

Public Health in Sheffield

What we do, what we commission and plans for the future

Introduction and purpose

This document gives a high level overview of the current work on Public Health Directorate in Sheffield PCT, and the Health Improvement Team in Sheffield City Council (SCC). Recent White Papers and the NHS Operating Framework outline how the future responsibility for improving the health of the population will shift from the NHS to local authorities. It has been stated that PH Departments will move to local authorities with a budget of around 4% of the NHS budget. For Sheffield this could be around £30m, although a yet to be determined amount of this is likely to be top sliced to fund the new organisation Public Health England. Despite recent uncertainties nationally, locally we are continuing to assume that the move will be completed by April 2013. The information provided in this “prospectus” forms a benchmark of current activity.

Already there are well developed arrangements for joint working between NHSS and SCC. As well as very long standing partnership arrangements, more recently several senior PH posts have been funded from, and operate across, both organisations. There is a lot of experience in the City of shared strategic planning for health and wellbeing, shared targets, performance management and pooled budgets, all of which can be built upon.

There are two very important elements of the new arrangements which are the subject of ongoing work. Firstly, how the GP Commissioning Consortia will fit into the health strategic planning framework and the Health and Wellbeing Board hosted by SCC. Secondly, how PH will continue to provide input into the commissioning cycle for health services which is to be led by GPs.

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What is Public Health?

The Public Health White Paper defines public health as:

“The science and art of promoting and protecting health and wellbeing, preventing ill health, and prolonging life, through the organised efforts of society.”

The three domains of PH are:

- Health improvement (including addressing inequalities, influencing the wider economic, environmental and social factors that affect health, as well as supporting people to improve their lifestyle)
- Health protection (including managing infectious diseases, environmental hazards and emergency preparedness)
- Health service improvement also described as health care public health (including ensuring that services are as effective and cost effective as possible).

PH practitioners in Sheffield work in these three domains, as outlined below, with their work often falling into more than one domain. PH activity is coordinated by a Senior PH Leadership Team and is based on local health intelligence. A lot of important PH work is already carried out in SCC and is described by “PH statements” by each Portfolio. Most of this is not covered in this document, but the work of SCC’s Health Improvement Team is included.

This prospectus describes the work we do, grouping current programmes under the three ‘broad headings’ of health improvement, health protection, and health service improvement. The description of each programmed covers:

- What we do
- Why we do it
- What we spend
- What are the outcomes
- Future plans

The spend has been split by spend on activity, commissioned from elsewhere and spend on the PCT PH team. The categories chosen have been determined largely by the financial details required by Department of Health returns set out in Table 1, at the end of this document.

Although this does not allow us to present our work just as we would wish, it does enable comparisons with other areas, which will be helpful. More details on the programmes of work and the resources attached to them will be available on the PH section of the NHSS web site <http://www.sheffield.nhs.uk/>



Public Health Programmes and Areas of Activity

1. Public Health Leadership

What we do: The Director of Public Health and other members of the senior team provide leadership across all programmes. They work closely with partners to implement the City Strategy, the Health Inequalities Action Plan and NHSS's health strategy, "Achieving Balanced Health".

Why we do it: "To add life to years and add years to life". There is still much disability, ill health and death which is preventable by the application of evidence based interventions at a City, community and personal levels.

What we spend: Around £350K is the core leadership team, the other £573K is senior staff who work most of their time on programmes set out in other sections.

PH team	Grand Total
£923,000	£923,000

What are the outcomes: We are a high performing team in a high performing PCT. PH took responsibility for key competencies in the World Class Commissioning assessment which judged NHSS to be in the top five in the country. The DPH Annual Report has been judged best in the county twice in the past four years, runner up once and has been shortlisted again this year. Sheffield has strong partnership working and a range of coherent strategies that contribute to improving health and reducing health inequalities.

Future plans: Strengthen our work on the determinants of ill health, which will be facilitated by the move to the Local Authority. Develop and strengthening our working arrangements with GP Commissioning Consortia and with the new organisation Public Health England.

2 Epidemiology

What we do: The PH Analysis, Research and Evaluation teams work with a range of partners, communities and data sources to generate public health intelligence. This includes collation, analysis, and interpretation and the 'marketing' of information.

