



THE DIRECTOR OF PUBLIC HEALTH FOR BARNSLEY

is pleased to present her

ANNUAL REPORT

for the year 2012 - 2013

BARNSLEY
Metropolitan Borough Council

An explanation of the armourial bearings of

BARNSLEY METROPOLITAN BOROUGH

The figures of a miner and a glassblower represent the two major industries. While the miner stands on a heap of coal, the glassblower stands upon a grassy mound representing the rural areas of the Borough. The former local authority areas brought together in 1974 to form the Metropolitan Borough are represented by an escarpuncle of fourteen points in the crest below the gryphons claw. The central shield includes two shuttles representing the19th century linen trade and crossed pick axes representing the mining industry. The falcon and padlock are taken from the coat of arms of Joseph Locke, the eminent civil engineer, whose widow gave the beautiful Locke Park to the town.

The boars' heads are taken from the Beckett family, bankers and merchants who had various interests in Barnsley and the surrounding area. The cross between two covered cups represents Monk Bretton Priory, which was dissolved by Henry VIII.

The motto on the scroll which forms the base of the coat of arms, 'Spectemur Agendo', means 'Judge us by our Actions'.

Table of CONTENTS

*Fore*WORD

I am very pleased to bring you this Director of Public Health Annual Report for 2013.

The past twelve months or so have been a period of tumultuous change for the Barnsley Public Health Department. Elizabeth Shassere, Director of Public Health, left Barnsley in July 2012 to take up a new position in another part of the country and I was asked to act up into the vacant position; a role I still hold. This period has also seen the departure of other members of the Public Health team, and new members join.

However, the most significant change has undoubtedly been the transfer of responsibility for public health from the NHS to local government under the new Health and Social Care Act 2012 and the move of the Barnsley Public Health directorate to Barnsley Council on the 1st April of this year.

Given these changes, the report takes on a different perspective from previous years. This report provides an opportunity to reflect back on the journey of Public Health in Barnsley from its beginnings in 1848 to the present day. Up until 1974, local government had been the home of public health for over 100 years. Now public health has returned home from where it started. Inevitably some priorities have changed but many remain the same – for example heart disease and cancers continue to be the main diseases that people die of in Barnsley and health inequalities continue to be present.

I want to make the most of the new opportunities that the move of public health back to the Council will bring to improve health and reduce health inequalities in Barnsley. This work has already started and will be the focus of future reports.

I am grateful to the many people who have supported and contributed to the report. These are listed on page 67 I would particularly like to thank the Barnsley Council Archives Team for their support and help with sourcing historical Public Health reports and information and the Council Graphics Department for their help with the report.

Finally, I want to thank Lisa Loach, Public Health Programme Manager for keeping the production of the report on track.

I hope you find the report interesting and enjoyable to read. I would welcome your feedback, comments and suggestions. Please get in touch by contacting Catherine Huby, my Personal Assistant, on 01226 773477 or emailing catherinehuby@barnsley.gov.uk

Sharon Stoltz
Director of Public Health (Acting)
Barnsley Metropolitan Borough Council

Executive SUMMARY

The Director of Public Health annual report for 2013 has been prepared to examine the current state of health of Barnsley residents and to make recommendations as to how health can continue to be improved.

The past year has seen a significant change in the way that public health services and activities are organised. The Health and Social Care Act 2012 changed the way that the NHS functions and also moved a lot of public health activity into local government.

Public health, as an organised activity, was first recognised in the 1840s with the publication of the first Public Health Act. From those early days until the 1974 Local Government reorganisation public health was the responsibility of local government and not the health services. Given that the latest changes have brought public health back into local government this report has reflected on the history of public health activity in Barnsley.

The report focuses on current priorities for public health in Barnsley. Where possible, however, historical viewpoints have also been discussed. These try to bring a different perspective on the challenges that Barnsley faces as it continues to focus efforts on improving health and reducing health inequalities.

The report has seven sections and these are summarised below:

1. Introduction and History of Public Health in Barnsley

This chapter takes the reader on a journey from the beginnings of the public health movement in the 1840s through to the present day. It uses a range of historical reports and highlights important developments for Barnsley, for Public Health and for the health status of Barnsley residents.

The key lessons from the look back at the history of public health and of Barnsley are as follows:

1. Health has improved with Barnsley residents now enjoying better health than at any time in the past; however, health inequalities remain both between Barnsley and England and within Barnsley.

2. Public health and local government: For the past 39 years the formal responsibility for public health has rested with the NHS; however, in Barnsley moves were made to jointly address public health issues with a joint Director of Public Health and a long term strategy requiring partnership action. The legacy of these joint approaches will be helpful in the coming years.

3. Influence and persistence: The historical reports are littered with examples of public health recommendations that have taken a long time to implement; or in some cases not implemented. These were, in many cases, for good reasons - public health has often been about influencing others and locally Public Health will need to continue to be persistent in how it influences decision makers in Barnsley.

4. Community: Public Health is not a practice that can be divorced from the community that it serves. The annual reports of the past have not reflected on significant developments in Barnsley. Public Health acknowledges the health impact of changes in the economic, social and environmental landscape. As Public Health moves back into local government there is an opportunity to re-engage with the communities that we serve.

2. Population health and health inequalities

This chapter examines the health of the population of Barnsley with an emphasis on the health gap both between Barnsley and the rest of the country and within Barnsley. Historical information is presented that helps put the existing population and state of health and health inequalities into context.

The population in Barnsley has matured over the ages and continues to rise in size with a consequent rise in the older age groups. The prevalence of major diseases is rising alongside the ageing population. Life expectancy in Barnsley is improving although the pace of improvement is slower when compared to England. Health inequalities persist within the Borough with marked differences between the east and west.

The three messages of this chapter are:

1. Barnsley experiences higher than national average prevalence in key diseases

2. Life expectancy is improving albeit not at a rate to close the inequalities gap with the rest of the country, and

3. Health inequalities persist between Barnsley and within Barnsley necessitating prolonged sustained action to address these inequalities in the short, medium and longer term.

3. Lifestyle Determinants of Health

This chapter sets out some of the lifestyles that are prevalent in Barnsley that are negatively impacting on the health of the community. There is an acknowledgement that lifestyle and behaviour are complex issues and that knowledge alone is not enough.

The chapter focuses on alcohol, tobacco and physical activity as three important lifestyle factors. Some stark information is presented.

- Alcohol specific admissions to hospital in the under 18s is the highest in South Yorkshire.
- Only 1 in 8 adults in Barnsley take enough exercise
- Despite the natural assets of Barnsley the use of green spaces for exercise is very low
- Almost half of all 14 and 15 year olds live with a smoker in Barnsley
- In some parts of the Borough 1 in 3 pregnant women smoke

The chapter recommends that the move of public health to the Council presents an opportunity to relook at how lifestyle services are commissioned.

4. Wider and Social Determinants of Health

This chapter examines the wider and social determinants of health and notes that living in poor social, economic and environmental conditions is bad for health at all stages of your life. It also makes the point that the unequal distribution of these factors drives heath inequalities.

