12 months:

(i) Working jointly with colleagues in the Employment and Skills team in:

- Commissioning locality based programmes to move people towards work
- Commissioning employment support which is evidence based and works with employers as well as employees
- Providing in work support that helps employers to provide 'good work' and which is designed to reduce the fall in and out of employment.
- Working with GPs and Job Centre Plus to develop clear pathways into good employment for patients where employment would be beneficial.

[41] The voluntary partnership between business and City Region local authorities to determine local economic priorities and lead economic growth and job creation within the City Region

(ii) Developing and agreeing a citywide commissioning framework (covering the Council, NHS, VCF sector and the Local Economic Partnership) focussed on increasing employment for those with health conditions and disabilities (including a target for achievement) to encourage resource allocation and to create a shared endeavour. This will greatly assist any devolution proposals for ESA clients.

(iii) Ensuring all Council, LEP and NHS investment aimed at supporting this objective is either part of, or closely linked to the City's 'Pathways to Employment Programme' [42] with the aim of moving participants into mainstream employment provision whenever possible. This could be a shared commissioning approach, across health, local authority and the LEP.

3.6 Maintaining a healthy weight throughout life

3.6.1 What is this about?

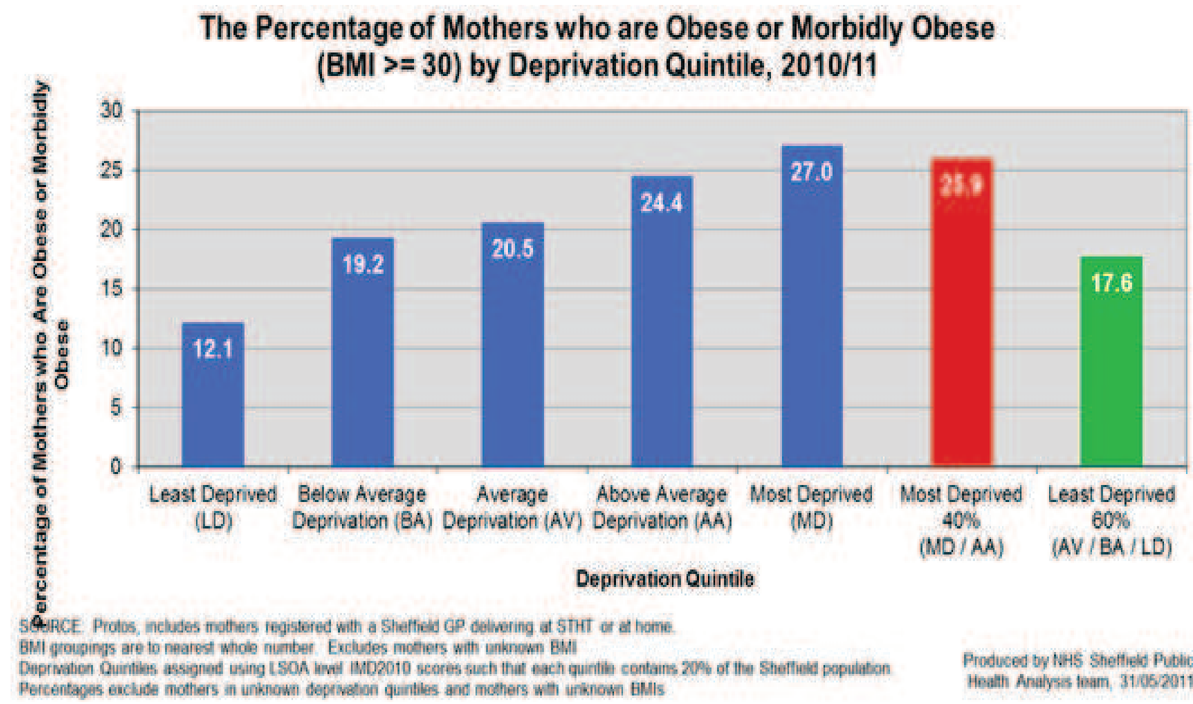
Obesity is a medical condition in which excess body fat accumulates to the extent that it may have an adverse effect on health, leading to increased health problems and reduced life expectancy. A number of health conditions are associated with being overweight and obese including: type 2 diabetes, hypertension, coronary heart disease and stroke, osteoarthritis and cancer.