Why we do it: High quality information and intelligence is the bedrock of Public Health. It supports monitoring, forecasting, assessment of risk and evaluation of health and wellbeing outcomes, including health inequalities. Information produced is used extensively in the PH Directorate and across NHSS to inform commissioning, and by partners across the City.

What we spend: PH team £356,000

What are the outcomes: The use of health intelligence:

- for successful design, commissioning, delivery and evaluation of services;
- by professionals, patients and the public in their decision-making processes,
- to co-produce information with local communities and groups across the City, which is owned by them.

Future plans:

- developing the Joint Strategic Needs Assessment (JSNA);
- evaluating the new Health Inequalities Action Plan;
- development of systems for delivering primary care health intelligence;
- improving our approach to evaluation of PH projects and programmes.

Health Improvement - Wider Determinants

3 Healthy Communities

What we do: The Healthy Communities Team tackles health inequalities. There are six areas of work:

- a. Healthy Communities Programme (HCP):** This Programme engages with local people in planning and delivery of programmes building on the assets, skills and talents of the community. 14 programmes cover 35 geographical neighbourhoods and “communities of interest” across the City. The HCP is *delivered* by voluntary sector organizations. A social model of health is used which increases social capital. It incorporates work previously done under the Enhanced Public Health Programmes (EPHP).
- b. Community Based Stop Smoking Service:** this operates in the City’s most disadvantaged areas to support individuals and groups in a range of community venues and their own homes. The service addresses the wider barriers to quitting via referral into other healthy communities programme activities such as stress management, healthy eating and debt advice, etc.
- c. Community Development and Health Programme:** this recruits local people for a 15 week course to promote confidence, skill-building and self help which in turn improves the health and wellbeing of individuals, their families and their neighbourhoods.
- d. Health Trainers:** trainers work with individuals, often referred to the service via general practices, to encourage and motivate behaviour changes leading to a healthier lifestyle ie loss of weight, increased physical activity and a healthier diet and improve self management of long term conditions..
- e. Expert Patient Programme:** This supports people of all ages with long term conditions to make positive health-related behaviour changes.
- f. Communities of interest:** These target our most vulnerable and seldom heard groups developing interventions to address their needs. Examples include the Pacesetters programme, identification of people at high risk of heart disease and the taxi drivers’ initiative highlighted in the Marmot Report.



A number of other projects are commissioned by Public Health from voluntary and community organisation, covering a number of different areas of work. These are currently being reviewed.



Why we do it: There is still an 11 year difference in life expectancy for men across the City, and big differences between some identified communities, such as BEM groups, and the rest of the population. Social and economic issues underpin many health problems.

What we spend: Funding sources for this programme are complex and overlap with funding of other programmes below, e.g. tobacco, nutrition and healthy weight, etc. In addition, staff frequently bid for external funding and the programmes generate invaluable income from several external sources. This is not detailed in this document.

	PH (Commissioned)	PH team	Grand Total
Healthy Communities Programme	532,000	415,000	986,000
Community stop smoking service	123,000	27,000	150,000
Health trainers	90,000	44,000	134,000
CDH programme	20,000	92,000	112,000
Expert patient	10,000	23,000	33,000
Communities of interest	44,000	104,000	148,000
Total	819,000	705,000	1,563,000

What are the outcomes?

- The HCPs have been associated with a faster improvement in overall health (measured by a basket of indicators) in these neighbourhoods than in Sheffield as a whole.
- Smoking quitters in targeted communities (population 27,000) increased by 64% (over 18 months from a defined baseline) compared with 22% in the rest of the City.
- Over 500 people completed the Community Development and Health courses, building skills and confidence. A third of participants have gained employment, while others have progressed to further education and voluntary work.
- 10 Health Trainers have worked with people with long term conditions, leading to savings to the NHS through reduced referrals and medication and a number returning work after many years of unemployment.
- 95 Community Health Champions (supported by HCP) have achieved significant change for those involved with many going on to gain employment.
- The Expert Patient Programme improves health outcomes and reduces inappropriate use of services (currently local evaluation is taking place).
- GPs have recognised behaviour change in patients and have expressed support for HCP

Future plans:

- Build on and sustain effective interventions supporting communities to improve health, work on the wider determinants of health and help people back to work.
- Strengthen the health role of the Community Assemblies.
- Implement changes to the HCP voluntary sector contracts identified in a recent review.
- Increase and develop interventions with GP practices to strengthen the links between the practice, community interventions and work to support self management of individual patients with long term conditions.
- Work closely with GPs to set up the chronic pain management service using health trainers.