The chapter describes recent work on environment and housing (including air quality, homelessness and excess winter deaths), workplace health, unemployment and poverty and emotional and mental wellbeing.

This chapter demonstrates the breadth of the public health agenda as it covers a wide range of activities from the science of air quality management to the creative and artistic approaches to support emotional wellbeing through the arts on referral programme.

The recommendations of the chapter will help to further develop the relationship between Public Health and the partners involved in addressing these fundamental determinants of health.

5. Health Protection

This chapter explains the breadth of the health protection agenda and focuses on a few issues of most relevance to Barnsley. It notes that the profile of health protection has increased in recent years with issues such as pandemic flu (Swine flu), healthcare associated infections, immunisations and communicable diseases often in the public eye.

The chapter examines healthcare associated infections, tuberculosis (TB), immunisation and vaccination, seasonal flu and sexual health. The overall picture is positive with Barnsley doing well on a range of issues including low rates of healthcare associated infections, low rates of TB and high uptake of immunisation and vaccination programmes.

Whilst such good performance is to be celebrated it cannot be a cause for complacency. Communicable diseases do not respect boundaries and Barnsley does not stand aside from the rest of the world. Maintaining good performance and a continued focus on health protection will not only benefit Barnsley but will ensure that we play our part in what is essentially a national and international imperative.

6. Progress on Recommendations from 2012 Director of Public Health Annual Report

This section provides a quick overview of progress since the last annual report. This report focused on smoking prevelance as a major issue for public health in Barnsley. The recommendations of that report have all been actioned with significant progress made.

7. The Future of Barnsley

This brief statement notes the significant changes in the public health and health and social care landscape in the past year. It highlights the important role of the new Health and Wellbeing Board and the work to update the Joint Strategic Needs Assessment for 2013.

Finally, it notes the challenges and opportunities that lie ahead and states the two outcomes that relate directly to Public Health in Barnsley Metropolitan Borough Council's corporate plan: as follows

- We will make the improvement of people's health and wellbeing everybody's business, with an emphasis on prevention and the contribution that all services can make

- We will prioritise the reduction of health inequalities between different parts of the Borough, and the Borough and the rest of the country

Summary

This annual report demonstrates that whilst progress has been made in improving health in Barnsley there is still much to do to close the inequalities gap both within Barnsley and with the rest of the country.

The move of Public Health back to the Council provides new opportunities to improve health and reduce health inequalities in Barnsley. This work has already started and will be the focus of future reports.

Introduction and History of Public Health
IN BARNSLEY

The Health and Social Care Act 2012 was a controversial piece of legislation and radically altered the public health, health care and social care system. The Act has now been enacted and new organisations and structures have been established.

As we reflect back on the past 12 months it is very obvious that it was a turbulent year. A lot of hard work went into making a safe and secure transition into the new system.

For local Public Health teams this meant moving out of the NHS and into local government. As we looked at our new world we couldn't help but reflect on not only the past year but also on the past 39 years. Since 1974 the NHS has been the custodian of public health and the vast majority of the local Public Health team have had NHS based careers. Whilst the team as a whole recognise the opportunities that have opened up in our new local authority home we have collectively also looked back on our past achievements.

From this reflection came the idea to use the Director of Public Health annual report to look back at the successes and failures of the past 39 years. It is clear that Public Health will have to develop new approaches to improving health, protecting health and reducing health inequalities in local government. It is equally clear that Public Health has developed strong methods of tackling difficult issues and we want to bring that experience to bear in the future.

As we began the planning of this report we found that the wonderful archives of the Council not only had the Director of Public Health reports during the NHS period from 1974 but also had the old Medical Officer for Health reports dating back to the mid-1800s.

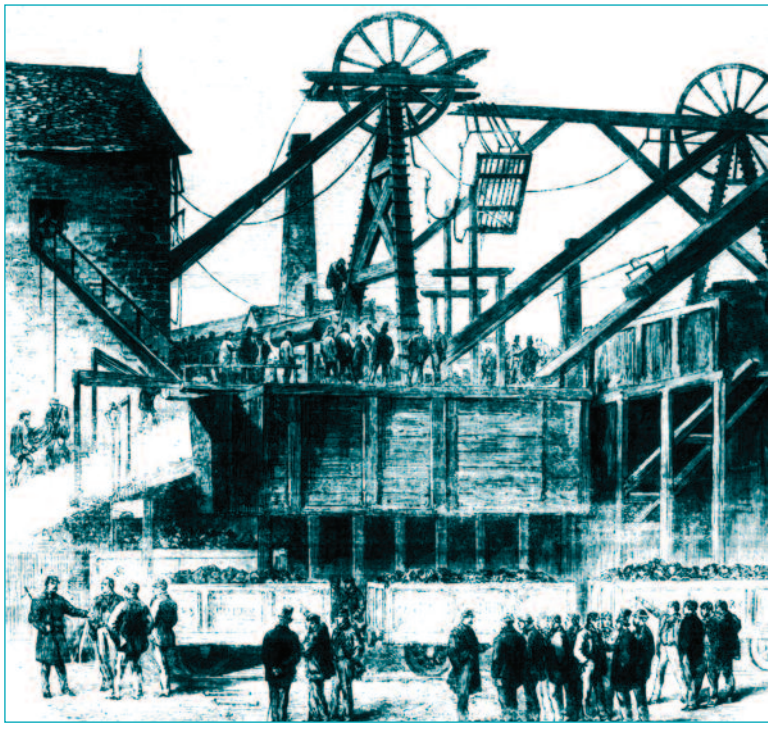
A lot has been written about the Public Health move back to local government and one of the main themes has been that the local government that Public Health left is not the one it is returning to. Nonetheless, we felt that this major shift in public health policy gave us a chance to reflect not only on the recent past but also on the longer journey that public health has taken.

It is our hope that this longer view will help the Council make the most of the lessons of the past in taking on their new public health responsibilities and duties. This chapter takes us on a journey from 1848 to the present day. 1848 marked the passing of the first ever Public Health Act and the birth of modern public health practice.

It will do this, in the main by looking at past Director of Public Health reports and before them the Medical Officer for Health reports. It is not, however, a full history of public health in Barnsley. As fascinating a subject as this would be there is neither space nor time available for this in this report but it is hoped that this brief look at the past will shine a light onto lessons for the future.

1850 to 1899

- This period was the early days of the public health movement. The first Public Health Act was made in 1848 and efforts were focused on clean water, sewage, streets and slaughterhouses.
- In Barnsley and the surrounding districts this was a busy and formative time.
- In 1865 the Beckett hospital was established and St Helens Hospital was built in 1885 on the site that is now occupied by Barnsley Hospital.
- The football club (1887), cricket club (1862) and Barnsley building society (1853) were established.
- The development of the railways played a major role in the development of Barnsley as a town enabling the growth of the local industry markets for coal, linen and glass.
- Industry was flourishing – albeit at a price. In the nineteenth century much of the work took place in high risk, dangerous environments such as in mining, textiles, engineering and agriculture industries where workers were forced to work long hours in dangerous conditions with little pay. The work could have long lasting health consequences and there were no regulations in place safeguarding employees through health and safety in the workplace.
- There were significant disasters with 145 lives lost at Swaithe Colliery; 361 men and boys lost at the Oaks disaster and 15 killed at Stairfoot in a train crash.



