HWB.01.10.2013/9
Appendix 1

BARNSLEY
Metropolitan Borough Council

Joint Strategic Needs Assessment 2013 Report

DRAFT

NHS
Barnsley Clinical Commissioning Group

Produced on behalf of the Barnsley Health and Wellbeing Board

Prepared jointly by:
Barnsley Clinical Commissioning Group
Barnsley Council Adults and Communities Directorate
Barnsley Council Children Young People and Families Directorate
Barnsley Council Performance and Partnerships, Corporate Services
Barnsley Council Public Health Directorate

Particular thanks go to Barnsley Healthwatch for their membership of and advice to the Joint Strategic Needs Assessment Steering Group

Comments on the Draft Joint Strategic Needs Assessment are welcome.

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Published September 2013.

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Foreword

I am pleased to present this report on the Joint Strategic Needs Assessment for Barnsley. A Joint Strategic Needs Assessment (JSNA) is the process through which public sector partners identify where best to invest their resources to reduce health inequalities and secure the health outcomes Barnsley people deserve.

The JSNA provides the data and intelligence on which the commissioning and delivery of health, wellbeing and social care services should be based. The Barnsley Clinical Commissioning Group (CCG) has a duty to have regard to the JSNA when developing their plans for health services for the local population. Barnsley Metropolitan Borough Council (BMBC) will use the JSNA to shape our commissioning strategies for adult, children's and public health services. Together, the partners on the Health and Wellbeing Board will use the JSNA to refresh the Barnsley Health and Wellbeing Strategy and inform our joint commissioning priorities.

The establishment of the Health and Wellbeing Board on the 1st April 2013 opens a new chapter in partnership working across the Borough to improve the health of the people of Barnsley and tackle health inequalities.

The JSNA 2013 has taken a different approach to previous years and is based on the principle that understanding health and wellbeing first requires an understanding of the ***people*** who live and work in the Borough, the ***place*** and the influences on health across the ***life course*** (being born, growing up, being an adult and growing old in Barnsley).

The benefit of this life course approach is that it encourages thinking around the broad range of factors that impact on health and wellbeing at different stages of life and helps to promote a joined up strategic approach across the Health and Wellbeing Board and its partners.

I would like to thank the officers of the Council, CCG and voluntary sector colleagues who have worked to produce the JSNA. However, producing the JSNA is just phase one. Phase two will see the production of ward based health and wellbeing profiles and consultation with local communities to find out what is important to them in terms of the information and support they need for themselves and their families to be able to live longer, healthier and productive lives. Phase three will see the refresh of the Joint Health and Wellbeing Strategy 2013-2016 and the development of joint commissioning strategies with ongoing evaluation of what is working and not working in achieving improved outcomes.

The JSNA, for the first time, has been developed as a web-based tool. This will enable the JSNA to be a truly living document, being continually refreshed and updated as new data and insights become available.

Future plans include establishing closer linkages between the JSNA and the Joint Strategic Intelligence Assessment produced by the Community Safety Partnership and the Pharmaceutical Needs Assessment.

I commend the JSNA to you.

Councillor Sir Stephen Houghton CBE
Chair of the Barnsley Health and Wellbeing Board

Section One: Introduction

The Joint Strategic Needs Assessment (JSNA) aims to provide a picture of the current and future health and wellbeing needs of the Barnsley population.

The production of the JSNA is a statutory duty and, from the 1st April 2013, the Council and the Barnsley Clinical Commissioning Group (CCG) both have an equal and explicit obligation to prepare the JSNA and this duty is discharged by the Barnsley Health and Wellbeing Board in accordance with the Health and Social Care Act 2012.

The JSNA:

- Is concerned with wider social factors that have an impact on people's health and wellbeing such as housing, poverty and employment
- Looks at the health of the population and factors which affect health such as smoking, diet and exercise
- Provides a common view of health and care needs for the local community
- Identifies health inequalities
- Provides evidence of effectiveness for different health and care interventions
- Documents current service provision
- Identifies gaps in health and care services, documenting unmet needs

Joint Health and Wellbeing Strategy

In addition to their duty for producing the JSNA, Health and Wellbeing Boards have a responsibility for developing a Joint Health and Wellbeing Strategy.

The Joint Health and Wellbeing Strategy 2013-2016 for Barnsley was published earlier this year. The strategy sets out a vision for Barnsley which is:

> *"Barnsley residents, throughout the Borough, lead healthy, safe and fulfilling lives, able to identify, direct and manage their individual health and wellbeing needs, support their families and communities and live healthy and independent lifestyles"*

The vision is based around the following core values:

- Promoting people's independence, choice and control, and;
- No decision about me, without me and preferably, made by me

To achieve the vision for Barnsley, a series of outcomes have been developed for the residents and communities of the Borough:

- Every child has the best start in life, able to fulfil their potential, achieve their ambitions and play their fullest role in society, thereby breaking the link between early disadvantage and poor outcomes throughout life
- Health inequalities within the Borough are reduced so that all residents have the best possible quality of life, with the gap against the national average reducing
- Older people achieve healthy, independent living – adding years to life and life to years
- Residents have greater choice and control over their health and wellbeing, able to manage their own needs and direct their own support

The Health and Wellbeing Board will review the strategy annually in the light of the most recent JSNA findings and through consultation with partners and local communities. This strategy should, in turn, inform local health and social care commissioning plans.

Who Is the JSNA For?

In addition to the Health and Wellbeing Board, the main audience for the JSNA are health and social care commissioners and service providers who use it to plan services.

It can also be used as an evidence base for preparing bids and business cases by the community and voluntary sector and other partners, and by the public to scrutinise local health and wellbeing information, plans and commissioning recommendations.

Who is Involved in Developing the JSNA in Barnsley?

The Barnsley Health and Wellbeing Board are responsible for overseeing the production of the JSNA. It is the responsibility of the Health and Wellbeing Board members to work together to understand the local community's needs, agree priorities and encourage organisations involved in health and care to work in a more joined up locally.

The JSNA Steering Group is responsible for producing the JSNA. This is a cross-sector group with representatives from across Barnsley Council, Barnsley Clinical Commissioning Group (CCG) and Healthwatch.

Principles of the Joint Strategic Needs Assessment

Government guidance on the purpose of JSNA's and the method for carrying them out has changed since the introduction of the Health and Social Care Act 2012. The new JSNA's are intended to be more strategic, involve more community engagement and act as a 'call to action'. There is a focus on the assessment of 'assets' as well as 'needs' so that gaps can be identified and addressed.

In particular, the new JSNA involves a greater emphasis on:

- The role of the JSNA in the development of the Joint Health and Wellbeing Strategy by the main statutory partners, the Council and the CCG and other members of the Health and Wellbeing Board
- The importance of not only identifying needs in the community but also assets. Assets include existing services and community-based assets such as the voluntary sector and other social networks
- Making recommendations for commissioning decisions, including areas for efficiency gains and with potential for de-commissioning in the light of the economic downturn and budget constraints

The principle that underpins the JSNA is that understanding health and wellbeing in Barnsley requires understanding of people, place and life course (being born, growing up, being an adult and growing old in Barnsley)..

There are factors about the individual characteristics of people who live and work in Barnsley that link to their health, for example age, gender, ethnicity, religion, income, employment status and qualifications.

There are also features of Barnsley as a place that impact on health, for example housing quality, green and open spaces, access to high quality public services.

Taken together, these people and place factors provide the background for explaining health and the potential for improving the health of people in the Borough.

What Does the Joint Strategic Needs Assessment Look Like in Barnsley?

The intention is that our JSNA is always under review and being improved in response to new information and feedback.

We use data from a range of sources. This includes information about the population, housing, employment, the effects of lifestyle choices on health, prevalence of diseases, services used and their effectiveness, community perspectives and other useful information.

The data used in this process is both qualitative and quantitative and may also come from existing reports, needs assessments, strategies and action plans.

This data will be added to over time as more information and insights becomes available.

JSNA's are flexible and enable local areas to focus on the priorities and present information in the way that is most relevant to them.This time, we have structured what we know about health status, determinants, evidence for effectiveness and current strategy around the life course. This is a different approach to that used in previous JSNA's but is consistent with the approach recommended by the Marmot Review[1] which highlights how a person's health depends on the accumulation of

[1] The Marmot Review, 2010. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010 available at www.marmotreview.org

positive and negative effects on health and wellbeing through the life course and sets out the evidence for action from before birth and throughout life.

