Sheffield NHS
Primary Care Trust

Making a Difference

Sheffield Director of Public Health Report 2007

Contents

Welcome and Introduction

This year's Annual Report of the Director of Public Health concentrates on the three identified public health priorities for the City. These were chosen because they are major public health issues, and because we think that we can really make a difference in these areas.

Inevitably, tobacco control is one of them. Smoking still kills about a thousand people a year in Sheffield, and it is the single biggest cause of the health inequalities that blight our City. Although 2007 saw the introduction of a ban on smoking in enclosed public places - so that no one has to breathe in other people's smoke unless they want to - we still have a long way to go to rid ourselves of this scourge. I am pleased to say that there is now an unprecedented coalition of partners working to reduce tobacco consumption in Sheffield.

Another priority is to address health inequalities through Enhanced Public Health Programmes in those parts of the City with the worst health. We think that through a combination of health promotion, increasing access to health services, and developing community capacity, we can make a real difference in health in these neighbourhoods. You can read in here how we are going about this.

The third priority is the health of children and young people. There are important health issues to be addressed for children and young people now - for example increasing breast feeding, halting the rise in childhood obesity, and reducing teenage pregnancy.

But in addition, if the population of Sheffield is to be healthier in the future than it is now, we must ensure that the current generation of children and young people are healthy, and carry forward healthy lifestyles into their adulthood.

Each of these public health priorities is one of the nine priorities identified in Sheffield PCT's overall strategy: 'Achieving Balanced Health'.

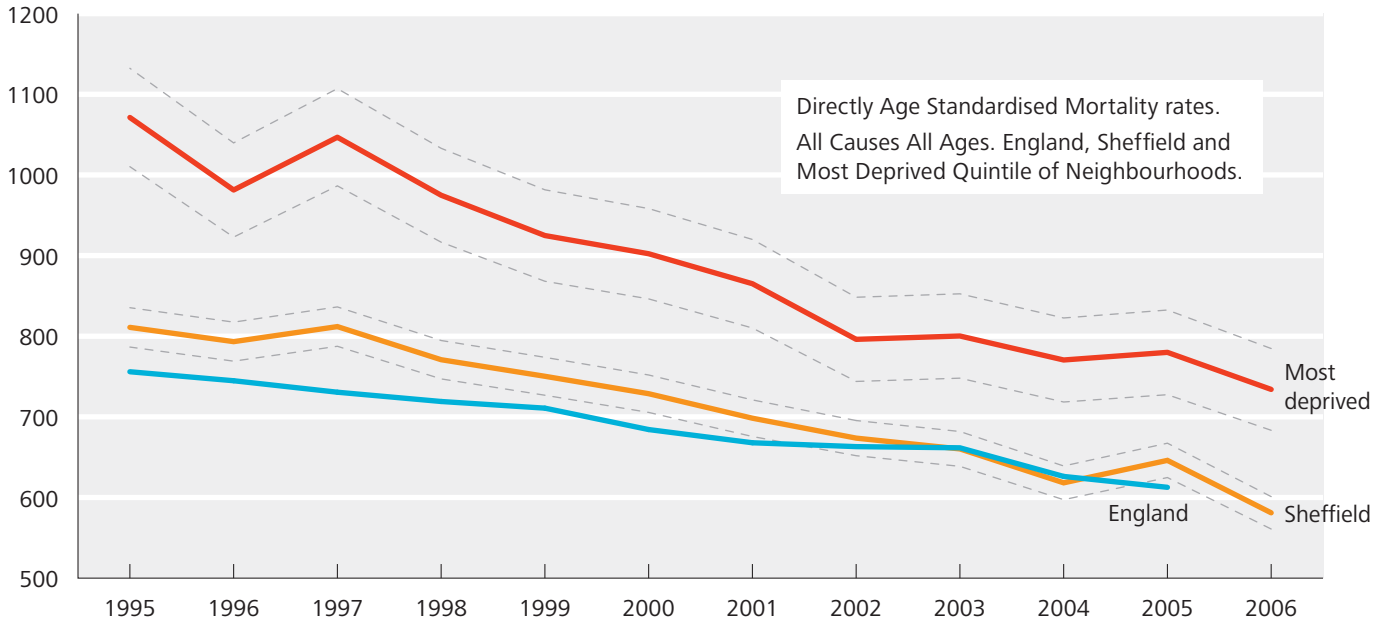
In addition to reports on each of these, the Report contains updates on the recommendations made last year. I am pleased to say that progress is being made in most of the areas about which I made recommendations. Perhaps most notably, climate change is now being recognised widely as a major public health threat, though we clearly still have an enormous task if we are to reduce carbon emissions to the level that will allow for stabilisation of the climate.

As last year, the report is a combination of a written report and a website - www.publichealthsheffield2007.nhs.uk . In response to feedback we have produced a fuller printed version than last year, but we are again using the technology of the internet to present the Sheffield Health and Wellbeing Atlas. This contains a host of health information on all the neighbourhoods of our City, in a way that simply would not be possible in a written report.

Sheffield's health overall is continuing to improve. Mortality rates overall, and from the 'big killers' continue to decline, and as a result life expectancy has increased further over the past year, as shown in the table below.