Maternal obesity is an established risk factor for increased complications during pregnancy and in the post-natal period compared to their counterparts who have a healthy weight. Findings from the Centre for Maternal and Child Enquiries observational study showed a correlation between increasing levels of obesity and an increase in hypertension, gestational diabetes, instrumental delivery, caesarean section, induced labour, postpartum haemorrhage, foetal abnormality, stillbirth and special care baby unit admissions.[43] Obese women are more likely to spend more days in hospital and the increased levels of complications in pregnancy increases the cost of antenatal care compared to women within the healthy weight range. Babies born to obese mothers have an increased risk of admission to neonatal intensive care compared to babies born to mothers of a normal weight.[44]

[42] The Council's mainstream local employment programme.
[43] Maternal obesity in the UK: findings from a national project. (2010),CMACE,UK. (page 7)
[44] NICE public health guidance 27, Weight management before, during and after pregnancy, July 2010.

Local data for 2011-2012 on the percentage of pregnant women who were overweight or obese at the time of ante-natal booking gives a figure of 67.9%.[45] The antenatal data also highlights which areas we should be concentrating prevention work on; for example, there is a clear correlation between deprivation and excess weight gain, as shown in Figure 17, as well as ethnicity and parity.

Figure 17



In 2013/2014 just under a fifth of children aged 4-5 years (YR) were overweight or obese (19%), rising to around one third (33.4%) of children aged 10-11 years. Prevalence of overweight in 4-5 year olds in Sheffield is significantly better than the England average. At 10-11 years (Y6) the figures are not significantly different. In general the rate of childhood overweight and obesity combined in Sheffield is improving. However, the relationship between deprivation and overweight and obesity in both YR and Y6 is significant, with higher rates of combined overweight and obesity correlated with greater deprivation. The inequality between the most and least deprived in the City is widening in Y6. (NCMP 2013/2014 academic year).

[45] Data obtained from the Clinical Commissioning Group (CCG) locally commissioned Public Health Births extract from Sheffield Teaching Hospital Trust. The numbers relate to births to Sheffield residents only, not the total number of deliveries which take place in the STHT as this includes non-Sheffield residents.

Excess weight is a term used for overweight including obesity and is defined as an adult body mass index (BMI) of ≥ 25kg/m2.[46] Public Health England excess weight data shows that 59.9% of Sheffield's adult population was overweight or obese in 2012 compared to the England average of 63.8%.[47]

The costs of obesity to both health services and wider society are significant. In Sheffield, the estimated annual direct cost of treating obesity and its consequences is £11.5 million. There are also wider costs, for example, the estimated annual cost of obesity related sickness absence in Sheffield is £14.5 million and it is estimated that by 2015, obesity and its consequences will cost Sheffield £165 million per year.[48]

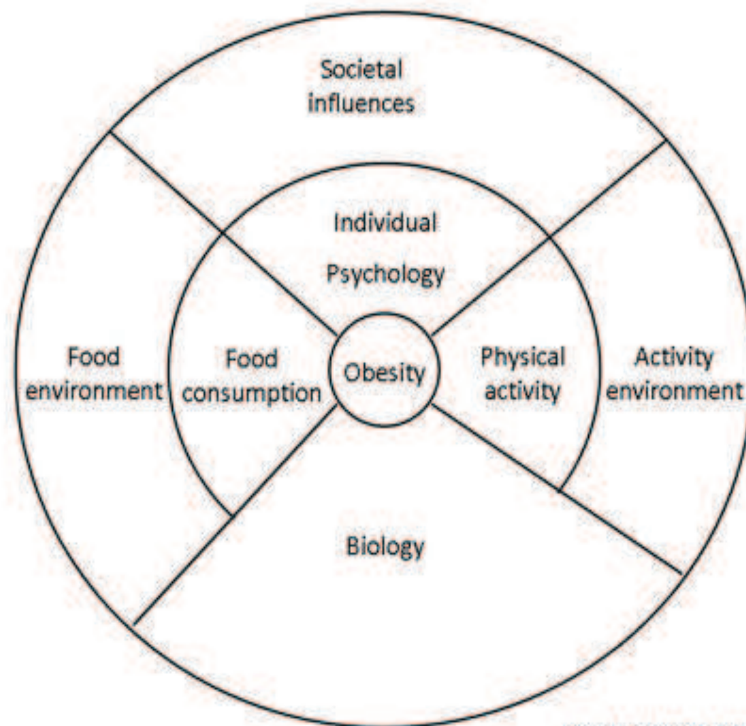
It has been widely predicted that obesity levels will continue to increase over the coming years and this makes the task of preventing and tackling obesity in Sheffield a priority both in the short and longer term.

