Working with you to make Sheffield HEALTHIER

Item No. **15.K**

NHS Sheffield Clinical Commissioning Group

Public Health Intelligence Update

Governing Body meeting

9 January 2020

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Purpose of Paper

The paper has set out a number of sources of commonly used intelligence on population health metrics. It is impossible to second guess all the potential analytic or performance questions that might crop up. The focus of the paper is setting out where intelligence is readily available. Thus the paper has set out where intelligence can be found and a selection of high level metrics in the context of the strategic approach to population health. The paper also contextualises these metrics into a broader strategy.

The paper also set out the approach to the Joint Strategic Needs Assessment. Collectively this should form the basis of commissioning decisions in terms of population need. There is always the possibility of adding new chapters to the JSNA and or specific pieces of bespoke analysis. The team is considerably smaller than it once was and it should be noted that data sharing across the CCG and the Local Authority is not yet a resolved issue. This significantly curtails the capability of the analytic team.

Key Issues

Population health intelligence is sourced from a number of places. The Public Health team uses the following to provide an overall sense of the state of health in Sheffield.

- Public Health Outcomes Framework
- Joint Strategic Needs Assessment
- PHE Fingertips Tool
- Local Health Area Profile

The top key messages from this collective information are:

- The absolute number of people aged >65 is increasing, but the overall age structure is not changing that quickly. Thus there are more “person years” in the population.
- Multi morbidity and the stalling life expectancy and Healthy Life Expectancy improvement are the main drivers of the unsustainable yet largely preventable growth in demand for health and social care services.

Is your report for Approval / Consideration / Noting

Consideration/Noting

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

1. Note the issues identified in the paper broadly, the PHE Health Profile and the JSNA.
2. Consider where new JSNA chapters might be warranted

3. Note that data sharing across the CCG and the Local Authority is not yet a resolved issue.
What assurance does this report provide to the Governing Body in relation to Governing Body Assurance Framework (GBAF) objectives?
This paper encompasses all of the CCG's objectives. **Description of Assurances for Governing Body** This paper provides assurance to Governing Body that there are robust and accurate information and intelligence available which examines the population health of Sheffield and is used to inform the CCG's priorities and commissioning intentions.
Are there any Resource Implications (including Financial, Staffing etc)?
None
Have you carried out an Equality Impact Assessment and is it attached?
Not required, there are no service or policy development implications.
Have you involved patients, carers and the public in the preparation of the report?
Not required.

NHS
Sheffield
Clinical Commissioning Group

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1. Introduction/Background

1.1 This paper picks up on a discussion at a previous Governing Body, in the context of the CCG quality and performance report, and the request for an update on the state of health in Sheffield. The paper is reasonably short, with a number of appendices. It is not intended to be a comprehensive "performance" report as it is impossible to second guess all the potential analytic or performance questions that might crop up. The focus of the paper is setting out where intelligence is readily available but it does set out some high level metrics and provides this in the context of the strategic approach to public health. The report also highlights where a range of readily available info can be found.

2. The approach to "public health"

2.2 **The Grant.** The Director of Public Health has responsibility for services within the PH Grant, this is discharged corporately and responsibility is with the Council's portfolios. The services concerned are funded to c£33.5m and cover drug and alcohol treatment, 0-19s, sexual health, tobacco control, weight and obesity, supported housing, Multi Agency Support Team, Citizens Advice Bureau, and a wide range of grant aid and commissioned services in the VCS. Inc PKW; and then a wide range of "other".

2.3 These are broadly universal services with limited specific offer to those with a physical or learning disability. It is true of all universal services that we should seek to proactively respond to specific populations with vulnerabilities. The extent to which we achieve this is debateable, and there is always a need to improve this. The approach is, obviously, considerably wider than easy read leaflets, but a far more systematic and structural approach to equality and possibly using equity audit and similar tools. These concepts apply more widely than simply services funded by the PH Grant.