The benefits of the life course approach is that it encourages thinking around the broad range of factors that impact on health at different stages of life and promotes an integrated strategic approach across all partners.

The JSNA has been developed as a web-based tool and is presented in a series of needs assessments arranged in the following sections:

- People and Place – the determinants of health and wellbeing
- Starting Well and Growing Well – giving children a good start in life
- Living and Working Well – a healthier and longer life
- Ageing Well – promoting independence

In a departure from previous years, needs assessments grouped under each section have been produced as individual documents which can be downloaded from the JSNA website; approximately 79 outcomes indicators are analysed.

In general, each needs assessment is designed to cover the following:

- Analysis of the data and benchmarking of Barnsley's performance against other areas.
- Factual information and evidence of need
- Evidence of best practice
- What we are doing about it in Barnsley
- Mapping of assets and identifying gaps in services

Wherever possible a section on 'community voice' is also provided.

These documents can be regarded as essential background for decision makers and are based on the latest information available.

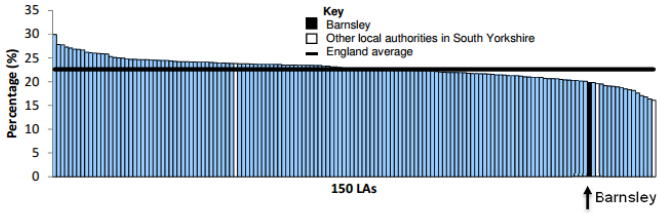
A snapshot of the front section of one needs assessment is provided below as an example:

Starting Well and Developing Well

Barnsley JSNA

Excess weight in 4-5 year olds (Public Health Outcomes Framework 2.6i)

2.6i Percentage of children aged 4-5 classified as overweight or obese



Percentage of children aged 4-5 classified as overweight or obese (2011/12)

	Number of Overweight or Obese	Number of children weighed	Proportion of overweight or obese children	Compared with England
Barnsley	523	2,632	19.9%	☺
Doncaster	810	3,396	23.9%	😐
Rotherham	494	3,068	16.1%	☺
Sheffield	1,144	5,817	19.7%	😐
England	**127,606**	**565,662**	**22.6%**	-

Source: Public Health Outcomes Framework Data Tool (May 2013)

In 2011/12, 97.1% of 4-5 year olds in Barnsley were weighed and measured. In Barnsley, a fifth (19.9%) of 4-5 year olds measured were either overweight or obese. Barnsley is significantly lower than the England average for the proportion of overweight or obese children.

Tackling obesity is a national priority. In England in 2010, almost a sixth of children (16%) aged 2 to 15 years were obese (The Health and Social Care Information Centre 2012). By 2050, 25% of children may be obese according to the Foresight Report produced in 2007. Children with a Body Mass Index (BMI) over the 95th percentile are classified as obese, based on the 1990 UK reference population (The Health and Social Care Information Centre 2012).

Obesity reduces life expectancy by an average of 9 years and is responsible for 9000 premature deaths a year in England. In addition, people who are obese can experience stigmatism and bullying that can lead to depression and low self-esteem. Around 58% of cases of type 2 diabetes, 21% of cases of heart disease and between 8% and 42% of certain cancers (endometrial, breast and colon) are attributable to excess body fat (Foresight 2007).

Established in 2005, the National Child Measurement Programme (NCMP) for England weighs and measures children in Reception (YR) (aged 4-5 years) and Year 6 (Y6) (aged 10-11 years). Data is collected annually by school nursing teams with the support of schools. Children are weighed and measured at school over the spring and summer terms (NHS Barnsley 2012).

To tackle overweight and obesity effectively we need to adopt a life course approach - from pre-conception through pregnancy, infancy, early years, childhood, adolescence and teenage years, and through to adulthood and preparing for older age (Department of Health 2011).

The overall approach to tackling overweight and obesity has been informed by the latest evidence of the underlying issues and causes, the latest evidence of 'what works, and in particular, good practice. This approach needs to be incorporated with extensive engagement with a wide range of partners.

This current evidence informs us that we need a new approach including: Empowering people and communities whilst building local capability, in conjunction with national leadership.

JSNA September 2013

Looking to the Future of the JSNA in Barnsley

The JSNA should be regarded as a repository of health and wellbeing related intelligence available on a website that all partners and public can access. Development of the JSNA will be overseen by a joint strategic intelligence working group, reporting to the Health and Wellbeing Board, and with membership that includes key partners as well as engagement with patient and service user representatives. The JSNA will be developed on two levels:

- Local profiles – these will be broad presentations of key data that can be measured at a local level. They will allow for the data to be interrogated according to a range of communities of interest and enable comparisons with national and local benchmarks using appropriate statistical techniques. The first of these will be ward based health and wellbeing profiles identifying health inequalities
- Needs assessments – these will be 'deep dives' in specific areas. They will examine underlying population need, existing service provision, activity, quality, outcomes and costs, and model the impact of potential service changes. Where possible they will consider Asset Mapping to explore the resources that communities might bring to meeting their own needs

The aim is for the JSNA to bring together all mandatory strategic needs assessments under one umbrella to ensure accuracy of information, avoid duplication and make the best use of increasingly scarce analytical resource. This will include developing linkages with the Joint Strategic Intelligence Assessment (JSIA) produced by the

Community Safety Partnership focused on crime and disorder and substance misuse and the Pharmaceutical Needs Assessment used to inform commissioning of local community pharmacy services.

The intention is to continuously update the JSNA, with quarterly newsletters being produced and disseminated to let people know what has been added to the website.

Section Two: Headline Messages

The following table summarises the key messages arising from the Barnsley Joint Strategic Needs Assessment as at September 2013:

Chapter Heading	Key Messages	Recommendations for Consideration by Commissioners and Service Providers
People and Place	• Barnsley has a population of 233,700 (ONS mid-2012 estimates) and is projected to increase to 242,000 by 2017. • The most significant increases are in the under 16's population and in people over 65. • 96.8% of Barnsley residents were born in the UK; 96.1% describe themselves as white British • 20.3% (30,120) of the working age population in Barnsley are receiving out of work benefits. This is the highest in South Yorkshire and significantly higher than the national rate of 28.7%. • Of the 30,120 residents who are on out of work benefits, an estimated 14,190 are claiming Employment Support Allowance and incapacity benefits – 41% are claiming die to mental health and behavioural disorders. • The number of people out of work for more than 12 months in Barnsley accounts for 30.5% of the of the Job Seekers Allowance claimants compared with the national rate of 28.7%. Over the last 12 to 18 months the number of long term unemployed residents in the Borough has increased by 14.3% • Almost 31,000 private sector dwellings are classified as non-decent and over 17% of households in the private rented sector are in 'fuel poverty'. It is estimated that 20% of excess winter deaths per year can be directly attributed to excess cold hazards.	• Recognising increasing demand on health and social care, from an ageing population and increasing costs, attention needs to be focused on preventing disease through prevention and early intervention, improving productivity, improving quality and reducing inefficiencies. • The close relationship between education, employment, worklessness and health needs to be better understood by those responsible for planning and commissioning services. Poor health, particularly mental health, can be both a cause and an outcome of long term unemployment. • There needs to be a greater focus on helping people with long term health conditions back into work. • If Barnsley is to become an easier place to become healthy, consideration of health impact will need to be at the heart of housing and planning strategy for the Borough. • The Local Development Framework is a major vehicle for shaping Barnsley into a place that builds health and wellbeing into everyday life. It is important that health and wellbeing impacts are factored into significant developments in the Borough. Consideration should be given to embedding health impact assessment into local planning frameworks.