3.6.2 What are we doing about it?

Weight gain occurs when you regularly eat more calories than you use through normal bodily functions and physical activity. There are complex behavioural and societal factors that combine to contribute to the causes of this weight gain and that can explain the increasing prevalence of overweight and obesity that has been seen in recent decades. The Foresight Report (2007)[49] referred to a "*complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain*" as illustrated in Figure 18. The report presented an obesity system map with energy balance at its centre.

[46] Body Mass Index (BMI) is calculated by dividing an individual's weight in kilograms by the square of the height in metres.
[47] Public Health England Yorkshire and Humber press release, Tuesday 4th February 2014.
[48] Health and Social Care Select Committee 2006
[49] Foresight Programme (2007) 2nd Edition. Tackling Obesities: Future Choices – project report. Government Office for Science.

Figure 18



Society has changed rapidly in recent generations, with major changes to the way we work, the way we move and travel, the food that is available, the way we consume food, and the leisure activities we choose to take part in. These changes have exposed an underlying biological tendency, possessed by many people (of all ages), to put on weight and retain it. Although personal responsibility plays a crucial part in weight gain, human biology is being overwhelmed by the effects of today's 'obesogenic' environment, with its abundance of energy dense food, motorised transport and sedentary lifestyles (taken from Foresight report, 2007). For example, as a nation our portion sizes have increased, average intakes of fat and sugar are above recommended levels and the periods of time we spend sitting and being physical inactive have increased significantly. This behaviour change is demonstrated when we consider children walking to school. This has steadily declined for decades and is now at an all-time low with fewer than half of all primary school children now walking to school and 43% travelling by car.[50]

[50] ONS http://www.statistics.gov.uk/cci/nugget.asp?id=1576

In response to these issues, Sheffield has invested in a number of new services that support people to achieve and maintain a healthy weight. The services are:[51]

- Pre-conception and ante-natal pilots as part of the Tier 2 adult healthy weight management service (based on the antenatal information shown above)
- Early Years Programme for children and families (0-4 years)
- Children, Young People and Family Healthy Weight Service delivering family weight management programmes for overweight children and young people aged 5-17 and obesity prevention support to schools
- Adult Tier 1 and Tier 2 Healthy Weight Service delivering obesity brief interventions training to frontline staff and providing weight management programmes for overweight adults including a specific focus on pre-conception and maternal excess weight
- Adult Tier 3 Specialist Weight Management Service delivering specialist weight management using a multi-disciplinary team approach for adults with very high BMIs and/or more complex needs and/or accessing bariatric surgery

Whilst the above services have a role to play in tackling obesity and are of benefit to those who use them, the evidence on obesity is clear that such services will not be enough to address the scale of the problem. Significant effective action to prevent obesity at a population level is required and evidence shows that a 'whole system' approach is critical – from production and promotion of healthy diets, to redesigning the built environment to promote walking, together with wider cultural changes to shift societal values around food and activity. This will require action by many partners including national and local government and by industry.