4 Tobacco Control

What we do: Work with partners on tobacco control to reduce levels of smoking and the harm caused by tobacco smoke. Commission Stop Smoking Services to help smokers to quit and support action on cheap and illicit tobacco.

Why we do it: There are around 900 smoking related, preventable deaths in Sheffield each year, with a disproportionate number occurring in the City’s poorest communities. £27m is spent by the NHS in Sheffield treating people with smoking related illness each year. It is estimated that the societal costs of smoking are £13.74 billion in England each year (pro rata to Sheffield £137 million). Investing in tobacco control work is highly cost effective for the NHS and the wider economy.

What we spend:

PH (Commissioned)	PH team	Grand Total
£1,208,000	£342,000	£1,550,000



What are the outcomes: The adult prevalence of smoking is falling (26% in 2002 to 23.4% in 2010) and many people are exposed to second hand smoke. Since 2008 NHS Stop Smoking Services have assisted over 9000 smokers to quit. Fewer pregnant women smoke at the time of delivery (17.2% 2005/6 to 13.6% 2009/10). 40 professionals have been trained to work in schools with the Smokefree Schools Toolkit.

Future plans: Continue to work on tobacco control measures in partnership with a range of organisations. Extend work on smoke free environments, lead the campaign for smoke free homes and cars. Commission and strengthen the citywide Stop Smoking Service.

5 Nutrition and Healthy Weight

What we do: Work with partners to strategically plan and commission population wide prevention and targeted support and treatment programmes to promote healthy diet, physical activity and healthy weight in adults and children. Staff work on bids for external funding.

Why we do it: The rising trend in childhood obesity and relatively high levels of poor diet and inactivity pose a major risk to health. Obesity, poor diet and inactivity are associated with higher risk of hypertension, heart disease, diabetes and certain cancers. Obesity is known to reduce life expectancy by on average nine years.

What are the outcomes: Previously rising trend in childhood obesity is levelling off; The Sheffield rate of combined overweight and obesity in Y6 children had increased steadily since 2006/07 (27.3%). The increase was much less in 2009/10, with 32.9% children aged 10-11 now overweight or obese. Encouragingly for YR children, the year on year increase in rates since 2006/07 reversed between 2008/09 and 2009/10 with a significant drop from 22.7% to 20.6%. Participation in the National Child Measurement Programme has increased across the city with 93.5% of YR pupils and 96.2% of Y6 pupils being weighed and measured during 2009/10 academic year. Higher participation means more reliable and accurate results. Over 1000 adults helped to become more active; 16,000 children have been involved in the bike it scheme in 50 schools; we have more than doubled the uptake of free school meals in targeted schools; all Sheffield schools participating in the Sheffield Lets Change4Life Programme with 10 secondary schools successfully implementing Stay on Site models. 700 professionals trained re healthy weight; planning processes taking greater account of impact on healthy weight; programme to promote healthy weight in eight of the largest workplaces. Community weight management services for obese children and adults established. £4.8m external money won from the DoH Healthy Towns Fund.

What we spend: (the minus figure is because income is received for this from elsewhere)

PH (Commissioned)
£813,000

PH team
£-270,000

Grand Total
£550,000



Future plans: Further develop coordinated action to reduce population levels of childhood and adult obesity in Sheffield. Contribute to implementing Sheffield's Food Plan. Expand targeted support and treatment for overweight and obese children. Undertake health economic analysis of interventions for obesity to inform commissioning.

6 Drug Misuse

What we do: Work with partners to reduce the number of people misusing drugs in Sheffield, ensure drug using offenders access treatment quickly and effectively and reduce the health harm and levels of crime caused by drug use. Commission drug treatment services and wrap around services as set out in the Sheffield annual drug treatment delivery plan.