1866 Cage thrown up into head gear at the pit mouth by explosion at the Oaks Colliery, Barnsley, on Wednesday 12 December 1866

1900-1949

- This period was dominated by two world wars and the major economic recession in the 1930s
- At the turn of the twentieth century there was no welfare state in Britain; no unemployment benefit, sick pay or old age pension. People had to pay to visit the doctor and dentist.
- The Welfare State was created in 1945. The intention was to provide a comprehensive system from 'cradle to grave' with the aim of an acceptable minimum standard of living in Britain below which nobody fell. The Welfare State proposed that all working people should pay a contribution to the state and in return benefits would be paid to the unemployed, sick, retired and widowed.
- A flu pandemic just after the end of the First World War killed between 3% and 5% of the world population
- Industry continued to dominate the local economy but disasters continued with a major disaster at Wharncliffe Woodmoor colliery.
- Barnsley St Peters reached the FA Cup Final in 1911 and won the FA Cup the following year in 1912.
- In 1932 Wombwell Open Air School opened – the first school for sufferers of TB.
- In 1948 in Britain smoking prevalence began to be measured by surveys. 82% of men smoked some form of tobacco, with 65% smoking cigarettes. After the second World War more women began to smoke.
- In 1948 the NHS was established.

1932 Wombwell open air school

1950-1973

- The post war period saw huge breakthroughs in medicine and public health.
- The link between smoking and cancer was proven in 1954; vaccines were made and a programme of vaccination introduced for diphtheria and polio (1958) and measles (1966).
- The Clean Air Act was introduced in 1956 initially focusing on residential homes responsible for very high levels of Sulphur Dioxide from fossil fuels.
- The 1959 Mental Health Act was passed which was heralded as a great piece of liberalising legislation. The 1959 Mental Health Act provided a legal framework against which people could be detained against their will if necessary.
- In the mid-1960s the Beeching report resulted in the closure of 2,363 stations and 5,000 miles (8,000 km) of railway line. Cars began to become more affordable and car journeys increased rapidly creating air quality issues, congestion and road accidents.
- 1970 saw Barnsley have the first special ambulance in the country to deal with heart patients.
- 1972 saw the first coal mining strike since 1926 with further strikes in 1974.

The last passengers stepping off the last train at Goldthorpe Halt on 9th September 1951.

1974-1999

- In 1974 Barnsley Metropolitan Borough Council was formed and responsibility for public health moved to the NHS.
- Significantly, in 1974 South Yorkshire County Council (SYCC) was created, comprising of Sheffield, Barnsley, Doncaster and Rotherham. The metropolitan county councils were given the responsibility for the provision of public transport. It was during this period bus services received a subsidy of up to 85% of operating costs, and low fares contributed to an increase in bus travel of 7% from 1974–1984, compared with a 30% decline elsewhere in the United Kingdom. This policy established a culture of low car ownership, high bus patronage, and some of the most frequent bus services in Europe. With the benefit of hindsight the environmental, health and congestion advantages of this policy never received full recognition.
- The formation of Unions in the early twentieth century forced companies to improve conditions with workplace health and safety and in 1974 this culminated in the Health and Safety at Work Act 1974.
- The Black report on health inequalities was published in 1979 and followed by the Whitehead report in 1987 and the Acheson report in 1997.
- Public health advances continue with MMR vaccinations and breast screening introduced in 1988. AIDS/ HIV fast became a global health concern.
- In Barnsley the new hospital opened in 1976.

1976 Barnsley District General Hospital

- The coal miners' strike of 1984 and subsequent pit closures changed the face of Barnsley forever and led to massive economic, environmental, social and health problems.

- In 1989 Officers from Barnsley Council established a partnership to develop a cycling, walking and equestrian route from coast to coast. In 2001 the Trans Pennine Trail (TPT) was opened and to this day the administration of the trail remains in Barnsley. Today the TPT has over one million users annually across the network. Many local people walk or cycle to work along various sections of the trail and the trail delivers economic benefits by attracting visitors to the borough.

- In 1994 Grimethorpe was declared as the most deprived community in Great Britain which was a direct result of the miners' strike. Unemployment in the village was at 50%. The levels of crime and drug abuse in the community were chronically high.

- The South Yorkshire Coalfields became a Health Action Zone in 1997.

- Barnsley FC was promoted to the top flight of English Football for the first time in 1997.

- In 1999 the levels of claimants on benefits in Barnsley were almost double those nationally and regionally reflecting the increase in unemployment resulting from the closure of the mines.

Penistone Trans Pennine Trail Signpost

2000-2012

- This period saw huge investment in NHS services and a more modern NHS provision
- Public health improvements continued with the introduction of smokefree public places legislation in 2007; HPV vaccination in 2008 and the launch of NHS health checks in 2009.
- The Licensing Act (2003) was introduced and allowed flexibility in the times that premises are allowed to sell alcohol. These changes, supported by the alcohol retail industry, were heralded as a way of changing the binge drinking culture in the UK.
- Barnsley Cricket Club won the 2006 Yorkshire ECB County Premier League for the first time in the history of the club.
- 2003 saw the launch of the Barnsley Fit for the Future - a bold, long term strategy to tackle health inequalities in Barnsley.
- The global credit crunch in 2008 and the subsequent recession have impacted on the local economy. The significant austerity programme remains a significant challenge.

fit for the future
Barnsley People Achieving Better Health

A programme to improve health and reduce inequalities

This quick journey and the reading of the old reports have been helpful in placing some of our future challenges into context and these have been outlined below:

1. Health has improved; health inequalities remain large

The state of the health of Barnsley people is covered in detail elsewhere in the report; but suffice to say that whilst substantial challenges still exist the overall health of the people of Barnsley is better now than at any time in history. Life expectancy has improved dramatically and deaths from the major diseases have fallen.

The 1993 report by Dr Bowns was a landmark report. In this report, the issue of health inequalities came to the fore with Dr Bowns expanding on the nature and causes of health inequalities in Barnsley. The emerging Health Strategy of the Health Authorities at that time adopted two significant priorities:

'Firstly, to narrow the gap between Barnsley and the country as a whole'

'Secondly, to reduce the inequalities between the different areas and social groups within Barnsley'

These priorities remain at the forefront of our priorities some twenty years hence and whilst it is certainly true that we have come a long way the challenge exposed here is not one that will be met without critically and honestly examining what Public Health does and how it relates to the community, to the rest of the Council and to other partners.

2. Public Health and Government

From the outside of the profession it may look as if the move back to the local authority came solely from the new Health and Social Care Act 2012 – the truth, however, is that during the period from 1997 Public Health was already on a journey back toward local authority control.

