

Fairer Sheffield, Healthy Lives

PAPER D REFERS



Health Inequalities Action Plan 2010-2013

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Foreword

Health Inequalities are of enormous concern to the Council and NHS Sheffield. For far too long such inequalities have meant that lives are cut short, and people are not living life to the full and enjoying opportunities open to them. It is unacceptable that some people in the City should have fewer opportunities, poorer life chances, lesser access to services, and poorer treatment than others, through no fault of their own. Inequalities in general give rise to health inequalities. Why is this?

There are many views and theories but there is overwhelming evidence that it comes down to lack of income, poor environments and housing, and less opportunity to live a healthy life. But it is not just this - inequalities in society seem to affect everyone's health. Even people at the top of the tree do worse in terms of their health in unequal societies.

In the Council and the NHS we will work together to ensure all have equal opportunities for health, and all have equal access to excellent services. But we need to go much further and tackle the *root causes* of ill health and inequality. Reducing health inequalities is an integral part of our local strategies-City of Opportunity for SCC and Achieving Balanced -Health for the NHS

The recently published Department of Health White Paper 'Equity and Excellence; Liberating the NHS' emphasises the importance of addressing inequalities and promoting health and we will make sure as the cities approach to health develops-addressing health inequalities will continue to be a priority.

Sheffield has been designated a World Health Organisation Healthy City for over 20 years, and have long been committed to tackling health inequality. We are proud of the progress we have made, but we have to step up our efforts

In this plan we set out what will do and how we will measure it. We need to work with many partner agencies, the Universities, the Police, the voluntary, community and faith sector, and local people most of all, if we are to succeed. We are determined to do all we can to have a good health for all in Sheffield, and to tackle inequalities and discrimination where ever they occur.

Cllr Steve Ayris, Cabinet Member for Health, Sheffield City Council

Jan Sobieraj, Chief Executive, Sheffield Primary Care Trust

Introduction and Context

The Marmot Review's 'Areas for action'

The recent National Review of Health Inequalities, 'Fair Society, Healthy Lives', led by Sir Michael Marmot, drew on extensive global research into Health inequalities. Reflecting on inequalities in our society and health inequalities in particular, this Prof Marmot stated:

'To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Greater intensity of action is likely to be needed for those with a greater social and economic disadvantage. But focussing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem'

The Marmot review identifies six 'Areas for Action'. These are:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of ill health prevention.

We are using the same structure in this plan. The first section contains commentary on each of these six areas. These all draw on the Sheffield City Council City of Opportunity, our Joint Strategic Needs Assessment, the Director of Public Health's annual reports and the 'State of the City' report, as well as reflecting current activity in each area. A significant amount of 'business as usual' activity occurring across the City has been referred to only briefly in this plan – for example educational attainment ambitions, affordable housing targets, community safety activity, tobacco control and stop smoking work etc. These all impact on health inequalities and must continue, but to include detail on all of them in this Plan would simply duplicate what is documented elsewhere. Moreover, this work is performance managed through other frameworks. Rather, we have made reference to the work already done, and have sought to identify **what additional initiatives need to be taken to make further progress.**

The Marmot Review is based on evidence from national and international research and we have drawn on this and other evidence. This gives us, we think, the best chance of making a difference. But as Marmot says, **we have to tackle all the issues, all at once.**

Historical Context

Differences in the health experienced by different population groups have been recognised for many centuries. When data first started to be collected systematically in the mid 19th century, it confirmed the very substantial differences in death rates between different social classes. In Sheffield, differences in death rates and life expectancy between different parts of the City have been documented in Director of Public Health reports for over a century. Those reports also make it clear that the pattern of distribution of health inequalities across the City has changed little over the decades, even though the absolute levels of health have improved enormously.

More recently, there has been extensive documentation of inequalities in health across the City, with analyses undertaken both at ward level, and more recently at neighbourhood level. Although there was some reduction in the differences in life expectancy across the City in the early part of the last decade, that progress now appears to have stalled. Overall, differences in health experience remain significant and persistent over many decades.

Political Context

In Sheffield NHS Sheffield and Sheffield City council are both committed to tackling health inequalities , The City of Opportunity and Achieving Balanced Health have set out priorities to improve health and reduce inequalities in health experience and provision of services . Moreover -community involvement, choice and empowerment have been central to local strategies in recent times

At a national level although the Black Report (1980) put the issue of health inequalities firmly on the policy agenda, it was not until the publication of the Acheson report in 1998 that national policy seriously addressed the issue. *Tackling health inequalities: A programme for action* (2003) set out a national strategy to deliver the national health inequalities targets for 2010. Progress towards meeting these targets is reported annually, but in spite of considerable effort, relatively little progress has been made at national level.

In November 2008, Professor Sir Michael Marmot was asked to advise the Secretary of State for Health on the future development of a health inequalities strategy in England post 2010. This review builds on the best global evidence from, among other places, the World Health Organisation Commission on the Social Determinants of Health. The report was published in February 2010.

At the same time the work of academics, including Richard Wilkinson¹ and others, has established the wider societal impact of inequality. In particular this has demonstrated that even the better off are disadvantaged by living in unequal societies, and that in general societies that are more equal, do better. Overall this has led to wide recognition of the socio-economic nature of the determinants of health inequality and a general consensus regarding the need to reduce those inequalities.

¹ The Spirit Level- Why More Equal Societies Almost Always Do Better – Richard Wilkinson & Kate Pickett 2009

Recent National Developments

On 12th July the new Government issued a White Paper 'Equity and Excellence: Liberating the NHS', describing their long term plan for the new NHS. It included structural changes which will impact on work towards delivering this plan in the future.

It stated an intention to:-

- i) Put patients and the public First
- ii) Improve healthcare outcomes
- iii) Deliver autonomy, accountability and democratic legitimacy
- iv) Cut bureaucracy and improve efficiency

Within this context there is a stated intent to improve Public Health, transferring PCT responsibilities for Health Improvement to Local Authorities and providing a ring fenced budget for Public Health based on health need. There are several other proposals within the White Paper including new commissioning structures of GPs together with Councils, and an increasing focus on social enterprise as a way of delivering services.

All of these present challenges and opportunities where new relationships will need to be forged and capacity developed. We aim to use this plan as an agenda within which we can develop relationships and capacities with GP consortia and the cities social enterprise structure (and other stakeholders) within the new economic climate within which the Plan will have to be delivered.

We expect a further White Paper in Autumn 2010 to develop the Government thinking around Public Health and intend Sheffield to be at the forefront of local implementation of this, but the issues within the plan will remain largely constant as it is clear from Sir Michael Marmots work that these issues require long term commitment to resolve them.

Measurement of Health Inequality

Health is a multi dimensional concept, and accordingly there are many ways in which both health, and hence health inequality, can be measured. Not only can health be measured in varying ways at the individual level, but populations can be aggregated to give different measures of health inequality across a population.

Because a significant proportion of illness is linked with socio-economic disadvantage, the pattern of health inequality is remarkably consistent irrespective of the particular measure chosen. Nevertheless it is clearly essential, if we are to make progress in reducing health inequality, to have a single or small number of agreed measures of health inequality in the City which we will use to set targets and monitor progress.

Unfortunately the national health inequalities targets are not meaningful at local level. This is because they either deal with differences between districts, or between socio-economic groupings for which data is not available at local level. However recently the NHS World Class Commissioning competency framework has mandated the use of the slope index of inequality (SII) as a measure of within district health inequality. This is a measure of the extent to which life expectancy varies across the district, based on an analysis of the life expectancy of different deciles of the population defined by the index of multiple deprivation. According to this measure, the difference in life expectancy across Sheffield is approximately 11 years for men and just over 6 for women.

Using a measure of differences in life expectancy has significant advantages since the data is collected routinely, and the reported measure is meaningful to lay people and professionals alike. However as a measure this does not capture issues relating to quality of life or the prevalence of chronic ill health. We are therefore advocating that in addition to the use of the slope index of inequality, we should measure health inequality in the City using health related questions in a regular local survey. NHS Sheffield also maintains a 'Basket of Health Inequalities Indicators' and this is shortly to be reviewed within the context of this plan

A third strand to the measurement approach will be the use of the new Health Profile for Sheffield. These profiles are produced nationally by the Association of Public Health Observatories and will enable both Regional and National Comparisons to be made regarding the health of Sheffield's population. The approach also enables prioritisation of resources within the plan by identifying major issues within the Indicator Set. The latest version of this profile is attached at Appendix I

Principles

The key principles of this plan are:

- To create an enabling society that maximises individual capabilities
- To reshape our society around social justice, fairness and equality of opportunity
- To prioritise health and wellbeing as much as wealth
- To focus on prevention and tackling the root causes of ill health.

Our Priorities

Having drawn on the Marmot Review and national and local data the following issues within the plan are considered as warranting special attention and focus:-

- Deprivation
- Extent of children living in poverty
- Infant death rates
- Physical Activity
- Early Death (Cancer, Coronary Heart Disease and Stroke)
- Incapacity from Mental Illness
- Homelessness

- Carers health
- Road traffic Injuries
- Teenage Pregnancy
- Educational Attainment
- Tooth decay in Children
- Nutrition
- Alcohol and Smoking

What do we Know About What Works?

The World Health Organisation Commission on Social Determinants of Health² argued that:

“Health inequities are the result of a complex system operating at global, national and local levels which shapes the way society, at national and local level, organises its affairs and input its different forms of social position and hierarchy. The place people occupy on the social hierarchy affects their level of exposure to health damaging factors, their vulnerability to ill health, and the consequences of it”.

An individual's health is determined by material circumstances, including the physical environment, social cohesion, as well as psycho-social factors, behaviour and biological factors. These circumstances are influenced by social position which is itself a factor of education, occupation, income, gender, ethnicity and race.

Our choice of interventions to address health inequality is driven by reviews such as the Marmot report, but also by our understanding of the causes of ill health and the kind of interventions that can impact on these.

These interventions may either be driven by a medical model of disease, using therapeutic interventions to address risk factors and treat disease in its early stages, or driven by a social model and thus seek to reduce disease and ill health problems by altering the social determinants of health. We have evidence that both approaches have been successful in Sheffield in recent years.

The Citywide initiative to reduce cardio vascular disease (CIRC) ran in Sheffield from 1999. This was very much based on the medical model, and built on the observation that the management of cardiovascular risk factors was suboptimal in more disadvantaged parts of the City. Moreover the availability of powerful therapeutic interventions (primarily statins, to reduce cholesterol levels), and the large contribution made by coronary heart disease mortality to overall mortality, meant that there was significant benefit to be had from systematically improving the management of cardiovascular risk factors in those areas.

This was achieved by working with those general practices serving those populations, to improve their care of those patients. As a result cardio vascular disease mortality fell very much more rapidly in those parts of the City over the following five years, which undoubtedly accounted for a very large part of the reduction in differences in life expectancy that occurred.

An alternative approach is being pursued by the NHSS Healthier Communities Programmes. These programmes have sought to address the root (social) causes of ill health, increase access to services and increase healthy lifestyles by engaging at neighbourhood level with the local population. Progress is being measured using the “basket of indicators” which are intended to reflect the underlying determinants of ill health and mortality. These indicators have improved faster in the areas in which the Healthier Communities Programmes are operating than in the rest of the City. Sheffield City Council has also undoubtedly contributed to reducing inequalities through its many services including housing and homelessness, social care, education and environmental health improvements.

It might be tempting to conclude that where there is lack of evidence about what works, little can be done until the evidence base is improved. However this would be a serious mistake, for a number of reasons. First, health inequalities are too extensive and too damaging to both individuals and society as a whole for us to ignore them. Doing nothing about it is simply not an option. Secondly, evidence about what works will only be generated through undertaking interventions and carefully evaluating them. Thirdly, we do have some good evidence that can give us confidence that what we are advocating in this plan is likely to make a difference.

This plan describes what we are going to do in Sheffield to address Health Inequalities over the next three years.

The Six Areas for Action

1 Give Every Child the Best Start in Life

The foundations for virtually every aspect of human development – physical, intellectual and emotional are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and well being from obesity, heart disease and emotional health to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children’s access to positive early experiences and ensure that we give every child the best start in life (Fair Society, Healthy Lives The Marmot Review, 2010).

To have an impact on health inequalities, investment in early years needs to be evidence based, cost effective and proportionate to need across the social gradient. **Later interventions are considerably less effective where good early foundations are lacking. The importance of** improving children’s health is reflected in Sheffield City Council’s ‘City of Opportunity’. There are a number of key factors which contribute to inequalities in maternal, child and young people’s health outcomes in Sheffield:

Pregnant women who smoke are more likely to have a premature baby, or a baby with low birth weight. Smoking in pregnancy is strongly related to socio-economic status and the prevalence varies from 0% to 40% across Sheffield neighbourhoods. At any one time, there are approximately 600 pregnant women in Sheffield who smoke.

Breastfeeding leads to significant health benefits and has a major role in promoting personal health and reducing inequalities for both baby and mother. There is wide variation in breastfeeding initiation rates across the City, from fewer than 50% in some neighbourhoods, to over 90% in others.

Children who are overweight are at higher risk of developing serious health problems both as children and in later life. Within Sheffield there are notable variations in childhood overweight and obesity, with some schools having significantly higher levels than the national average. The introduction of a new community based weight management service for children and targeted support for schools in areas with high prevalence of overweight and obesity will work towards reducing prevalence as well as a whole city- whole systems approach to obesity prevention.

There were 501 accidents in Sheffield between 2000-2009 which involved a child being killed or seriously injured. The ongoing county wide 'Worst First' project is aimed at reducing fatal and serious injuries. Traffic calming measures have been implemented in residential areas of Sheffield, to mainly address child accidents.

Teenage pregnancy is strongly associated with low birth weight, poor neonatal outcomes and reduced life chances for the mother and child. Although Sheffield's rate is not out of line with other UK cities and has decreased in recent years national and local targets for reducing teenage pregnancy have not been met. The establishment of integrated targeted intervention programmes (such as the 125 Health Programme and Aspire for Life Programme) to support those young people identified as vulnerable will provide effective support at key points in a young person's life such as transition to secondary school, reducing risk taking and poor outcomes across a range of areas, including teenage conceptions, substance and alcohol misuse, youth offending and becoming NEET (not in Education Training or employment).