Why we do it: Drug dependency is a health problem that affects not only drug users but also their families and the communities they live in. Drug misusers suffer poor physical and mental health and commit offences, all of which impacts upon families, communities and wider society. Drug misusers are at risk of death from an overdose. Dealing with these harms costs the tax payer an estimated £15.4bn a year country wide (pro rata to Sheffield £154m).

What we spend:

PH (Commissioned)	PH team	Grand Total
£7,233,000	£754,000	£7,987,000

What are the outcomes: To reduce the number of individuals using drugs in Sheffield by increasing the number accessing treatment – target of 2563 drug users engaging in treatment in 2010/2011. To reduce harm to health and drug related crime.

Future plans: Implement the national drug strategy in Sheffield by delivering on the actions set out in the Sheffield annual drug treatment delivery plan.

7 Alcohol Misuse

What we do: Work with partners to reduce alcohol related harm, including levels of alcohol related crime and anti social behaviour and to moderate the drinking culture in Sheffield. Commission alcohol treatment services and to implement the Sheffield Alcohol Strategy 2010 - 2014.

Why we do it: Excessive drinking among some sections of the population is a cause for considerable concern. Estimates in 2004 put the annual costs of excessive drinking – in terms of damage to health, crime and disorder, and loss of work productivity – at around £20 billion per year in England and Wales (£200m in Sheffield).

What we spend:

PH (Commissioned)	PH team	Grand Total
£235,000	£229,000	£464,000

What are the outcomes: To achieve the agreed overall vision for Sheffield:

- A responsible drinking culture is present and drinking is a positive, rather than damaging, aspect of social interaction;
- Alcohol is a positive part of the city entertainment offer and contributes to a vibrant economy, within both the city centre and neighbourhoods;
- Harm from alcohol is minimised through agencies and communities working effectively together to achieve cultural change in how alcohol is perceived and used.

Future plans: Implement the Sheffield Alcohol Strategy 2010 – 2014 and deliver on the recommendations as set out in the strategy.

8 Workplace Health

What we do: Lead partnership activity on health policy with regard to health and work and liaison with Sheffield Chamber, Westfield, Department of Work and Pensions, Job Centre Plus and SCC. Employment support delivered by VCF sector (Mental Health, Learning Disabilities) currently reported to Sheffield First for Economic Development and the Health and Wellbeing Board. Work is commissioned from the Sheffield Occupational Health Project which works in general practices.

Why we do it: Being in work leads to better physical and mental health. Although Carol Black's report emphasised the economic cost of ill health (£100 billion a year), work is a key factor in individual's self-worth, family esteem and identity. Poor access to timely, appropriate employment support can lead to long term sickness – devastating for whole families and affecting children's long term futures. The Marmot Report recommends work on the cross cutting theme 'creation of fair employment and good work for all'.

What we spend:

PH (Commissioned) £114,000 (PH Team £15,000 ¼ wte included above in section 3)

What are the outcomes: Effective partnership working leading to improvement in workplace environments, reduced absenteeism and better quality services to jobseekers. Improved SCC and NHSS workplace health programmes, improved access to health advice for JCP customers, DWP advisers trained, engagement with 27 local businesses on mental health. The Sheffield OHP helps practices manage occupational health more effectively and efficiently.

Future plans: Develop work with Sheffield Chamber, Westfield Health and the Local Ethnic Business Forum South Yorkshire, to promote mental wellbeing at work. Pursue the joint European Regional Development Fund (ERDF) "Business Excellence" bid to improve workplace health in small to medium enterprises (SMEs).

- To link with the proposed new 'Employment and Health Plan' for the City, contributing to the City's agreed priorities for unemployment and health, recognising the strong association between mental health conditions and musculo-skeletal disorders - both primary barriers to work.
- Develop local baseline indicators for measurement
- Further develop work with partners to improve health at work, and promote healthy working environments.

Pursue the joint European Regional Development Fund (ERDF) "Business Excellence" bid to improve workplace health in small to medium enterprises (SMEs).

9 Health Improvement Team Sheffield City Council

What we do: Provide strategic leadership in the City Council for improving health and reducing health inequalities. The team has a Director of Health Improvement Funded by SCC, a Healthy Cities Coordinator (funded by NHS Sheffield) a temporary Food Plan coordinator (who delivered the food festival and is currently developing a food plan for the City) funded by Lets Change for Life, and a temporary post delivering shared projects around the Joint Strategic Needs Assessment. We coordinate the Health and Wellbeing Board and Performance Board.