This largely started with a national change in policy, with health policy being driven largely by the desire to reduce health inequalities. This policy intention led Public Health to tackle the wider determinants of health; the focus started to move away from a purist disease model to one focused on social injustice. This brought Public Health closer to the work of local government and there was a general move to joint working. Barnsley was a clear leader in this respect. As Director of Public Health posts began to morph into Joint posts across NHS and Local Government, Barnsley was a front runner. Dr Redgrave was appointed Joint Director of Public Health and the Council not only contributed to the cost of the post, but also provided management support, office space and invested in its own Public Health staff and operational budget. The team behind the Director became a Joint team and this has laid the ground for a successful transition into the system we now have.

Public Health practice was therefore already in transition and this was cemented by the legislation.

3. Influence and persistence

One of the guiding principles in public health is the use of evidence based practice. Public health as a profession prides itself on understanding the causes of illness and then putting in place interventions that are known to work. This path is not always an easy one to walk. A striking example can be seen in the case of water fluoridation.

In 1968 Dr Neill (1968, p24) noted that the *'professional staff of the Dental Department advise that the fluoridation of Barnsley domestic water supply …would reduce the rate of dental decay'.* However, these proposals were rejected and he noted that '*it is difficult to forecast any hope for improvement in the general dental condition of the Barnsley school population beyond the present extremely poor state'.*

In the 1988/89 report Dr Oddy also confirmed the evidence that adding fluoride to water is both a safe and effective method of reducing dental decay. Dr Oddy (1989, p50) states that *'It is the single public health measure available to the community that would have the most dramatic effect on the level of dental decay'.* He also notes that *'Barnsley Health Authority at its meeting on 23rd November, 1988, approved the fluoridation of public water supplies to Barnsley and the decision conveyed to the Trent Regional Health Authority'.*

Fluoridation of the water supply has not yet been put in place for Barnsley; 45 years after Dr Neill's comments and 25 years since the Public Health department convinced the health authorities of its effectiveness and safety. Barnsley's rates of tooth decay are still poor when compared to other areas.

Evidence of need and of effectiveness of interventions by themselves is not sufficient. Public health is clearly a subject that relies on substantial partnership working and the ability to influence and persuade is as much a part of modern public health as it was in the past.

Moreover, a similar pattern can be seen in the trials and tribulations of Dr Sadler. Dr Sadler was a Medical Officer in the Barnsley District in the 1910s and time after time returned to the topic of privy ashpits in his annual reports.

Privy ashpits were an improved type of toilet that came about following legislation in 1848 that required all new homes to have water closets or ash pits. The privy ashpit was an improvement but still did not amount to a hygienic sewage system; requiring regular emptying.

In 1911 the summer was a good one but this had the effect on an increase in deaths through diarrhoea.

Dr Sadler provided analysis that linked deaths from diarrhoea (156 in total) to the proximity of privy ashpits and concluded that by replacing privy ashpits with water closets would save 56 lives per year. He goes on to plead his case.

'… the hot Summer of 1911 only serves to emphasise the plea put forward in my last Report, that the conversion of the privy ashpits into water closets should be speeded up. It is of course simply a matter of finance, and, as your advisor in matters Sanitary, I cannot help feeling that other demands for expenditure might well postpone their claims to this most important Sanitary improvement.'

In his last report, in 1915, Dr Sadler (1915,p9) returned to this cause. After noting that the diarrhoea death rate in Barnsley surpassed other towns he noted.

'*I emphasise this point so that the public of Barnsley may become aware how urgently necessary it is that your Committee should take the action they propose taking in regard to the Privy Ashpits of the town…over privies and manure heaps the Sanitary Committee has power and this factor in our high diarrhoea death rate is the only one over which you have control, and is, therefore, the point at which you must make your effort…*'

Dr Sandler concludes his last report (1915, p13) with these words.

'In this my last report I should like to thank you, gentlemen of the Sanitary Committee, for the uniform courtesy and kindness with which you have always listened to my advice on sanitary subjects, even when my advice has been in conflict with your ideas of economy'.

Public Health must sometimes put its head above the parapet and recommend courses of action that may not be palatable. It has done this in the past as these examples show and it may well need to do so again. In doing so Public Health will need to be fair, unbiased, persistent and persuasive.

Moreover, public health is clearly not a short game. Some of the historical examples above demonstrate that improvements can only be seen decades later. Public Health must remain focused on the long term ambitions for the people of Barnsley and should not resort solely to short term initiatives.

4. Community connectedness

In the preparation of this chapter a number of reports were examined. These were selected to reflect either a notable legislative or organisation change (e.g. formation of the NHS, local government reorganisation), notable events in public health (e.g. years where there were global influenza pandemics) and notable events in Barnsley's history (e.g. Industrial action).

It is interesting to note that the impact of legislation were reported at length, with the long standing Dr Neill reporting on the early NHS and the local government reorganisation in 1974.

Significant public health events seemed to have less impact on the annual report with scant mention of global disease outbreaks; there being much more discussion on any local outbreaks.

What is striking is the absence of commentary or reference to any significant events in Barnsley's history. There are plenty of comments, as would be expected on local service developments but little to put these into a broader social context. Dr Sadler (1912, p11) commented on the effects of a coal mining strike in 1912, *'During the strike and since, I have found mothers feeding their children on a variety of improper foods'* and later reports gave passing acknowledgement of the economic position of Barnsley and the impact on health. In addition, there were no mentions of any positives. There was, for example, no mention of Barnsley FC winning the FA Cup in 1912 nor the promotion to the Premier League in 1997. This may, of course, reflect the different writing styles of former years, with an emphasis on factual analysis and statutory reporting requirements - but the truth remains that public health is a practice for the benefit of the people - and therefore Public Health needs to be close to public opinion. Major developments in the Borough, for the good of health or otherwise could be reflected on in future reports in a more meaningful way than they perhaps have in the past.

Having a close connection to the community is beneficial for the practice of public health. Society can change quickly and understanding changes can help Public Health commission more effective services.

No-one can deny that the way that people access and deal with information has changed rapidly over the past decade. A look back at the old Medical Officer for Health reports clearly demonstrates a similar story: The Medical Officer for Health for Barnsley County Borough Council from 1950 to the reorganisation in 1974 was Dr Neill and whilst undertaking many of the traditional Medical Officer roles he also reported on matters relating to health education.

Dr Neill was critically commenting on health education as far back as his 1951 report (1951, p8)
'A very great deal of work has been done making use of various kinds of publicity to try to teach people how to preserve their health and how to use the Health Service to the best advantage. The time is coming when the question must be asked, "How effective has all this been?" An honest answer to this question would hardly be encouraging'.

Dr Neill was back commenting on health education in 1958 (1958, p3). The timing is important; several years earlier in 1954 two researchers, Dill and Bradford, conclusively proved that smoking was harmful to health. Bringing this message to the public would have been a challenge in the 1950s and the depth of this challenge comes through in a paragraph from the 1958 report that illustrates not only the challenge but the sophistication of the response.