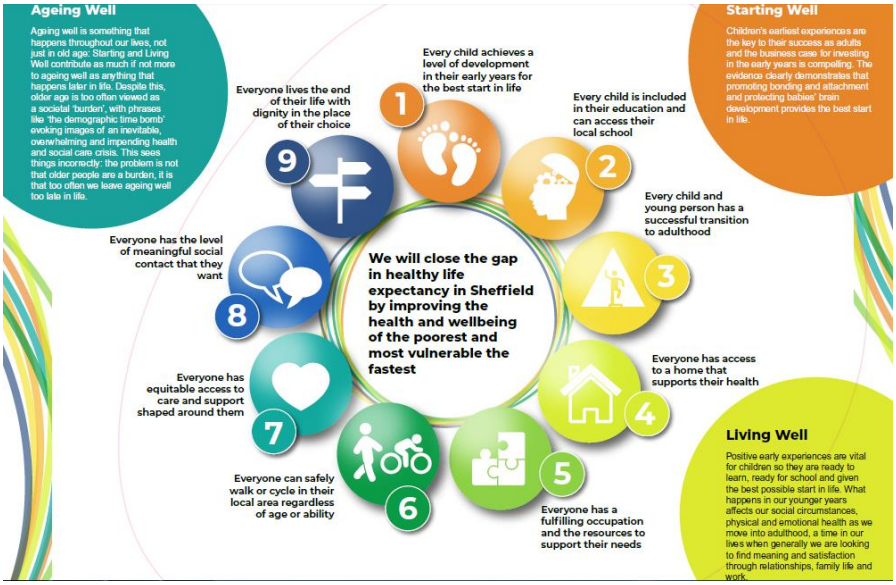
2.4 **The broader function.** The Leader of the Council has articulated on many occasions that SCC is a public health organisation; this implies that the totality of the organisation's functions and services contribute to health and wellbeing. Sheffield operates with this model.

2.5 There are five broad areas: health protection (for example response to incidents, screening and vaccination, emergency preparedness); lifestyles (framed in Sheffield through a lens of commercial determinants of health); and health and wellbeing in all policies. In addition we maintain a small strategic intelligence function and significant support to NHS commissioning. The role of the strategic public health function is to bring this together into a whole. There are many areas of important services that are not in the control of SCC, for example NHSE is the responsible commissioner for vaccination and screening. Thus the role of public health is one of system leadership and ensuring outcomes are improving.

2.6 **The strategy.** The majority of "public health" is done by people who don't have those two words in their job title, nor by people who consider themselves as "public health". Putting a scope and boundary on public health and the approach to public health in Sheffield is impossible.

2.7 The broad strategy is set out as the Health and Well Being Strategy, and the broad approach to Health and Well Being in Sheffield is owned by the Health and Well Being Board. The HWBB has decisively shifted its focus onto health and wellbeing in its entirety (as opposed to a narrower focus on NHS and social care integration).

2.8 The HWBB has recently adopted a new strategy for the city. This sets out 9 core challenges and a broader challenge of building wellbeing into all of our policy formation and decision making. The approach being taken is one of whole life course and a concept that all sectors contribute to "health".



2.9 Health inequality is a theme that runs throughout the strategy. Sheffield did have a (2014) health inequalities strategy. This has recently been reviewed in detail, most of the commitments made were fulfilled. The Health and Well Being Strategy becomes in effect the health inequalities strategy.

3. Health metrics

3.1 A wide range of summary health and wellbeing measures, mainly at local authority level are published by PHE. These are listed below.

3.2 No single individual profile or readily available intelligence product will answer all potential questions. It is best to explore specific questions in a responsive manner. The JSNA is used to provide more detailed analysis on particular issues. There remains capacity to set up specific scenarios and try to shine a light on more bespoke questions. In this it should be noted that the capacity of the analytics team to undertake this work is 2/3 smaller than it was 6 years ago. It should also be noted that data sharing across the CCG and the Local Authority is not yet a resolved issue. This significantly curtails the capability of the analytic team.

3.3 **The Public Health Outcomes Framework** (https://fingertips.phe.org.uk/profile/public-health-outcomes-framework) is reported publicly, and updated regularly. There are over 180 indicators in total, thus a full report on all of the PHOF indicators is not included here. Many or the PHOF indicators have been incorporated into the SCC performance framework in some guise, particularly those pertaining to the broader social determinants of health.

Of the 165 indicators within the public health outcome framework, 80% are stable or improving.

3.4 **The PHE Fingertips Tool** (https://fingertips.phe.org.uk/) provides a very wide range of data and indicators, organised into thematic groups as indicated below: It remains the best single source of intelligence on health need, key process measures and outcomes at practice level.

3.5 For a full list of profiles produced by Public Health England, see the fingertips website: https://fingertips.phe.org.uk/

Of particular note are the General Practice profiles https://fingertips.phe.org.uk/profile/general-practice

The Local Authority Profiles https://fingertips.phe.org.uk/profile/health-profiles

The Marmot profile https://fingertips.phe.org.uk/profile-group/marmot is focused on the wider determinants of health and the gap between best and worst.