Dental decay is a preventable disease, however there is evidence that dental disease levels may be increasing amongst 5-year-olds. The average number of decayed, missing due to decay and filled teeth among 5-year-olds in Sheffield in 2007/8 was significantly higher than the England average. Also, the experience of dental decay is not evenly distributed across the city, with pockets of poorer dental health seen in the more deprived areas. **Overall, 41% of 5-year-old schoolchildren have decay**, with each of these children having approximately 4 teeth affected. Eighteen per cent of decayed teeth were treated by extraction, which in younger children often involves a general anaesthetic. This can be a particularly unpleasant and distressing experience for a young child,

2 Enable all Children, Young People and Adults to Maximise their Capabilities and have Control over their Lives

We want a socially mobile Sheffield where people are enabled to overcome barriers which may restrict their ability to fulfil their potential. Among these barriers are low educational attainment, training and skills, low incomes, poor health and a lack of engagement in society, the economy and the decision making process. Barriers such as poor levels of health and poor educational attainment interlink, and restrict

people from improving their socioeconomic position and that of their families. It is important therefore that both aspiration and subsequent achievement are increased if this link is to be weakened.

Overall educational achievement is low, particularly for 5-11 year olds. The picture is slightly more positive at age 16, and the latest information on attainment by age 19 shows significant improvement. Primary school attendance is quite good, but worsens at secondary school level, although there has been recent improvement. The percentages of 16 year olds and 16-18 year olds not in education, employment or training are high, but improving steadily. Educational attainment is strongly linked to socio-economic deprivation.

Clearly academic education is only one of a number of opportunities for children, young people and adults in the City. The City Council works towards making sure everyone has the same chances in life, and removing any barriers that prevent people and families from achieving their full potential. All of the Council's strategies, most notably the Corporate Plan 'City of Opportunity', plans, services and actions are underpinned by a desire for equality of opportunity and fairness for all. By delivering on our priorities in Sheffield, we will enable people to improve their socioeconomic, physical and mental wellbeing.

Promoting equality of opportunity in Sheffield means giving individuals the chance to achieve their potential, free from barriers, prejudice and discrimination. To achieve this, we will follow five key principles of inclusion:

- **Reach it** – access to services
- **Understand it** – communicating about services to all people
- **Find it** – services located in places which people can access
- **Control it** – people in control of their services and are able to be independent
- **Relate to it** – customer focused services driven by customer need

We are committed to equality of opportunity for all - where you live or your background should make no difference to the opportunities you have, your well-being or the services you receive. The aim is for a fairer city built on the understanding that inequality harms both those who are less well off and the more affluent.

However, we know there are clear differences in health outcomes between different communities, both when analysed geographically and in other ways. The key issue here is to enable those facing poorer health to be in a position to make choices and take independent decisions to improve their health and the health of their communities.

It is an ambition of the Council and the NHS that people in Sheffield should get on well together, with good community spirit, and a shared sense of endeavour. We will challenge any actions by individuals or groups that undermine our communities.

The personalisation agenda will give people more choice about what services they receive to meet their individual needs, whilst making sure that people's rights to access good standards of education, housing and care continue to be met.

There isn't one simple approach to enable people to overcome barriers such as health inequalities so that they can achieve their full potential. Social mobility and our five principles of equality of opportunity do not therefore have a specific section in this Plan, because they are inherent in everything we do. The actions in the Plan all have at least one of the five principles of equality of opportunity at their core.

Financial Inclusion and Reducing Poverty

Material deprivation (in particular living in poverty) has been seen to exclude people (particularly children and old people) from many aspects of social life, leading through isolation and psycho-social stress, to ill health. Financial exclusion is inextricably linked with poverty, and it remains a major challenge for Sheffield, which has the highest levels of financial exclusion in almost half of its wards (affecting approximately 218,743 people in 48% of wards)ⁱ.

Financial inclusion is about everyone having access to basic financial services, like basic bank accounts, free debt and money advice, and affordable, responsible credit – as well as having the financial capability skills to make the most of these services. Local and national objectives to increase financial inclusion are about helping people to use these skills and services to manage their money day-to-day, plan for the future, cope with financial pressure, and to deal with financial distress.

Financial inclusion and poverty are cross-cutting issues which have implications for many of the areas of action in this plan. For example, reducing child poverty is a key consideration in ensuring children get the best start in life; tackling debt is often a factor in improving mental health and well-being; financial exclusion leads to barriers to sustaining employment; and, financial capability (money management skills) impact on individuals ability to afford good quality housing and eat healthily on a budget.

Recommendations to improve levels of financial inclusion in communities include a reduction in wage and salary differentials (including those between men and women and between ethnic groups as well as between socio-economic groups), more progressive tax structures and simplification of benefits to ensure greater take up. At a local level, it is important that key stakeholders in the city (such as Sheffield Council, the NHS, the social housing sector, Probation Services, and Job Centre Plus) further embed ways to increase financial inclusion into the day to day delivery of their services, .Financial inclusion is a priority in 'City of Opportunity'

Sheffield will tackle financial inclusion by:

- Ensuring everyone in the city has the financial capability skills they need
- Access to affordable, manageable credit for people in Sheffield when they need it
- Provision of effective assistance available to people if they get into money difficulties
- Financial inclusion services and initiatives also play a key part in providing the support that people need. For example, the Chief Medical Officer's 2009 Annual Report acknowledges the health benefits of investing in financial inclusion initiatives

3 Create Fair Employment and Good Work for All

Delivering a 'whole person' approach to support people to get back to work and progress in the labour market

Understanding the relationship between health and employment is an integral part of preventing and finding solutions to health inequalities. It is clear that getting people into employment is important for improving health, as employment, job security and attaining 'better' jobs have significant bearing on the way people live and feel. The Marmot review provides evidence for this link. People with a higher socioeconomic position in society also have better health.

This area is of increasing importance given the short and long term impacts of recession. Since June 2008 Job Seeker Allowance registrations have been rising. Any reduction in claimants has halted, as the number of employment opportunities reduce and competition for jobs intensifies. In Sheffield there are 16,400 Job seeker allowance claimants, 41.2% of whom have been out of work for 6 months or longer. In addition there are 32,800 individuals on 'out of work benefits', approximately 10,000 of whom are suffering from 'mental or behavioural problems'. In the tighter labour market, there is a real risk that health inequalities as a result of unemployment are entrenched. We therefore need to take action to support those businesses and individuals who have been affected by recession and this is why improving skills and employment is a corporate priority for Sheffield City Council, NHSS and the Sheffield First Partnership

Unemployment has multiple effects on an individual's health. Loss of wages results in a lower standard of living, as well as anxiety and depression. It also impacts on 'health behaviours' such as being physically active, smoking and alcohol consumption, with increasing effects as unemployment is prolonged. Long term unemployment can result in increased rates of limiting long-term illness, including mental illness and cardiovascular disease.

Rates of unemployment are highest among those with no or few qualifications and skills, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and, in particular, young people. Individuals with disabilities and mental ill health are particularly at risk, as the unemployment and disability can become mutually reinforcing.

Recent work by Sheffield Hallam University identified some of the key barriers to work. Among these were poor health, lack of confidence, lack of skills, transport difficulties, lack of access to training, a tight job market and discrimination by employers against those with health problems.

It is clear then to help these individuals access work and better opportunities we need to address wider barriers to work, such as social skills, confidence and language barriers, as well as addressing social exclusion, social immobility and increasing job skills.

Working with Employers to Create More, and Better, Employment Opportunities;-

It is also important to recognise the health values of 'good work' and job security. Low paid jobs, with poor working conditions and no prospects for progression, can damage health. It is important therefore that we build into our support a mechanism by which people, particularly vulnerable groups, can increase their skills and progress in the labour market. We also need to support businesses, to ensure that there are 'good', sustainable jobs available to these groups.

Improving Health and Wellbeing in the Workplace

The workforce is a major resource for economic development: if the health of the workforce is not sustained, losses in productivity will be experienced. Dame Carol Black's recent report 'Working for a Healthier Future'³ emphasises that having good health will not only improve an individual's chances of being employed, but being in employment means the individual will benefit economically which, in turn, is known to improve health.

It is not only physical health problems that account for loss of productivity. There is now an increased awareness of the impact of mental health problems.

One estimate suggests that loss of productivity attributed to mental health problems within the working environment is 1.5 times as much as that attributed to sickness absence.

4 Ensure a healthy standard of living for all

Providing Healthy Affordable Housing

There is currently a shortage of good quality affordable housing in Sheffield. Living in poor and inappropriate housing conditions has a direct correlation with ill health. The provision of good quality affordable accommodation will reduce health inequalities. Very often it is the most vulnerable people in the City, whose health outcomes are worst, have the worst housing conditions, or are homeless.

The spatial planning and integration of housing with economic activity and community infrastructure occurring as part of the 'Single Conversation' with the Homes and Communities Agency will address the sustainability of communities in the City. However there are still aspects of housing provision which contribute significantly to Health Inequalities, including homeless accommodation processes, housing for migrants and supported housing for vulnerable residents.

The 'City of Opportunity' prioritises investing in housing and providing more affordable housing for Sheffield's Communities. Investment in improving private property within the City is aimed at improving the lives of vulnerable people and enabling them to remain in their own homes and communities for as long as possible. Home improvement loans and disabled facilities grants are main themes within this area of work

³ Working for a Healthier Tomorrow 2008

Using Our Food System to Reduce Health Inequalities

A healthy diet is essential for a healthy life. Some of the most pressing health issues we currently face in Sheffield are dietary related, including obesity, heart disease, and diabetes and dental decay. It is estimated that nationally, 70,000 deaths a year could be prevented in the UK if people's diets complied with nutritional guidelines. Poorer social groups are less likely to have access to a healthy diet. Dietary related illnesses are more common in lower socio-economic groups as well as in some ethnic communities. For example, coronary heart disease and diabetes are significantly more common in people from South Asian backgrounds.

Sheffield's new Food Plan will be launched in Summer 2010 and aims to address issues around food affordability, availability and skills. It will take a broad approach to food, covering the health, environmental, economic and social aspects .

Having a more sustainable food system can have positive effects on health inequalities, not only because it reduces carbon emissions but also because it makes food prices less vulnerable to price increases that disproportionately affect people on lower incomes. Sheffield's new Food Plan will seek to develop a more sustainable and resilient food system for Sheffield and an important way this will be done is by supporting local food production. Areas of action to develop a more sustainable food system include:

- Working to increase provision of healthy affordable food in specific areas of the city, which may increase the take-up of five a day as well as reduce car use for food shopping.
- Ensuring that people have the confidence to prepare and cook healthy meals.
- Supporting local food businesses by linking up suppliers and retailers
- Ensure organisations across the city work to reduce their food related carbon footprint through such things as procurement.

5 Create and Develop Healthy and Sustainable Places and Communities

A transport system that makes it easier to stay healthy

Transport is vital to everybody. It gets people to work, to shops, to education, to socialise, to get support. Transport can improve or detract from a person's quality of life and life chances. Public transport for all will increase mobility and life chances. Sheffield is currently developing its transport vision which aims to influence and support the third South Yorkshire Local Transport Plan Transport Strategy. Essentially the vision focuses on choice and information: 'Choosing to travel less and choosing to travel in different ways'. Transport has an impact on health through air quality, noise, road accidents, and through people walking or cycling, - 'active travel'.

Air Quality

Transport is a major source of air pollutants. The worst affected areas are close to the City's busiest roads. Poor air quality has short and long term health impacts, particularly respiratory and heart disease. It leads to increased hospital admissions

and death. Based on national estimates,⁴ between 240 and 325 deaths each year in Sheffield are attributable to air pollution, and these will be in the more deprived and hence more polluted parts of the City. It is also estimated that air pollution can reduce the average life expectancy by 7-8 months for the population as a whole.⁵ However, the health impact is greater for younger and older people, those with existing heart and lung problems and those living in areas where the air quality is regularly poor.

Noise

Noise from transport can be such that it impacts upon people's quality of life. Effects can include annoyance, sleep disturbance and loss of productivity. It is estimated that 67 million Europeans are regularly exposed to road noise levels considered potentially harmful to health⁶. The Environmental Noise Directive requires the adoption of action plans to manage noise, such as that from transport. Noise Action Plans for major roads, major railways and major agglomerations, including Sheffield, were adopted by the Secretary of State for Environment, Food and Rural Affairs on 15 March 2010. These plans must now be implemented by the relevant authorities.

Road Accidents

National data⁷ shows that children from households in the lowest socio-economic group are five times more likely to die in road accidents than those from the highest. Our approach focuses on improving awareness, education and training to prevent road accidents. We will also continue to make physical improvements that will make our roads safer. We have stepped up our road safety educational activity in the last two years so that 2000 rather than 250 children per year gain pedestrian training and the child injury rate has decreased by 43% in the same period. For the Child Safety Zone programme the Council focused resources on reducing child casualties in the areas with the highest accidents. Responsibility for this has been devolved to Community Assemblies in the form of the Community Assembly Highway programme.

Active Travel

Sheffield has the highest level of adult obesity and the lowest levels of physical activity of the eight English Core Cities. Our most recent data shows that 22% of adults in Sheffield are obese and 34% overweight, and that the proportion of children who are overweight increased between 2006/7 and 2008/9 from 27.3 to 31.7% at Y6 and from 16.8 to 22% at Y8. However even this does not show the whole picture as our obesity rates are much higher in our least Healthier Communities.⁸ Encouraging more active travel will help tackle obesity.

Designing Out ill Health

The Sheffield Development Framework aims to provide a structure through which housing, work, transport and social and commercial infrastructure operate together in

⁴ Commons Environment Audit Committee March 2010

⁵ Commons Environment Audit Committee March 2010

⁶ Managing Transport Noise in Cities, Environmental Protection UK, August 2009

⁷ Cabinet Office, Social Exclusion Unit report, Making the Connections: Final Report on Transport and Social Exclusion Interim Findings

⁸ Sheffield's Healthy Community Challenge Fund Stage 2 Application

a way that improves the economic, social and environmental wellbeing of the city. It can influence the availability of work, the coherence of neighbourhoods, and access to transport, food and other infrastructure. All of these are recognised as affecting the health of the population.

The wellbeing of the city's residents is seriously affected by the reality and fear of crime and disorder, and therefore any inequality in distribution of these factors are likely to create associated health inequalities. In this way Keeping Sheffield Safe is key to reducing inequality.