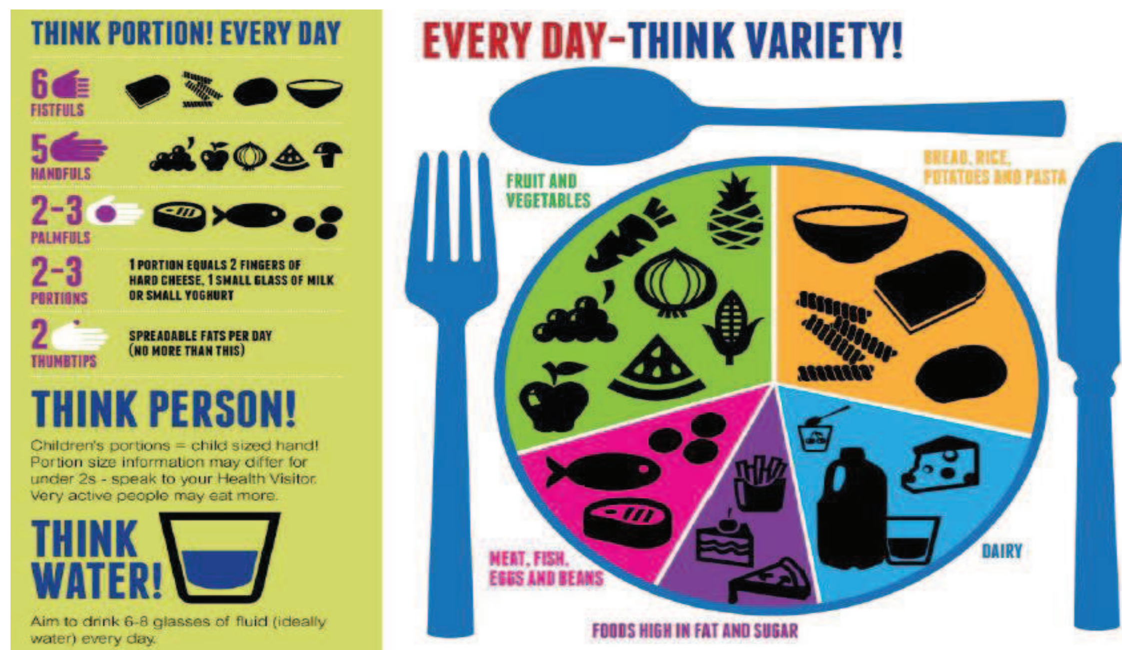
It is important that if we are to reverse the trend in excess weight gain and encourage healthy behaviour change, particularly amongst children and young people, the environment in which we live needs to change to make being physically active the easiest option. By making 20mph the default speed limit wherever individuals and families live, work or play; encouraging playing out schemes in local neighbourhoods; investing in more sustainable safe walking and cycling routes to school; and creating parking and drop off exclusion zones within the school areas can all contribute to reversing obesity.

[51] The 0-4 Children and Families service is delivered by the Children and Young People and Families Public Health Team. All other services are delivered by Why Weight Sheffield

In terms of creating an environment that encourages healthier eating and increasing physical activity, the Sheffield Food Strategy and Move More Plan[52] identify a number of areas for local action across both areas. These include developing initiatives for those in food poverty that can improve the accessibility of affordable and nutritious food; working with schools to encourage school meal uptake; providing education on what makes up a healthy balanced diet (see the illustration in Figure 19); food preparation skills working with fast food outlets to improve the nutritional content of the food on offer; and encouraging public sector organisations and partners to procure and provide healthier food to staff, service users and the general public.

In addition to the local action that is being taken there is also the need for intervention at a national level. Actions such as the recent national school food standards are an example of where this can be of benefit. There is evidence that further regulation such as tax on unhealthy foods, further restricting advertising to children, and improving consumer-friendliness of food labelling would also have benefits.[53] The Move More plan includes six outcomes which focus on creating active environments, empowering communities, creating active workforces, schools and families; using physical activity as medicine.

Figure 19



Source: Sheffield City Council portion size guide [54]

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[52] https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/what-the-board-does/priorities/work-programmes/food-physical-activity.html
[53] Lancet, 2015 http://www.thelancet.com/series/obesity-2015
[54] https://www.sheffield.gov.uk/caresupport/health/lifestyle/eat-well.html

3.6.3 What difference will it make?

There are a number of Public Health Outcomes that we can use to help us track whether our actions are making a difference and the impact we can have on levels of obesity, healthy eating and physical activity.