3.6 **The Local Area Health Profile for** Sheffield (https://fingertips.phe.org.uk/static-reports/health-profiles/2019/e08000019.html?area-name=sheffield) is published annually. The metrics are appended. In summary the key points are:

- Sheffield is one of the 20% most deprived districts/unitary authorities in England and 23.2% (23,095) of children live in low income families
- Life expectancy for both men and women is lower than the England average
- Life expectancy is 9.3 years lower for men and 8.3 years lower for women in the most deprived areas of Sheffield than in the least deprived areas
- In Year 6, 21.1% (1,270) of children are classified as obese
- The rate for alcohol-specific hospital admissions among those under 18 is 17 / 100,000, better than the average for England. This represents 20 admissions per year
- Levels of GCSE attainment (average attainment 8 score) and smoking in pregnancy are worse than the England average
- Levels of breastfeeding are better than the England average
- The rate for alcohol-related harm hospital admissions is 700 / 100,000, worse than the average for England. This represents 3,603 admissions per year
- The rate for self-harm hospital admissions is 125/ 100,000, better than the average for England. This represents 765 admissions per year
- Estimated levels of physically active adults (aged 19+) are better than the England average

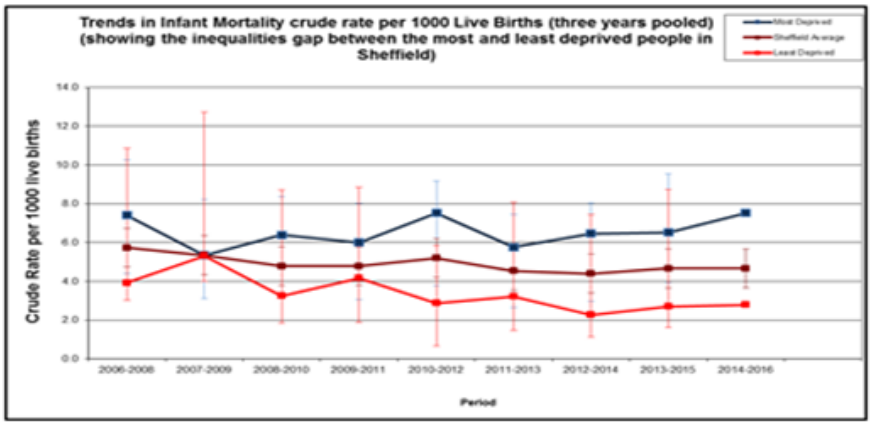
- The rates of hip fractures in older people (aged 65+) and new sexually transmitted infections are better than the England average
- The rates of statutory homelessness, violent crime and hospital admissions for violence
- Under 75 mortality rate from cardiovascular disease is worse than the England average.

Appendix 1 sets out the high level indicators for Sheffield.

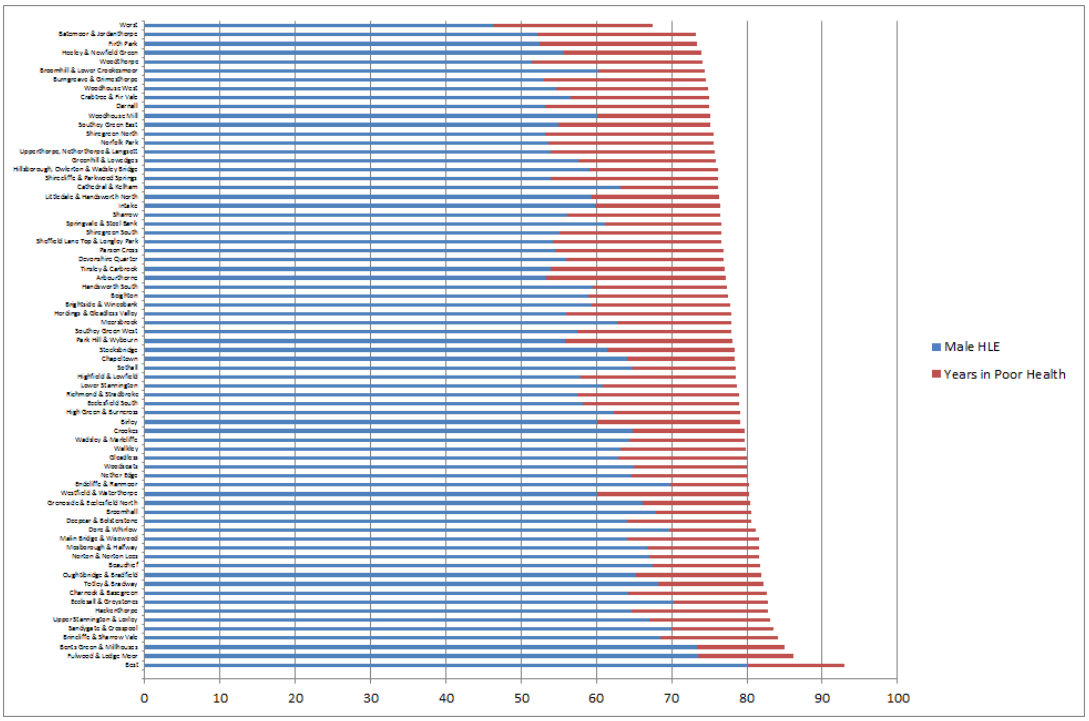
3.7 With regard to the Health and Well Being Strategy performance framework, there will be a set of measures within each of the nine ambition areas and an overarching framework for population health – most likely healthy life expectancy and infant mortality. The gap will be a dominant feature of all of the indicators.