The neighbourhood in which you live has a huge impact on your health both physically and mentally. There are a number of frameworks and strategies operating across the City which aim to provide more sustainable communities. These will include the Sheffield Development Framework, Keeping Sheffield Safe (the community safety strategy), the Thriving District Centres Strategy, the Housing Strategy and the Green and Open Space Strategy

Open Space, Physical Activity and Mental Wellbeing

Sheffield's Green and Open Space Strategy will deliver the Quality Standard Project and Physical Delivery of Quality Improvements to raise the quality of Sheffield's green and open spaces. Green space and green infrastructure improve mental and physical health and have been shown to reduce health inequalities.⁹ Green infrastructure networks reduce urban temperatures and improve drainage, reducing the risks to health associated with heat waves and flooding. Well designed spaces green spaces can encourage social interaction, play and exercise, and contribute to community cohesion.

Increasing physical activity levels in our City can make a major impact on improving health and reducing health inequalities. Some population groups are less likely to be physically active due to the barriers that they face. These include: women and girls, older people, some minority ethnic groups (apart from Black Caribbean and Irish populations), lower income groups, disabled people and people with mental ill health.

Locally Sheffield is below the national average in terms of physical activity participation with 20.2% of adults participating compared to 21.45% nationally. Of children and young people, 49% are participating in 2 hours of school sport per week, compared to 50% nationally. These statistics reinforce the need to prioritise physical activity provision across the city with a particular focus on those population groups who are least likely to participate.

Physical activity can:

- Reduce the risk of all age all cause mortality by up to 30%
- Be as effective as anti depressants in the treatment of mild to moderate depression
- Offer opportunities for social interaction and contribute to children and young people's achievement and mental well-being

⁹ Fair Society Healthy Lives –a Strategic Review of Health Inequalities post 2010 (Marmot Review) February 2010

- Reduce the risk of a range of medical conditions including Coronary Heart Disease (CHD), Diabetes and Osteoporosis. Physical inactivity has been identified as the cause of 37% of deaths from CHD
- Reduce the risk of falls thus enabling independence
- Help people feel better about themselves and reduce psychological reactions to stress.

Improving Mental Health and Wellbeing Across all our Communities

Improving mental health brings benefits to individuals and society. There is a clear association between good mental health and better outcomes across a number of domains: years of life, physical health, and educational achievement, criminality, maintaining a home and employment status. There is now increasing evidence that investment in particular interventions – in psychological therapies, for example, and tackling childhood conduct disorder – can produce much greater savings over time. Living a life that has a sense of purpose and meaning is also important for our mental well-being, whether it is achieved through work, family, volunteering, or through developing creativity and shared values.

The Sheffield Strategy for Mental Health and Well Being 2009 identifies promoting mental health as 'everybody's business'. This five year plan aims to work with partners to develop programmes that promote mental health, tackle stigma and discrimination, improve awareness of mental health problems and make Sheffield a mentally healthy place to live and work.

The forthcoming national strategy for mental health, , will set out a comprehensive plan including a public mental health framework to improve well-being and help prevent mental illness. The strategy is likely to recognise that interventions to reduce the risk of mental and related physical illness and speed recovery could reduce some of the well-known health and social inequalities. Equally, interventions that tackle social inequalities such as homelessness or debt may be of benefit to individual mental health.

There are two targets in respect of mental health: to achieve at least a 20% reduction in the death rate from 'injury and undetermined death' by 2010 and to increase employment opportunities for people receiving specialist mental health treatment as part of the Care Programme Approach (CPA).

Although mental health does not contribute greatly to death rates (though suicide is a significant contributor to the life expectancy gap for men, accounting for 4.5%), mental ill health is very prevalent. Data from Sheffield Health and Illness Prevalence Survey and more recently from General Practice Quality and Outcomes Framework reveal mental ill health as very common and more common in more deprived populations and in some BME groups. There is a real need for more preventive approaches and early treatment.

Addressing Poor Health within Communities of Interest

We have historically tended to analyse health inequality in the City on a geographical basis, according to where people live. This is because almost all health data is collected on a geographical basis. However we know that some communities which are not defined geographically do suffer worse health than others. Addressing poor

health in “Communities of Interest” has been hampered by lack of firm data on both their health status and service use. However this must not prevent us from addressing these health needs.

Sheffield First for Health and Wellbeing has identified four specific “Communities of Interest” who are known to have relatively poor health status. These are black and minority ethnic communities (included within which are established communities, vulnerable migrant communities, asylum seekers and refugees, and gypsies and travellers), people with physical cognitive and sensory disabilities, including learning disability homeless people, and people in supported accommodation. These are of course heterogeneous groups containing individuals with very different health status and health needs. Other communities of interest suffer inequalities due for example to gender inequality, and or sexuality discrimination

Our main aim should be to seek to improve life circumstances of communities of interest, tackle discrimination to prevent ill health as far as possible. However it is also important to ensure that for individuals who do become ill they are not disadvantaged when accessing services. For some individuals (e.g. those who are homeless or people with learning disabilities) this will mean ensuring that services are delivered in such a way as to make them more accessible. However we must also note that a small minority of people from some communities of interest are not entitled to NHS care and Council services (in particular failed asylum seekers). These people suffer amongst the worst health of all people in our community, and this represents a particular challenge to us in addressing health inequalities.

6 Strengthen the Role and Impact of ill Health Prevention

Tobacco Control and Stopping Smoking

Smoking is the largest single avoidable cause of death and accounts for half of the inequalities in health in the City. As well as being a major risk factor for both coronary heart disease and stroke, it accounts for 9 out of 10 cases of lung cancer, which causes more deaths from cancer than any other. Tobacco use (both smoked and smokeless) is also a major risk factor for mouth cancer, which has a five year survival rate of less than 50%.

The big contribution that smoking makes to health inequalities is because of the very strong association between smoking and socio-economic disadvantage. However any attempt to reduce smoking prevalence must reflect the way that personal circumstances determine smoking habits. This is why it is so important to influence all aspects of the circumstances in which people live. The broader initiatives described in this plan will help to do that.

Reducing smoking prevalence involves working to stop people from starting to smoke, as well as helping smokers stop through the provision of stop smoking services. We are targeting populations in the City where smoking rates are highest. By focusing our efforts to promote stop smoking services in areas and communities with higher rates of smoking, we aim to achieve health gains in those areas more quickly than in the rest of the City, and so contribute to a reduction in health inequality. In 2008-09 the rate of people who quit in these priority areas was 26.6 per 1,000 smokers, this compares to 28.9 per 1,000 smokers for the rest of the City.

However we need to improve this quit rate. In order to do this, Sheffield Stop Smoking Service had a 2009/10 target of 1,387 4-week quitters from EPHP areas. One initiative to help achieve this is work to reduce the availability and supply of cheap and illicit tobacco. This illegal trade targets the most vulnerable smokers including young people, and those on low incomes. We are also increasing the accessibility of stop smoking services, and increasing access to Nicotine Replacement Therapies (NRT) by introducing a NRT voucher scheme.

Accessible and Equitable Health Care and Disease Prevention

There is national and local evidence demonstrating the effectiveness of strengthening prevention and early detection of those conditions most strongly related to health inequalities. Those at highest risk of illness or disability and people with the lowest levels of well being are often unidentified. They may have poor access to, and often do not routinely access, health services. It is important to provide an interface between primary care and local communities, helping people to access treatment and care, and practices to access the community health promotion programmes.

Preventing and Providing Support for Addictions

Drugs and Alcohol

The Sheffield Drug and Alcohol Action Team (DAAT) is led by the Director of Substance Misuse Strategy and is responsible for implementing the National Drug Strategy in Sheffield on behalf of the Safer and Sustainable Communities Partnership.

Although alcohol consumption has an inverse social gradient, the health damage caused by alcohol (hospital admissions and death) increases with increased levels of deprivation. There is also an association between the number of individuals in contact with structured drug treatment services and levels of deprivation. As a result of these associations, the prevention and support for addictions play an integral role in addressing Health Inequalities.

4. Action plans

Give every child the best start in life by:-

Improving early years health

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibility
To reduce health inequalities in pregnancy and birth	Assess equity of access and outcomes to maternity services , ante natal and post natal support with respect to age, ethnic group, postcode and deprivation	Equity audit completed	In more deprived and BME groups: Increase in early take up of antenatal support i.e. <10wks	October 2010	Joint Consultant In Public Health NHS Sheffield/ CYPS Sheffield CC
	Develop and implement action to improve equity of access and outcomes	Action plan developed and implemented to improve equity of service provision	Lower rates of smoking in pregnancy Fewer low weight births Reduction in maternal obesity	March 2011	
To reduce inequalities in early development of:physical and emotional health cognitive, linguistic and social skills	In context of 0-5 strategy and Healthy Child Programme, review investment in early years provision (children's centres) including:	Review completed	In more deprived groups: Decrease in infant mortality rate Increase in breast feeding rate at 6-8 week post natal check Decrease in YR prevalence childhood obesity	December 2010	Joint Consultant in Public Health NHS, Sheffield/ CYPS, Sheffield CC
To build resilience and well being of young children across the social gradient	• Post natal support • Parenting & family support • Support for additional needs • Breast feeding support • Early years education & transition to school • Child care • Healthy Early Years Standards	Joint commissioning plan developed Joint commissioning plan implemented	Increased take up parenting support Increased take up child care Improved foundation stage scores	April 2011	
	Develop and implement a joint commissioning approach to ensure all services are evidence based, cost effective and proportionate to need Delivering high quality early years support in the context of budgetary constraints			October 2011	
Tackle family and child poverty	In line with the statutory duties outlined in the Child Poverty Act (March 2010) Lifelong Learning, Skills and Communities will work with partners, including the Child Poverty Unit based in Sheffield, to draw together a needs assessment of the key indicators of child and household poverty.	Key indicators identified and used to develop a city wide poverty needs assessment	Poverty needs assessment developed and used to Identify and prioritise the key issues and actions underlying and contributing to poverty for children and households in Sheffield.	October 2010	Director Lifelong Learning, Skills and Communities , Sheffield CC
	Following consultation the needs assessment will be used to develop a city wide Child Poverty Strategy that will identify and address the key issues underlying and contributing to poverty for children and households.	Poverty needs assessment consultation event for partners	Partners agree priorities for action to reduce child and household poverty	February 2011	
		Poverty needs assessment used to develop a poverty strategy and action plan	Child Poverty Strategy and action plan agreed and adopted by all partners used to improve outcomes for children and households		
		Strategic partners involved in finding joint, cost effective solutions to the hard to fix problems underlying and contributing to poverty for children and households	Dissemination of the strategy and implementation of plan		
Develop holistic support for vulnerable children and young people living in Sheffield, including Looked After and Adopted Children Young People	Deliver the Aspire for Life Programme to 450 targeted vulnerable young people across Sheffield (including one to one support from an Advocacy Worker and participation in 125 Health Programme Group Work	450 young people participated in programme by April 2011	Lower levels of risk taking: • Substance misuse/alcohol • Number of under18 conceptions • Youth offending	April 2011	Director Commissioning CYPS Sheffield CC/ Joint Consultant in Public Health NHS, Sheffield/ CYPS Sheffield CC
	Increase number of below KS2 floor target schools delivering 125 programme to Y6s	10 additional schools engaged and delivering	Increased participation by vulnerable young people in positive activities Improved levels of educational attainment & attendance.	April 2011	
	Review investment in Targeted Youth Support services within Sheffield with reference to targeting, outcomes and cost effectiveness	Review completed	Improvement in Emotional well being in all vulnerable groups	Dec 2010	
	Develop vulnerability index agreed across children's services	Vulnerability Index agreed across children's service	Fewer young people Not in Employment, education or Training.	Dec 2010	

	Develop joint commissioning of integrated programmes tackling multiple risk factors	Plan in place and agreed by all partners	Improved emotional health and well being in LAAC	April 2011	
	Looked after and adopted children AAC – priority access to Tier 1 & 2 mental and emotional health services	Referral pathways in place	Improved emotional health	April 2011	Joint Consultant in Public Health NHS, Sheffield/ CYPs, Sheffield CC
Reduce the number of childhood accidents	Implement 'Think Ahead' the Child Pedestrian training scheme into primary schools with high numbers of child road accident figures in their area.	Target 40 primary schools across the East, Central and North East Community Assembly areas to participate in the programme	2,100 Y4 children receive pedestrian training and are taught how to find safer places to cross the road.	April 2011	Director Transportation
Ensure Health Inequalities are a key strand of Strategic Planning of Children's Services	Implement Infant Mortality Action Plan arising of the National Support Team Visit to Sheffield February 2010.	Draft Strategy Developed Stakeholder event Delivery Plan in place	Contained within plan	July 2010 September 2010 October 2010	Consultant In Public Health, NHS Sheffield
	Implementation of the Healthy Child Programme	Targets within plan	- Robust Healthy Child Programme Team operating within MAST	November 2010	Joint Consultant In Public Health, NHS Sheffield/ Sheffield CC
	Delivery of the Prevention and Early Intervention Strategy	Contained within Plan	Successful early identification of vulnerable children, young people and families.	March 2011	Director of Children and Families, Sheffield CC
	Delivery of the Sheffield Reducing Teenage Pregnancy Strategy	Targets within Plan	Contained within Plan	March 2011	Joint Consultant In Public Health, NHS Sheffield/ Sheffield CC
Improve oral health of children	Delivery of the Sheffield oral health promotion strategy	Targets within plan	Contained within plan	March 2012	Director of Dental Public Health, NHS Sheffield
	Delivery of the Baby's Teeth, Healthy Teeth programme	Dental pack for every baby Health visitors trained in Oral Health Promotion	People supported to access care for children at an earlier age and informed of good oral health practices.	Ongoing	Director of Dental Public Health, NHS Sheffield
	Development of Oral Health Action Teams	Teams set up in the 4 areas experiencing the worst oral health.	Community oral health promotion within nurseries, schools and community groups Tooth brushing clubs established in nurseries, schools and extended-hours clubs.	December 2010	Director of Dental Public Health, NHS Sheffield
	Implementation of Delivering Better Oral Health	Apply fluoride varnish twice yearly Train dental nurses in fluoride varnish application	Lower levels of tooth decay in children in Sheffield	Ongoing	Director of Dental Public Health, NHS Sheffield
	Improve access to a dentist	Promotion of the dental helpline which assists in finding an NHS dentist. Letter to all parents of 7 month old babies	Increased access to primary dental care	Ongoing	Director of Dental Public Health, NHS Sheffield
	Develop community fluoride programme	Fluoride milk scheme reviewed and community fluoride programme in place	Improved oral health	Programme in place December 2011	Director of Dental Public Health, NHS Sheffield

Enable all children, young people and adults to maximise their capabilities and have control over their lives by :-