	• Episodes of violent crime at 10.9 per 1,000 population in Barnsley are lower than the England average at 14.6 (2010/11 data). However there is some indication that acquisitive crime may be on the increase across the Borough, linked to the economic downturn.	• The Community Safety Partnership should consider greater efforts to ensure that the links between crime and health are better understood. The move towards integration of the JSNA and JSIA should assist with this process.
Starting and Growing Well	• 23.5% (54,500) of the population of Barnsley is under the age of 20 (ONS 2011). This is projected to increase to 57,390 by 2020. • 5.6% of school children aged 5-16 years (1,493) are from a black or minority ethnic group. • The level of child poverty is worse than the England average with 24.9% of Barnsley's children under 16 years living in relative poverty compared with the England rate of 21.1%. 26% of children in Barnsley are reported as living in a household reliant upon out of work benefits. • Educational attainment continues to improve in Barnsley but results at age 16 remain well below the national average in relation to the proportion of children attaining 5 A* to C grades at key stage 4 including English and Maths. • The number of people in Barnsley aged 16 and over with no qualifications is improving but is still significantly higher than the England average. Almost a third of the adult population does not have any formal qualifications. • Infant and child mortality rates are similar to the England average but there is a link between infant mortality and deprivation. • The teenage pregnancy rate is significantly higher than the national average and is increasing. There is a link between teenage conceptions and alcohol misuse. • The number of women smoking during pregnancy in Barnsley is	• The Marmot Review (2010) is unequivocal in stating the critical importance and need to prioritise physical, emotional, social and cognitive development in early years • Recognising the key importance of good education, attention needs to be focused on ensuring there are sufficient high quality early years and school places available across the Borough. • The efforts to improve educational attainment at all key stages need to continue and consideration needs to be given to opportunities to accelerate progress in this area • Recognising the potential negative impacts of child poverty this should continue to be a key focus for the Anti-Poverty Board and its partners • The importance of the antenatal period in shaping the future health of babies born in Barnsley cannot be overstated. As the commissioner of maternity services, the CCG needs to understand the nature of current service provision and any barriers to women accessing high quality maternity care before, during and after delivery • Recognising the importance of early years development, the funding of the Having a Baby Programme from the Public Health Grant should continue with ongoing evaluation to assess whether it is being accessed by families who can benefit the most. Consideration should be given to scaling up this programme so that more families can benefit • Work is already underway focused

	significantly higher than the regional and England average. There is a link between high levels of smoking and deprivation. • Only 61.7% of mothers initiate breastfeeding when their baby is born which is less than the England average of 74%. This falls to 27.3% of mothers who are still breastfeeding 6 to 8 weeks after the birth of their baby compared to 47.2% for England. • The proportion of children aged 4 to 5 years classified as overweight or obese in Barnsley is 19.9% which is lower than the England average at 22.6%. This represents positive progress. At 32.8%, the proportion of Barnsley children aged 10-11 years classified as overweight or obese is similar to the England average of 33.9%. This remains cause for concern. • Although the uptake of childhood immunisation in Barnsley is good further efforts are required to maintain coverage at 95% to ensure children are adequately protected. • There is some indication that alcohol related hospital admissions are higher among young people in Barnsley. • Other areas of concern include dental health of 5 year olds, emotional health and wellbeing and improving the health outcomes of children looked after. • The importance of continuous improvement of safeguarding services and services for children in care	on evaluating current approaches to reducing smoking during pregnancy. This needs to continue and inform future commissioning strategies and plans • The rise in teenage pregnancies is cause for concern. As part of the work in implementing the Barnsley Young People's Health and Wellbeing Strategy, consideration should be given to further consultation with young people to find out their views on what would work in terms of reducing unwanted teenage pregnancies • The efforts to promote breastfeeding should continue within the context of an approach that is focused on improving maternal and infant nutrition through the Healthy Start programme • Although progress is being made in reducing the proportion of children who are overweight or obese, the numbers of children affected are still too high and there needs to be a continued focus on promoting a healthy weight through school based programmes and family interventions • The delivery of the childhood immunisation programme has become more complex since the dissolution of the PCT and establishment of new commissioning organisations on the 1st April 2013. Commissioners and providers of childhood immunisation must make working together a priority to ensure that immunisation targets are met and children are adequately protected • Alcohol and substance misuse remain cause for concern and need to be a continued focus for attention through evidence based interventions • The Children's Trust should seek assurance, through partnership arrangements, that there are robust strategies and plans in place to

		focus on improving health and wellbeing outcomes for children and young people across a range of issues, including dental and emotional health which have already been flagged as areas of concern. • The focus on safeguarding and improving outcomes for children in care continue to be of the highest priority. The importance of prevention and early intervention needs to be a key focus of attention with improvements driven through the newly established Think Family Board.
Living and Working Well	• Overall health in Barnsley is worse than the England average. • Life expectancy at birth is 77.4 years for men and 80.9 years for women compared to 78.9 years and 82.9 years nationally. • There is marked variation in life expectancy across the Borough with a gap of 6.1 years between the wards with the highest and lowest life expectancy for men and a gap of 7.6 years for women. The lowest life expectancy can be found in the East of the Borough. • Death rates from the 3 main killers – cardiovascular disease (heart disease and stroke), cancer and respiratory disease have fallen over the last 10 years but still remain significantly higher than the England average. Cancer, particularly lung cancer, is the main cause of premature death. • The percentage of adults in Barnsley taking enough exercise is lower than the national average with only 1 person in 5 meeting the recommended guidelines for physical activity • The proportion of adults in Barnsley eating healthily is only 20.3%, lower than the England average of 28.7% • Smoking prevalence in adults remains high in Barnsley at 25.6%	• The 3 major causes of premature death in Barnsley – cancer, CVD and chronic lung disease are strongly linked to deprivation • As the 3 main causes of the gap in life expectancy between Barnsley and England and between different communities within Barnsley, these should be priority areas for the Health and Wellbeing Board • The impact of unemployment, poverty, poor housing conditions will potentially worsen these conditions and also have an adverse impact on other health issues such as mental health. This is likely to create additional demand on primary care services • The high prevalence of behavioural risk factors, particularly smoking, is a key barrier to reducing the gap in life expectancy. The importance of taking a common risk factor approach should be recognised by commissioners when developing strategies for dealing with 'lifestyle' issues such as smoking, food, exercise and alcohol use • Obesity continues to be an important contributory factor to the high levels of diabetes in Barnsley and associated high death rates from CVD. Commissioning of weight management services is complex across the care pathway and

	compared with an England average of 20%. There is considerable variation in smoking prevalence across the Borough with high levels of smoking linked to deprivation. High levels of smoking are the predominant cause of high lung cancer deaths in Barnsley. • Levels of obesity and diabetes are higher in Barnsley than the national average contributing to high death rates from cardiovascular disease (heart disease and stroke). • Barnsley's levels of successful completion of drug treatment for both opiate (5.6%) and non-opiate (26.5%) users are cause for concern. Successful treatment levels are significantly lower than the England average at 8.6% and 39.5% respectively. • Hospital stays for alcohol related harm are significantly higher in Barnsley. • The percentage of adults with a diagnosis of depression is higher in Barnsley at 15.8% compared with an England average of 11.7% • The proportion of Barnsley residents living with a limiting long term illness is 24.4%. This is significantly higher than the England average of 16.9% • Of the 30,120 residents in Barnsley who are on out of work benefits, an estimated 14,190 are claiming Employment Support Allowance and incapacity benefits – 41% are claiming die to mental health and behavioural disorders. • Take up of national screening programmes for breast and cervical cancer in Barnsley is good at 81.7% and 79.4% compared to 76.9% and 75.3% nationally but there is still room for improvement to reduce the number of avoidable deaths • At 72.9% access to diabetic eye screening in Barnsley is lower than the England average at 80.9%. It is	partners need to work together to find evidence based solutions to reducing health impacts of excess weight • The reasons why Barnsley has one of the lowest rates of successful completion of drug treatment need to be better understood. Current arrangements for tackling drug and alcohol issues need to be evaluated and appropriate actions taken to significantly improve outcomes • The current Health and Wellbeing Strategy does not include mental health as a priority. Given the significance of the burden of mental ill-health on individuals, families and the economy through work sickness absence and welfare benefits claims the Health and Wellbeing Board should give consideration to including this as an area to focus on • Given the high proportion of Barnsley residents living with a long term illness consideration should be given to whether sufficient attention is being given to helping people develop more confidence in self managing their condition and understanding when they need to seek help. Greater efforts to promote effective self management, together with improving access to primary care, should help to reduce the number of A&E attendances and unplanned admissions to hospital for ambulatory • Whilst take up of cancer and non-cancer screening programmes in Barnsley, across all age groups, is generally good there is no room for complacency and efforts need to continue to raise awareness of the importance of screening. • The low uptake of diabetic eye screening in Barnsley is cause for concern and merits further examination to understand the reasons for this. This should include an age breakdown to better understand access to screening by