Appendix 2 sets out comparative (YH) and trend data for most of the 9 ambition areas, this should be viewed as illustrative as a final decision on precise indicator set is not yet made.

3.8 **The critical population health metrics remain two fold – infant mortality and healthy life expectancy.** The recently published Health Foundation report (https://www.health.org.uk/publications/reports/mortality-and-life-expectancy-trends-in-the-uk) provided a comprehensive analysis of recent trends. The forthcoming Director of Public Health Report will set out a more detailed analysis in this area, likely themed around the interplay of both poverty and housing as core health determinants. Infant mortality remains one of the "peak" indicators for population health. For the population as a whole improvements over last 40 years are now slowing. The national position is mirrored in Sheffield, our strategy is focused very broadly on the wider determinants of infant mortality. Local data is articulated below.



3.9 Healthy Life Expectancy is the other peak indicator. The fact that people in the most deprived areas of England spend less time in good health is well documented nationally and also it can be seen locally. The chart below shows life expectancy (the full bar), healthy life expectancy (the blue component) and years lived in poor health (red) for each of the MSOAs in Sheffield. Our healthiest areas eg; Bents Green & Millhouses, a man could expect to live to 86 with 73 years in good health. This equates to a seventh of that man's life in poor health, or 13 years. In our least healthy areas for example Firth Park a man can expect to live to about 73 of which 52 years will be in good health. This equates to nearly a third of that man's life in poor health, or 21 years with death at a younger age.



These findings are not new. The factors that contribute to Healthy Life Exepectancy are well beyond only more or better health and social care, though that does matter enormously but that whole life span, whole of society perspective for interventions, across every part of local (and national) government, and well beyond govt. This is why the Sheffield Health and Wellbeing Board based its recently refreshed strategy on tackling the wider causes of poor health and inequalities in the city. https://www.sheffield.gov.uk/home/public-health/health-wellbeing-board. Overall the strategy's goal is to close the gap in healthy life expectancy (over a generation) by focusing in particular on nine key areas of health and wellbeing across the life course.

3.10 **The Joint Strategic Needs Assessment** is the responsibility of the HWBB and is intended to set out a high level overview of health needs in the local population. It is structure – orientation around communities of interest as well as shifting topics away from orientation around individual conditions, assets as well as needs/deficits trying to ensure lived experience and reflected in the JSNA. The JSNA online resource (https://sheffieldcc.maps.arcgis.com/apps/Cascade/index.html?appid=96383090af4149b49112b66dadf2ea3a) has a range of downloadable materials.

The structure of the JSNA is broadly set. We are making efforts to build qualitative data and lived experience into it. For example, we are currently developing chapters on work and health, multi morbidity and financial insecurity. The range of specific chapters is only limited by people to provide topic expertise and access to data. The public health intelligence team are always happy to consider fresh chapter suggestions.