Giving them the best chances in education opportunities

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibility
To close the gap in educational attainment (0-19 year olds)	FOUNDATION STAGE Deliver Quality Improvement Strategy PRIMARY Deliver comprehensive action plan to address World Class Primary Programme SECONDARY Robust Raising attainment plans in place for all national challenge and gaining ground schools	Contained within Plans	Increased % children achieving 78+ + 6pts in each aspect of CLL and PSED in the EYFS profile. All school reaching 'Floor Targets' All greater than average achievement gaps removed Improved KS4 results	July 2011	
Provide an enhanced offer on health in Schools and Colleges	Engage schools in Enhanced Healthy Schools Status Programme	25 Schools+2 college engaged	Increased activity to reduce obesity, teenage pregnancy and bullying	March 2011	Joint Consultant In Public Health, NHS Sheffield/ Sheffield CC

Increasing Financial inclusion and reducing poverty

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibility
Ensure everyone in the city has the financial capability skills they need	Work with Personal Financial Education Group (PFEG), a government-funded charity, to support financial education in schools.	Increase in number of schools using PFEG resources.	Young people in Sheffield are more financially capable which will help give them the best start in life.	Mar-11	Director of Policy and Research, Sheffield CC
	Liaise closely with the Consumer Finance Education Body (CFEB) to: - Promote national Money Made Clear (MMC) financial capability resources. - Arrange CFEB workplace financial capability training for Council staff and staff of other major city employers.	Sheffield citizens access the telephone and web MMC service. Sheffield citizens access the face-to-face MMC service when it becomes available from end Dec 2010. Financial inclusion actions identified for key services	People in Sheffield are more financially capable, which will help maximise income and reduce financial distress	Sep 2010 Dec 2010	
	Explore the potential for building money management skills into standard support procedures in services such as homelessness, health and social care services, etc	Actions implemented and evaluated (including for health impacts)	Vulnerable people using key public services are more financially included, also leading to positive outcomes in other areas such as health	Nov 2010	
		Increase in credit union membership from the Council and other major employers (including higher paid staff, as "ethical savers").			
Access to affordable, manageable credit for people in Sheffield when they need it	Encourage Credit Union membership amongst Council staff, staff of other major city employers, and social-rented tenants	Increase in credit union membership amongst social rented tenants.	Increase in capacity of Credit Union, which will help them to support financially excluded people	Sep 2010	Director of Policy and Research, Sheffield CC
	Investigate the possibility of entering into a partnership with a commercial bank so that the Council or other partners are able to set up basic bank accounts for vulnerable people without them having to visit the bank in person, which can be intimidating for some people.	The Credit Union is able to open basic bank accounts for their customers The Council and other partners are able to open basic bank accounts for their customers.	Social rented tenants avoid financial distress by saving for the future and maximising their income by accessing affordable credit if they need it Increase in vulnerable people opening and effectively using basic bank accounts. Increased capacity of Credit Union and public services which rely on customers using basic bank accounts (e.g. reduction of footfall in Credit Union; providers able to arrange payments more easily).	Sep 2010	
Provision of effective assistance available to people if they get into money difficulties (including debt and welfare/benefits advice)	Ongoing activity to encourage take-up of benefits and to tackle fuel poverty.	Sheffield citizens, including those in hard-to-reach groups, receive the housing and council tax benefits they are entitled to and home insulation where possible.	Decrease in citizens in poverty, including fuel poverty.	Ongoing	Director of Policy and Research, Sheffield CC
	Promote the Trading Standards Stop Loan Sharks programme of work to citizens and front-line staff to improve intelligence on the activities of illegal doorstep lenders, prosecute more of them, and protect their victims.	Council front-line workers understand the support available to those at risk from loan sharks from the regional Stop Loan Sharks team	Sheffield becomes a city where loan sharks find it difficult to operate	Ongoing	
	Continue running the 'Mortgage Rescue' scheme; and develop 'Breathing Space' and 'Repossession Prevention Fund' schemes to help mortgage holders remain in their homes.				
	Put in place a Council / Sheffield Homes corporate debt policy to better coordinate the way we seek repayment of outstanding debts from local people (such as Council Tax or rent arrears).	Consultation/planning period (including with Financial Inclusion stakeholders for "customer perspective"). Corporate Debt in place. Corporate Debt Policy being monitored and used effectively.	Customers do not suffer more difficult debt problems as a result of how the Council and Sheffield Homes manage debt.	Nov 2010	
	Work closely with partners in the NHS to investigate the potential for strengthening links between health services/GPs surgeries and money management / debt advice provision.	Those who are being made ill by financial distress, or whose illness is contributing towards financial distress, are able to be referred to appropriate services.	Reduction in health problems linked to financial exclusion	Nov 2010	

Address cross-cutting financial inclusion and poverty issues related to key areas of action in this plan.	Ensure that financial inclusion and poverty impacts are identified by stakeholders responsible for this plan as part of the ongoing process of implementing this plan.	Impacts considered on areas such as: Reducing child poverty (embedding financial inclusion actions in the Strategy) Improving mental health and wellbeing Financial exclusion barriers to sustaining employment; Financial capability (money management skills) impacting on individuals ability to afford good quality housing, eat healthily on a budget, manage direct payments/personalised services etc.	Financial inclusion and poverty reduction measures embedded within the work of key stakeholders and the actions identified in this plan, leading to a more sustainable reduction in financial exclusion and poverty.	March 2011	Director of Policy and Research, Sheffield CC
	Further develop contacts between health partners and other key stakeholders working towards the reduction of poverty and financial inclusion (e.g. community/voluntary sector; DWP [Job Centre Plus etc]).	Key contacts developed and maintained	Better joint working on financial inclusion and health issues on between different sectors.		
	Explore potential for further joint working between health stakeholders and other partners working on financial inclusion, to work towards a reduction in health problems linked to financial exclusion.	Explore areas such as: embedding financial capability into Health Champions Scheme and Pathways to Health, Social Care schemes, other networks e.g. via Community Assemblies opportunities for research into financial inclusion and health via CLARKS	Reduction in health problems linked to financial exclusion		

Empowering individuals and communities and encouraging community involvement

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibility
Build capacity to make sure people can take advantage of opportunities to take control of their own health, and take part in improving the health and well being of others.	Implement the recommendations in the Voluntary sector review specifically aimed at addressing the major health inequality priorities, e.g. focussing proportion of SHEFFIELD CC small grants on health related activities Increase volunteers in health related areas of work:	Agree specific targets for small grants	Integrate the VCF Review across the SHEFFIELD CC and PCT	Sept 2010	Director of Policy and Research Sheffield CC
	Support the implementation of Sheffield Volunteering Strategy to increase the number of volunteers for health interventions.	Support the implementation of Sheffield Volunteering Strategy to increase the number of volunteers for health interventions.	Contained within Strategy Increase volunteering by 10% per year	2010- 2012	Director of Policy and Research, Sheffield CC
	Increase volunteers in health related work using the NHSS volunteering strategy.	10% increase in health related volunteering year on year for 5 Years Time-bank and collaboration with mental health services to evaluate its impact on positive mental health outcomes More volunteers recruited	Increase volunteering by 10% per year Increased skills and opportunities for gaining employment.	2010-2012 2010 -2012	Consultant in Public Health (Healthy Communities) NHS Sheffield
	Develop strategies for strengthening community infrastructure particularly in areas without local voluntary sector providers: Work with the voluntary sector Wellbeing Consortium to develop a strategy to strengthen community infrastructure including interim strategies – hub and spoke structures, supporting smaller voluntary sector organisations to develop, utilising neighbouring organisations as short term providers. Build on the models developed in the Healthier Communities Programmes working with local community networks and health partnership groups.	Strategy developed Hub and spoke model established Neighbouring voluntary organisation contracted as providers	Increased opportunities in communities for participation in interventions to improve health. More voluntary sector providers Increased potential for investment. Community infrastructure strengthened.	2010 – 2012 Strategy -Oct 2010	Consultant in Public Health , Healthy Communities NHS Sheffield

Develop the skills and ways to enable people to engage with agencies at all levels, influencing service planning and delivery	Deliver the Introduction to Community Development & Health (ICDH) course in partnership with a range of community organisation	Delivery of 10 ICDH courses per annum 80 individuals completing ICDH course per annum	ICDH courses delivered as a precursor to generating community champions and voluntary capacity in the city	2010 -12	Consultant in Public Health (Healthy Communities), NHS Sheffield
	Transformation of services for individuals to promote full and equal citizenship for disabled people.	Right to Control plan delivered	The health of the city is reviewed rigorously within the Democratic process	2011	Director Adult Services, Sheffield CC
	Support Service users and their representative contributing to partnership involvement including Expert Elders, 50+, Partners 4 Inclusion	Health and Well-being Board and sub board review delivered		2011	Director of Health Improvement, Sheffield CC
	Support greater public involvement in the Council's Scrutiny process	Scrutiny Review completed		2010	Director of Communications and Performance, Sheffield CC
Work alongside the voluntary and community sector to support community led activity to tackle health inequalities	Further development of Health Champions to promote health including: - Supporting the development of the health champions commissioned through the voluntary sector Well Being Consortium -Regional lottery Altogether Better funding Sheffield and Lets Change for Life - Establishing new models of provision in areas with limited capacity	Sustain the work of the 120 Health Champions who will support 3600 beneficiaries Increased number of organisations providing health champions and increased number of areas covered.	Increase Health capacity especially in areas with limited health infrastructure Development of new skills and increased employment opportunities Improved Mental Health and increased self esteem	March 2011	Consultant in Public Health (Healthy Communities), NHS Sheffield Director of Health Improvement, Sheffield CC
	Further develop the Sheffield Health Trainers programme: Increase the number of people supported by health trainers	Establish DH database for monitoring health trainer activity Health Trainers programme procured through voluntary sector providers	Increased number of people supported by health trainers. Increased access to primary care	March 2011	Consultant in Public Health (Healthy Communities), NHS Sheffield
	Use community Assemblies to address localised inequalities		Local needs related interventions contribute to reduction in health inequalities		
	Develop joint work between Practice Based Consortium and Community Assemblies	Community Assembly health priorities agreed	Engage local people in the development of local primary care services Increased access to services. Increased links between GP practices and community interventions	2010-2012	
		Health interventions included in the community plans			
Join up approaches to voluntary sector provision, and community empowerment and involvement activity across partners	Create a joint plan and programme to develop and empower communities making sure no people or places are left behind	Establish Joint Empowerment Task Group	Positive impact on health inequalities through greater participation and control over resources and decision making at individual and community level Reduced duplication of involvement resources	Sept 2010	Director of Modern Governance, Sheffield CC
	Develop the Healthier Communities Programmes to strengthen interventions to influence the wider determinants of health, access to services and improve healthy lifestyles by: - Utilising the local health partnership groups and community networks to increase engagement in planning and delivery of health interventions. - Develop work with the most vulnerable groups across the city particularly communities of interest - Empower local people to improve health in their community engaging them in decision making and delivery of the programmes - Commission programmes through local voluntary sector providers and in partnership with other organisations - Support delivery of key community health interventions including programmes with external investment.	Engage VCS in developing plan Integrated activity into Community Assembly Involvement Plans Increased interventions and points of contact Voluntary sector providers increased Establish GP Citizens advice Bureau pilot intervention utilising the wider support available in the Healthier Communities Programmes Regional Innovations fund Diabetes intervention commissioned.	The majority of indicators in the Basket of Indicators improve at a faster rate in the EPHP areas than the Sheffield average. Increased skills and opportunities for employment More people supported Increased to access services at an earlier stage Increased investment in local community and personal income. Increased access to affordable warmth schemes	2010 -2012	Consultant in Public Health (Healthy Communities), NHS Sheffield
	Develop oral health action teams	Work within the community development structures already in place through the Health Communities Programmes.	Positive impact on oral health inequalities	Dec 2010	Director of Dental Public Health NHS Sheffield

Create fair employment and good work for all by:-

Delivering a 'whole person' approach to support people to get back to work, and progress in the labour market

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibilities
Encourage the participation of vulnerable groups in the labour market.	Use section 106 and planning applications to embed employment and skills outcomes into economic development activity. Working through these routes to create jobs, apprentices, encourage training and integrate long term unemployed people, particular those from vulnerable groups into the labour market.	Work with Planning department to embed process.	Increased employment opportunities and participation in the labour market from vulnerable groups, reducing health impacts of long term unemployment.	To March 2012	Director Lifelong Learning, Skills and Communities, Sheffield CC
	Use the Employment and Skills Delivery Partnership to address social exclusion and social immobility, by developing programmes to support homeless people, ethnic minorities, disabled individuals and those with mental health conditions in place.	Contract in place by Aug 2010 Begin Delivery of programme Sep 2010		Start Aug / Sep 2010	Director Lifelong Learning, Skills and Communities, Sheffield CC
	Pilot 'family intervention pilot' in Manor, Arbourthorne and Darnall with 30 families. Joining up service provision to provide a 'whole person' approach to help vulnerable families progress towards the labour market.	Key workers in place Families identify		To March 2011	Director Lifelong Learning, Skills and Communities, Sheffield CC
Work at the local level to promote training and re-skilling of less qualified segments of the workforce, and vulnerable groups.	Adopt and implement with each Community Assembly area a local learning, skills and employment plan. Undertaking skills audits and targeting provision based on these audits.	Embed plans by Sep 2010	Increased employment rates across assembly areas. Increased skills to encourage progression in the labour market.	To March 2012	Director Lifelong Learning, Skills and Communities, Sheffield CC
Delivering an inclusive learning offer for adults and young people, particularly for those most vulnerable, to remove barriers to work and develop 'soft-skills' for employment.	Launch of 'My City Learning' working with special schools and the provider network to provide better learning and training support (through assistive technology, equipment and qualifications) to young people with learning disabilities.	Work with 4 special schools and 7 providers by Sep 2010	Appropriate and targeted provision for young people with learning difficulties and disabilities.	Delivery Sep 2010 – Sep 2011	Director Lifelong Learning, Skills and Communities, Sheffield CC
	Work with the Youth Offender Service teams to create 'individualised resettlement packages', to ensure learning and support packages are in place for those at risk of offending or in need of resettlement.	5 'model' packages developed by Oct 2010	Increase in Youth Offenders in learning and reduce rate of re-offending.	To March 2011	Director Lifelong Learning, Skills and Communities, Sheffield CC
	Deploy Neighbourhood Learning in Deprived Communities funding for adults, to meet the needs of the most socially excluded, including older learners, those with additional language needs and socially isolated groups.	Fund deployed and contracted by July 2010	Engagement of learners most in need of basic skills,	Start July 2010	Director Lifelong Learning, Skills and Communities, Sheffield CC
	Commission NEETS reduction activity through 40 providers in geographical areas of most need and with flexible provision to be shaped around the needs of each area.	Tender close June 2010-06-03 In place Sep 2010	Targeted learning and support provision in disadvantaged areas.	To March 2012	Director Lifelong Learning, Skills and Communities, Sheffield CC
Promote policies to maintain employment during economic downturns to protect high risk groups.	Publish a revised Employment Plan that addresses the challenges of the recession and cyclical unemployment in addition to long term worklessness and the barriers faced by those vulnerable groups furthest from the labour market.	Complete employment plan by Sep 2010	More sustainable employment across economic cycles.	Completed Dec 2010	Director Lifelong Learning, Skills and Communities, Sheffield CC
Working with employers to create more and better employment opportunities					
Provide support and encourage businesses to employ individuals from vulnerable groups.	Through the Sheffield Employability Programme recruitment strand, support employers to recruit, retain and train individuals from 'at risk' groups. This includes retention, coaching and mentoring support packages for employers, line managers and employees delivered across 5 key sectors; retail, hospitality, construction, business and finance and health and social care.	10 coaches across 5 sector areas by June 2010	Increased employment opportunities and participation in the labour market from vulnerable groups.	To March 2012	SHEFFIELD CC Director Lifelong Learning, Skills and Communities
		Work with 1000 employers by March 2011			
Equip businesses employing individuals from vulnerable groups with the skills and tools they need.	Working with partners through the Sheffield Employability Programme, provide employers with a range of support packages (including job brokers) that equip them with the skills and knowledge to identify and support the retention of vulnerable and at risk employees.	Launch event July 2010 to raise awareness of service to employers 865 Jobs safeguarded by March 2012	Increase in the retention of vulnerable and at risk employees with health conditions.	To March 2012	SHEFFIELD CC Director Lifelong Learning, Skills and Communities
Work with businesses to increase job stability and appropriate career advancement for employees through investing in training and skills.	Develop Challenge 4 in the Skills Strategy 'Build a demand led system' to ensure that training and skill offered to individuals meets the needs of businesses.	Benchmark study reports on current employers experience to identify employer needs / gaps and good practice June 2010	Increased volumes of employers offering skills progression to Sheffield's workforce.	To March 2012	Director Lifelong Learning, Skills and Communities, Sheffield CC