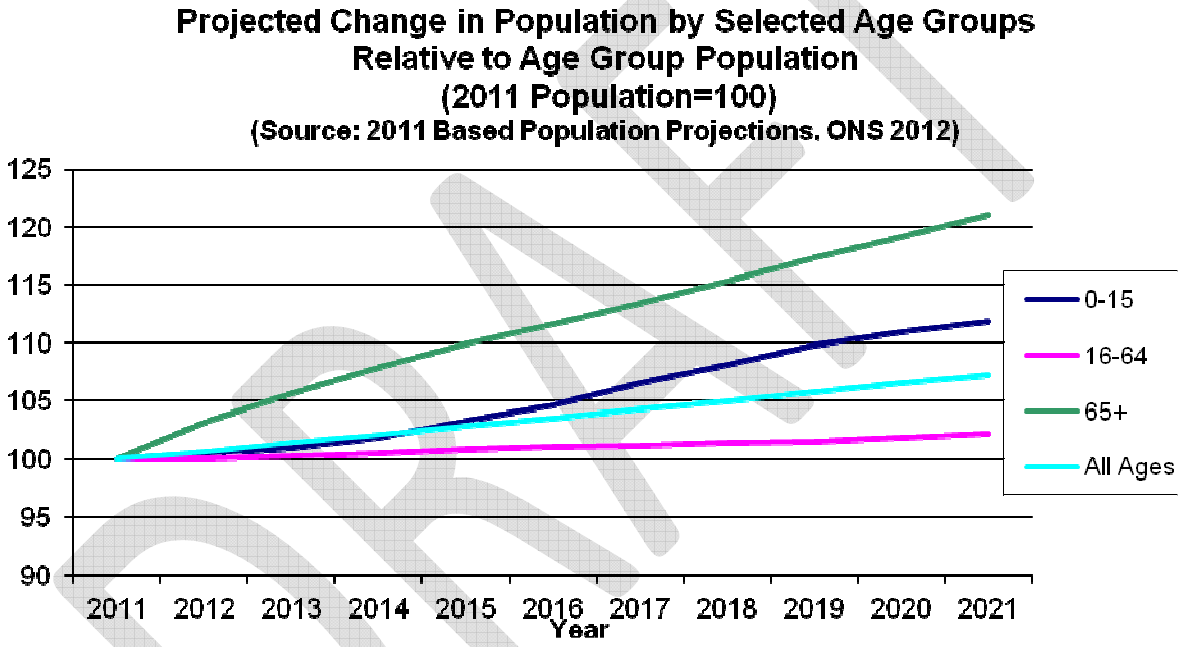
	important that Barnsley residents with diabetes take up screening to help prevent avoidable sight loss. This is an area for improvement.	different age groups, including children and young people. The commissioning responsibility for this programme passed to NHS England on the 1st April 2013.
Ageing Well	• The proportion of older people in the Barnsley population is forecast to increase. • One person in every 200 in Barnsley has been diagnosed with dementia (2011/12) and with the growing elderly population this number is expected to increase. • Fuel poverty in the elderly with low incomes is an increasing concern. It is estimated that 20% of excess winter deaths per year can be directly attributed to excess cold hazards. • Falls in the elderly resulting in a hip fracture are higher in Barnsley than the England average but this increase is not statistically significant. • Uptake of seasonal influenza vaccination for the 2011/12 winter in people aged over 65 in Barnsley was significantly lower than the England average at 72.7%. This was below the recommended minimum target of 75%. • In the latest survey of patient satisfaction with GP services, the lowest levels of satisfaction were with out of hours services. • Only 1 person in 5 who wanted to die at home was able to do so.	• Recognising increasing demand on health and social care, from an ageing population and increasing costs, attention needs to be focused on preventing disease through prevention and early intervention, improving productivity, improving quality and reducing inefficiencies. • The expected increase in demand for dementia diagnosis, treatment and support services needs to be planned for • In the context of the localisation agenda and locality based community consultation and engagement strategies e.g. through Area Councils and Ward Alliances, there is a substantial opportunity to drive more integrated and innovative partnership working at a local level in a way that meaningfully engages local people in improving their local services. This includes the opportunity to focus on primary care services to make them more accessible • Efforts to mitigate against fuel poverty and strategies to prevent excess winter deaths continue to be important • Although Barnsley does not appear to have a statistically higher incidence of hip fractures, falls in the elderly are potentially avoidable and so consideration should be given to reviewing falls prevention strategies and to what extent these are effective • Seasonal influenza is an important health problem in older people and those with long term health conditions. It is an important cause of hospital admission during the winter months and contributes to excess winter deaths. It is largely

		preventable through an effective seasonal flu immunisation programme. Every effort should be made to ensure that all eligible residents in Barnsley are offered seasonal flu immunisation and that uptake continues to be closely monitored

Section Three: People and Place

Population

Barnsley has a population of 233,700 according to the mid-2012 estimates from the Office of National Statistics (ONS). This represents an increase of 0.8% between 2011 and 2012. Of the increase, most was due to the net[2] arrival of 846 more people from the rest of the UK (called internal migration), then natural growth (our 2,970 births being 739 greater than the 2,231 deaths), and finally 225 net international migration. Growth in the younger and older age groups (children and retired people) has been greater than expected. The population in Barnsley is predicted to increase by 3.6% to 242,000 by 2017. The most significant increase is expected to be in the number of people aged over 65.



96.6% of Barnsley residents were born in the UK. The table below shows the ethnic groupings in the population.

Ethnic Group	Percentage
White UK	96.1%
Other White	1.5%
Mixed/ multiple ethnic groups	0.7%
Asian / Asian British	0.7%
Black / African / Caribbean/ Black British	0.5%
Other ethnic group	0.2%

[2] Net refers to the difference between people arriving and leaving Barnsley for the rest of the UK/rest of the world.

The great majority describe themselves as 'white' (97.6%). It is estimated that there are around 200 Gypsy or Travellers, one-third of whom are children living on several sites in the borough.

Almost all (98.7%) households contain at least one person whose first language is English. However, there are 1,339 households in Barnsley where no-one speaks English as a main language.

Just over two-thirds (68.5%) of Barnsley residents stated on the 2011 Census that their religious belief was of the Christian faith; almost a quarter (24%) said they had no religious belief. 6.5% of people chose not to answer this question.

Employment and Unemployment

The 2010 Index of Multiple Deprivation (IMD) identified Barnsley as being the 47th most deprived local authority in England and the 27th most deprived place for employment.

Unemployment and underemployment are comparatively high in the borough and have increased during the recession (since 2008). Those aged under 25 or over 50, men, those with disabilities and people with low levels of education and training are most affected; and the centre and east of the Borough are most affected.

Currently 20.3% (30,120) of the working age population in Barnsley are receiving out of work benefits. This is the highest number in South Yorkshire and significantly higher than the national average (13.1%). Of the 30,120 residents who are on out of work benefits, an estimated 14,190 are claiming Employment Support Allowance (ESA) and incapacity benefits, of which 41% are claiming due to mental health and behavioural disorders.

The ONS annual population survey (2012) found that 23.1% (33,500) of residents of working age in Barnsley are classified as being economically inactive. Of this economic inactive cohort, 40.3% are classified as being long-term sick. Only an estimated 27.5% were actively seeking work.

The number of people unemployed for more than 12 months in Barnsley accounts for 30.5% of Job Seekers Allowance claimants. This is higher than the national rate of 28.7%. Over the last 12 to 18 months, the number of long term unemployed residents in the Borough has increased by 14.3%. Increases have been recorded in residents aged 50 to 64 years and 25 to 49 years at 8.3% and 5.8% respectively. The links between long term unemployment and ill-health are well known and so the increasing numbers of people out of work are likely to have a negative impact on health and wellbeing across the Borough.