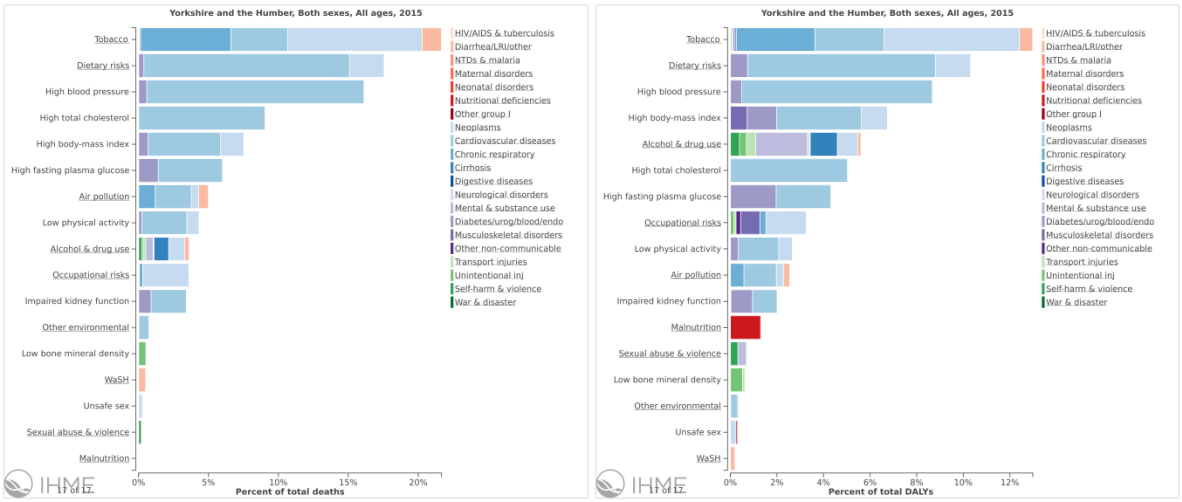
Key Headlines from the last 12 months of JSNA include:

- Population growing slowly with the biggest % increase in the over 65s and biggest % decrease in the under 5s;
- Mortality rates (all age all cause) increasing with changes in the leading cause of death in people over 40;
- Healthy life expectancy worsening – especially for women;
- Sheffield ranked as the 57th most deprived local authority in England, out of 317 (compared with 60th in 2015);
- Child obesity growing and inequalities widening;

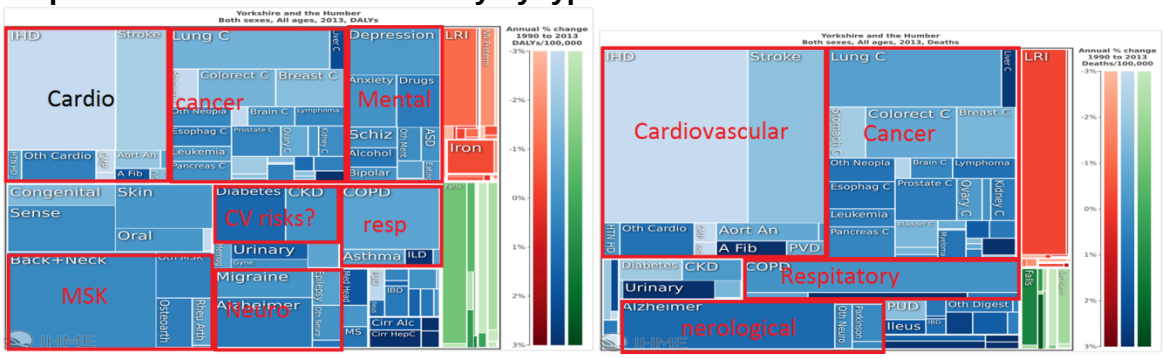
- There could be upwards of 20,000 people with autism in Sheffield; we're probably aware of 8,500;
- Risk of loneliness and social isolation in Sheffield people over 65 greatest in the most deprived communities;
- Problem gambling is more common among men and young people and especially online gambling among students;
- Health and wellbeing profiles for the Primary Care Networks published here: https://sheffieldcc.maps.arcgis.com/apps/Cascade/index.html?appid=6da47d22dcb844c3894dd16d1aae6799

3.11 The Global Burden of Disease study is a significant global undertaking to produce a representation of the burden of illness and risk factors. There is functionality (https://vizhub.healthdata.org/gbd-compare/) to provide data on the burden of death and illness attributable by cause and risk factor. There is functionality do to this at region and district level. The charts below illustrate the proportion of morbidity and mortality by risk factors contributing and by type.

Proportion of death and morbidity split by risk factor



Proportion of deaths and morbidity by type



3.12 The Public Health team uses Fingertips, the LA profiles and the PHOF indicators to provide an overall sense of the state of health in Sheffield. This is formally undertaken once a year through the DPH report. More frequent analyses are undertaken to help answer specific commissioning questions or provide more in-depth understanding of specific topics.

Taken collectively the key messages are:

- The absolute number of people aged >65 is increasing, but the overall age structure is not changing that quickly. Thus there are more "person years" in the population.
- **Multi morbidity and the stalling life expectancy and HLE improvement are the main drivers of the unsustainable yet largely preventable growth in**

demand for health and social care services. This basically leads to more "unhealthy person years" in a fixed capacity system. Thus there are more people in poorer health at a (slightly) younger age than previously. Multi morbidity is NOT an issue of "age", there are more working age people with multi morbidity than people above 65, thus underscoring the importance of the health of the working age population. There is no doubt this is driving demand for health and social care services.