	Support and sign post employers to appropriate training provision and associated funds available.	Account managers in place by July 2010		To March 2012	Director Lifelong Learning, Skills and Communities, Sheffield CC
Enhancing Potential, Education and Skills	Continue to develop 14 -19 learning and training provision which meets the needs of the most disadvantaged. Work with special schools, YOS and the provider network to develop more holistic provision Continue to develop the expertise of the provider network across the city to identify and support young people with behavioural and / or mental health issues e	Annual evaluation and commissioning round. Launch of 'My City Learning' (LDD offer for post 16). Commissioning of NEETS reduction activity.	More appropriate and targeted provision. More appropriate and diverse learning and support in city. Increase in YO in learning and reduce rate of re-offending. Increased awareness across diverse provider base. Engagement of learners for communities most in need in basic skills, ESOL.	April 2010 May 2010 Ongoing February 2010 Quarterly	Director Lifelong Learning, Skills and Communities Sheffield CC
Increasing Job Security	Launch the Sheffield Skills Strategy Agree with each community assembly area a local learning, skills and employment plan.	Launch complete. Plans agreed.	Skills strategy launched and employer 'buy in' secured. Increased skills and employment rates across assembly areas.	April 2010 April 2010 Ongoing Ongoing May 2010	Director Lifelong Learning, Skills and Communities, Sheffield CC
Increasing participation at work	Deliver the Sheffield Employability Programme	Targets within plan	Increase in the retention of vulnerable and at risk employees with health conditions.	Feb 2010	Director Lifelong Learning, Skills and Communities, Sheffield CC
Re-integrating sick, disabled and unemployed with particular emphasis on mental health.	Deliver the Sheffield Employability Programme, Promote early intervention and treatment of employees with health problems	Targets within Programme	Increase in the retention of vulnerable and at risk employees with health conditions	Dec 2010	Director Lifelong Learning, Skills and Communities, Sheffield CC
Encourage vulnerable groups participation in the Labour Market of.	Use the Employment and Skills Delivery Partnership to address social inclusion and social mobility	Programmes to support homeless people, ethnic minorities, disabled individuals and those with mental health conditions in place.	Increased participation in the labour market of socially excluded individuals.	April 2010	Director Lifelong Learning, Skills and Communities, Sheffield CC

Support employers to survive recession and assist them in employing people at risk of poor health

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibility
Ensure business is financially and organisationally equipped to survive	Roll out of Access to Finance service – Summer 2010	Access to Finance Service delivered	Increased business survival and jobs safeguarded	2010	Director of Economy and Skills, Sheffield CC
	Raise awareness of Train to Gain	Train to Gain action plan activities reviewed in light of new Skills Funding Agency.	Increased volumes of employers offering skills progression to Sheffield's workforce	2011	Director Lifelong Learning, Skills and Communities Sheffield CC
Support employers to take on previously unemployed people	Roll out of Opportunity Sheffield employability programme summer 2010	Opportunity Sheffield programme delivered	Employers supported to employ previously unemployed or workless individuals	2010	SHEFFIELD CC Director Lifelong Learning, Skills and Communities
Provide employers with a range of support packages to identify and support the retention of vulnerable and at risk workers					

Improving health and well-being in the workplace

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibility
Develop the workplace as a setting to reduce the health burden on vulnerable adults.	Deliver the city's Mental Health Partnership 8 point action plan	20 Organisations signed up to Charter. 10 Organisations taking up training places. 30 Managers trained. 10 Organisations compliant with Mindful Employer Charter	Reduction in employee absence. increase in levels of manager's knowledge & awareness of mental health issues in the workplace.	2010-2012	Consultant in Public Health(Mental Health), NHS Sheffield
Increase workforce wellbeing support to SME business	Develop a funded programme to provide workplace health support directly to SMEs, via European Regional Development Fund. Develop an education and training programme to improve health outcomes for males in routine and manual trades at increased risk of CVD/ CHD e.g. SHEFFIELD CC Drivers, Contractor / Partner organisations. Assess the feasibility for funding, resources and roll out.	Programme developed. Funding Secured. Indicative timescale advised - Delivery beginning September 2010 following confirmation of funding. Bid Approved July2010 Delivery September2010 Programme developed, Funding Secured	Increase in self referrals for CHD & Diabetes screening services.		

Enable greater access for people in local communities, into paid work in the Health and Social Care Sector	Deliver Pathways to Health course - 8 weeks/10 Modules	Delivery of 1 x Pathways to Health Course.	12 x participants trained with job search in place	2010-2011	Consultant in Public Health (Healthy Communities), NHS Sheffield
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Ensuring a Healthy Standard of Living for all by:-

Providing Healthy, affordable housing

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibility
Ensure the city's housing stock meets the needs of sectors of the population likely to suffer ill Health	Improve best practice among Registered Social Landlords on housing options for disabled people.	Meet with the 6 largest RSLs by December 2010	Improved knowledge of best practice on housing options for disabled people among RSLs	March 2010	Executive Director Communities, Sheffield CC
	Carry out a review of the Responsible Landlord Scheme (RLS) and ensure inclusive approaches are reflected in the RLS accreditation		Make private rented housing a real choice for disabled people	2010	Executive Director Communities, Sheffield CC
	Develop a mental health project to help increase support for those dealing with Anti-Social Behaviour	Deliver Sheffield Homes policies and procedures review re victimisation	Improved outcomes of the ASB problems by people with learning difficulties/mental health problems	End of 2010	Executive Director Communities, Sheffield CC
	Work with BME communities to identify their housing needs and aspirations	Agree bidding priorities	Improved living conditions for Gypsy and Travellers communities, who suffer poorer health levels than other communities	2011	Executive Director Housing, Sheffield CC
	Develop a mental health project to help increase support for those dealing with Anti-Social Behaviour	Deliver Sheffield Homes policies and procedures review re victimisation	Improved outcomes of the ASB problems by people with learning difficulties/mental health problems	End of 2010	Executive Director Communities, Sheffield CC
	To deliver a pilot project aimed at reducing health inequalities by reducing accidents in the homes of older or vulnerable people living in sub-standard private sector housing in the city	Area agreed Properties identified Surveys completed	Reduction in extent of unsatisfactory private sector housing conditions for older people, measured by reductions in accidents	March 2012	Executive Director Communities, Sheffield CC
Ensure Health Inequalities are a primary focus within Housing Strategy	Incorporate Health Inequalities into Housing Strategy	Review completed	Strategy addresses inequalities within final document	Dec 2010	Director Health Improvement Sheffield CC
	Deliver on the fuel poverty Indicator (NI 187) Deliver the Supporting People Strategy	Contained in Strategies	Reduced fuel poverty Reduced dependency on temporary accommodation	March 2012	Executive Director Communities Sheffield CC
	Deliver Housing Market Renewal Plan	450 homes to be delivered by the end of 2008/11.	Warmer homes Lower fuel bills	2008/11	Director Housing, Enterprise and Regeneration Sheffield CC
Ensure Housing Policy is delivered in a way that prevents Housing contributing to Health Inequality	Develop a scheme to address under occupation, to help free up homes for overcrowded households.	Scheme up and running	Fewer people in overcrowded conditions, improving quality of life	July 2011	Director Housing, Enterprise and Regeneration Sheffield CC
	To ensure the housing conditions of the migrant population in the city do not contribute to the significantly poorer health status of that group	Appropriate private rented sector checks have been increased	Standard of Migrant accommodation is now assured	March 2011	Executive Director -Communities
Ensure that the administration of Housing Benefits supports access to affordable, decent and appropriate housing.	Improved speed and accuracy of Housing Benefit claims processing	To be among the top quartile of Metropolitan Authorities for 2010/11.	Reduced rent arrears, reduced risk of eviction and sustained tenancies. Citizens' ability to access decent quality accommodation is improved through increased confidence in HB scheme. Wider availability of Private Sector accommodation due to improved confidence of Private Landlords in HB scheme.	April 2010-March 2011	Assistant Director of Finance (Shared Services)

Using our food system to reduce health inequalities

Objectives *	Actions	Milestones	Outcomes	Timescales	Responsibility
Remove the food based factors producing disadvantage to the cities population	Ensure all Sheffield schoolchildren enjoy sufficient food (calories & nutrients) to maintain good health while at school	Review of provision completed	Above average meal uptake, nutritious packed lunches and removal of unhealthy alternatives.	2011	Director of Business Strategy CYPD Sheffield City Council
	All Sheffield communities have the capacity to access a healthy diet	Buywell scheme introduced to encourage availability of fresh produce in targeted areas	All citizens have physical access, economic ability & knowledge to access and consume healthy food	2012	Director of Health Improvement Sheffield City Council
	Introduce nursery minimum food standards	Minimum standard agreed	Improved nutrition standard of	2012	Director of Business Strategy CYPD Sheffield City Council
	Healthy and enjoyable food for all during key life stages	Peri-natal diet programme produced	Physical, social and economic barriers relating to healthy diet and food enjoyment and life stage are overcome	2011	Senior Public Health Consultant NHS Sheffield

Create and develop healthy and sustainable places and communities by:-

Providing a transport system that makes it easier to stay healthy

Objectives *	Actions	Milestones	Outcomes	Timescales	Responsibility
Provide a transport System in the City which makes it easier to stay healthy	Delivery Air Quality Action Plan	Cabinet approval to consult on draft Air Quality Action Plan	Reduction in the health problems associated with low air quality	New Action Plan by Dec 2010	Director Development Services Sheffield CC
	Manage the impact of transport related noise, including noise reduction if necessary	Guidance to be issued regarding process (July 2010)	A reduction in the number of people exposed to road traffic noise	July 2010 - June 2011	Head Of Transport and Highways Sheffield CC
Reduce the number of people killed and seriously injured in road accidents	Deliver Road Safety Plan	Plan delivered	A continuing reduction in the number of people killed or seriously injured on our roads.	Academic years 2010/13	Road Safety Team Leader Sheffield CC
	Implement the Sheffield elements of the South Yorkshire 'Worst First' scheme to improve road safety through both education and engineering solutions.	The Worst First LTP Group will confirm funding levels in April.		Funding confirmation due July 2010	Head Of Transport and Highways Sheffield CC
	Implement accident saving schemes to reduce accidents on major roads	Have 2 large schemes fully built Have 6 small schemes fully built		By March 2011	Head Of Transport and Highways Sheffield CC
Encourage and enable active travel	Deliver WOW – Walk Once a Week.	Supply all participating schools with classroom resources.	Increased uptake of active travel with reduced obesity levels and other health benefits. The percentage of pupils being driven 'every day' to participating Bike It schools has reduced from 20% to 13%. There has also been a significant increase in walking to participating schools.	Sept 2010	Head Of Transport and Highways, Sheffield CC
	Deliver the Bike It project. This project promotes cycling as a healthy, environmentally friendly and fun way to get to school.	Work intensively with 24 schools –.		September 2009 to July 2010	Head Of Transport and Highways, Sheffield CC
	Deliver the Travel for Life Programme.	Engage 12 schools April 10 (8 in EPHP areas, 4 in areas with high car use)		2010/11	Head Of Transport and Highways, Sheffield CC
	Deliver the School Travel Reward Programme.	Carry out STP review with all Sheffield schools		2010/11	Head Of Transport and Highways, Sheffield CC
	Bikeboost –+Bus Boost promoting alternative ways to get to work	9 major employers identified and involved 2010 9 major employers identified and involved 2011		2010/11	SHEFFIELD CC, Head Of Transport and Highways, Sheffield CC
Enhance Workplace Travel Plans	Walking Challenge – 2010 pilot to encourage employees to walk further, either while at work or to and from work.	4 employers to take part Oct 2010 400 new cyclists 600 new bus users 300 to continue to cycle to work 400 continuing to use the bus		June 2010- June 2012 Sep – Nov 2010	Head Of Transport and Highways, Sheffield CC