Why we do it: The wider social determinants of health are influenced by local authorities' policy in many areas – the local economy, education, child development, transport, urban planning, housing, leisure and open space, etc. We ensure the influence of SCC on improving health in the City is maximised.

What we spend: £165,000 (£95K from SCC and £70K from NHSS)

What are the outcomes: Increased public health capacity, knowledge and commitment across SCC, strong working relationships across SCC, which contribute to the improvements in health inequalities outlined elsewhere in this document. The Food Plan will create a more resilient food system in the City.

Future plans: The NHS White Paper proposes bringing the public health function into the Local Authority. This will create a single resource within the Council for improving health and reducing health inequalities. This team will be part of that new structure



Health Protection

10 Health Protection

What we do: Work with the Health Protection Agency and partners to manage any issues relating to infectious diseases, environmental hazards and emergency planning.

Why we do it: Managing conditions such as TB, HIV, meningitis, flu, sexually transmitted infections, etc, in an effective way to prevent spread of ill health and interventions are generally highly cost effective. Environmental hazards and emergency planning demand ongoing work on risk assessment and ensuring plans are fit for purpose, as well as skills to respond to incidents when necessary.

What we spend:

PH (Commissioned)	PH team	Grand Total
Emergency preparedness	£213,000	£213,000
Infectious diseases	£208,000	£208,000
Total	£421,000	£421,000

What are the outcomes: Risks relating to these issues and costs of treating infectious diseases are minimised.

Future plans: Work with Public Health England, the Local Authority and other partners to ensure that these functions are provided in an efficient and effective way.

11 Immunisation

What we do: Strategically plan and commission coordinated delivery of childhood and adult vaccination and immunisation programmes.

Why we do it: To protect the population against infectious disease and cervical cancer.

What we spend:

PH (Commissioned)	PH team	Grand Total
£1,050,000	Included in Children's section 12	£1,050,000

What are the outcomes: Improved coordination and monitoring infrastructure across all children’s workforce and immunisation providers. Increased awareness of the importance of vaccinations – in particular the new HPV Cervical Cancer Vaccine and increased uptake of the childhood immunisation programme. Costs of treating these diseases minimised.

Future plans: Further strengthening of coordination and monitoring systems to achieve maximum population coverage, focusing on increasing uptake in all vulnerable groups.

Health Services

Staff who work in this area of Public Health have a unique configuration of skills specifically relevant to commissioning. These include ensuring health and social care services are commissioned according to the needs of the population and the evidence base, which reduce health and social inequalities and which represent good value for money and engage with users and carers.

12 Long Term Conditions (LTC) and Older People

What we do: Provide a strategic approach to the management of LTC and the health of older people across health and social care, supporting commissioners. In addition staff provide the leadership and technical expertise to drive and support clinical commissioning, based on the application of clinical epidemiology and prioritisation skills to the population of Sheffield for areas from long term conditions, to all major conditions, to the interface with specialised commissioning. Our specialist PH development nursing team works closely with primary care to increase the quality of LTC management.

Why we do it: To ensure that the needs of patients are met in line with the best evidence available.

What we spend:

PH (Commissioned)	PH team	Grand Total
£924,000	£376,000	£1,300,000

What are the outcomes: Improved case finding of long term conditions such as heart disease, diabetes (in recent years actual prevalence in practices is now close to modelled expected prevalence). Improved quality of primary care (documented in detail by primary care QOF outcomes); reduced secondary care costs including inappropriate attendances and admissions, redesigned services according to evidence based care pathways (e.g. COPD), reduced health inequalities (CHD programme selectively improved outcomes in disadvantaged practices).

Future plans: To ensure that Sheffield has high performing pathways for LCTs, where primary care, secondary care and social care services work closely together. This will be in line with the needs of the population, best evidence of effectiveness and cost effectiveness, and will ensure that patients/clients receive high quality care which is jointly commissioned where appropriate across the city. To ensure that the communities portfolio and Adult Joint Commissioning Group makes evidence based commissioning decisions for older people including prevention.