- **The other key drivers of healthcare cost growth** are (not necessarily in order, apart from the first) population growth, deprivation (a proxy for lifestyles then disease incidence and prevalence - and itself a proxy for wider determinants), over diagnosis, new technology often of marginal value, and age profile change (which we believe is a proxy for number of people with a closeness to death), an over focus on "cost" and under focus on value or outcomes, a 30 year lack of systemic attention to prevention, and lastly a neglect of the inequalities agenda. (see references 1,2,3)
- This demand is not evenly spread across the city, underscoring the need to focus attention on those with most need whilst maintaining an offer for all.
- This requires consideration of the type and model of health service delivery, moving to a focus on population health or population risk management. However, simply a focus on better services will not be sufficient. Prevention remains key – primary, secondary and tertiary. The obvious objective is to bend the multimorbidity curve, prevent illness and slow or avoid complications - instead of developing your first long term condition in your late fifties, you develop it in your sixties instead, as well as having fewer long term conditions overall.
- Many argue the core problem of the NHS is that it hasn't kept up with the epidemiology or the needs of the population, an overemphasis on hospitals and underinvestment in community services, with the inevitable consequence that there are people in hospital who do not need to be there, over centralisation of the NHS, and lack of democratic and local accountability. Most of the significant bodies of research draw a similar view.
- Whilst demand on the system is increasing on account of the above, the supply in the system is falling, in some sectors faster than others. Also there may be an argument there is oversupply in some areas of the service and undersupply in others. This leads to nuanced solution that involves prevention, addressing inequalities and growing some forms of supply whilst holding other forms of supply.

4. Summary

The paper has set out a number of sources of commonly used intelligence on population health metrics. It is impossible to second guess all the potential analytic or performance questions that might crop up. The focus of the paper is setting out where intelligence is readily available. Thus the paper has set out where intelligence can be found and a selection of high level metrics in the context of the strategic approach to population health. The paper also contextualises these metrics into a broader strategy.

The paper also set out the approach to the Joint Strategic Needs Assessment. Collectively this should form the basis of commissioning decisions in terms of population need. There is always the possibility of adding new chapters to the JSNA and or specific pieces of bespoke analysis. The team is considerably smaller than it once was and it should be noted that data sharing across the CCG and the Local Authority is not yet a resolved issue. This significantly curtails the capability of the analytic team.

5. Action/Recommendations for Governing Body

The Governing Body is asked to:

- Note the issues identified in the paper broadly, the PHE Health Profile and the JSNA.
- Consider where new JSNA chapters might be warranted
- Note that data sharing across the CCG and the Local Authority is not yet a resolved issue.

Paper prepared by: Greg Fell, Director of Public Health

On behalf of: Brian Hughes, Director of Commissioning and Performance

31 December 2019

Appendix 1: PHE Health Profile for Sheffield – core indicators
Appendix 2: HWBB metrics.

Appendix 1

High level indicators from the LA Health Profile for Sheffield

https://fingertips.phe.org.uk/profile/health-profiles

Life expectancy and causes of death

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
1 Life expectancy at birth (male)	All ages	2015 - 17	n/a	79.2	78.7	79.6	↑
2 Life expectancy at birth (female)	All ages	2015 - 17	n/a	82.4	82.4	83.1	↓
3 Under 75 mortality rate from all causes	<75 yrs	2015 - 17	4,630	353.7	362.3	331.9	↑
4 Mortality rate from all cardiovascular diseases	<75 yrs	2016 - 18	1,077	82.7	82.0	71.7	↓
5 Mortality rate from cancer	<75 yrs	2016 - 18	1,797	138.3	141.2	132.3	↓
6 Suicide rate	10+ yrs	2016 - 18	120	8.1	10.7	9.6	↑

Injuries and ill health

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
7 Killed and seriously injured (KSI) rate on England's roads	All ages	2015 - 17	673	39.1	45.7	40.8	↑
8 Emergency hospital admission rate for intentional self-harm	All ages	2017/18	765	125.3	194.6	185.5	↓
9 Emergency hospital admission rate for hip fractures	65+ yrs	2017/18	498	515.7	569.2	577.8	↓
10 Percentage of cancer diagnosed at early stage	All ages	2017	1,030	49.0	50.6	52.2	↓
11 Estimated diabetes diagnosis rate	17+ yrs	2018	n/a	77.3	81.9	78.0	↑
12 Estimated dementia diagnosis rate	65+ yrs	2019	5,018	80.0 *	71.6 *	68.7 *	↑