Designing out ill health using Development powers

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibility
Embed Health Inequalities Considerations into The Policy Layer Of The Emerging SDF	Planning applications assessed using the 'Building for Life' (BfL) checklist to ensure that development is of high design quality and addresses key determinants of health.	Adoption of SDF City Policies & Sites Development Plan Documentation	Planning policies adopted that systematically address a range of health factors.	2012 Current practice	Director of Development Services, Sheffield CC
	Develop planning policies that would encourage access to healthy food choices, particularly in areas identified as 'food deserts'.	Adoption of SDF City Policies & Sites Development Plan Document	Planning able to encourage a genuine mix of retail development offering a variety of food choices.	2012	Director of Development Services, Sheffield CC
	Consider scope for future submissions under the Sustainable Communities Act 2007 that would enable planning policies to differentiate between types of food retailers, and therefore encourage those offering healthy food choices	Proposal to amend Use Classes Order submitted to the Local Government Association for consideration		2010	
	Food deserts identified and where appropriate, further Hot Takeaway uses (A5) restricted	'Food deserts' identified	Areas identified as 'food deserts' and, where appropriate, uses such as 'Hot Food Takeaways' restricted accordingly.	2011	
Introduce appraisal systems which ensure the needs of different sectors of the community are addressed in future developments, including their health requirements	Lifetime Neighbourhoods settlement appraisals undertaken in areas of Housing Renewal.	Established 4 appraisals completed	Housing development is tailored to the needs of local areas.	July 2010	Director of Development Services, Sheffield CC

	Emerging planning policies subject to comprehensive Sustainability Appraisals Explore scope for a corporate approach to policy appraisal that incorporates health impact assessment, sustainability and equality appraisals.	SDF City Policies & Sites appraised and Sustainability and Equality Reports published for consultation	Planning policies support the creation of an environment that offers the best opportunities for healthy lifestyles.	Appraisal process, Reports published June 2010 Summer 2011	Director of Development Services Sheffield CC Head of Governance and Involvement Director of Health Improvement
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Using open space to improve health and encourage, physical activity

Objectives	Actions	Milestones	Outcomes	Timescales	Responsibility
Ensure the green and open spaces in the City are provided and managed in a way that eliminates any inequalities of opportunity	Deliver Sheffield's Green and Open Space Strategy Stage 1 Programme Projects 2 and 4	Baseline Sheffield Quality Standard and improvements set. Mapping and identification of shortage by type of green and open space especially in EPH areas.	An even standard of quality in green and Open spaces across Sheffield with a high quality space in ever area of the city Welcoming and safe green and open spaces for all to use and enjoy	2010 2014	Director, Parks and Countryside Green and Open Space Strategy Core Management Group Sheffield CC
Make better use of our greenspace to encourage physical activity in sedentary individuals	Delivery of health walks programme targeting sedentary people in areas of highest risk Cycle for Health A programme of 12 weekly cycling sessions in Sheffield Parks	Training locally recruited walk leaders (80 to date)'Stepping Out' programme and 'Step Out on Saturday	Increase the number of walkers by 5% per annum. 50% of participants increasing their activity levels over the duration of the programme	1999 – Ongoing 2008 - 2010	Green and Open Spaces Partnership Sheffield CC
Promote the wider use of green and open spaces for growing food for the benefit of physical and mental health, targeting disadvantaged communities	Allotment and community gardens developed to provide opportunities for all to grow food.	Community gardens for Sheffield providing 100 plots for families and young people to 2 new allotment sites developed	50% increased activity levels in participants 200 more people able to grow their own food	2010 – 2012 2010 - 2012	Green and Open Spaces Partnership, Sheffield CC
	A Growing Together, partnership to provide allotment volunteering opportunities for mental health service users.	Link coordinator appointed Service users identified	80 service user volunteers experienced working within the project 20 service user volunteers trained Clear and restore 70 allotment plots and bring into active cultivation	2 years 2010-2012	Green and Open Spaces Partnership, Sheffield CC
Provide additional opportunities for, and participation in, physical activity for communities at risk of ill health	Wheels for All Programme for disabled people, using adapted bikes	1500 disabled participants 3 LDD young people trained as assistant trainers	Support, encourage and engage disabled people to progress their cycling skills	2 years 2010-2012	Director Parks and Countryside and the Green and Open, Sheffield CC
	Re promote the Physical activity Referral Scheme to health professionals working with adults with mental health issues Expand the Minds Over Football project (a football project that works with SHSCT to engage clients in physical activity in order to improve mental health).	Referrers identified Presentations and promotional information given Number of referrals monitored New sites identified in conjunction with SHSCT Sessions organised Sessions promoted	Contribution to reducing to increasing physical activity levels of adults with mental illness 5% increase in referrals 50% of patients increasing their physical activity levels over the period of the scheme 2 new sessions developed 2 new 'Minds over Football' sessions developed	2010-2011	Director Culture (Activity Sheffield Sheffield CC

Minimising the impact of climate change on the health and wellbeing of vulnerable people

Objectives	Actions	Milestones/performance measures	Outcomes	Timescales	Responsibility
Improve community resilience to climate change and extreme weather events (such as flooding, heat waves, cold winters)	Undertake risk assessment in line with NI188 Develop city-wide Adaptation Strategy	Undertake 'rapid resilience' pilot programme with Arup Utilising 'rapid resilience' pilot programme	Reduced risk of future climate change on people's health, services and city infrastructure	Oct 2010 March 2011	Director Sustainable Development Sheffield CC

Improving mental health and wellbeing across all our communities

Objectives	Actions	Milestones/performance measures	Outcomes	Timescales	Responsibility
Develop sustainable, connected communities where mental health services are delivered in sustainable and culturally appropriate ways	Devise local plans for World Mental Health Day, Time to Change campaign and Exposed magazine articles Roll out Mental Health First Aid programme across the city Deliver Race Equality in Mental Health	Course evaluations of 14 courses run 500 first Aiders trained	Tackling stigma and celebrating mental health, production and distribution of materials	Oct 2011 Mar 2011 Ongoing	Public Health Consultant (Mental Health), NHS Sheffield
	Deliver BME Action Plan Work with community organisations to support delivery of: mental health promotion, prevention, self-help, and awareness raising Work with services to increase their understanding, competence and access to different community groups	Meet target of 6 BME Community Development Workers Reporting and review	Equality of access to mental health services achieved Improved community engagement	Mar 11 Mar 11	Public Health Consultant (Mental Health) NHS Sheffield

Deliver prevention focused services from the third sector	Assess commissioned services against Confident Communities, Brighter Futures* Revise contracts to ensure prevention is a key feature	Performance Monitoring and evaluation Contract variation	Measures of prevention and wellbeing developed Third sector services prevention focused	March 2011	Public Health Consultant(Mental Health NHS Sheffield
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Ensuring our communities are free from discrimination, violence and harassment:

Objectives	Actions	Milestones/performance measures	Outcomes	Timescales	Responsibility
Review the existing framework for action against discrimination	Seek to agree a common standard for equality impact assessments Provide outcome information disaggregated by different relevant communities of interest, age and gender Promote access to Health Champions, CD workers and Advocates for support for victims of discrimination	Standard Agreed Provide monitoring information on all health inequalities broken down by different relevant communities, gender and age	Increased Community Cohesion	2012	Director of Modern Governance, Sheffield CC
Ensure the vulnerable members of communities are not subject to crimes affecting their mental wellbeing	Ensure mental health is addressed in the Hate Crime action plan due for release in summer 2010 and the plan links to NHS activity and priorities Establish Sheffield CC Hate incident reporting system Ensure recording of incidents relating to and between Sheffield CC staff	Hate Crime Action Plan Delivered Reporting System established	System established for monitoring based on race, ethnicity, disability, sexual orientation, gender, religion/belief, Levels of hate incidents reduce over time	Sep-10	Director of Neighbourhood Renewal and Partnerships, Sheffield CC
Reduce repeat incidents of Domestic abuse	Launch the new Integrated Domestic and Sexual Abuse Service Awareness raising of domestic abuse support projects to communities and groups of interest (in a discreet manner)	Service Launched	Reduced incidence (after initial increase due to detection) More women of diff backgrounds receive advice support and refuge if necessary	May 2010	Director of Neighbourhood Renewal and Partnerships, Sheffield CC
Reduce fear of crime	Monitor by communities of interest BME, disabled, gender, sexual orientation, religion, age	Hate crime data analysed and reduction targets set	All communities experience similar and low fear of crime	March 2011	Director of Neighbourhood Renewal and Partnerships, Sheffield CC

Addressing health inequalities within Communities of Interest

Objectives	Actions	Measures of Success	Outcomes	Timescale/	Responsibility
Improving the health of the established black and minority ethnic communities in Sheffield	Ensure that ethnicity data is routinely collected in all contacts with health, social care and local authority services. Ensure services are delivered in culturally appropriate manner.	Multi – Agency Equalities Group deliver joint approach	BME communities are accessing appropriate Health and care services pro rata.	March 2011	Director of Modern Governance Sheffield CC
	Ensure GP consortia are supported to deliver targeted health interventions in BME population groups , Interventions to focus on prevention, detection and treatment . High risk patients identified through screening programmes and national and local health intelligence. Focus on cardiovascular screening and national screening programmes where take-up is lower than the national average i.e. cancer , stroke	Increased take-up of screening Increased access to services Increased completion and follow-through of care pathways	Early diagnosis of high risk communities, earlier treatment . Improved health outcomes Improved access to primary care.	March 2013	Director of Public Health NHS Sheffield
	Encourage BME population engagement with services both through BME specific organisations as well as generic patient and public involvement mechanisms. Promote the learning of English amongst people who are unable to speak it. Make translation and interpreting services available where necessary.	BME Infrastructure supported		March 2012	
Safeguarding the health of vulnerable migrant communities	Promote General Practitioner registration. Review and optimise TB screening	TB Screening Reviewed	Reduction in TB cases in migrant population	March 2011	Director of Public Health NHS Sheffield
	Ensure Housing Provision does not increase the risk of poor health in migrant communities.	Housing Study completed ²	Reduction in housing related health conditions in migrant population	June 2011	Director Housing, Sheffield CC

Safeguarding the health of asylum seekers and refugees	Continue to support the asylum seeker and refugee primary care service. Consider ways in which healthcare can be made available to failed asylum seekers who are ineligible for NHS care.	Secure Strategic Health Authority guidance and best practice	Improved access to primary care and improved living and working opportunities	Ongoing	Public Health Consultant(Primary Care) NHS Sheffield
	Deliver effective housing support and employment support for asylum seekers and refugees.	Housing Study completed ² Employment programme delivered ³		March 2012	Director Housing, Director of Employment, Skills and communities Sheffield CC
Safeguarding the health of gypsies and travellers including Slovak Roma community	Promote registration with General Practitioners. Targeted health promotion work particularly related to vaccination of children. Targeted health promotion work relating to use of health services.	Work with BME Network to deliver culturally appropriate messages	Reduction in health related conditions associated with Gypsies and Travellers including Slovak Roma Communities	March 2012	Public Health Consultant NHS Sheffield
	Provide Employment and financial support and advice.	Financial Inclusion Plan Delivered			Director Policy and Research Sheffield CC
Safeguarding the health of people with physical, sensory and cognitive impairments	Work with Chamber of Commerce and employers to ensure that people with physical, sensory or cognitive impairment are not inappropriately discriminated against with regard to employment	Establish a mechanism to communicate more effectively with NHS, SCC, Chamber, and VCF	Wider dissemination of discrimination issues around employers in the City	March 2012	Director of Public Health, NHS Sheffield
	Ensure that all NHS services are fully accessible to people with physical, sensory or cognitive impairment	DDA is fully implemented Monitor compliance of the DDA Identify a framework to improve data quality collection/ evidence for DDA			
Safeguarding the health of people with learning disability	Promote employment to people with learning disability). Deliver appropriate awareness raising sessions with the Chamber of Trade and local employers.	National Indicator 148 – Number of residents with Learning disabilities in employment Target delivered	Higher levels of gainful employment for people with learning difficulties		Sheffield SFHWB Board
	Continue implementation of recommendations in 'Six Lives: the provision of public services to people with learning disabilities' to address the premature death rate and reduced life expectancy of this group who are 58 times more likely to die below the age of 50.	Increased Life expectancy of people with learning disability			Director of Public Health, NHS Sheffield
	Assessment of oral health needs of children with learning disability	Formal assessment process agreed and underway	Improved understanding of oral health needs	Dec 2011	Director of Dental Public Health, NHS Sheffield
Safeguarding the health of people with sensory impairments	Undertake formal assessment of the health needs of people with sensory disabilities.	Formal assessment process agreed and underway	Improved understanding of health needs	Aug 2011	
Improving the health of homeless people	Addressing homelessness	Deliver homelessness strategy	Health outcomes improved. Exact measures development	Dec 2011	Executive Director Communities Sheffield CC
	Promoting registration with General Practitioners	Promotion scheme delivered		Dec 2011	Senior Public Health Consultant (Primary Care)NHS Sheffield
	Ensure alcohol services and mental health services recognise the needs of homeless people in the city	Deliver Alcohol Strategy		Oct 2010	Director Substance Misuse Strategy NHS Sheffield
Safeguarding the health of people in supported housing	Work with the Sheffield Supporting People Partnership to ensure the health needs are being met.	Regular health representation at Board meetings, health assessments undertaken and actions delivered	Health more appropriately addressed within supported accommodation provision	March 2011	Director of Public Health, NHS Sheffield

**Strengthen the role and the Impact of III- Health Prevention by:-
Tobacco Control and stopping smoking**

Tobacco Objectives	Actions	Milestones	Outcomes	Timescales	
Target smoking cessation at most at risk groups + reduce the number of new smokers	Deliver Smoking Cessation Plan	Contained in Plan	Reduced incidence of smoking related illness and death in the City	2010/13	Consultant in Public Health NHS Sheffield
Reduce the availability and supply of cheap and illicit tobacco	Implement the Sheffield Action Plan on Cheap and Illicit Tobacco	Contained in Plan	Less illegal tobacco available in communities	10/11	Consultant in Public Health NHS Sheffield

Increase the number of quitters in the Healthy Communities Programme	Further develop the work of the voluntary sector 6 community CP stop smoking posts. Strengthen the work HCPs and the 6 posts including wider community interventions such as smoke free homes.	Contained in Plan	Reduction in smoking and inequalities re CHD Increased number of quitters from the most deprived areas Reduction in the inequalities in smoking prevalence	Ongoing	Consultant in Public Health NHS Sheffield Tobacco Control Board
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Preventing and providing support for addictions