Health Indicator	Sheffield's Position		England Position
	2003-2005	2004-2006	2003-2005
Life Expectancy at Birth for Males (years)	76.6	77.4	76.9
Life Expectancy at Birth for Females (years)	80.6	81.3	81.1
Premature death rate (<75 years) from Coronary Heart Disease & Strokes (rate per 100,000)*	91.5	87.0	90.5
Premature death rate (<75 years) from all types of Cancer (rate per 100,000)*	122.5	120.7	119.0
All Cause Mortality (Under 75 years) (rate per 100,000)*	325.4	320.9	319.5
All Cause Mortality (All Ages) (rate per 100,000)*	641.5	615.1	633.5

* Directly standardised European rates

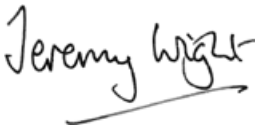


Our main challenge is to make sure that as this trend continues, the health of the worse off parts of the population improves faster than the average, so that the serious health inequalities in the City narrow. The graph above shows how mortality in the most deprived quintile (one fifth) of the City is falling so as to become closer to the City average. We must make sure that this continues.

I hope you find the report informative and thought provoking. As always, I would be delighted to have any feedback, whether this be comments on the content of this year's report, or suggestions for future years.

Thanks

As always, the report is the result of lots of people's hard work over the year. This year I wish in particular to thank John Soady, Frances Cunning and Chris Nield, who have written the sections on tobacco control, the health of children and young people, and the enhanced public heath programmes, as well as John Skinner who has put the report together, Ann Richardson who has ensured that the Health and Wellbeing Atlas is up to date, and Amy Benson who masterminded the website. Many other people have also contributed - my thanks to all of you.



Dr Jeremy Wight
Director of Public Health
Sheffield PCT and City Council

November 2007

The Three Priorities for Public Health

- Tobacco control
- The health of children and young people
- Enhanced public health programmes

This section of the report focuses on the three priority areas for Public Health. For each of these three areas, we describe the reasons for it being chosen as a priority, outline the actions that are going to be taken, explain the difference that this will make, and state what resources are required to carry out this work.

Tobacco Control

Contact

John Soady
Head of Tobacco Control
Tel 0114 226 4730

1 Why is this a priority?

Smoking is still the biggest, reversible cause of ill health and premature death. In addition, smoking in pregnancy reduces birth weight, and contributes significantly to stillbirth and infant mortality. It is also the largest single cause of health inequalities.

Nationally, smoking accounts for about 60% of the difference in all middle age deaths between the most affluent and worst-off groups. In Sheffield the prevalence of smoking varies between from about 13% in Ecclesall to around 40% in Woodside.

Sheffield PCT has been set very challenging targets by the Department of Health (DoH) and needs to substantially increase the number of people entering the Stop Smoking programme in order to meet these targets. In 2006/7 the Stop Smoking programme helped around 2,600 smokers to quit. For 2007/8 the DoH target is 4,385 smoking quitters. Smokefree legislation, which came into effect on 1st July 2007, has raised the profile of stopping smoking within the general population and should thereby encourage more smokers to enter the programme.

Adult smoking

The most recent local survey in 2002 found that 26% of the Sheffield adult population were smokers (around 110,000 people). The national picture tells us that, although the prevalence of smoking has fallen very significantly since the 1970s, it has shown only a very slow decline over the 1990s. Sheffield appears to be broadly in line with the national picture, and needs to continue to progress towards the government target of 24% by 2010. In addition, we have unknown rates of non-smoking tobacco use in minority ethnic communities.

Reducing smoking prevalence is also a priority because it can make a major contribution to one of the PCT's key strategic objectives of narrowing the health inequality gap by targeting programmes in less affluent areas.

A greater number of smokers are accessing the service and successfully quitting in those 36 neighbourhoods covered by the Enhanced Public Health Programmes (EPHP), than in the rest of the City. When expressed as a proportion of smokers resident in those areas, access to quit programmes in the EPHP areas is equivalent to that in the rest of the City. The percentage who then successfully quit is about the same in both EPHP and non-EPHP areas. Although we are in general achieving equitable rates of access to stop smoking programmes throughout the City, if we are to reduce inequalities, our aim should be to achieve even higher rates of access and quitting in our target areas.

Achieving good compliance with smoke-free legislation will also help to reduce smoking related inequalities. People working in those places that are most affected by this legislation, such in the traditional 'wet' pubs & clubs, and manual occupations, tend to be drawn from less affluent communities and non-smokers there have the greatest to gain from full compliance with the legislation.

Smoking in pregnancy

Sheffield is one of very few health communities in Yorkshire and The Humber that has managed to maintain a year-on-year decline in the rate of smoking in pregnancy. The proportion of women smoking at delivery during 2006/7 was 16.2% in Sheffield. We have a DoH target to reduce this proportion by one percentage point per year, meaning a target of 15.2% to achieve during 2007/8. It remains a considerable challenge to maintain this reduction and a significant input of resources will be required.

A greater proportion of pregnant women are receiving NHS support to stop smoking in our Enhanced Public Health Programme target neighbourhoods than in the rest of the City. However this is reversed when expressed as a proportion of the number of pregnant smokers. This means that access to, or take up of, stop smoking services is less good in our priority areas in relation to the size of the problem. We need to address this through the combined efforts of the Stop Smoking Service, Community Maternity services and Children Centres.

Smoking in children and young people

The Department of Health target is to reduce smoking among children nationally from 13% to 9% or less by the year 2010. If achieved, this will mean approximately 1,100 fewer children smoking in Sheffield by 2010 compared with the late 1990s. Whilst rates of smoking in children nationally have declined over recent years, this is much less so in young girls than in boys, which is a concern.

Smoking in this age group needs to be tackled through effective preventive measures, however, there are few approaches that are backed with strong evidence of efficacy. One such evidenced approach is based around a school-based smokefree class competition aimed at the age groups most at risk of starting smoking. This is a WHO European promoted approach (piloted in Sheffield during 2003-5), which aims to delay or prevent the onset of smoking, and to help pupils who have already experimented with smoking to quit. A further option is based on youth advocacy. These additional approaches to smoking prevention need to be integrated with the Healthy Schools Programme, to provide a comprehensive environment for promoting the adoption of healthy lifestyles and tackling risky behaviours.