13 Maternity and Children

What we do: With our partners we strategically plan and commission universal and progressively targeted services according to need, for pregnancy and ensure all infants, children and young people are healthy and safe.

Why we do it: Foundations for health in adult life are laid down in childhood, interventions for children and young people are highly cost effective in the long term, and currently outcomes for children and young people in the UK, benchmark very poorly with other developed countries.

What we spend:

	PH (Commissioned)	PH team	Grand Total
Maternity and Children 0-5	5,918,000	£200,000	£6,118,000
Children 5-19	1,574,000	£168,000	£1,742,000
Safeguarding	347,000	£16,000	£363,000
Total	7,839,000	£384,000	£8,223,000

What are the outcomes: Increased breast feeding initiation rate from 72.0% in 2005/6 to 76.9% (increase of 4.9%) in 2009/10; reduced smoking in pregnancy rate from 17.2% in 2005/6 to 13.6% (decrease of 3.6%) in 2009/10; redesigned health visiting service delivering evidence based Healthy Child Programme for 0-five year olds. 96% of Sheffield schools have achieved healthy schools status; with 40 schools working towards enhanced HSS. For more information link to the Infant Mortality work is as follows:

<http://www.sheffield.nhs.uk/professionals/infantmortality.php>.



Future plans: To develop joint commissioning work to deliver more cost effective services to children and families, with a focus on early years and vulnerable children and young people. To commission delivery of the Healthy Child Programme for five -19s. Lead the development of an emotional well being and mental health strategy for children and young people, giving priority to increasing capacity of universal services to promote resilience and emotional well being. Leading concerted city wide action on reducing Infant mortality. Further promoting healthy early years, enhanced healthy schools and healthy further education through the development of a Healthy Settings approach.

14 Sexual Health

What we do: We commission sexual health promotion services, contraception and termination of pregnancy services, screening and treatment services for sexually transmitted infections (STIs) and HIV. Strategically planning, giving priority to widening access to advice and support for those most at risk of poor sexual health.

Why we do it: The consequences of poor sexual health can be serious - unplanned pregnancy, avoidable illness related to STIs and mortality from HIV/AIDS. A disproportionate burden of poor sexual health is experienced by young people, men who have sex with men, and black African ethnic groups.

What we spend:

PH (Commissioned)	PH team	Grand Total
£6,149,000	£44,000	£6,193,000

What are the outcomes: Reduced teenage pregnancy rates (14% reduction in teenage conception rates between 2006-2009), increased early access to termination of pregnancy, increased uptake of long acting reversible contraception (LARC) by 50% from 2007/08-2009/10, over 20,000 15-24 year olds screened for Chlamydia each year. Halting the year on year rise for number of cases treated for HIV.

Future plans: To develop and commission a more integrated sexual health service, in line with QIPP; further widening access to HIV testing and reducing unplanned teenage conception and rates of STI infection.

15 Mental health and wellbeing

What we do: Policy and population needs analysis to inform commissioning, planning and service delivery. Commission programmes from NHS and VCF agencies to promote social inclusion, resilience and improve mental health and mental wellbeing. Co-ordinate the Suicide Prevention Plan.

Why we do it: It is estimated that one in four adults will experience some kind of mental health problem during the course of a year, with some population groups at increased risk. Mental health has human and social costs as well as economic costs – estimated at £105bn in England. Wellbeing interventions to prevent mental ill health and promote wider population mental health enable recovery and resilience to adversity, including physical ill health. Good mental health underlies all health and is associated with a range of good outcomes.

What we spend:

PH (Commissioned)	PH team	Grand Total
£777,000	£105,000	£882,000

What are the outcomes: Suicide rates remain relatively low (7.4/100,000) compared to national average (7.85). We have undertaken a City wide audit and produced a multiagency Suicide Prevention Plan. We have delivered Mental Health First Aid courses across VCF and Public service sectors. We have commissioned mental health and wellbeing services for identified communities, notable BME community development workers delivering race equality priorities, ensuring more appropriate and responsive services, community engagement and better information provision.

Future plans: We will continue to work in partnership to inform commissioning of mental health services, including mainstream mental health services, promotion of positive mental health and prevention of mental ill health. We will use the evidence base and appropriate indicators to inform health needs analysis including strengthening the JSNA.