Objectives	Actions	Milestones	Outcomes	Timescales	
Reduce alcohol related (A&E) hospital admissions Problematic Drug Users in Effective Treatment – 10% increase from baseline Objectives Reduce alcohol related (A&E) hospital admissions Problematic Drug Users in Effective Treatment – 10% increase from baseline	Award contract for A&E liaison nurse Continue to collect A&E data on alcohol admissions	Q1 2010/11 Ongoing	Simple brief interventions delivered through A&E Early intervention referral pathway into alcohol treatment from A&E Baseline data for A&E alcohol admissions showing a reduction in admissions in line with interventions	2010/11	Director Substance Misuse Strategy, NHS Sheffield
	Continue procurement activity to reconfigure an effective, recovery focussed, sustainable and resilient treatment system which provides value for public money. Continue proactive quarterly performance monitoring; data and care plan audits; and performance improvement plans to ensure effective treatment is delivered.	Monthly submission to NDTMS	2749 problematic drug users in effective treatment	NDTMS submission of June 2011 - August 2011 frozen data published which confirms final position against target	Director Substance Misuse Strategy NHS Sheffield

Improving access to care and information

Objectives	Actions	Milestones/performance measures	Outcomes	Timescales/	Responsibility
Increase access to interventions preventing and treating major inequality conditions., focusing on practices with the highest CVD premature mortality.	Strengthen the pathway between Primary Care and community interventions by development of the Enhanced Prevention in Communities (EPIC) Develop the Regional Innovations Fund Diabetes project utilising health trainers and health champions. Implement NHS Health Checks if included in the new NHS strategy. starting in the most at risk communities Deliver social marketing project in BME communities	Provision of information to target practices about community health activities in the EPHP areas. Run initial pilot Undertake procurement Health checks programme in place Social marketing project initiated. Pilot evaluated and linked to CLAHC stroke	Earlier access to treatment in primary Care settings. Narrow the gap that currently exists where more deprived and ethnic communities have poorer health and higher risks of strokes	Ongoing NHS Sheffield	Director of Public Health NHS Sheffield
Develop and increase interventions with at risk of poor health.	Identify funding to sustain and increase community screening programme building on successful interventions – Asian Taxi drivers. Provision of Active Programmes – Diabetes and Cardiac and Pulmonary Rehab and Desmond for BME groups. Provision of Public health interventions with economic migrants and Asylum seekers	Provide community screening programmes for BME groups. Increase number of people from BME groups accessing Active programmes.	Reduce CVD and type 2 Diabetes in BME groups. Improved health of BME groups.	2010-2012	Public Health Consultant NHS Sheffield
Increase early detection of cancer in most at risk groups.	Improved access to screening programmes for the most at risk groups with the greatest inequalities. Increase awareness of risks, signs and symptoms for priority cancers (lung breast colorectal), Establish a Cancer Health Improvement Practitioner post	Provide training for front line health to deliver brief interventions around Cancer awareness – Deliver training to health trainers and community smoking advisers, health champions, Develop a volunteer support project Develop local cancer prevention campaigns to link with national campaigns.	Earlier detection of Cancer - leading to improved treatment outcomes. Reduce inequalities in cancer mortality. (There is a two fold difference in cancer mortality between our least and most deprived areas)	2011	Public Health Consultant NHS Sheffield
To widen access and increase geographical spread of health care services	Produce Health Impact Assessments for 4 new LIFT Health Centres - Bluebell, Foxhill, Darnall and Norfolk Park.	HIAs produced Recommendations implemented	Maximise the positive health Impacts of the new buildings to reduce inequalities. Improved access to services at an earlier stage	March 2011	Public Health Consultant NHS Sheffield

To increase the skills and knowledge of the wider workforce to maximise their public health role. "Making Every Contact Count" initiative	Implement Level 1 competency from Prevention and Lifestyle Behaviour Change Competence Framework. supporting staff to carry out their public health role including getting key messages out to family and friends Develop the commissioning process to commission for behaviour change utilising the Prevention and Lifestyle Behaviour Change Competence Framework.	Number of staff trained Number of courses delivered Inclusion in Organisational Development strategy Develop a set of health gain measures suitable for incorporating in provider contracts.	Improved staff competence and confidence Ability of staff to implement behaviour	2010-2011	Public health Consultant lead and Human resources lead
Improve access to an NHS dentist	Undertake health equity audit of dental services	HEA completed	Equitable dental services	March 2011	Director of Dental Public health, NHS Sheffield

How will we deliver this Plan?

Placing it the heart of Governance and Planning

To ensure Health Inequalities are addressed within the Main Corporate Governance structure we will:

- Refresh City Strategy and ensure inequality is addressed in the document
- Ensure that the issue of Health Inequalities is at the forefront of the cities approach to delivering the of the Department of Health White paper 'Equity and Excellence'; Liberating the NHS
- Review Health Partnership substructures in Sheffield First to prioritise Health Inequalities work
- Produce a Community Assembly Based Public Health report
- Agree and maintain a Joint Strategic Needs assessment document.
- Produce and secure commitment to this Joint Health Inequalities Plan across the City
- Strengthen the City Councils role in scrutinising health provision in its broadest sense across the City.
- Secure Closer working between SHEFFIELD CC and NHS Sheffield
- Increase capacity for improving the health of the City by giving people the knowledge to understand what they can do, in their everyday roles, to improve the health of the cities residents.

Training and marketing

The Marmot Report recognises the importance of addressing the wider determinants of health as well as individual behaviours when tackling Health inequalities at a city wide level. This means there has to be a shared understanding of the language of Health Inequalities across a number of agencies and at a number of levels, from front line officers making day to day decisions on operational service delivery through to Politicians and Board Members making decisions on resource allocation and strategy.

This training and marketing will aim to develop a shared narrative on wider determinants and signpost to resources across the city which can assist organisations and individuals with a responsibility and ability to have an impact in reducing Health Inequalities.

Training and Marketing is therefore to be provided across various levels as follows:-

- (i) Information at a leadership level by developing a training programme in partnership with the IDEA and other Local Authority Partners aimed at delivering the Recommendations of the Marmot review at a city- wide level
- (ii) Information at Community Assembly level to influence and inform decisions at a local level , affecting local inequalities
- (iii) Information at service level aiming to coordinate and add value to current activity and signpost to contributory actions elsewhere
- (iv) Using contracts with third sector providers to develop individual and family based information provision. This currently involves the provision of Community Health Champions and Community Health Trainers
- (v) Developing training programmes such as the integrating Community Development and Health

- (vi) Using existing needs analyses such as the Joint Strategic Needs Assessment and Joint Strategic Intelligence Assessment to develop understanding of the issues
- (vii) Develop systems aiming to assess and quantify the impact of the various actions trying to reduce Health Inequalities in order to ensure decisions on resource allocation deliver maximum impact.

The Role of the Voluntary, Community and Faith Organisations

The voluntary community and faith organisations in the city are vital to the work on tackling health inequalities. Such organisations and networks are close to communities and understand local needs. They are often well placed to respond to needs in acceptable and effective ways. It is important therefore that the NHS and Sheffield CC work closely with local organisations to provide support to help sustain the sector and also commission services from them. Actions outlined in this plan seek to support this approach across all of the themes. Furthermore by investing in grassroots bodies we will be building social capital, in the form of more robust communities who support each other and who are involved in local decision making. We have more to do in this work in the city and this will not be easy at a time of financial constraint. However, the NHS and Sheffield City Council will seek to work closely via the Partnership Board and Compact on the health inequalities agenda.

Performance Managing the Plan

The issue of Health Inequalities does not sit within a single department within the local Authority or the NHS. It is important that all organisations recognise their responsibility for health and health inequalities within Sheffield as their responsibility. The Marmot Review clearly emphasises that. Delivery of this Plan requires contributions from across the Council, the health sector, the rest of the public sector, the private sector, the universities and the VCF organisations in the City. The performance management of the Plan therefore needs to be embedded within the emerging Partnership structures of the City. A specific Health Inequalities group across the delivery agencies and chaired jointly by the Director of Public Health and the Portfolio Member for Healthy and Independent Living will therefore manage performance of the Plan. This process will be integrated into any new arrangements emerging from the current White Paper Proposals contained in 'Equity and Excellence Liberating the NHS'

NHS Sheffield Currently provide data to enable us to monitor health inequalities across the city through a Basket of Indicators which can be tracked over time to measure effectiveness of major programmes targeting inequalities in the City. The Health Inequalities Plan will inform an imminent review of this basket, which, when completed will provide the performance measures for a Performance management framework. However there are other factors which need to be incorporated into any such Framework including best practice from elsewhere and current national thinking around the issue. Of particular relevance are the recent work by the Scottish Public Health Observatory, the London Health Observatory, the work being undertaken by the Marmot Review team and more recently the National proposals to develop a new Outcomes Framework linked to NHS changes.

Current Composition of the NHS Sheffield Basket of Health Inequalities Indicators

In total, 24 indicators are included in the Basket. In addition the Basket reports on the headline indicator of life expectancy.

Clearly the latest plan composition is not reflected in the Basket and this will be addressed as part of the 2010 review of the existing Basket. Appendix 2 sets out the existing indicators in the Marmot Categories. Potential new indicators for a revised Basket set are in bold in the table.

Sheffield

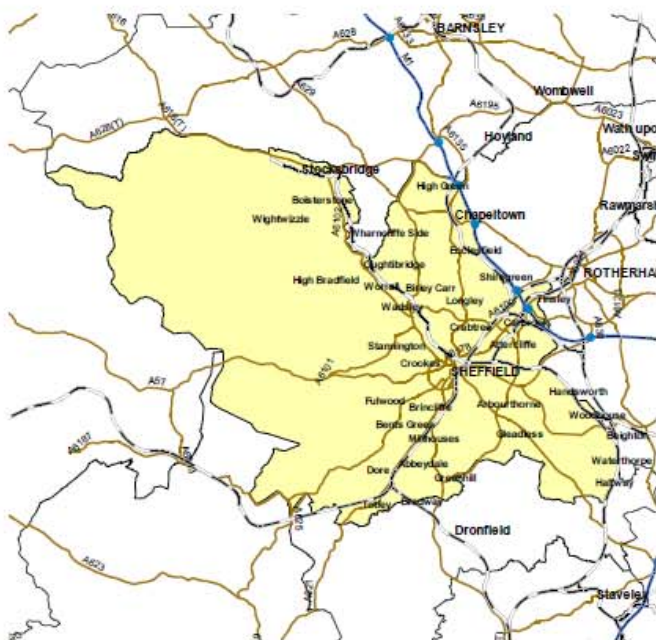
This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

Health Profiles are produced every year by the Association of Public Health Observatories.

Visit the Health Profiles website to:

- see profiles for other areas
- use interactive maps
- find more detailed information

www.healthprofiles.info



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DH 100020290 2010. Other map data © Collins Bartholomew.

Population 534,500

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk



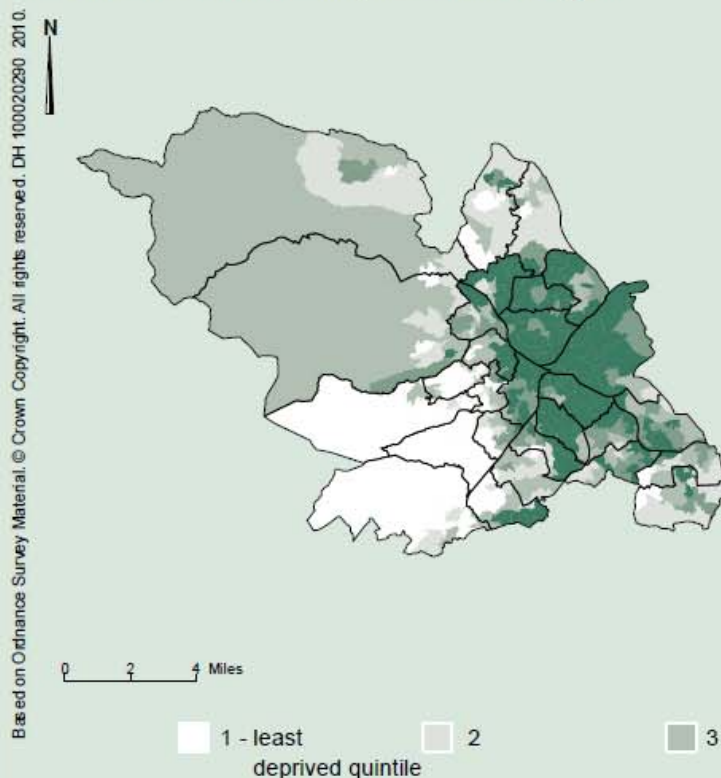
Sheffield at a glance

- The health of people in Sheffield continues to improve.
- There are inequalities within Sheffield. For example, life expectancy for men living in the least deprived areas of the City is over 8 years higher than for men living in the most deprived areas.
- Over the last ten years, death rates from all causes and early death rates from heart disease and stroke and from cancer, have decreased faster than the England average and are now similar to the England average.
- The percentage of mothers initiating breast feeding is better than the England average. The percentage of women smoking in pregnancy has improved. However, the percentage of physically active children is lower than the England average.
- There are fewer hospital stays for alcohol related harm, and fewer road injuries and deaths than the England average.
- Sheffield has higher rates of people; claiming incapacity benefit for a mental illness, who are homeless and who develop skin cancer (malignant melanoma) than the England average.
- Sheffield's Local Area Agreement has prioritised tackling health inequalities measured by differences in death rates from all causes, smoking, physical activity, people with mental illness & learning disabilities in employment, teenage pregnancy & childhood obesity.
- Sheffield's Annual Public Health Report provides further details on the health of this area and is available from: www.publichealthsheffield2009.nhs.uk