Behavioural risk factors

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
13 Hospital admission rate for alcohol-specific conditions	<18 yrs	2015/16 - 17/18	61	17.5	33.4	32.9	↓
14 Hospital admission rate for alcohol-related conditions	All ages	2017/18	3,603	699.5	697.0	632.3	↑
15 Smoking prevalence in adults	18+ yrs	2018	58,153	12.5	16.7	14.4	↓
16 Percentage of physically active adults	19+ yrs	2017/18	n/a	68.9	64.0	66.3	↑
17 Percentage of adults classified as overweight or obese	18+ yrs	2017/18	n/a	62.5	64.1	62.0	↑

Child health

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
18 Teenage conception rate	<18 yrs	2017	156	18.0	20.6	17.8	↓
19 Percentage of smoking during pregnancy	All ages	2018/19	679	11.7	14.4 ~	10.6	↓
20 Percentage of breastfeeding initiation	All ages	2016/17	5,047	78.3	69.3	74.5	↓
21 Infant mortality rate	<1 yr	2015 - 17	95	4.8	4.1	3.9	↓
22 Year 6: Prevalence of obesity (including severe obesity)	10-11 yrs	2017/18	1,270	21.1	20.6	20.1	↓

Inequalities

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
23 Deprivation score (IMD 2015)	All ages	2015	n/a	27.6	-	21.8	–
24 Smoking prevalence in adults in routine and manual occupations	18-64 yrs	2018	n/a	19.8	27.4	25.4	↓
25 Inequality in life expectancy at birth (male)	All ages	2015 - 17	n/a	9.3	10.3	9.4	↓
26 Inequality in life expectancy at birth (female)	All ages	2015 - 17	n/a	8.3	8.4	7.4	↓

Wider determinants of health

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
27 Percentage of children in low income families	<16 yrs	2016	23,095	23.2	19.7	17.0	↑
28 GCSE attainment (average attainment 8 score)	15-16 yrs	2017/18	n/a	44.8	45.3	46.7	→
29 Percentage of people in employment	16-64 yrs	2018/19	284,600	74.6	73.7	75.6	↑
30 Statutory homelessness rate - eligible homeless people not in priority need	Not applicable	2017/18	401	1.7	1.0	0.8	↓
31 Violent crime - hospital admission rate for violence (including sexual violence)	All ages	2015/16 - 17/18	941	48.8	53.3	43.4	↓

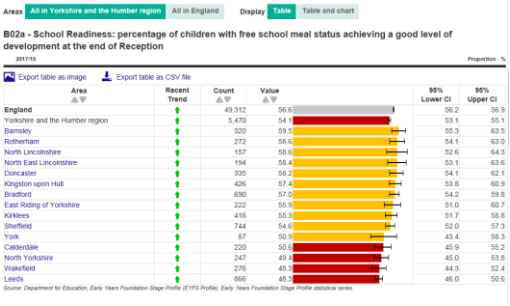
Health protection

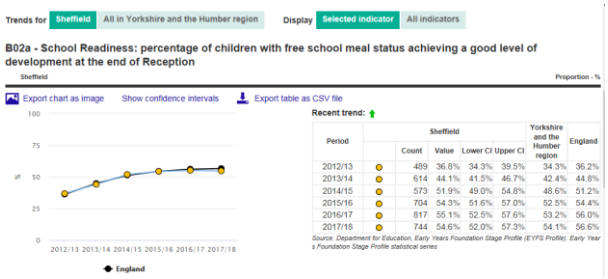
Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
32 Excess winter deaths index	All ages	Aug 2017 - Jul 2018	436	28.4	31.1	30.1	↑
33 New STI diagnoses rate (exc chlamydia aged <25)	15-64 yrs	2018	2,516	651.8	629.1	850.6	↑
34 TB incidence rate	All ages	2016 - 18	155	8.9	6.8	9.2	↓

Appendix 2

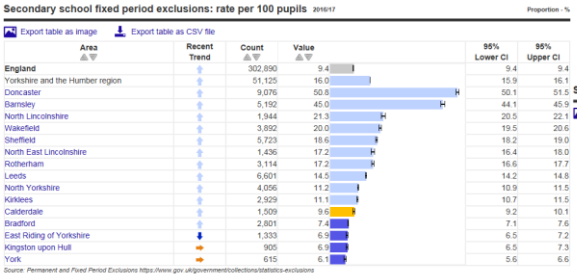
Illustrative high level indicators relevant to the ambition within the HWBS