In addition to those people becoming unemployed, for perhaps the first time in their lives, the Borough has a significant number of people who have never worked. This number was 12,599 identified in the 2011 Census.

Educational Attainment

Educational attainment in Barnsley continues to improve but there is still much to do to narrow the gap between Barnsley's performance and the national average. Results at age 16 remain well below the national average in relation to the proportion of children attaining the 'gold standard' of five A* to C GCSE grades including English and Maths at key stage 4.

Outcomes reflect a complex pattern of inequalities that exist between different pupil groups and different areas of the Borough. For example, girls' attainment is higher than boys throughout all stages of formal education and this gap has been widening from age 11 onwards over recent years. While the gap in attainment has closed in pupils with special educational needs by the age of 11, it has widened by the age of 16.

The number of people in Barnsley aged 16 and over with no qualifications is improving but is still significantly lower than the England average. Almost a third of the local population has no formal qualifications. This low level of skills is likely to have an adverse impact on the economic growth of the Borough and is cause for concern.

Housing

Barnsley's Private Sector Stock Condition Survey (PSHCS,2010) showed that 19,300 homes in the private sector have a Category One hazard which is defined as posing an 'unacceptable' health and safety risk to people living in, or visiting, the property.

Almost 31,000 private sector dwellings are classified as 'non-decent' and over 17% of households in the private sector are in 'fuel poverty'. This is a significant issue and can have adverse health impacts; it is estimated that 20% of excess winter deaths each year can be directly attributed to excess cold hazards with the old and the very young most vulnerable.

Improving the energy efficiency of the Borough's housing stock will help to reduce fuel poverty and improve living conditions, leading to improved physical and mental health as well as reducing excess winter deaths.

Falls to adults in Barnsley cost the local NHS an estimated £1.9 million a year. Results from the PSHCS 2010 survey showed that the highest number of Category One hazards were falls on stairs accounting for almost 55% of falls hazards. Hip fractures are the most common injury relating to falls in older people and can have a devastating impact leading to loss of confidence and social isolation, disability and death. Meeting the accommodation needs of increasing numbers of elderly people is going to be a significant challenge.

Analysis of the general housing market supply and using latest survey results suggests that housing demand outstrips supply across all wards. It is estimated that there is a shortfall of 136 dwellings per year.

The impact of the Government's welfare reform is likely to have a negative effect on the income of social housing providers and this, in turn, may impact on their ability to maintain their dwellings at an acceptable standard. Changes to housing benefit and the under occupancy rules could also lead to an increase in homelessness (SHU, 2013).

Barnsley has low levels of homelessness. In addition, local authorities in South Yorkshire have significantly lower rates of households in temporary accommodation than the England average and Barnsley (rate of 0.6) along with Doncaster, has the lowest rate of households in temporary accommodation in South Yorkshire.

Transport and Access to Services

Transport opportunities in the built environment can have a range of positive and negative effects on people, communities and places. Positive effects include opportunities for walking and cycling, access to employment, education, shops, social support networks, essential services, such as healthcare, and the countryside. However there are also negative effects such as air pollution, traffic injuries, noise which may cause stress and anxiety, land loss and planning blight and the physical segregation of established communities.

Overall traffic levels in Barnsley have been stable since 2011. Nearly 2 in 3 journeys are made by private car while rail use is increasing and bus use decreasing. Over reliance on the car can impact on air quality and noise and also promote weight gain if the car is used for short journeys that could be made by walking or cycling. Lack of affordable and appropriate transport is a barrier to employment, healthcare and social, cultural and sporting activities.

One of the strategic objectives of the Local Development Framework Core Strategy is *"to reduce the need to travel, but where travel is necessary to make it easy for people to move between home, work, health, community and leisure facilities by walking, cycling, or where necessary using public transport".*

Accessibility to a hospital A&E for Barnsley residents is average by national standards, with 64% of residents within a 30 minute journey by public transport.

Some of the most deprived communities in the east of the borough have the poorest access to a hospital. Over a quarter (27%) of all households within Barnsley do not have availability of a car or a van, therefore accessing services for these people can be problematic. More than half of African or Bangladeshi households do not have access to a vehicle.

Environment and Climate Change

The world's changing climate presents unprecedented and potentially catastrophic risks to health and wellbeing. This is not only a global issue, but also a local one. Projections for Yorkshire and Humber show that these changes will lead to increased air temperatures, decreased summer rainfall and increased winter rainfall over the next 80 years. The major impacts of these changes for Barnsley by 2050 will include:

- Increased storm intensity and frequency

- Increased flooding (winter and summer high intensity surface water run-off)
- More heat waves with a predicted average daily temperature increase of approximately 2.3^{o}C
- Drought problems with decreases in summer rainfall by up to 19%

Barnsley, at 5.4% has the lowest proportion of mortality in the over 30s attributable to air pollution in South Yorkshire; lower than the England average of 5.6%.

The rate of complaints about noise, per 1,000 population in Barnsley at 6.0 is significantly lower than the national average (7.8 per 1,000), and complaints have fallen over the last two years.

Community Safety

The South Yorkshire Police and Crime Plan 2013-2017 sets out a vision 'to make South Yorkshire the safest place to live, learn, work and run businesses'. The plan, developed by the South Yorkshire Police and Crime Commissioner, has a number of overarching priorities and also the following local priorities for Barnsley:

- Re-offending
- Vulnerable people, including work to protect children against sexual exploitation
- Alcohol and drug abuse
- Anti-social behaviour

The Community Safety Partnership in Barnsley is now established as a sub-group of the Health and Wellbeing Board and this provides an opportunity to strengthen partnership working with the NHS on the linkages between crime and health.

The move toward integrating the JSNA with the Joint Strategic Intelligence Assessment (JSIA) produced by the Community Safety Partnership will help with this process in identifying areas where there are common goals.

Section Four: Starting Well and Growing Well

The early years of a child's life are significant in forming the person they will become; physically, intellectually and emotionally. Experiences in infancy and early childhood, both positive and negative can have a lifelong effect on the health and wellbeing of an individual. In order to give a child the best start in life, it is crucial to reduce inequalities in early development. This means ensuring high quality services such as maternity services, parenting support, childcare ad early years education.

Although women seem relatively satisfied with services during pregnancy, they express only average levels of satisfaction with care during birth. Over 1 in 5 said they had not been given the option of a home birth, and they were least satisfied with how long they could stay in hospital and the levels of kindness and understanding they were shown after birth.

The smoking rate amongst pregnant women in Barnsley, at 21.9%, is nearly 10% higher than the national average. In 2011/12, only 35% of pregnant smokers successfully quit in Barnsley. This was significantly fewer than both the national and regional averages of 45% and 49% respectively. Deprivation is highest in eastern parts of the borough and this pattern of deprivation is reflected in the pattern of mothers smoking at time of delivery. This represents a significant health risk to infants and opportunity for health improvement.

The UK has low breastfeeding rates compared with the rest of Europe and Barnsley's initiation rate, 61.7%, is below the national average of 73.9%. Rates fall rapidly over the first few weeks of life and by 6-8 weeks, only 27.3% of Barnsley babies are breastfed; the lowest in South Yorkshire. Again, breastfeeding rates are strongly related to levels of deprivation across the Borough. Breastfeeding protects the health of babies and mothers and reduces the risk of illness and infant mortality. Increasing breastfeeding will improve the health of families in Barnsley.

In 2011/12, almost 1 in 5 (19.9%) of 5 year olds in Barnsley were overweight or obese. This demonstrates real progress and is better than the national average of 22.6%. Of those aged 10 or 11 who were weighed, almost 1 in 3 (32.8%) were overweight or obese; only slightly below the national average (33.9%), but falling consistently for three years. It is possible that the progress made for those aged 5 will also translate into lower rates at older ages in the future. The highest rates in both age groups are in the east of the borough.

A recent report published by Public Health England showed that in 2012, by the age of 5, the average child in Barnsley had 1.61 decayed, missing or filled teeth compared to the England average of 0.94. 41% of 5 year olds in Barnsley had obvious tooth decay compared with 27.9% nationally and 33.6% for Yorkshire and Humber. 38.5% of Barnsley 5 year olds had untreated decay; this is an increase since 2008 when the number was 34.6%.