'*Over the years a very great deal of critical thought has been given to this subject [Health education] in Barnsley. Recent events in certain fields have, it is felt, emphasised the necessity for such thought. A very strong impression has been formed that the traditional conception of Health Education and the conventional methods employed in it do not achieve results to the extent desired or expected. It is not denied that some results are obtained. However the net value of these would appear to be altogether disproportionate to the amount of effort and money expended on them. It would seem that in the last ten years the Health Service has learned that the whole question of indoctrinating the mind of the community as to health and healthy living calls for an entirely new approach'.*

By the time we move into the early 1970s the world has changed and the way that people interact with mass media has changed with it. Dr Neill (1971, p49) again:
'The media of mass information are tending more and more to give attention to health matters and to stimulate interest in health'.

The new approach that Dr Neill called for in 1958 may always be needed – public health practice cannot stand still or in isolation from the community that it serves.

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Population Health and HEALTH INEQUALITIES

Introduction

This chapter focuses on the population of Barnsley and describes the current state of health in Barnsley, drawing attention to some major challenges.

This chapter is split into 3 sections:

- The changes over the past 200 years as background to the current state of the population in 2013.
- The current population health issues.
- Addressing Population Health and Health Inequalities in Barnsley.

The 3 key messages in this chapter are that

1. Barnsley experiences higher than national average prevalence in key diseases

2. Life expectancy is improving albeit not at a rate to close the inequalities gap with the rest of the country and

3. Health inequalities persist between Barnsley and within Barnsley necessitating prolonged sustained action to address these inequalities.

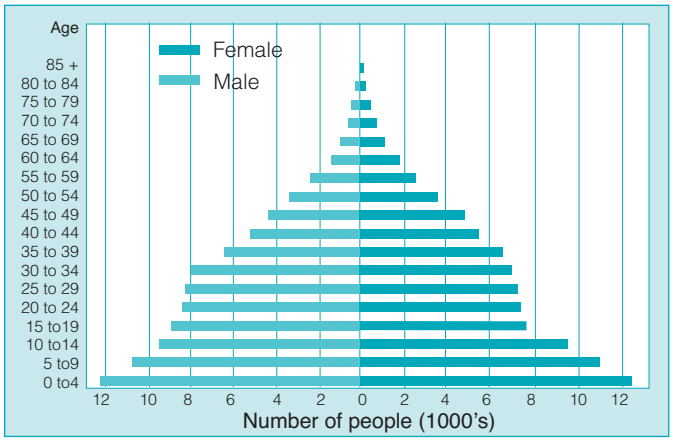
Changes over the past 200 years

Analysis of the change in population size and age structure across the ages in Barnsley demonstrates the successful growth of small communities during the 1800's into today's mature large diverse metropolitan borough of 2013.

Up until the start of the 1800's Barnsley was a small town which formed a hub for the outlying villages. The town's population grew from 1,740 people in 1750 to almost double of 3,606 in 1801 when the first official census was taken. [Changing Barnsley, From Mining Town to University Town, Edited by Cathy Doggett and Tim Thornton 2009, Wharncliffe Books].

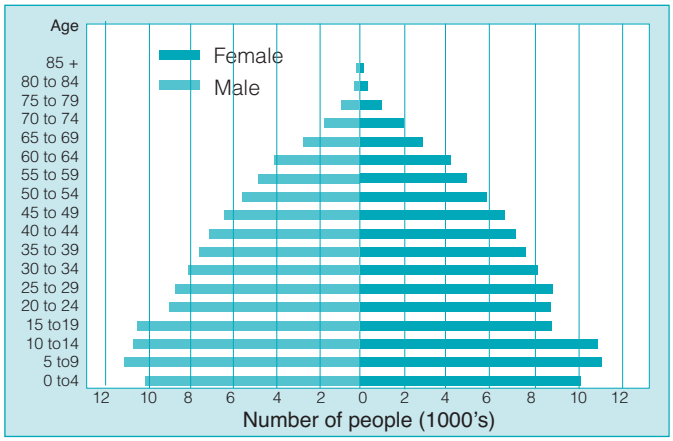
At the turn of the twentieth century the birth rate was high and life expectancy low, with a smaller percentage of the population living to 65 years. However progress in reducing infant mortality, better housing, sanitation and healthcare resulted in more people living longer as seen in the dramatic change in shape of the population pyramids across the decades.

1911



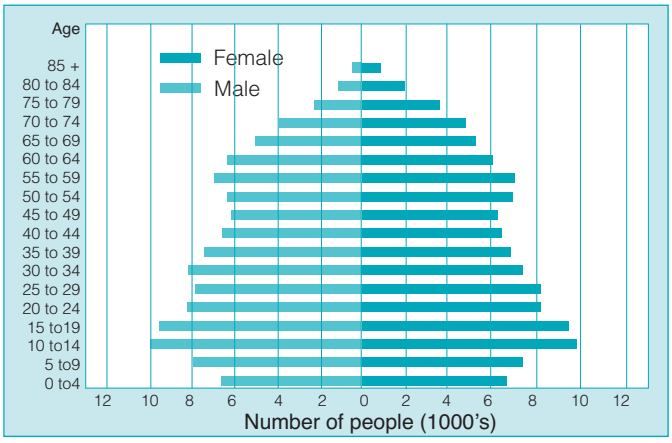
Source: University of Portsmouth/Humphrey Southall 2004

1931



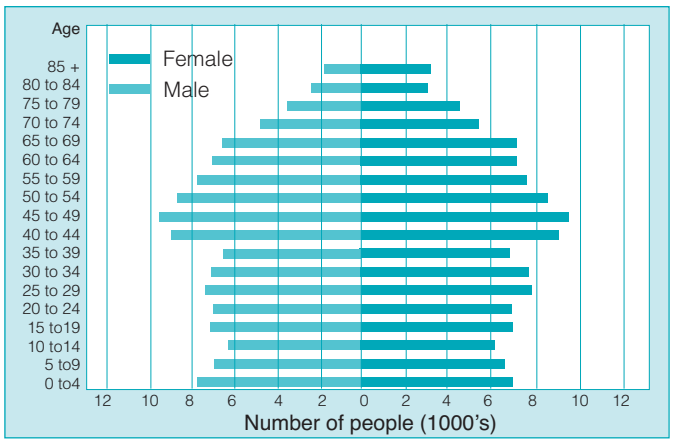
Source: University of Portsmouth/Humphrey Southall 2004