16 Cancer and Screening

What we do: Through the North Trent Cancer Network arrangements and in partnership with GP practices and individual families and communities the main focus of our public health work is on increasing awareness and early diagnosis of cancer and increasing equitable uptake in the three cancer screening programmes.

Why we do it: Cancer a major cause of premature death in the City and the distribution of cancer mortality across Sheffield's communities mirrors deprivation. After tobacco control programmes, the next highest impact interventions we can take to reduce cancer mortality and related inequality are concerned with identifying the signs and symptoms of cancer early on (to ensure treatment starts as soon as possible) and improving access to a range of treatments (enhancing survival). For example mortality from breast cancer, cervical cancer and bowel cancer can be reduced by 35%, 95% and 16% respectively in those who participate in the relevant screening programme.

What we spend:

	PH (Commissioned)	PH team	Grand Total
Cancer	£2,827,000	£65,000	£2,892,000
Non- cancer	£1,426,000		£1,426,000
Total	£4,253,000	£65,000	£4,318,000

What are the outcomes: The main outcomes are a reduction in premature cancer mortality and improved one and five year survival rates. Premature mortality (in people under the age of 75 years) from all types of cancer has reduced by over 20% in the last 10 years. This equates to almost 600 lives saved a year. Cancer survival rates are increasing. For example one year survival for lung cancer, breast cancer and colorectal cancer increased by 10%, 4% and 10% respectively over the 10 year period for which the most recent data were available.

Future plans: For two years in a row Sheffield has been successful in attracting significant additional national cancer monies to roll out awareness and early diagnosis work on Breast, Bowel and Lung Cancers. This will continue into 2011-12. As part of this programme, we will utilise local public health intelligence, social marketing insight and community engagement mechanisms to improve uptake in all three cancer screening programmes.

17 Oral Health

What we do: Work with partners to promote healthy eating, use of fluoride, tobacco avoidance and safe alcohol consumption. Commission oral health improvement programmes, screening of vulnerable groups (children in special schools and older people) and surveys of oral health. Provide strategic professional and public health advice to commissioning of dental services. Lead on improving the quality of dental services.

Why we do it: Dental and oral diseases are amongst the commonest chronic diseases and are preventable. The cost of treating dental and oral disease in Sheffield is £41,981,000. Inequalities exist in the distribution of dental disease across Sheffield.

What we spend:

PH (Commissioned)	PH team	Grand Total
£152,000	£296,000	£448,000

What are the outcomes: Improved quality of care. More equitable access to NHS dental services. Health, education and social care professionals trained in oral health improvement messages. Local information on oral health needs.

Future plans: Review community fluoride programmes. Assess oral health needs of people with learning disability.



Table 1 Sum of Budget 2010/11

	PH Categories (required by Dept of Health return)	Public Health commissioned work £	Public Health team costs £	Total £
1	Public Health Leadership		923,000	923,000
2	Epidemiology		356,000	356,000
3	Healthy Communities Team	819,000	705,000	1,563,000
4	Tobacco	1,208,000	342,000	1,550,000
5	Nutrition and Healthy Weight	813,000	-270,000	550,000
6	Drug Misuse	7,233,000	754,000	7,987,000
7	Alcohol Misuse	235,000	229,000	464,000
8	Workplace health	114,000		114,000
9	Health Improvement Team SCC		165,000	165,000
10	Health Protection		421,000	421,000
11	Immunisation	1,050,000		1,050,000
12	Long Term Conditions (LTC) and Older People	924,000	376,000	1,300,000
13	Maternity and Children	7,839,000	384,000	8,223,000
14	Sexual Health	6,149,000	44,000	6,193,000
15	Mental Health and Wellbeing	777,000	105,000	882,000
16	Cancer and non cancer screening	4,253,000	65,000	4,318,000
17	Oral Health	152,000	296,000	448,000
	Seasonal Flu (one off cost)	744,000		744,000
	Other voluntary sector projects	403,000		403,000
	Small Project Budget		39,000	39,000
	Grand Total	32,713,000	4,934,000	37,647,000

Note

Currently the above figures exclude estates overhead costs