Episodes of diarrhoea and/or vomiting in young children (under 5), severe enough to lead to a stay in hospital, are more common in Barnsley than the most of England.

Emergency asthma admissions for children (0-19 years) are similar to the national average, as are emergency admission due to injuries. There remains some room for improvement in both.

Barnsley has significantly higher alcohol related hospital admissions among children and young people under 18 than the England average. Though they are forecast to fall slightly, there is significant room for improvement.

Results from the 2013 Barnsley Year 10 Health and Lifestyle Survey asked pupils whether they had ever smoked a cigarette. Girls (44.3%) were more likely to try smoking than boys (32.8%). Furthermore, by Year 10, 6.5% boys and 13.2% of girls were regular smokers. These figures are significantly lower than 2010 results when 17.6% of boys and 20.9% of girls were regular smokers.

Data from the 2013 Barnsley Year 10 Health and Lifestyle Survey (2013) shows that 21.7% of boys and 29.9% of girls aged 14 and 15 years old reported having sex; 47.9% of boys and 55.1% of girls reported not using a condom every time they had sex. In 2011/12, 21.5% of 15-24 year olds in Barnsley were tested for Chlamydia compared to an England average of 20.5%. In 2012, Barnsley's Chlamydia diagnosis rate in those aged 15-24 was not significantly different from the national average. It is thought that the substantial increases in the number of diagnoses made in England between 2000 and 2010/11 has probably decreased the prevalence of Chlamydia among sexually active under 25 year olds.
In 2011, teenage conceptions (ages under 18) were the highest in South Yorkshire and significantly above the national average; 39.8% leading to terminations. Rates are highest in the east and centre of the borough. There is an association between teenage conceptions and the misuse of alcohol.

The Human Papilloma Virus (HPV) vaccine programme for girls aged 12 – 13 years commenced in September 2008. HPV is a sexually transmitted virus that causes 99% of invasive cervical cancers. In 2011/12, 90% of eligible girls in Barnsley received a full course, slightly better than the national average. In the long-term, this will have a significant impact, reducing the incidence of a cancer that is more common in Barnsley than the country as a whole.

Although Measles, Mumps and Rubella immunisation uptake rates in Barnsley are significantly higher than national average for 5 year old children, at 93.9% they are below the target of 95%, which helps to protect the entire community (including those who have not been vaccinated – so called ‘herd-immunity’).

One in four children grow up in households where there is not enough money to keep warm in the winter, to eat healthily, to travel, see friends and to take part in school activities. Those in the east of the Borough have the worst experience.

Early Years and childcare provision includes daycare in Children's Centres, childcare in the private, voluntary and maintained sector and childminders. Good quality early years provision is proven to have a positive effect on the outcomes for young children and their readiness for school. This is particularly effective for those children that are experiencing other disadvantages. Barnsley is a little above national average for the quality of early years and childcare provision. Ofsted

assessments rate pre-school education in Barnsley as the highest quality in South Yorkshire.

In terms of educational performance, primary school attendance has improved recently and is only a little below the national average. In contrast, although secondary school attendance, is also improving at 93.1% (2011/12), this is 1.2% below the national average. Persistent absence is also comparatively high at secondary level. Although there is some suggestion that attainment for ethnic minority pupils may be similar to the average, those for looked after children may still be lower, though measurement is statistically unreliable. While the gap in attainment has closed in pupils with special educational needs by the age of 11, it has widened by the age of 16.

Young people aged 16-18 (academic age) year olds not in education, employment or training (NEET) are comparatively low at 5.2% (March 2013), having fallen by 13.3% since 2012. There is, however, a very steep inequality gradient across the town from 1.9% in Penistone East to 11.8% in Dearne North.

The 2011 Census Borough Overview tells us that 27,167 (11.7%) people in Barnsley said that they provided unpaid care to family members, friends or neighbours with either long-term physical or mental ill-health/disability or problems related to old age. Some 1,935 of these carers are aged under 25 (further age details are not available). Substance misuse was not included in the list of conditions which people were asked to comment on with regard to providing care. Parental substance misuse data provided by the Drugs and Alcohol Team (DAAT) in February 2013 shows that more than half (793 of 1,309) of the adults in structured substance misuse treatment were parents; they had 1,399 children. Some of these children are likely to have a caring responsibility.

Protecting vulnerable children is a key priority for the Children's Trust. Numbers of children in care are relatively low. For those children who are in the care of the local authority, Barnsley Council takes its corporate parenting duties very seriously and aims to ensure that, when young people leave care, they are ready emotionally, physically and educationally for a successful adult life. Priority areas for continuous improvement are to improve health and educational outcomes and to increase the number and range of local authority foster carers. This will create more choice so that the right placements are available for children, including meeting ethnicity and cultural needs, whilst also bringing down the costs attached to commissioning independent foster and residential placements. In terms of children leaving care, priorities are to work with partners to increase choice in suitable accommodation, to improve the response to homeless young people and to increase opportunities for employment and training and have more young people moving on into further and higher education.

Section Five: Living and Working well

Living a healthy life can increase life expectancy and improve quality of life. Making the right lifestyle choices reduces the likelihood of premature death and suffering certain long term conditions. Lifestyle risk factors, such as smoking and poor diet are often precursors for ill-health and they also have a relationship with deprivation in Barnsley and in England overall. People living in the most deprived areas are significantly more likely to smoke, be obese, be physically inactive and have poor nutrition compared to those from more affluent areas. They are therefore more likely to suffer from non-communicable diseases, such as cardiovascular disease and cancer as a consequence. The health of people in Barnsley is generally poorer than in many other parts of the country.

Life expectancy is a good indicator of trends in the overall health of a community. Life expectancy is increasing in Barnsley but at a slower rate than the rest of the country and the gap is widening. Latest data shows that life expectancy in Barnsley is 77.4 years for men and 80.9 years for women; this is 1.5 years lower for men and 2.0 years lower for women compared to England. Men and women in Barnsley have the lowest life expectancy when compared with the other local authorities in South Yorkshire.

There are also differences in life expectancy between men and women In Barnsley and between different areas across the Borough.

Gender	**Wards with significantly higher rates**	**Greatest difference**
Men	Dearne North Kingstone Wombwell Worsborough	Men living in Wombwell live 6.1 years less than men living in Penistone West
Women	Dearne South Kingstone Monk Bretton North East Wombwell	Women living in Monk Bretton live 7.6 years less than those living in Penistone West

The 3 main causes of death in Barnsley are cardiovascular disease (heart disease and stroke), cancer and respiratory disease.

Mortality among people aged under 75 years or younger (so called 'premature death') is a good indicator of ill-health caused by conditions which can be prevented either by people improving their lifestyle or by receiving the right care and treatment which delays the onset of serious illness.

Barnsley's death rate (2009-2011) for adults under the age of 75 due to diseases of the heart and blood vessels (circulatory disease) has fallen rapidly over the last decade, but remains significantly higher than the national average and also significantly higher than the rate in Sheffield. Death rates are expected to halve in just over a decade]. Rates in Kingstone and Dearne North are currently significantly higher than the borough average.

In 2009-2011 the death rate for those aged under 75 years due to cancer in Barnsley was significantly higher than the national average and the trend is relatively static. There is a large variation in the under 75 mortality rates from cancer by ward, though only two wards are significantly different from the Barnsley average, Penistone West has a significantly lower mortality rate from cancer and Dearne North has a significantly higher rate. Lung cancer is the most common cause of premature mortality.

In 2009-2011 the death rate for those aged under 75 years due to respiratory disease in Barnsley was significantly higher than the national average. Two wards have under 75 mortality rates from respiratory disease that are significantly higher than the Barnsley average, St Helen's and Dearne North.

Smoking is the single biggest cause of preventable death in Barnsley and in Britain, claiming more lives each year than the next six most common risk factors combined (Department of Health 2001). In 2011/12 over a quarter (25.6%) of the adult population in Barnsley were smokers; significantly higher than the national average of 20%. Rates have changed little over the last decade and are particularly high in 10 wards; Central, Cudworth, Dearne North, Dearne South, Kingstone, Monk Bretton, North East, Stairfoot, Wombwell and Worsbrough.