Continuing to tackle the under-age sales of cigarettes will also contribute to this target.

2 What are we proposing to do?

We have an agreed smoking cessation action plan for 2007/08, which includes working with the local hospitals and the City Council. The main aim of this plan is to encourage more smokers to contact the Stop Smoking Service. Targeted stop smoking initiatives are included in the enhanced public health programme target areas. The main points of the action plan are as follows:

Adults

- We will maintain a local Stop Smoking Service with capacity to deliver quit programmes to meet Department of Health targets through a combination of commissioned and directly provided services.
- A PCT "task force" approach will be taken to help GP practices to refer more smokers into the stop smoking service, and to provide support to in-house stop smoking clinics in GP surgeries and community pharmacies, and wherever possible creating even more clinics.
- The Stop Smoking Service will work with GP practices and pharmacies to improve their conversion rates to successful quitters.
- There will be a focus on community level actions to tackle smoking and to recruit to stop smoking programmes within each of the EPHP areas. This involves integrating public sector services and local communities in joint approaches. To underpin this programme, the EPHP teams will use local networks with community groups and service providers to establish an additional level of provision to meet demand.
- The PCT and the City Council will work closely in the promotion of the stop smoking service through local services and in the local media. Council staff will be able to make direct referrals to the Stop Smoking Service from appropriate service locations, such as First Point in the city centre, and will support the Stop Smoking work being carried out by the EPHP teams.
- In hospitals, the smoking status of patients will be assessed prior to surgery, and smokers will be offered immediate NHS support to stop smoking. Staff carrying out pre-operative assessments will continue to be updated on the best ways of giving brief advice to help smokers to quit.
- The City Council and the PCT will work closely to ensure high levels of compliance with the smokefree regulations, and through a proactive programme of employer engagement will promote and provide stop smoking service programmes in the workplace.

Pregnancy and early years

- All pregnant women will be asked about their smoking status. Those who smoke will have the matter raised at every contact with their midwife. A brief intervention will take place for smokers and midwife support offered for anyone wanting to quit including arranging provision of NRT.
- Community midwives and peer support workers will be trained to provide brief advice and ongoing support to pregnant women who wish to stop smoking.
- Community midwives will be able to follow criteria to refer 'high risk' cases to specialist smoking cessation midwives for support.
- Community pharmacists should promote awareness of the dangers of smoking from an early stage in pregnancy.

- Children's Centres should have smoking interventions mainstreamed within the commissioned 'early years' offer' with a particular focus on the former Sure Start areas.
- A smokefree homes programme will be established throughout the City, and all newly pregnant mothers will receive information packs about creating a smokefree family environment.
- Smoking prevention components within the Healthy Schools Programme will be strengthened with the introduction of evidence-based programmes of engagement, such as the WHO smokefree class competition and/or youth advocacy approaches.
- The City Council will continue to detect and tackle under-age sales of cigarettes.

3 What difference do we think we can make?

Having an active programme of smoking cessation promotion and maintaining a visible local stop smoking service with a community presence are vital to making sure that rates of quitting are maintained in those communities that are at higher risk of smoking related disease and death. Service capacity and smoker recruitment programmes should be aimed at delivering around 5,000 quitters annually in Sheffield. People from the more affluent areas of the City are more likely than others to quit, either unsupported or as a result of self-referral to the service. Without targeted smoking cessation programmes, therefore, there is a danger that health inequalities could increase.

In terms of the impact of smokefree legislation, the Department of Health's Regulatory Impact Assessment (RIA) concluded that the effect of the regulations in England would result in a 1.7% reduction in smoking prevalence. That would mean around 1,800 fewer smokers in Sheffield in the medium term as a direct result of the legislation. Over the longer term, that would translate into an estimated 18 smoking related deaths avoided per year.

Our local smoking cessation programmes will make a vital contribution to reducing health inequalities in the City because of their targeted nature.

Of the 5,000 per year that we aim will successfully stop smoking through the NHS Stop Smoking Service, approximately one fifth (i.e. about 1,000 per year) will remain abstinent longer term.

That annual number over the long term equates to an estimated 10 further smoking related deaths avoided every year. There are currently about a thousand smoking related deaths per year in Sheffield. Many of the benefits of stopping smoking will be seen in the short term because the reduction in disease specific risk can become apparent very quickly after quitting; for example, heart attack risk reduces by about 50% after only one year.

The combined local effect of establishing smokefree environments and delivering planned smoking cessation outcomes will be an estimated 28 deaths avoided, and a saving of circa £1.6 million to the Sheffield NHS in treating smoking related disease.

It is more difficult to quantify the effects of achieving further reductions in smoking in pregnancy. However there are strong associations between smoking in pregnancy and stillbirth, infant mortality, asthma onset, and the development of disease in later life. It is therefore important to maintain a reduction of 1% per year in the proportion of women who continue to smoke throughout their pregnancy.

4 What resources do we need to do this?

A fully staffed Stop Smoking Service is needed in order to deliver the smoking cessation action plan for 2007/08. This includes advisors and specialist advisors to run stop smoking programmes and to liaise with other health agencies and employers, along with an administrative and management support structure.

Recommendations

1. The Public Health team should promote stop smoking interventions in those communities and services that will lead to the greatest increase in the number of adult smokers contacting the Stop Smoking Service.
2. The PCT should ensure that stop smoking advice for pregnant women is included in all routine aspects of maternity care, by including this in the service specification for maternity services.