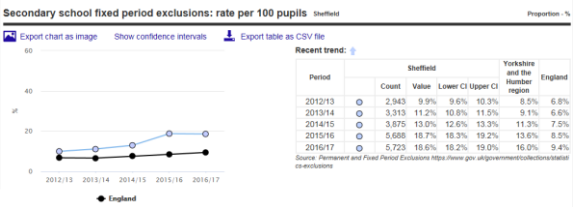
Ambition 1 – best start in life. School readiness





Ambition 2 – inclusion and education

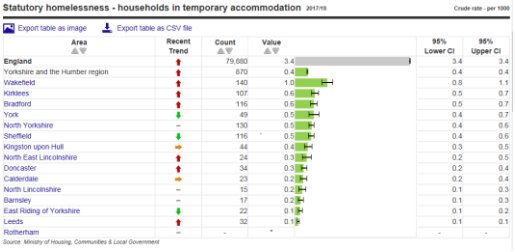


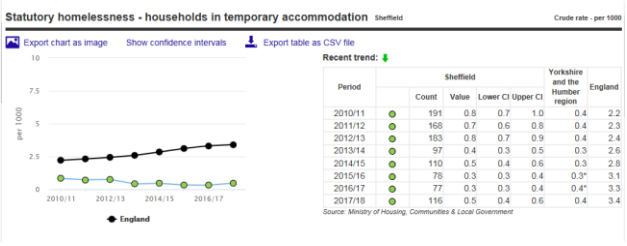


Ambition 3 – transition to adulthood and independence.

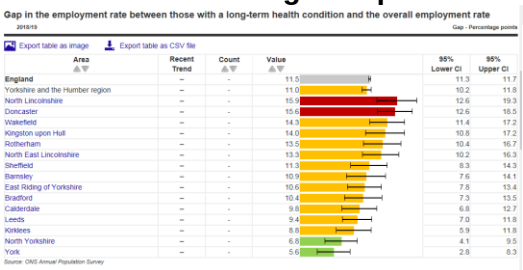
No ready indicator developed.

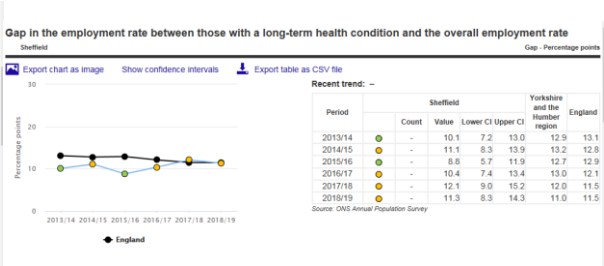
Ambition 4 – home supportive of health



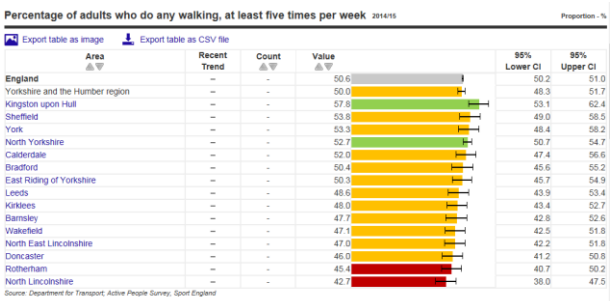


Ambition 5 – fulfilling occupation

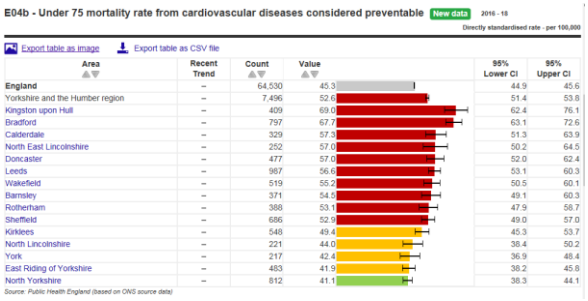


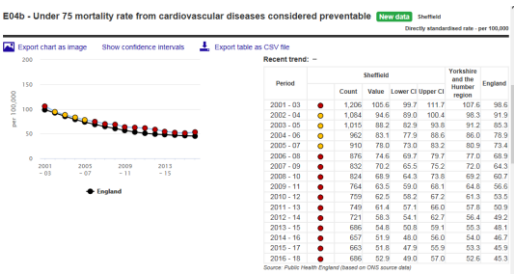


Ambition 6 – active travel



Ambition 7 – health care





Ambition 8 – loneliness

Not yet developed appropriate indicator.

Ambition 9 – end of life