- **Percentage of children in YR (age 4-5) overweight or obese and percentage of children in Y6 (age 10-11) overweight or obese**: These indicators are reducing in Sheffield which is positive. Our aim is to continue to reduce the overall prevalence of overweight and obesity in Sheffield. We also aim to close the gap between the most and least deprived children in Y6 as this has widened in recent years. Targets are in the process of being agreed
- **Fruit and vegetable consumption: Percentage of adults eating'5-a-day':** This is a new measure so we do not yet know whether Sheffield is improving or not. Nevertheless, Sheffield has a significantly lower percentage of people reporting eating five or more portions of fruit and vegetables a day than the England average so our aim should be to improve to at least the national average
- **Excess weight in adults:** The percentage of adults who are overweight or obese in Sheffield is 59.9% compared to the England average of 63.8%. Sheffield's rate is also significantly better than other areas of South Yorkshire such as Barnsley (70.5%); Doncaster (74.4%) and Rotherham (65.3%).
- **Proportion of physically active and inactive adults:** Sport England data show an upward trend of people who are physically active in Sheffield and we should seek to maintain this positive trend.

3.6.4 Priorities for action

We have identified the following three actions as priorities for the next 12 months:

(i) It is everyone's responsibility to engage with the Move More message; from creating environments which make being physically active the easiest choice to the individual responsibility of building physical activity into daily lives and just moving more! The Health and Wellbeing board should ensure schools in Sheffield give all children the opportunity to participate in appropriate exercise.

(ii) Continuing to monitor the impact of food poverty and developing a broad range of support for individuals and families experiencing food poverty to ensure that everyone in Sheffield is able to access a diet that is safe, affordable and that benefits their health and wellbeing.

(iii) Agreeing local targets for reducing childhood obesity, noting that these are likely to focus on: reducing the overall prevalence of overweight and obesity and closing the gap between the most and least deprived children in Y6.

4 Progress on recommendations from 2014

Each year the DPH report makes recommendations about improving the health of the local population and directs these recommendations towards particular organisations or groups. In this section we report on the progress made on the recommendations of the DPH Report for 2014.

Recommendation 1
The Council should develop and implement a programme of signposting walking routes with the time it takes to reach the destination.
Progress
There was no funding allocated to the sign posts so it has not been possible to progress this recommendation to date.

Recommendation 2
Sheffield people should consider traveling short distances on foot or by bicycle rather than by car, and sign up to 'Move More'
Progress
The Move More website is up and running and well used. There has been a plethora of activity relating to promoting cycling in Sheffield and the partnership with British Cycling is now in its second year. An asset mapping exercise to discover where people are currently cycling has been carried out and we are working to address the barriers to cycling in some communities. The actual number of people cycling in the City is difficult to capture but the perception is that there has been a step change and more people do appear to be using cycling as active sustainable travel.

Recommendation 3
The Council should commit to increasing the number of 20 mph zones in the City as quickly as possible.
Progress
Funding to accelerate this work was not supported. The Council is progressing the work as planned but without additional resource. We are also looking at how we can connect initiatives for 20mph zones, playing out areas, active travel (cycling and walking), the 'streets ahead' programme and road closing.

Recommendation 4
The Council and local hospital trusts should develop their food purchasing arrangements to reflect environmental and health factors, including reduced reliance on meat and dairy in menus.
Progress
Food for Life accreditations[55] have been achieved by Sheffield Teaching Hospitals Foundation Trust and the school meals provider, endorsing their progress in using fresh ingredients free from undesirable additives and trans fats, which are better for animal welfare and comply with national nutrition standards. Caterers at the University of Sheffield are considering working towards Sustainable Restaurant Association Accreditation. A recently issued contract for running two new leisure venues in Sheffield stipulates a requirement for provision of a healthy food offer to customers. Sheffield International Venues continue to work towards Change4Life healthy leisure centre catering guidance.

Recommendation 5
Sheffield people should consider reducing the amount of meat they eat by adopting at least one meat free day per week.
Progress
It has not been possible to assess whether people are aware of or are trying to reduce their meat consumption.

Recommendation 6
The Council's forthcoming fuel poverty strategy should include steps to increase the standards of insulation in the private rented sector, so that the average SAP for the sector is 65 by 2020, and the minimum SAP is 65 by 2025.
Progress
The strategy has not been drafted due to uncertainties in national direction as well as local resourcing - setting a strategy to increase SAP ratings through a programme of insulation is difficult when current Green Deal and Eco Programmes are under review. The Council is seeking to address some of these issues however, for example by developing a revolving loan scheme for residents which will work better than current national schemes. It is also looking to develop its own Energy Service Company to develop local energy production and delivery programmes. The selective licencing scheme is also underway to help landlords provide quality rented accommodation across the City.