The Health of Children and Young People

Contact

Frances Cunning
Consultant in Public Health
Tel 0114 226 2455

1 Why is this a priority?

If the population of Sheffield is to be healthier in the future than it is now, then we must make sure that the health of children and young people is as good as it can possibly be. Not only do they make up a quarter of the City's population but today's children and young people embody the City's future. Their health and lifestyle choices will be taken forward into future decades.

'Every Child Matters' is the Government's approach to the well-being of children and young people. The aim is for every child, whatever their background or their circumstances, to have the support they need to:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being

This means that all organisations involved in providing services to children will be working together, to protect children and young people from harm and help them achieve what they want in life.

There are approximately 120,000 children and young people between the ages of 0-19 in Sheffield. Of these, about 35,000 require some form of additional support. 10% of these children are classified as 'children in need', and will require some form of direct support and intervention to secure their well-being. About 650 children are 'looked after' by the City, and approximately 400 will be on the child protection register.

There are a number of specific priorities which affect the health of children and young people, and which contribute towards health inequality within the City. In many parts of Sheffield only a minority of infants are breastfed and a substantial number of women smoke during pregnancy. Childhood obesity is increasing steadily within Sheffield as elsewhere, and very little progress has been made in reducing teenage conception rates. Educational attainment (which has a strong association with health in later years) of young people in Sheffield is below the national average.

Breastfeeding

Three quarters of Sheffield mothers start to breastfeed their babies at delivery. However, there is wide variation across the City, from less than 50% in some neighbourhoods, to over 90% in others. Breastfeeding leads to significant health benefits and cost savings[1] and has a major role to play in promoting personal health and reducing inequalities. It has short and long term benefits for both baby and mother.

Smoking in pregnancy

Pregnant women who smoke are more likely to have a premature baby, or a baby with a low or very low birth weight. Such babies are at higher risk of asthma and bronchitis and other diseases. Passive smoking is also harmful to the foetus and newborn. Smoking in pregnancy is strongly related to socio-economic status and the prevalence varies from 0% to 40% across Sheffield neighbourhoods. It is thus a major driver of health inequality in the City. At any one time, there are approximately 600 pregnant women in Sheffield who smoke.

Aspiration and self-esteem

Health and education are closely connected: poor educational attainment affects health and vice versa. In Sheffield, educational attainment, although improving, is still below the national average. Improvement must be accelerated, particularly in the primary years. The difference in attainment levels across the City reflects the health inequalities.

Teenage conceptions

Teenage pregnancy is strongly associated with low birth weight, poor neonatal outcomes and reduced life chances for the mother. Although Sheffield's rate is not out of line with other UK cities, it is not decreasing significantly, and is strongly associated with socio-economic status. It is a further indication of the need to raise levels of aspiration.

Childhood Obesity

Children who are overweight tend to grow into adults who are overweight and they therefore have a higher risk of developing serious health problems both as children and in later life. Obesity is associated with many health problems including coronary heart disease, stroke, type 2 diabetes, kidney failure, osteoarthritis and back pain. The association between obesity and cancer has been known for a while, but recent evidence is showing that it is stronger than previously thought. Being overweight can also cause psychological distress. Teasing and bullying about their appearance can affect a child's confidence and self-esteem; it can lead to isolation and depression, which in turn can impact on their attendance and attainment levels. Within Sheffield there are notable variations in childhood overweight and obesity, with some schools having significantly higher levels than the national average.

2 What we are proposing to do?

Our approach to these priority areas is documented in the PCT's Children and Young People's Plan 2006-2009. This broadly outlines the action to take forward this agenda.

Breastfeeding

We will implement the National Institute for Clinical Excellence (NICE) recommended package of effective interventions to address the diverse needs of a local population. Specifically, we will implement the UNICEF UK Baby Friendly Initiative as routine practice across the NHS Hospital Trusts, the Primary Care Trust, Sure Start Programmes and Children's Centres.

Parental smoking and smoking in Children and Young People.

We aim to develop the concept of the smokefree class competition as delivered elsewhere in Europe, by expanding the pilot carried out in Sheffield in 2005 to include all eligible schools. We will further develop the Smoke Free homes concept.

We will continue to work with local midwives and others to ensure that women who smoke in pregnancy are given the strongest encouragement and assistance to stop. Further detail is included in the tobacco control section of this report.

Aspiration

To improve children and young people's aspirations, we will target work with vulnerable children and young people and their parents and carers. This will be achieved through implementing a range of interventions in early years, in schools and youth and community settings, for example the 125 programme, SEAL[2] programme in primary and secondary schools, and the development of a citywide approach to social marketing targeting adolescents. These interventions will concentrate on raising self esteem, improving emotional literacy, developing life skills, problem solving, building resilience, reducing risky behaviour, and investing in parenting capacity.

Teenage Pregnancy

There is already a well-developed plan for teenage pregnancy and we will continue to implement this.

Childhood Obesity

The PCT is currently reviewing a range of existing models being implemented across the country to tackle childhood obesity. In Sheffield, the lottery funded MEND (Mind, Exercise, Nutrition, Do-it) programme is running in schools and community venues across the City. Future service development in Sheffield will be informed by the evaluation of these various approaches.

These developments will form part of the PCT's obesity action plan, to be developed in line with NICE guidelines to tackle childhood obesity, which were published in December 2006.

The Department of Health's weighing and measuring programme of reception and year 6 pupils which began in 2005/06 will continue to provide a baseline against which progress can be measured. It will also help to further strengthen the targeted work of the Healthy Schools Programme. We will provide schools with extra support around nutrition, physical activity and emotional health and well-being, as part of a broader healthy schools approach.

3 What difference do we think we can make?

There is robust evidence to show that health benefits can be achieved in the short term from interventions in the early years. We can therefore be very confident about definite outcomes for this age group. However, it is much more difficult to quantify the extent to which the benefits of increased attainment and self-esteem amongst children and young people extend into adulthood. This is partly because of the longer timescales involved, but also because of the great number of other potentially contributing factors.