1981



Source: University of Portsmouth/Humphrey Southall 2004

2013

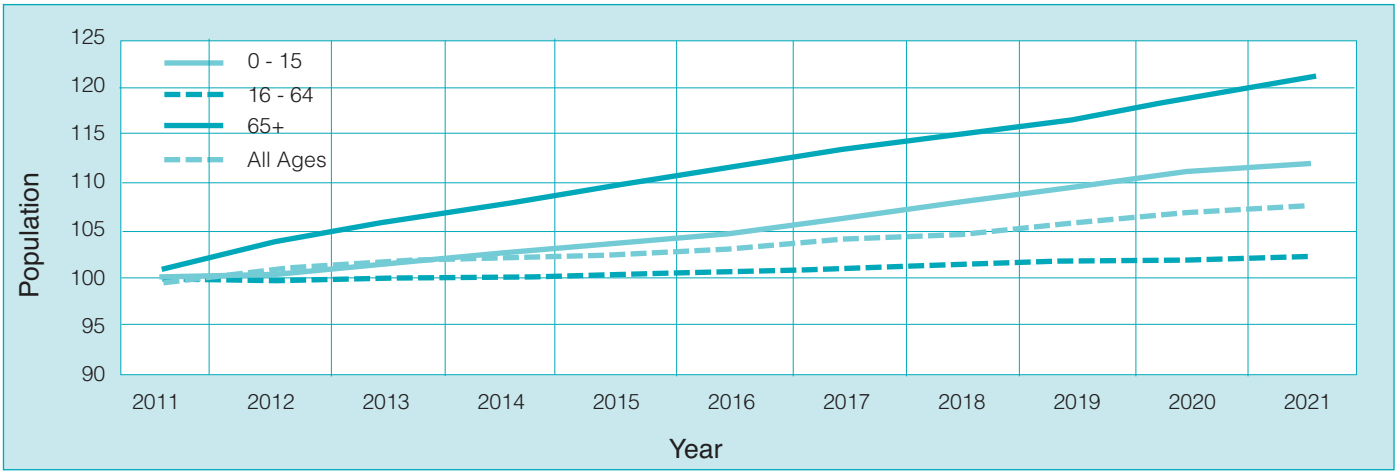


Source: ONS Interim 2011 based Subnational Population Projections

1928 St Helen's Hospital, Gawber

The current estimated resident population of Barnsley is 235,097 and is expected to continue increasing in size with rising number of births and people over 65.

Projected Change in Population by Selected Age Groups Relative to Age Group Population (2011 Population = 100)



Source: ONS 2012, 2011 based population projections

Population health has also changed over the past 200 years. Infectious diseases such as diarrhoea in childhood due to poor sanitation, fatal childhood viral illnesses and tuberculosis were the causes of the majority of deaths before vaccinations and antibiotics were introduced.

As post-war rationing ended and the National Health Service grew to provide universal access to primary and secondary care in all parts of the United Kingdom, life expectancy improved but with people developing cardiovascular disease, cancer and respiratory diseases due to smoking, diets with high salt, saturated fat, alcohol and more sedentary lifestyles.

Current Population Health issues in Barnsley

Population health is a description of the health outcomes of a group of individuals and the distribution of such outcomes within the group. This section will focus on 3 key population health issues for Barnsley:

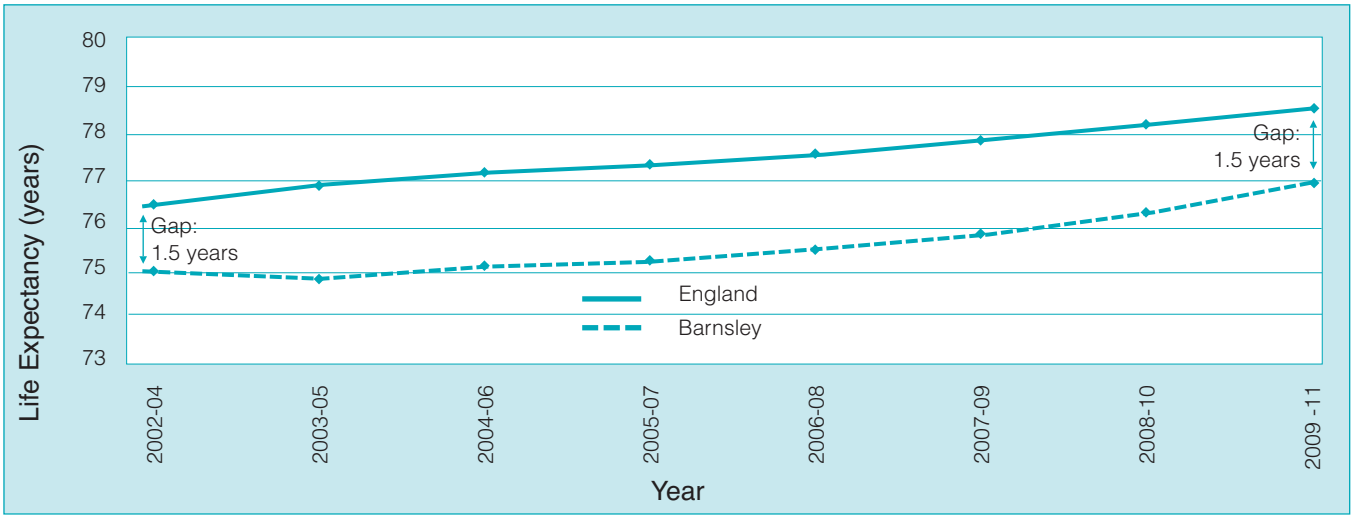
- overall life expectancy
- health inequalities in life expectancy between England and within the borough and
- prevalence and death rates of the three major diseases - Cardiovascular disease, Cancer and Chronic Obstructive Pulmonary Disease in Barnsley.

This description of the health status of the population will allow discussion of the public health approach being taken to address these issues in the following chapters.

Life expectancy

Life expectancy is increasing in Barnsley but at a slower rate than the rest of the country. Between 2009-11, life expectancy in Barnsley was 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.

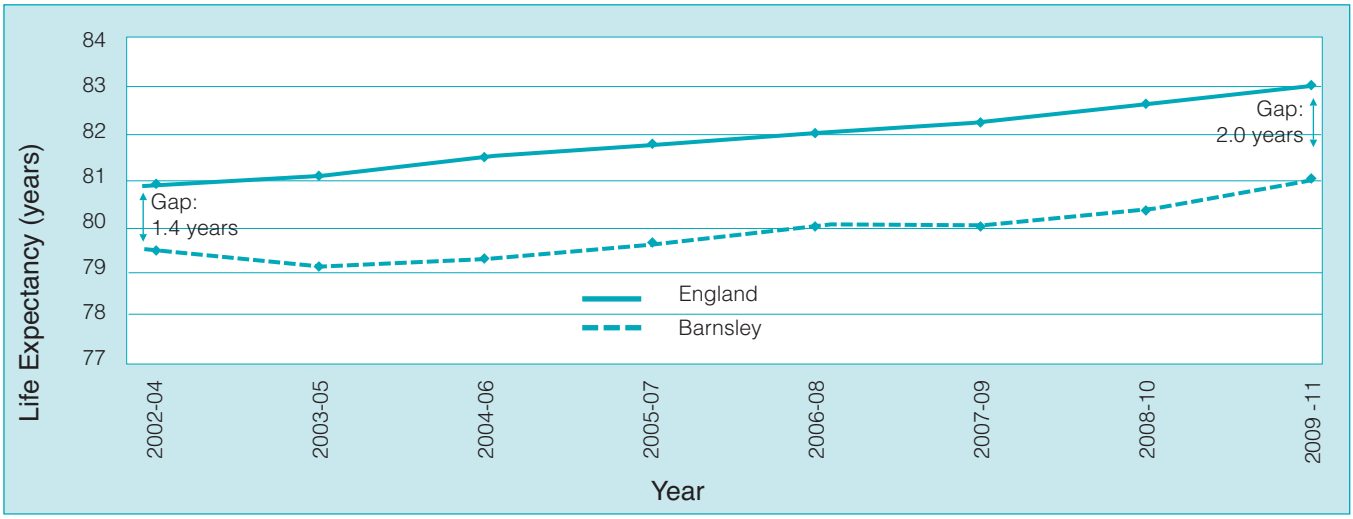
Male Life Expectancy at Birth (years) Barnsley and England, 2002-04 to 2009-11



Source: ONS

Trend data shows male life expectancy in Barnsley has increased by 2.4 years between 2002-04 to 2009-11. However, life expectancy for women in Barnsley has only increased by 1.4 years over the same time period.