[55] http://www.sacert.org/catering

Recommendation 7
Health and care professionals should systematically identify the people and properties most vulnerable to fuel poverty, and ensure that advice and assistance is available to them to address that.
Progress
The City has fed into recently produced NICE guidance (NG6) on excess winter deaths and cold related illness and this is now published, and will be included within the approach to Fuel Poverty. Public Health has also funded local VCF sector organisations to develop the basis of this approach, with some success. This will be further refined in the next 12 months.

Recommendation 8
The Council and the Local Enterprise Partnership (LEP) should work to implement the findings of the *Mini-Stern Review* and explore opportunities for low carbon infrastructure investment and the development of low carbon technologies.
Progress
The author of the Mini-Stern Review, Professor Andy Gouldson, gave evidence to the Sheffield Green Commission on 21 April 2015. The Report was submitted as part of the information for the LEP. Low carbon emerged as a key theme of the LEP's European Funding Strategy and £21.4m has been allocated to funding low-carbon infrastructure development/low carbon technologies. £12m of 'calls' have been developed as at June 2015. The Council has funded a comprehensive review of the renewable energy potential in the City and agreed to fund up to 6,000 solar panel installations on council housing and is investigating funding for wider implementation. It is also part of two Horizon 2020 bids covering heat network schemes and has stated its intention in the Corporate Plan to form a Sheffield Energy Company. There is interest in identifying a former industrial site as a sustainable development area potentially using the Sheffield City Region Investment Fund to support the infrastructure. The Council is also working to pilot the generation of heat through a second biomass power plant in the South of the City.

Recommendation 9
The Council, working with the voluntary sector and other organisations, should continue work to develop social capital in local communities.
Progress
The Community Wellbeing Programme, Health Trainers and Health Champions have continued to develop resilience by mobilising the community, building on individual and community assets and skills. Current contracts give VCF providers more freedom to develop social capital and resilience in their communities. The Community Development and Health training programme has been shown to make a real difference to health and wellbeing at the individual, family and community level. Sheffield First has led a collaborative process aimed at understanding how organisations develop resilience, resulting in a set of principles currently being considered by the Sheffield Executive Board in order to develop a single city approach to community empowerment. The Local Area Partnerships have identified key priorities to develop resilience in each area by tackling social isolation and financial inclusion. Public health training for Council frontline staff will equip them with the skills and confidence to support people to have more control over choices impacting on their health and wellbeing.

Recommendation 10
The Health and Wellbeing Board and Sheffield's NHS Trusts should adopt an explicit sustainability policy aimed at ensuring that Sheffield meets its carbon reduction obligations by 2020. This should be underpinned by the adoption of a sustainability manifesto for the health and social care system in the City.
Progress
The Clinical Commissioning Group Sustainability & Carbon Management Group, with the Council are undertaking a mapping of sustainability measures/initiatives of NHS providers across the City with the aim of showcasing good practice and identifying gaps where support is needed. This group is also canvassing NHS and social care for their views on the development of a Sustainability Manifesto. An initial scoping exercise will determine the scale of the task and the required capacity/commitment of resource from NHS/social care.

Recommendation 11
The Health and Wellbeing Board should give urgent consideration to the ways in which the implications for carbon emissions of different approaches to the delivery of health and social care in the City can be evaluated. A system of carbon accounting needs to be developed.
Progress
The Council is liaising with the NHS Sustainable Development Unit regarding well-regarded/tested approaches to carbon accounting in health & social care. Based on the recommendations from the NHS SDU, options to take this forward will be appraised and presented to the Health & Wellbeing Board. Ways to take this forward include: • Using Nottingham City CCG's methodology for average carbon intensity assessments • Using NAO report on carbon in the NHS to tackle carbon hotspots e.g. procurement, pharmaceuticals, medical instruments • Looking at the Models of Care Health and Well Being toolkit on SDU website and use a demonstration site to look at comparative carbon accounting approaches (e.g. a detailed 'deep dive' or a clinical audit)

Recommendation 12
The Health and Wellbeing Board should consider how to enforce and report on actions set out in the Heatwave Plan for health and social care facilities such as care homes before next summer.
Progress
Local NHS Trusts have put in place heatwave plans for 2015. Under Care Quality Commission regulations and requirements, care homes are expected to have a Business Continuity Plan that makes reference to heat waves and what action staff should take regarding care of residents in relation to hydration, ventilation and sun protection (e.g. curtains, blinds, sun cream, hats etc.)