Nevertheless, we expect to make the following difference to the health of children and young people:

- improve the breastfeeding rate by at least 2% per year
- reduce the number of preventable infections and unnecessary paediatric admissions in infancy due to gastroenteritis and asthma
- make progress towards reducing the teenage pregnancy rate by 50% by 2010
- reduce the rise in obesity in under 11s
- halve the difference, within 3 years, in infant mortality rates between the worst fifth of Sheffield neighbourhoods and the City average**[3] (this equates to saving 4 babies per year)
- contribute to closing the gap between the most affluent and worst off neighbourhoods in education attainment and attendance, teenage pregnancy and those children and young people not in education or employment .

4 What resources do we need to do this?

To deliver the PCT's Children and Young People's Plan 2006-2009, we need to:

- Ensure midwifery, health visiting, school nursing and youth services are sufficiently resourced to provide children, young people and their parents with the skills to manage and improve their own health in later years.
- Invest in peer educators and support workers to support infant and maternal health and smoking cessation work in the community.
- Invest in implementing Baby Friendly status in Sheffield. Costs decrease each year and savings increase, so that by year 4 the savings from Baby Friendly status are greater than the costs.
- Invest in the Healthy Schools team to strengthen their role and ensure they are mainstreamed as a delivery mechanism for early intervention and primary prevention work in school and community settings.

[1] Sheffield PCT Public Health Analysis Team April 2007 'Breastfeeding in Sheffield 2006 Statistical Report'

[2] Social and emotional aspects of learning

[3] It needs to be noted that the numbers are small and they fluctuate and we cannot be confident that they are statistically valid but overtime this is the level of change we would expect to see.

Recommendations

1. The PCT and Sheffield City Council must work towards Sheffield becoming a WHO accredited Baby Friendly City.
2. The PCT and Sheffield City Council must take further action to reduce smoking in children and young people and pregnant women.
3. Sheffield City Council Children and Young People's Directorate should implement evidence based interventions in school and community settings to improve the aspirations of vulnerable children and young people.
4. The PCT and Sheffield City Council must continue to implement the Sheffield Teenage Pregnancy Action Plan.
5. The Public Health Directorate must evaluate models for tackling childhood obesity and propose a clear way forward for the City.

Enhanced Public Health Programmes

Contact

Chris Nield
Consultant in Public Health
Tel 0114 226 2246

1 Why is this a priority?

In Sheffield, mortality rates have fallen dramatically, particularly the rates for coronary heart disease. As a result, life expectancy has increased. However, enormous disparities remain within the City. There is a 14 year difference in life expectancy between our best and worst off neighbourhoods and there is a three-fold variation in all-cause mortality rates. Whatever measure of health and wellbeing one chooses to use, there are enormous differences between the better and worse-off neighbourhoods.

As well as these differences between neighbourhoods there are also big differences between populations as defined in other ways. For example, health differences between Black and Minority Ethnic (BME) communities and the rest of the population are well documented. A recent health needs assessment of Sheffield's BME population highlighted much higher levels of diabetes and coronary heart disease, greater levels of emergency admissions to hospital and much lower uptake rates of key health screening and prevention services in that population compared to the rest of the City.

2 What are we proposing to do?

We are developing Enhanced Public Health Programmes (EPHPs) in the one third of the City that has the worst health and wellbeing indicators. The aim of these Programmes is to reduce health inequalities over the next 3 years through a combination of health promotion initiatives, developing a systematic approach to the identification of those at highest risk, and increasing access to a range of services. This is being done in partnership with the City Council, and constitutes the 'Healthier Communities' block of the current Sheffield Local Area Agreement.

These programmes are intended to lead to a substantial improvement in health in the areas covered, both through a combination of interventions to tackle the wider determinants of health and health promotion, as well as increasing uptake of appropriate health services. They are being led by PCT public health staff, working in close cooperation with local communities.

It is intended that this will lead to a reduction of health inequalities in the City.

We are implementing a focussed programme of activity, based around a business-case approach for each EPHP, developed and delivered in partnership with each local community. This evidence-based approach is designed to develop community and individual engagement, to facilitate healthier lifestyle choices, and to tailor the delivery of services to the needs of individual communities.

A priority within these programmes is to increase access by the most at risk individuals to primary and secondary prevention, treatment and care, particularly with regard to cardio vascular disease.

In order to achieve this we will:

Engage with the local community to identify health need

Those at highest risk of future illness or disability and people with the lowest levels of wellbeing are often unidentified and may have poor access to services. Identifying those at high risk before they become ill can be achieved partly during visits to the GP surgery, for example for diabetes, blood pressure checks, and routine screening. However, this will not be enough, since many people at risk do not routinely access health services. A key part of the EPHPs, therefore, is to work with community groups to help local populations understand who is likely to be most at risk and encourage them to access services.

Increase accessibility of services

We must increase the accessibility of services to help those at risk. This will include working with GPs and others to ensure that primary and community health services are as accessible as possible and meet local population needs. This will involve establishing new ways of accessing assessments, treatments and other health promotion interventions, particularly with regard to primary and secondary prevention of cardio vascular disease. It is also important to develop risk registers and other systems in GP practices which identify those at greatest risk.

Develop Health Promotion Interventions

A significant area of work within most of the EPHPs is health promotion interventions to support lifestyle changes. These interventions cover a range of topics including smoking, physical activity, and healthy eating. They have been identified through local partnership groups: a key element is to support the delivery of this work by local people, with interventions such as peer mentors and community nutrition workers. It is also important that GP practices are aware of local health promotion initiatives in order to encourage uptake, and that direct referral and social prescription schemes are developed.