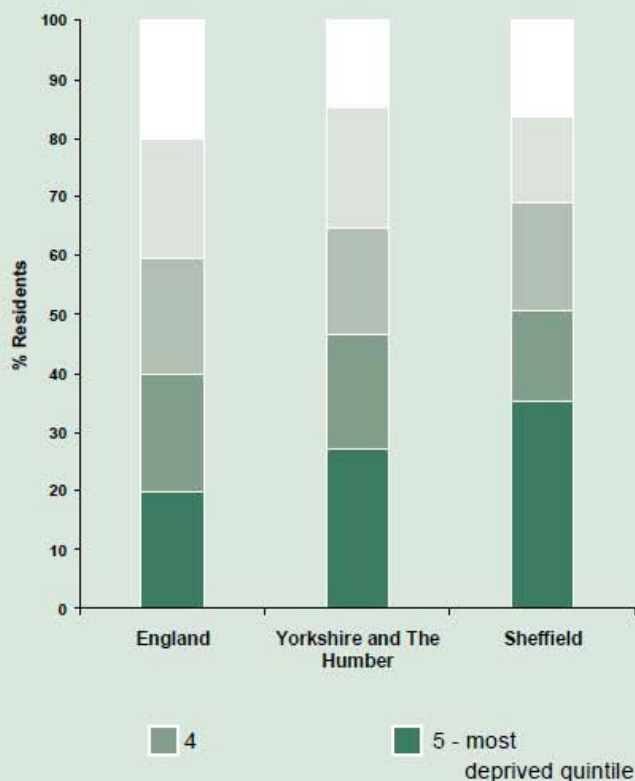


Deprivation: a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

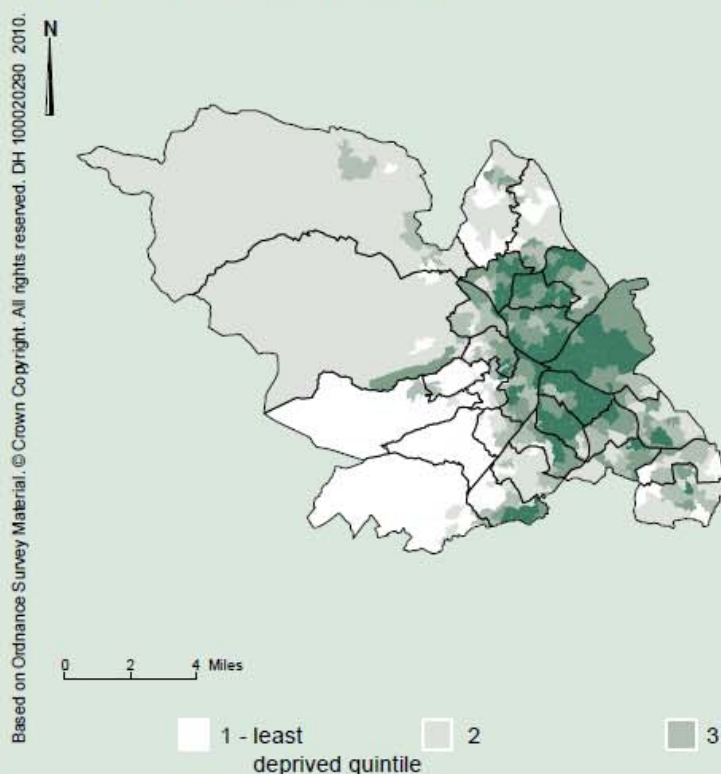


This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.

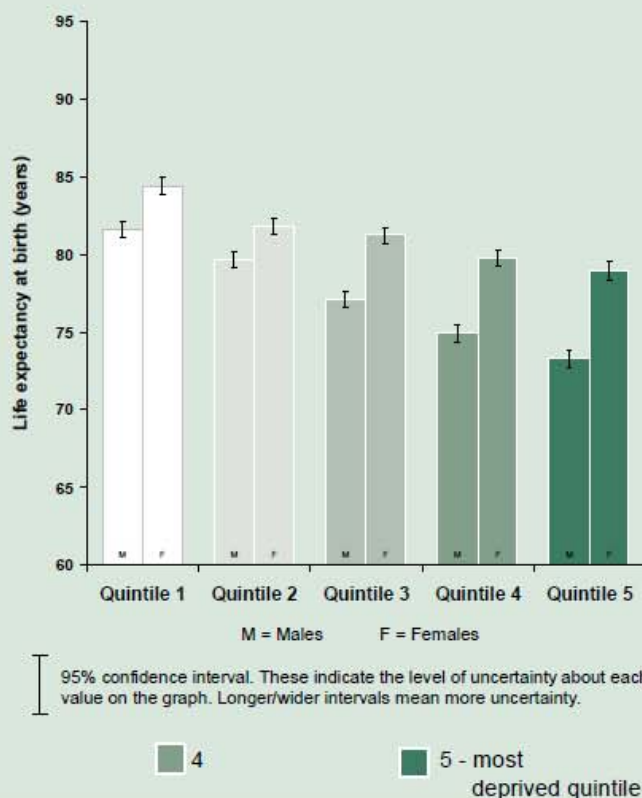


Health inequalities: a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.



Health inequalities: changes over time

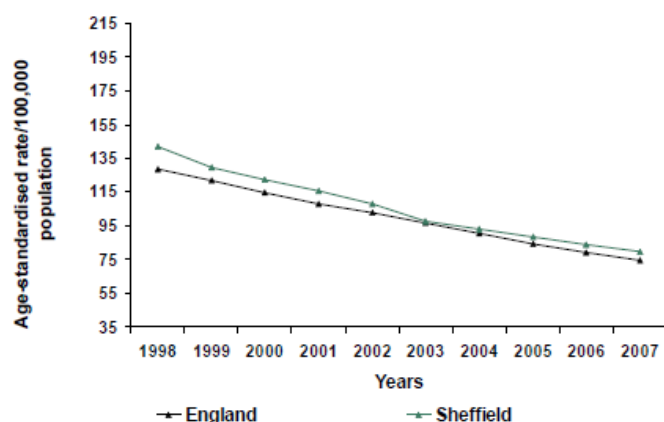
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

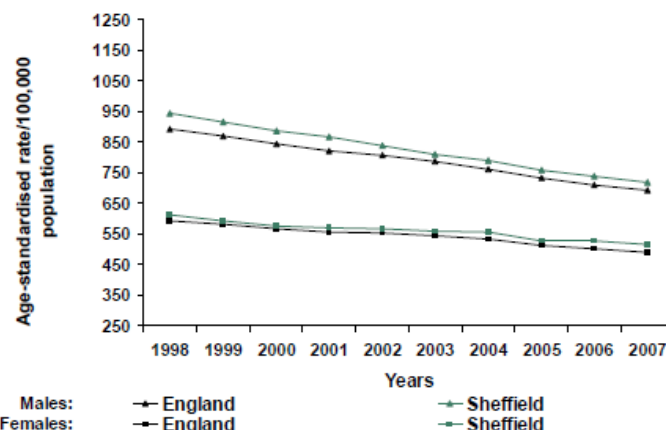
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

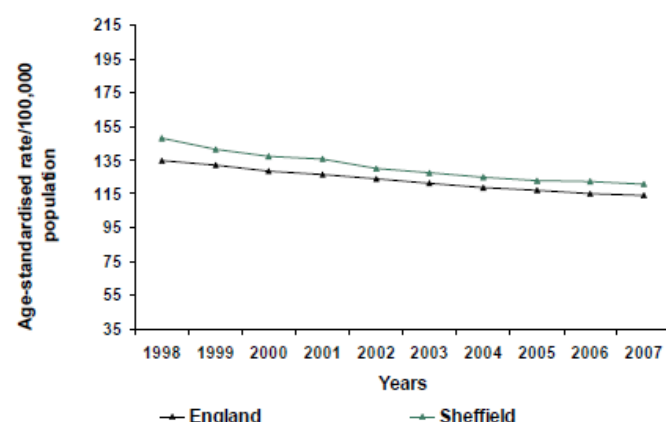
Trend 2: Early death rates from heart disease and stroke



Trend 1: All age, all cause mortality

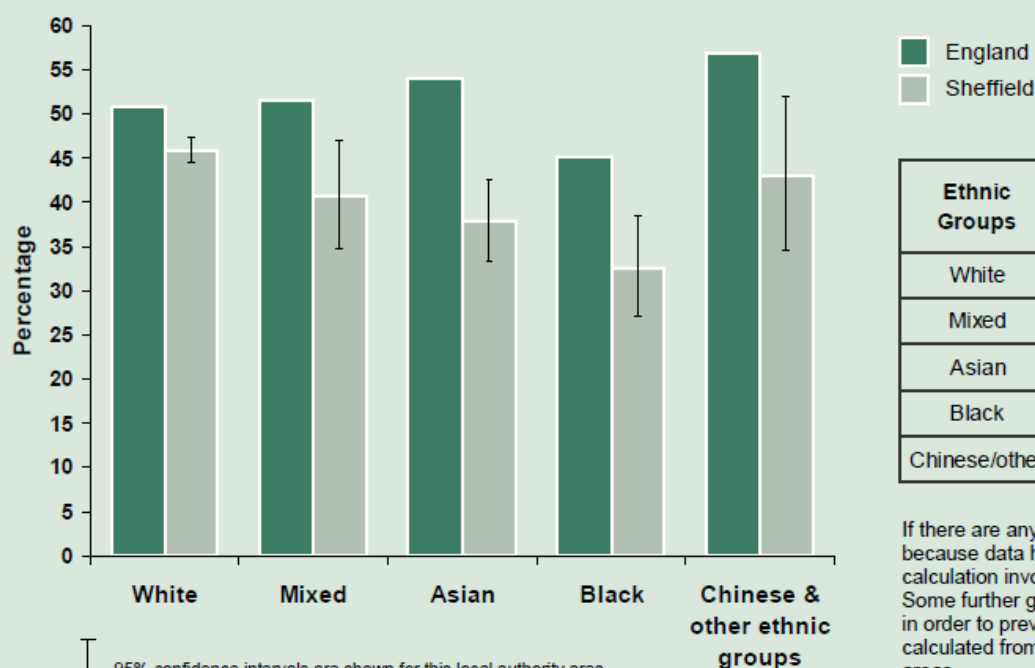


Trend 3: Early death rates from cancer



Health inequalities: ethnicity

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	45.9	2,145
Mixed	40.7	99
Asian	37.8	156
Black	32.5	83
Chinese/other	43.0	52

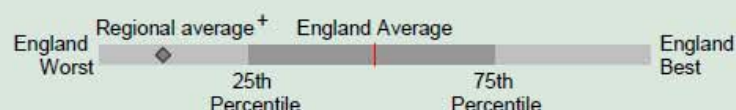
If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Sheffield

00CG

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



⁺ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	184374	35.3	19.9	89.2		0.0
	2 Children in poverty	24700	26.1	22.4	66.5		6.0
	3 Statutory homelessness	1440	6.20	2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	2553	44.5	50.9	32.1		76.1
	5 Violent crime	8509	16.0	16.4	36.6		4.8
	6 Carbon emissions	3443	6.5	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	893	13.9	14.6	33.5		3.8
	8 Breast feeding initiation	4909	76.4	72.5	39.7		92.7
	9 Physically active children	28095	44.5	49.6	24.6		79.1
	10 Obese children	490	9.4	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.7	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	454	48.8	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	24.3	22.2	35.2		10.2
	14 Binge drinking adults	n/a	30.1	20.1	33.2		4.6
	15 Healthy eating adults	n/a	22.5	28.7	18.3		48.1
	16 Physically active adults	n/a	11.6	11.2	5.4		16.6
	17 Obese adults	n/a	24.2	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	95	18.8	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	10855	31.7	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	8879	1490	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	23690	4.43	4.30	6.72		2.69
	23 New cases of tuberculosis	106	20	15	110		0
	24 Hip fracture in over-65s	547	494.7	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	237	14.9	15.6	26.3		2.3
	26 Life expectancy - male	n/a	77.5	77.9	73.6		84.3
	27 Life expectancy - female	n/a	81.5	82.0	78.8		88.9
	28 Infant deaths	38	5.77	4.84	8.67		1.08
	29 Deaths from smoking	880	229.1	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	434	79.6	74.8	125.0		40.1
	31 Early deaths: cancer	655	121.1	114.0	164.3		70.5
	32 Road injuries and deaths	252	47.6	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO₂ emissions per capita (tonnes CO₂ per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

More indicator information is available in The Indicator Guide: www.healthprofiles.info For information on your area contact your regional PHO: www.apho.org.uk

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Appendix 2

Current Basket of Health Inequality Indicators (new indicators under consideration in bold)

Giving Every Child the best Start in life

1. Child Poverty. % of children in households receiving benefits.
2. Low Birth Weight Babies. % Live Births <2,500 grams.
3. Breast Feeding Intention at Delivery
4. Average Age of Mother at First Registerable Birth
9. Dental Decay in 5 year olds

Prevalence of obesity in reception year pupils

Enable all children, young people and adults to have control over their lives

6. Primary School Attendance rate
7. Secondary School Attendance rate
8. Year 11 Pupils staying in Learning

Percentage 11 years olds achieving the expected level 4 or above maths and English key stage 2

Percentage of 15 year olds in schools maintained by the Local Authority achieving 5 or more GCSEs at level A-C

Teenage conception rates per 100,000 population

Create and develop Healthy and sustainable Places and Communities

20. Children killed/seriously injured in road accidents by site of accident
24. Total incidence of crime per 1,000 population

Affordable housing (average house price/average gross full time earnings)

Number of homeless families with children living in temporary accommodation

Number of violent offences per 100,000

Level of air quality NOx and PM10 exceedances

Average annual rate of reported child (0-15) road traffic casualties per 100,000 population

Age standardised mortality rate (direct standardised mortality rate per 100,000 population) from suicide and injury undetermined

Number of beneficiaries/ claimants of incapacity benefit / severe disablement allowance with mental or behavioural problems per 1,000 working age population

Provide accessible and equitable care and disease prevention:-

10. Emergency admission rates. All ages
11. Emergency admission rates. Aged 65+
12. Average waiting times for Hip/Knee operations
13. Access: ratio of elective to non-elective admission rates for Chronic diseases
14. All Cause Mortality rate < 75 years
15. Cancer Mortality rate <75 years
16. Circulatory Mortality < 75 years
17. A&E Attendance rate > 65 years
18. Mental Health 1st Outpatient Attendances rate
19. Home Care Provision as % of >65 years population

Prevalence of Drug misuse per 1000 population

Number of smokers who had successfully quit at the 4 week follow up –per 100,000 population

Number of primary care professionals per 100,000 population

Emergency admissions rate for asthma and diabetes per 100,000

Mortality from all cancers by local deprivation quintiles, directly age standardised rate persons under 75

Mortality from all circulatory disease by local deprivation quintiles, directly age standardised rate persons under 75

Mortality from lung cancer by local deprivation quintiles, directly age standardised rate persons under 75

Create fair employment and good work for all

21. % Households receiving Income Support/Job Seekers Allowance

22. % Households moving in previous year

23. % Vacant Properties

Those unemployed as a percentage of the economically active population

The proportion of young people(18-24) in full time education or employment

The proportion of unemployed people claiming benefits who have been out of work for more than a year