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40-74 who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce and manage their risk. Barnsley, with 81.9% of those offered a health check receiving a health check in 2012/13, has one of the highest percentages in the country. Nearly 9,000 people living in Barnsley received a health check in that year alone. Although we have good rates of uptake there is considerable variation between practices in rates of invite and uptake of health checks.

Similarly cancer screening acceptance rates are comparatively high in Barnsley (see table below).

Cancer	**Screening interval**	**Barnsley (2012)**	**England (2012)**	**Comments**
Breast (women aged 47-73)	3 years	81.7%	76.9%	
Cervix [	3-5 years	79.4%	75.3%	
Bowel		54.2% (ages 60-69) 52.3% (ages 70-74)	53.1% (ages 60-69) 48.7% (ages 70-74)	The NHS Bowel Screening Programme began in England in 2006; a newer screening test is being introduced from 2015.

Regular physical activity has substantial health benefits, yet only a minority (approximately 21%) of the population in Barnsley achieve the minimum levels as recommended in the Sport England "Start Active, Stay Active" report. In terms of sport and active recreation there's a clear east/west divide with much lower rates in the eastern part of the district.

Similarly the proportion of adults eating healthily in Barnsley is estimated to be only 20.3% which is lower than the England average of 28.7%.

The most recent death rates due to liver disease for Barnsley residents are similar to the national average. However, at 2254 per 100,000, Barnsley has a higher alcohol-related admission rate than the England average (1974 per 100,000).

On average 77 people in Barnsley are reported to be killed or seriously injured on the road each year. The rate of people who are killed or seriously injured on the road in Barnsley, at 33.7 per 100,000, is significantly lower than the England average.

There were 30,373 people with depression recorded on GP registers in 2011/12 in Barnsley, giving an 18+ age specific prevalence of 15.8%. The prevalence rate observed in Barnsley is significantly higher than the England average.

In 2012/11 mortality rates for mental health service users aged 19+ was 3.6 times the rate of the general population. As well as having the expected higher rates of mortality for mental and behavioural disorders and dementia, they were also higher for the following lifestyle related diseases:

- Nearly 4 times higher than the general population for death from diseases of the respiratory system
- Just over 4 times higher than the general population for diseases of the digestive system, including liver disease
- 2.5 times higher than the general population for diseases of the circulatory system

Research consistently shows that people with mental health problems have higher rates of physical ill health, largely from treatable conditions associated with modifiable risk factors such as smoking, substance misuse and inadequate medical care.

Although Barnsley has a higher suicide rate than the England average, at 8.2 compared to 7.9, this is not significantly different. Similarly, in 2010/11, the hospital admission rate for self-harm in Barnsley was also higher than the national average, 227.3 per 100,000 compared to 212.0; again, this difference is not statistically significant.

Long-Term Health Problems or Disability

The Census data also provided information on those residents who said that they have long-term health problems or disability that limits their day-to-day activities, and has lasted, or is expected to last, at least 12 months. The data shows the following:

- 12.6% of all Barnsley residents day-to-day activities are limited a lot, England average 8.3%.
- 11.3% of all Barnsley residents day-to-day activities are limited a little, England average 9.3%.
- 5.9% of all Barnsley residents aged 16 to 64 years day-to-day activities are limited a lot, England average 3.6%.
- 6.0% of all Barnsley residents aged 16 to 64 years day-to-day activities are limited a little, England average 4.6%.

These figures are all significantly higher than the national average, highlighting the high levels of health problems or disabilities within Barnsley.

The GP Patient Survey from 2012/13 asked people about their levels of satisfaction with a range of GP services. The lowest levels of satisfaction, and the only areas where Barnsley patient's satisfaction was significantly lower than in the country as a whole, related to knowledge about how to contact out of hours services, and satisfaction with the out of hours GP service. It is possible that these difficulties, real or perceived, contribute to avoidable attendances at hospital Accident and Emergency departments. Other questions in the survey related to how able people felt they could manage their own long-term illnesses. Whilst a high proportion of Barnsley patients reported such illnesses, they had lower levels of confidence that they were able to manage these illnesses themselves. This may mean that patients more readily seek help and access services when they experience any worsening of their health problems.

Data on claimants of welfare benefits also show a considerable burden of ill-health. Of the 30,120 residents who are on out of work benefits, an estimated 14,190 are claiming Employment Support Allowance (ESA) and incapacity benefits, of which 41% are claiming due to mental health and behavioural disorders.

There are almost 900 people registered as deaf or who are hard of hearing and approximately 80% of these are aged over 65 years.

There are almost 2,000 people registered as blind or partially sighted which equates to approximately 3% of the overall population and projections show this is likely to rise to 3.3% by 2020.

All people with diabetes aged 12 years and over should be offered screening for sight threatening retinopathy at least once a year. Progression of retinopathy can be slowed by good management of diabetes and treatment of the disease in its earliest stages. Barnsley has one of the lowest screening rates in the country, with only 72.9% of diabetic patients aged 12+ who were offered being screened; significantly lower than the England average of 80.9%. Improvements to this programme should reduce an avoidable cause of sight loss in the borough.

As at the 31 March 2013 there were 1,036 people aged 18 years and over registered on the local authority learning disability register. Of these people 57.6% were female and 92.8% were adults aged 18 to 64 years. People with Learning Disabilities die

younger and have poorer health than the general population. These differences are to some extent avoidable and therefore represent health inequalities.

Carers

The 2011 Census has also provided information on those that claim that they are a provider of unpaid care, either in their own or another household; not including any activities as part of paid employment. From this information 11.7% of Barnsley residents provide unpaid care, of whom:

- 6.7% provide 1 to 19 hours of care per week;
- 1.8% provide 20 to 49 hours and
- 3.3% provide over 50 hours per week.

Staying healthy is important for everyone, but it's especially important for carers. Many carers have little time to themselves for cooking nutritious food or exercising, and many feel emotionally drained or stressed and sleep badly. This makes carers prone to poor health, which can be exacerbated by a lack of time to be able to see a doctor or pharmacist.

Section Six: Ageing well

Ageing is inevitable but suffering ill-health in later life is not. It is never too late to adopt a healthier lifestyle and take steps to prevent ill-health. It is just as important for people in older age to have a balanced diet, remain physically active, not smoke and maintain a positive mental attitude.

Increasing age, however, is the most important factor for predicting ill-health and as the proportion of older people in the population rises, so too will the burden of illness in Barnsley. Key conditions for older people are cancer, cardiovascular disease, diabetes, respiratory conditions (such as pneumonia, chronic obstructive pulmonary disease) and dementia.

Diabetes is an important condition because it is a major cause of cardiovascular disease and because it is becoming more common as more people in Barnsley, and in the rest of the country, become overweight and obese. The highest prevalence of diabetes is found in older people. In 2011/12, Barnsley's GPs diagnosed diabetes in 6.59% of the adult population; significantly higher than the England average of 5.76%. This is despite a comparatively low population from the most susceptible ethnic groups. It may reflect a combination of high obesity levels and early diagnosis.

Reflecting a legacy of smoking and occupational risks, levels of chronic obstructive pulmonary disease ('chronic bronchitis') diagnosed by GPs in Barnsley are among the highest in the country, affecting 3% of the population. Levels are likely to be highest in more deprived communities and lead to high admission rates and excess deaths. Levels are expected to increase, despite falling smoking rates.

GPs records suggest that 0.51% of Barnsley's adults had been diagnosed as having dementia in 2011/12. This is lower than the England average of 0.53%, but is not significantly different. Barnsley's rate is significantly lower than the other South Yorkshire CCGs, suggesting there may be some under-diagnosis. Numbers are expected to increase from around 2,700 to over 3,200 by 2020. As a significant proportion of dementia is due to problems with the heart or blood vessels to the brain, improved prevention will have an impact on the mental health of older people in Barnsley.

Although most people will recover within weeks of an attack of seasonal flu, people in risk groups – older people and people with long term illness can become very ill and even die. In 2010/11 67% of the people who died from flu were in a risk group. Barnsley's seasonal flu vaccination rate among people aged 65 and over was 72.68%, significantly lower than the England average of 74.02% and levels in the other three South Yorkshire authorities. In addition, rates are highest among the least deprived communities in the borough, which contributes to health inequalities among older people. There is room for improvement in this important preventative measure.