Build Community Capacity

Real and sustained improvement in wellbeing in deprived communities can only come from the communities themselves. Community engagement in delivering improvements in health and wellbeing can result in more appropriate and cost effective use of health and social care services, and better health and well being. Promoting involvement, empowerment, and a sense of ownership of health and social care is likely to be the best way to ensure that people adopt healthier lifestyles, and are able to live independent lives for longer. As in Saving Lives: Our Healthier Nation Report, July 1999:

When people are involved in making the decisions which affect health their lives their self confidence and self esteem and self confidence rise, in turn improving their health and well being. And, of course, many local people have a good understanding of the community's main health problems and of priorities for action. Real change can come only from the local community itself by harnessing the energy, skills and commitment of local people in setting clear objectives for change and forming new partnerships for action.

The Community Development and Health Programme has demonstrated success in empowering local people and improving their health, with many participants going on to further employment, voluntary work and education. Neighbourhood Renewal Funding has enabled these health improvements to take place building on established community groups.

In the future, we want to:

- encourage local community groups to establish partnerships with service providers and funding organisations. This would enhance capacity in the community to sustain its own development and would lead to opportunities for paid and voluntary work.
- through the Health Champions lottery initiative develop a support network through a tendering process to encourage local individuals to become 'Health Champions' for their community. The role of Health Champions will vary, and could include influencing friends and family about health issues, contributing to or setting up a support group, or delivering a health promotion session such as healthy eating or physical activity.
- provide additional training and support for Health Champions including a programme of training around physical activity, healthy eating and mental health, linking with wider training and employment opportunities.

3 What difference do we think we can make?

Obesity, high cholesterol, high blood pressure, smoking, sedentary lifestyle, and poor diet are risk factors associated with coronary heart disease (CHD) and stroke, and contribute to premature death. If the EPHPs can impact directly on these risk factors at a population level, there will be a reduction in chronic diseases such as CHD, stroke, diabetes and renal disease, a reduction in cancer incidence and a reduction in premature deaths.

Reduction in these risk factors will reduce acute events such as heart attack and stroke, reduce hospital admission, reduce the need for long-term care, reduce premature deaths and improve quality of life. Other benefits will include improved mental health, increased involvement in community networks, and more people in employment, training and voluntary work. These factors will themselves in turn impact favourably on quality of life and mortality rates over time.

We can estimate how many lives could be saved in the EPHP areas, using the example of lives saved from reducing circulatory disease.

- By successfully identifying and treating 9,000 patients for high cholesterol levels and 2,000 patients for high blood pressure - **11 lives saved per year**.
- By increasing the number of smokers who have quit at 4 weeks by 2,500 (equating to 500 long term quitters) - **5 lives saved per year**.
- By encouraging an extra 5,000 people aged 50 years and over who participate in moderate physical activity - **9 lives saved per year**.
- Concentrating these activities in the worst-off neighbourhoods of Sheffield will contribute to a reduction in health inequalities. As well as reducing the number of deaths, there will be many more people whose health is improved through reductions in high blood pressure, cholesterol, smoking, and increased levels of exercise.

4 What resources do we need to do this?

The delivery of Enhanced Public Health Programmes is partly dependent on external funding, some of which is currently provided through Neighbourhood Renewal Funding. However this is finishing this financial year, and there is no certainty that any replacement funding stream will continue to support the programmes.

Regional Lottery funding has recently been made available to support the development of the community capacity and community based interventions in mental health, healthy eating and physical activity.

Each of the 16 programmes is led by a member of the PCTs Public Health Directorate. Significant support is also provided by the Sheffield First for Health and Wellbeing health partnership team. In addition, there are staff from the local authority who contribute through Neighbourhood Renewal Funding, and Primary Care staff have a key role in providing access to early intervention programmes. The voluntary sector is intrinsic to the success and achievements of local programmes and attracts additional funding from a range of sources.

Recommendations

1. The Public Health team must engage with local communities to identify health needs, and in the planning and delivery of interventions to address those needs.
2. The PCT must establish new ways for local people to access services in the Enhanced Public Health Programme areas.
3. The PCT should further develop health promotion programmes in local communities.
4. The PCT should help build community capacity to improve health particularly through the Community Development and Health Programme and the lottery Health Champions initiative.
5. Sheffield City Council and the PCT must consider the impact of the cessation of Neighbourhood Renewal Funding on the delivery of Enhanced Public Health Programmes, and make replacement of this funding a priority.

Summary of Recommendations 2007

1. The Public Health team should promote stop smoking interventions in those communities and services that will lead to the greatest increase in the number of adult smokers contacting the Stop Smoking Service.
2. The PCT should ensure that stop smoking advice for pregnant women is included in all routine aspects of maternity care, by including this in the service specification for maternity services.
3. The PCT and Sheffield City Council must work towards Sheffield becoming a WHO accredited Baby Friendly City.
4. The PCT and Sheffield City Council must take further action to reduce smoking in children and young people and pregnant women.
5. Sheffield City Council Children and Young People's Directorate should implement evidence based interventions in school and community settings to improve the aspirations of vulnerable children and young people.
6. The PCT and Sheffield City Council must continue to implement the Sheffield Teenage Pregnancy Action Plan.
7. The Public Health Directorate must evaluate models for tackling childhood obesity and propose a clear way forward for the City.
8. The Public Health team must engage with local communities to identify health needs, and in the planning and delivery of interventions to address those needs.
9. The PCT must establish new ways for local people to access services in the Enhanced Public Health Programme areas.
10. The PCT should further develop health promotion programmes in local communities.
11. The PCT should help build community capacity to improve health particularly through the Community Development and Health Programme and the lottery Health Champions initiative.
12. Sheffield City Council and the PCT must consider the impact of the cessation of Neighbourhood Renewal Funding on the delivery of Enhanced Public Health Programmes, and make replacement of this funding a priority.