Recommendation 13
All organisations should promote uptake of The Environment Agency's 'Floodline Warnings Direct' service for local residents and businesses to help preparedness for flooding. This could be promoted by providing a link to sign up for the alerts on organisations' internet sites.
Progress
The Council, Environment Agency and the Sheffield Chamber of Commerce and Industry have led schemes to protect the Lower Don Valley from flooding. Significant freeboard measures to allow for global warming through physical structures and the maintenance and cleaning of the river channel have been introduced. South Yorkshire Housing Association has mapped flood risk whilst Amey, the Council's strategic partner for the provision of Highway Services, receive half hourly updates about weather, and also has a climate change adaptation plan that identifies key risks from flooding. The Living Highways Project has a focus around sustainable urban drainage and helping to prevent flooding through better management of verges. Sheffield Hallam University require all landlords to have a major incident response plan and all university new builds are required to comply with flood resilience.

Recommendation 14
The Local Health Resilience Partnership (LHRP), and Local Resilience Forum (LRF), should audit local organisations' plans for dealing with the health consequences of severe weather events, and ensure that they are adequate.
Progress
Rather than focussing on the consequence of adverse weather events, the LHRP and LRF have this year been concentrating on the two higher priority issues of Ebola and Pandemic Influenza. This included a number of exercises to test whether plans to deal with potential cases of Ebola in South Yorkshire were robust. Exercise Alberio was held in April 2015 testing plans to deal with an influenza pandemic. Both exercises showed areas of strength in plans and preparations as well as highlighting areas that could be refined or enhanced. Work is now underway to amend plans based on these exercises.

Recommendation 15
The Council should ensure that health issues are built into local development and regeneration plans and integrating adaptation principles into the local planning framework.
Progress
Information has been provided on health issues and health inequalities in the development of the sustainability framework of the Local Plan for Sheffield. This has included approaches that can minimise inequalities in health and information that can provide a base line for evaluating the effectiveness of the Local Plan. Awareness of the importance of public health to the Local Plan and planning procedures has been raised through, for example, regular updates to the Council's Public Health Team and inviting the planning team to make a presentation on the Local Plan to the local Public Health Network, contributing information to a workshop on the development of the new Local Plan for Sheffield and contributing information to the Age Friendly Cities Policy.

5 Your Views

Feedback form: Please help us to improve future reports by filling in and returning the questionnaire below:

1. Was the layout clear and well designed? Yes ☐ No ☐

If No, please state reason:

2. Were the topics selected appropriate for Sheffield? Yes ☐ No ☐ Unsure ☐

If No, please state reason:

3. Did the report, in your view, make reasonable recommendations? Yes ☐ No ☐ Unsure ☐

If No, please state reason:

4. Were there issues or subjects that you would have liked to have included? Yes ☐ No ☐ Unsure ☐

If No, please state reason:

5. Was the report the right length? Too long ☐ just right ☐ too short ☐ unsure ☐

6. Will you be using this report in your work with partner organisations? Yes ☐ No ☐ not applicable ☐

If No, please state reason:

7. Do you have any suggestions for improving this report for the next time?

8. Please indicate the organisation you work for:

Thank you for taking the time to complete this form. Please return to:

Stephen Horsley, Interim Director of Public Health
Sheffield City Council]
Town Hall
Sheffield
S1 2HH

This report can be downloaded from:
https://www.sheffield.gov.uk/caresupport/health/director-of-public-health-report-2015.html (Full Report of the Director of Public Health for 2015)

Sheffield DPH Report
Sheffield City Council
Town Hall
Pinstone Street
Sheffield
S1 2HH

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