Deaths and serious injury from accidents have been falling for some time but remain an important cause of preventable ill-health. Barnsley's 2011/12 admission rate for accidents among people aged 65 and over is similar to the England average;

Barnsley's rate is the second lowest in South Yorkshire, but is significantly higher than the rate in Sheffield, indicating there is further potential for improvement. Admissions specifically due to fractured neck of femur – 'broken hip' are also similar to the national average and levels in our neighbours in South Yorkshire.

Falls to adults in Barnsley cost the local NHS an estimated £1.9 million a year. Results from the Private Sector Housing Condition Survey 2010 survey showed that the highest number of Category One hazards were falls on stairs accounting for almost 55% of falls hazards. Hip fractures are the most common injury relating to falls in older people and can have a devastating impact leading to loss of confidence and social isolation, disability and death. Meeting the accommodation needs of increasing numbers of elderly people is going to be a significant challenge.

Cancer survival has improved nationally and locally; the table below shows recent patterns and trends for the four most common cancers. Barnsley's greatest cancer problem is clearly lung cancer.

Cancer	**New cases**	**Survival (2004-2010 figures)**	**Death rates**	**Inequality**
Lung	Falling, though only in the last few years	Below average; only improving very slowly.	Falling, though again, very recent.	Lung cancer incidence and death rates are higher in Barnsley than the country as a whole. Lung is the second most common cancer in the UK but is the most common cause of cancer deaths in Barnsley. Trends differ between men and women.
Breast	Rising, though expected to change very little over the next five years.	Below average; improving, expected to continue.	Falling, expected to continue.	Local death rates have been below the national average for five years.
Bowel	Rising, though expected to rise only slightly over the next five years.	Below average; improving, expected to continue.	Falling, expected to continue.	Local incidence and death rates are very similar to the national average. Bowel cancer is more common among deprived communities.
Prostate (men)	Rising, though expected to change very little over the next five years.	Rising, though expected to change very little over the next five years.	Probably improving generally, but complicated by increasing detection of less aggressive disease.	Barnsley has lower incidence rates but similar death rates to the national average, though this is difficult to interpret.

Fuel poverty is a crucial issue, as it is clear that low temperatures are strongly linked to a range of poor health. In 2011, a higher proportion (18.4%, national average 14.6%) of Barnsley households experienced 'fuel poverty', having high fuel bills related to their income. Excess winter deaths in Barnsley have fallen from above average levels in the 1990s and mid-2000s to 15.8% in 2008-2011; better than the national average (19.1%) and our South Yorkshire neighbours. Given our high levels of fuel poverty, this suggests that preventive work in Barnsley has been effective, but must be maintained.

Safeguarding vulnerable adults is an important priority. Vulnerable adults include older people who are dependent on others for part, or all, of their care; similarly people of any age with learning difficulties, mental illness or physical disability. For example, national estimates are that 2.6% of people aged 65 years and over living in private households had experienced mistreatment involving a member of the family, close friend, or care worker in the past year – four per cent of incidents involving neighbours and acquaintances. Physical abuse was the most common mistreatment (30%), followed by neglect (23%), financial abuse (20%), emotional abuse (16%) and sexual abuse (6%). The Barnsley Adult Safeguarding Board Annual Report provides more detail on the local picture across the Borough.

It is an objective of the health and social care system to support people to be cared for, and die, at home, if that is their preference at the end of their lives. Over the period 2008/10, one person in five (20.4%) in Barnsley were able to die at home; a very similar proportion to the national average. Based on current trends, forecasts suggest that the percentage of people dying at home will increase to 26.4% by 2014/16.

Section Seven: Next Steps

Work on the JSNA will continue and new supporting information will be added to the JSNA website as it becomes available.

Key priorities for improvement for the JSNA over the coming year are:

- Embedding the JSNA and the areas highlighted in the refresh of the Health and the Wellbeing Strategy 2013-2016 and in the development of joint commissioning strategies, together with ongoing evaluation of outcomes
- Consulting with the Health and Wellbeing Board and key partners on gaps in the JSNA and priority areas for more detailed needs assessment, linked to Health and Wellbeing Board priorities
- Increasing the involvement of local commissioners across health and social care in developing the JSNA and other strategic needs assessments
- Increasing the involvement of third sector partners and strengthening community engagement – finding out from communities what is important to them in terms of their health and wellbeing.
- Developing a communications and engagement strategy to better disseminate the findings of the JSNA on an ongoing basis as new information is added to the website.
- Producing ward based health and wellbeing profiles to support the move towards localised commissioning and a focus on tackling health inequalities
- Establishing a joint strategic intelligence group, reporting to the Health and Wellbeing Board, with responsibility for producing statutory needs assessments including the Joint Strategic Needs Assessment, Joint Strategic Intelligence Assessment and Pharmaceutical Needs Assessment

Appendix 1 – List of Indicators

CHAPTER	SUB HEADING	INDICATOR
People and Place		Population
		Housing
		Economy
		Education
		Transport
		Environment
		Community Safety
Starting Well and Developing Well	Maternity and Post-Natal Care	Women's experiences of maternity services
		Smoking status at time of delivery
		Breastfeeding
		Antenatal screening*
		Newborn screening*
	Family Life	Children in poverty
		School readiness
		Domestic violence
		Safeguarding children
		Young carers
		Children in care
		Emergency gastroenteritis admissions in under 5s
		Measles, Mumps and Rubella (MMR) vaccination
		Childhood immunisation
		Tooth decay in children
		Excess weight in 4-5 year olds
		Excess weight in 10-11 year olds
	Developing Well	Services to disabled children - short breaks
		Emotional health & wellbeing
		Emergency asthma admissions in under 19s
		Hospital admissions due to injury (age under 18 years)
		Young people and substance misuse
		Smoking prevalence - 15 year olds
		Chlamydia diagnoses (15-24 year olds)
		Under 18 conceptions
		Youth justice
		Pupil absence
		16-18 (academic age) year olds not

		in education, employment or training (NEET)
		Care Leavers
		Human Papilloma Virus (HPV) vaccination coverage (females 12-13 year olds)
		Narrowing the attainment gap between pupils with SEN and Non SEN pupils
		Take up of school meals / free school meals
Living Well and Working Well	Overarching Outcomes	Healthy life expectancy*
		Differences in life expectancy and healthy life expectancy between communities
		Under 75 mortality rate from all cardiovascular diseases
		Under 75 mortality rate from cancer
		Under 75 mortality rate from respiratory disease*
		Learning disabilities
	Mental Wellbeing	Hospital admissions as a result of intentional self-harm
		Suicide rate
		Excess under 75 mortality from serious mental illness*
		Depression
	Lifestyle Choices	Smoking prevalence - adults over 18
		Successful completion of drug treatment - opiate users
		Re-offending levels
	Community Impacts	Air Pollution
		Population affected by noise
		Killed or seriously injured on the roads
		Statutory homelessness
	Alcohol Harms	Alcohol-related hospital admissions
		Under 75 mortality from liver disease
	Screening and NHS Health Checks	Sickness absence rate
		Breast cancer - cancer screening coverage
		Cervical cancer - cancer screening coverage
		Bowel cancer screening
		Abdominal Aortic Aneurysm (AAA) screening
		Diabetic retinopathy - access to non-cancer screening programmes
		Take up of NHS Health Check

		programme by those eligible
Ageing Well	Emergency Hospital Admissions in the over 65's	Injuries due to falls in people aged 65 and over
		Bone health and osteoporosis
	Winter Health	Fuel poverty
		Excess winter deaths
		Population vaccination coverage - flu
	Co-ordination of Care	Access to GP Services
		Proportion of people feeling supported to manage their condition
		Dementia and its impacts
		End of life care
		Ageing well*
	Chronic Disease Management	Recorded diabetes
		Breast cancer survival
		Bowel (colorectal) cancer survival
		Lung cancer survival
		Prostate cancer
		Chronic Obstructive Pulmonary Disease (COPD)
		Improving outcomes from strokes*
		Cancer incidence and referrals*
		Cancer diagnosed at stage 1 & 2*
		Hospital admissions

Indicators indicated with * are deferred until further notice