Progress on implementing the recommendations from the 2006 Director of Public Health Annual Report

	Health Challenge	DPH Recommendation	Progress against recommendation
1	More HIV is being diagnosed in Sheffield than ever before: How should the City respond?	The PCT should prioritise the prevention of HIV transmission through: maximising opportunities for HIV testing in GUM, antenatal, general medical and primary care settings in accordance with British Association for Sexual Health and HIV guidelines effective commissioning of evidence-based HIV prevention measures including education, condom distribution and needle exchange	All patients attending GUM and antenatal care are offered HIV testing. Work is ongoing to develop sexual health service provision in primary care. The Centre for HIV and Sexual Health carries out targeted outreach and peer education with high-risk groups. The increasing prevalence of HIV and the need for targeted prevention work is being addressed through the new commissioning strategy.
2	Can we do more to improve sexual health and reduce sexually transmitted infections in Sheffield?	Sheffield PCT should lead the development of a comprehensive commissioning strategy for sexual health that prioritises prevention (including screening). The commissioning strategy will require high-level leadership from key stakeholders, effective partnerships and adequate resourcing.	A comprehensive needs assessment has been completed with the guidance of the Sexual Health Network. Key recommendations for commissioners will inform the next stage of the commissioning strategy. These were considered by the PCT Board in November 2007.
3	How can we ensure the healthiest outcome for all pregnancies in Sheffield?	Sheffield PCT must learn from and liaise with Bradford PCT, following the publication of their Commission report into infant mortality. This should offer invaluable insight into ethnicity and deprivation and their relationships to death in infancy.	The Bradford report has now been published and considered by a multi organisational group in the City who can influence activity to address the modifiable risk factors identified that contribute to a high infant mortality rate. An action plan needs to be agreed by these people to achieve the target of a reduction in infant mortality.
4	We need to achieve a sustained increase in the number of babies being breastfed: How can we best achieve this?	Sheffield City Council, and other members of the Sheffield First Partnership must work with the PCT to turn Sheffield into a Baby Friendly City.	The Maternal and Infant Nutrition Group have started the process of becoming accredited as 'Baby Friendly'. This includes agreeing a Breastfeeding Policy, planning training for Health Professionals who have contact with pregnant women and mothers of young babies and reviewing peer support available across the City. This group is a multiagency group where key organisations in Sheffield are working together to increase breastfeeding initiation and duration rates.

	Health Challenge	DPH Recommendation	Progress against recommendation
5	How can we increase the number of people in Sheffield benefiting from stopping smoking and maintain the decline in the proportion of women who smoke throughout their pregnancy?	NHS organisations and the City Council should work closely on delivery of community-based programmes to engage more effectively with smokers and provide or signpost to stop smoking services. The statutory bodies should explore possible roles for voluntary and social enterprise organisations.	The Smoking Cessation Action Plan for 2007/8 involves working with local hospitals and the City Council to encourage more smokers to contact the service. A task force approach will support GP practices and pharmacies to refer smokers. There will be a focus on community level actions to tackle smoking in each of the Enhanced Public Health Programme areas. Council staff will be able to refer smokers directly to the service. All pregnant women will be asked about their smoking status at every contact with their midwife
6	In what ways can we best secure the capacity and capability to deliver improved health and reduced inequity for the people of Sheffield?	The resources available to public health in Sheffield must be safeguarded. As soon as the overall financial position of the PCT permits, recent cuts in public health budgets must be restored, and the further investment necessary to enable the public health team to deliver the 'Choosing Health' agenda, fully resource the Enhanced Public Health Programmes, and support the population in becoming 'fully engaged', must be made available.	The Public Health Directorate in the new Sheffield PCT has been designed to be 'fit for purpose'. When all the posts are appointed to, it will be a well-staffed team. However the Public Health agenda remains huge and further investment in public health would undoubtedly be a cost effective way in which to improve the health of the population of the City. Only a small proportion of the 'Choosing Health' monies have been allocated as intended.
7	How should Sheffield respond to the threat to public health from climate change?	The Department of Health should make a reduction in carbon emissions by the NHS a key priority, require action plans from all NHS organisations for the achievement of the 2010 targets, and performance manage them against these.	Although climate change has risen to the top of the national and international political agenda, the Department of Health has not implemented this recommendation. The urgency of the issue has been underlined by this year's flooding, and the recommendations should be reviewed.

	Health Challenge	DPH Recommendation	Progress against recommendation
8	Discrimination, disadvantage and social exclusion are interrelated causes of significant health inequalities: How can we bring about the sustained level of change needed to ensure equality and equity of access becomes central to all that we do?	Health Impact Assessments are developed by the PCT to include the requirements of Equality Impact Assessments.	Agreed all Health Impact Assessments will consider the effect of the equality dimensions of race, disability, gender, age, sexual orientation and gender identity and religion or belief when conducting the assessment. A clinical audit of ethnicity data is underway, as well as a Health Equity Audit on gender equality in relation to CHD.
9	The number of new cases of TB in Sheffield has been rising steadily: What would be the most effective response?	The Sheffield PCT should invest in tuberculosis services to provide the optimum primary and community services needed to screen for and treat this disease.	The PCT has increased the Community Tuberculosis Nursing Team by an additional full time member of staff to a total of 3 staff in 2007/08. This will reduce the workload of each nurse in the team to a level approaching the national recommended 40 cases per annum. Sheffield still has a challenge to meet in providing an effective screening programme for new immigrants in line with national guidance [1] (work to address this has begun). In addition, the Sheffield TB Forum is being reconstituted as a clinical advisory group to commissioners.
10	How can we best ensure appropriate planning and preparedness across primary and community services in the event of a major emergency such as an influenza pandemic?	Independent contractors (General Practitioners, General Dental Practitioners and Pharmacists) must undertake business continuity planning and work with the PCT to produce a robust and rehearsed citywide pandemic 'flu plan.	As of October 2007 we are still awaiting the national guidance so that we can take our pandemic flu plans forward. We have made a number of attempts to engage independent contractors in Business Continuity Planning over the last two and half years through the LMC, LPC and the Dental Public Health Unit. This has been challenging and some progress has been made, however there is still a long way to go to achieve total commitment.