Female Life Expectancy at Birth (years) Barnsley and England, 2002-04 to 2009-11



Source: ONS

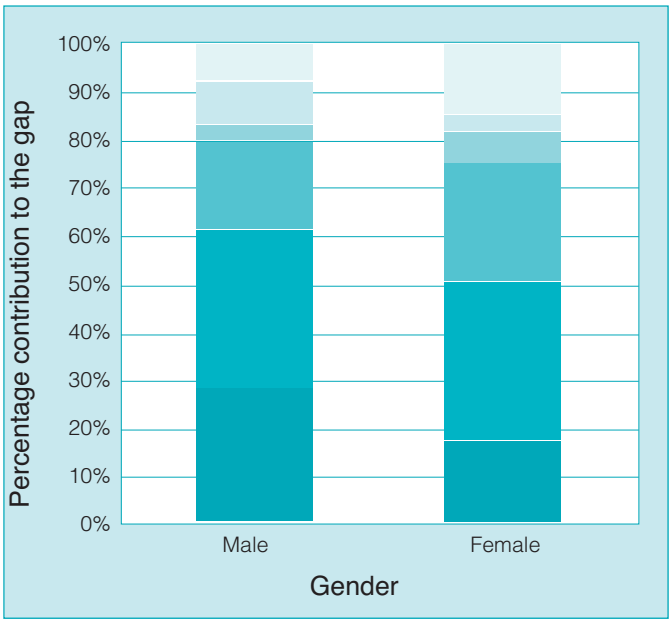
Health Inequalities

The health inequality gap between Barnsley and England, in terms of life expectancy, has increased between the 1995-97 and 2009-11 figures. For men this has increased from 1.4 years to 1.5 years and for women it has increased from 1.7 years to 2.0 years.

Barnsley's 2009-11 life expectancy for men is ranked 282 out of 324 local authorities in England (324=worst) and 308 out of 324 local authorities for women.

The causes of the life expectancy gap between Barnsley and England is shown below and draws attention to the diseases we need to focus on to help people live longer.

Percentage Contribution by Diseases to Gap between 2009/11



Source: Public Health Intelligence, BMBC

- Other
- External causes
- Digestive diseases
- Respiratory diseases
- All cancers
- All circulatory diseases

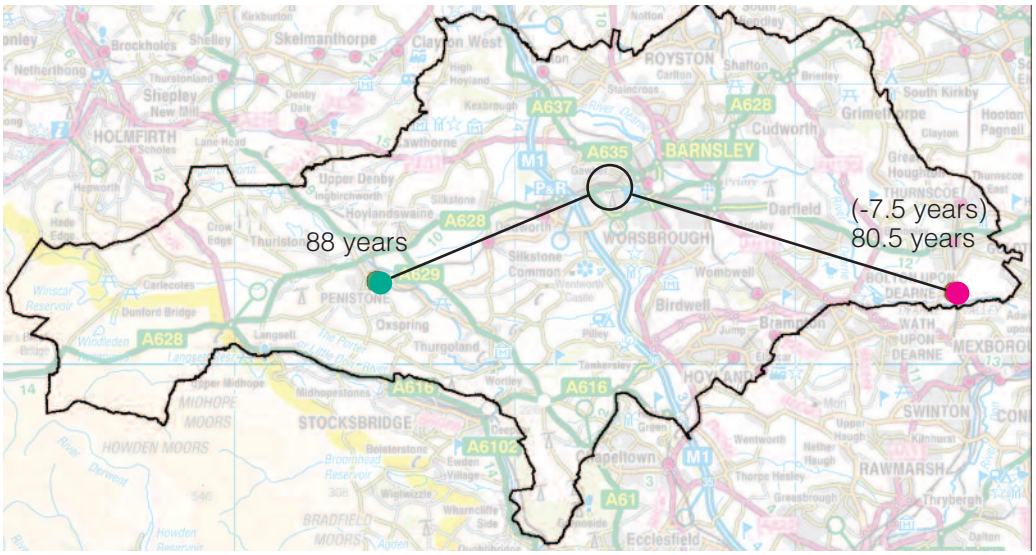
The causes above can be quantified in terms of numbers of excess deaths occurring below 75 years of age which could be avoided. Some of these are excess deaths contributing to the widening health inequalities gap with England.

In Barnsley, on average each year, 864 people die under the age of 75 of which around 173 of these could be avoided.

Heath Inequalities also exist within the Borough with people living longer in the west of the Borough.

This variation can be depicted using a hypothetical journey from west to east. Life expectancy in Penistone for females is 88 years compared to the Dearne which is 80.5 years a difference of 7.5 years.

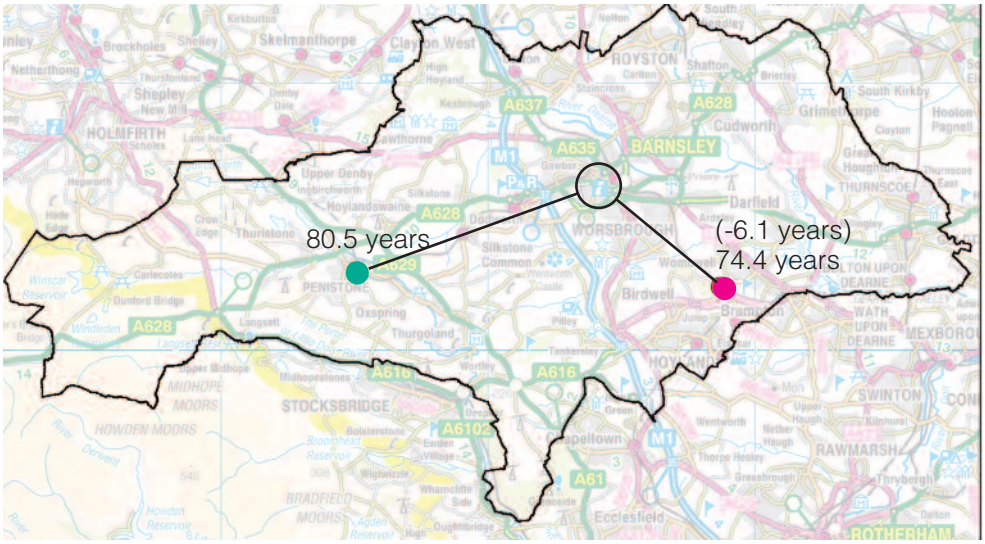
Female inequalities in Barnsley 2007-11: travelling 16 miles from Penistone on the A628 and A635 to Bolton-Upon-Dearne means that you lose 7.5 years of life



Source: Public Health Intelligence Team BMBC © Crown copyright and database rights (2013) Survey Licence number 00022264

Similarly life expectancy in Penistone for males is 80.5 years compared to Wombwell which is 74.4 years a difference of 6.1 years.