[1] NICE clinical guideline 'Tuberculosis - clinical diagnosis and management of TB and measures for its prevention and control', and by the DoH publication 'Tuberculosis Prevention and Treatment: a toolkit for planning, commissioning and delivering high quality services in England'.

Sheffield Health and Well-being Atlas

The Sheffield Health and Well-being Atlas is an interactive tool displaying health data at different geographic levels across the City. The levels currently available are the 100 Neighbourhoods, and 7 Children and Young People's Service Districts. The Atlas is constantly updated as new data become available.

How to Access the Atlas

For staff connected to the NHS web:

nww.sheffield.nhs.uk/healthdata

or

Sheffield Health Data Online (SHDO), under Geography - neighbourhoods (general).

For anyone else:

Via the Sheffield PCT website www.sheffield.nhs.uk/atlas

Please note: to use the Atlas you will need to have Adobe Flash version 8 or higher viewer installed on your PC.

Contents

Data are grouped under the headings of Births, Dental Health, Deprivation, Disease groups, Education, Environment, Housing, Life Expectancy, Mortality, and Population. Data are available for several years allowing time trend analysis. The Atlas also contains themed maps, data tables, trend tables, graphs covering all of the areas, details of data sources and notes.

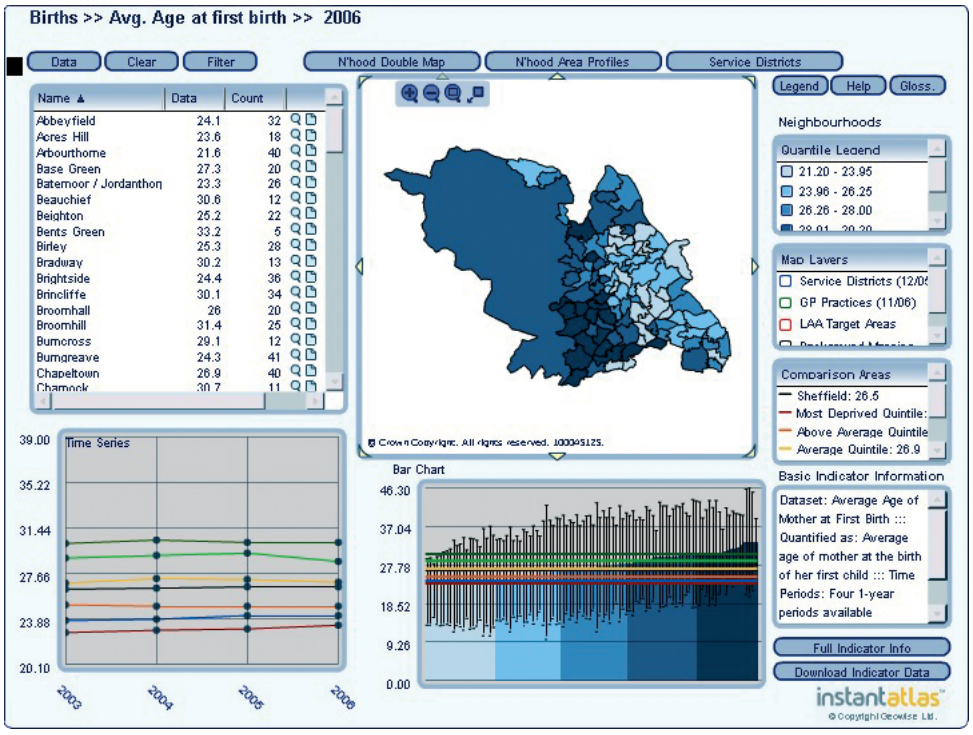
Display

There are several options for viewing the data. You can easily move between different types of views, different geographies and different time periods. All displays open in a new browser window.

A Single map view allows you to look at a single neighbourhood or service district.

A Double map view allows you to look at the relationship between two different indicators or time periods for neighbourhoods or service districts.

An Area Profiles view is a bar chart display showing all of the indicators on one page and a comparison to the base Sheffield value. It also allows comparison between two neighbourhoods or service districts.



More Information and Contacts

We're keen to hear your view on this report. If you would like to make any comments please contact the Director of Public Health:

Dr Jeremy Wight
Director of Public Health
Sheffield PCT & City Council
Don Valley House
Saville Street East
Sheffield
S4 7UQ

Email: dphr@sheffieldpct.nhs.uk
Telephone: (0114) 226 4549

An on-line version of this report is available on the Sheffield PCT website at www.publichealthsheffield2007.nhs.uk

More copies of this report can be obtained from:

Dr John Skinner
Sheffield PCT
Email: John.skinner@sheffieldpct.nhs.uk
Telephone: (0114) 226 4640

Sheffield Primary Care Trust
Don Valley House
Saville Street East
Sheffield S4 7UQ

Tel: 0114 226 4400/01
Fax: 0114 226 4402
www.sheffieldpct.nhs.uk