Male inequalities in Barnsley 2007-11: travelling 12 miles from Penistone on the A628, A635 and A633 to Wombwell means that you lose 6.1 years of life



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Prevalence and death rates of the three major diseases

Cardiovascular disease

The prevalence of cardiovascular disease (heart disease, stroke and other vascular diseases) is set to rise steadily both nationally and in Barnsley over the next 10 years. Barnsley currently has a higher prevalence than England for vascular diseases.

Modelled prevalence of CVD 2006 - 2020

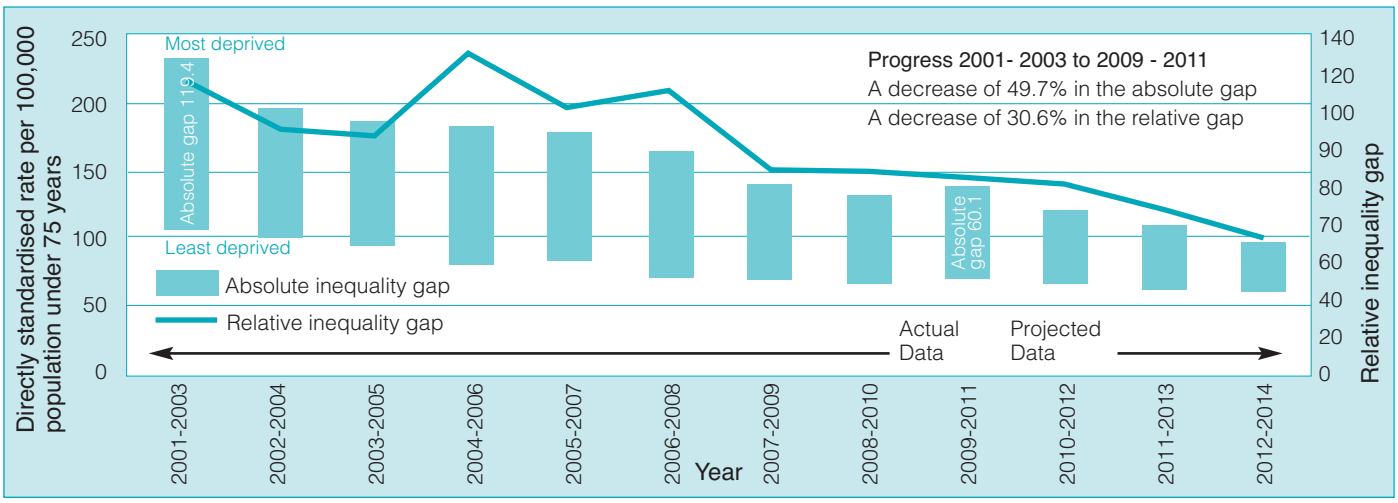
	2006	2007	2008	2009	2010	2015	2020
Barnsley	7.0%	7.0%	7.1%	7.2%	7.2%	7.7%	8.2%
England	6.5%	6.6%	6.6%	6.6%	6.7%	7.0%	7.4%

Source: APHO CVD prevalence modelling

There are approximately 224 deaths each year in those aged under 75 from all cardiovascular disease. In 2009-11 the under 75 mortality rate from all cardiovascular disease in Barnsley was 80.7 per 100,000 in Barnsley which was significantly higher than the national average and the highest in South Yorkshire.

Despite this there is evidence to show, in the graph below, that targeted work on health inequalities for cardiovascular disease which has taken place in different parts of the Borough over the past 10 years has successfully resulted in reducing both the absolute and relative gaps between the most and least deprived areas.

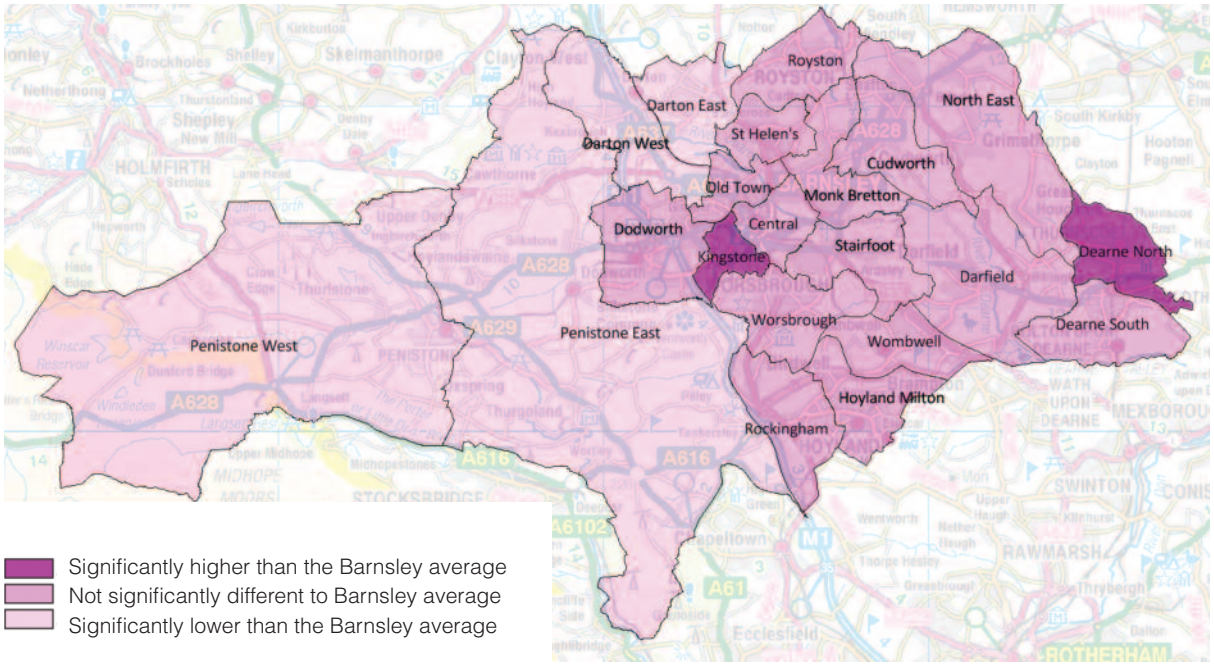
Graph Showing Circulatory Disease Mortality in People Aged Under 75, Absolute and Relative Inequality Gap Between the Least and Most Deprived Quintiles in Barnsley 2001-03 to 2009-11, with Trajectories to 2014



Source: Office for National Statistics Annual Mortality Files 2001 - Census mid year poulation estimates

There is significant variation in cardiovascular disease mortality within Barnsley at ward level, with Kingstone and Dearne North wards experiencing significantly higher cardiovascular disease mortality rates in the under 75s than the Barnsley average.

Barnsley Electoral Ward Under 75 Mortality Rate from all Cardiovascular Disease Directly Age Standardised Rate 2007 - 2011

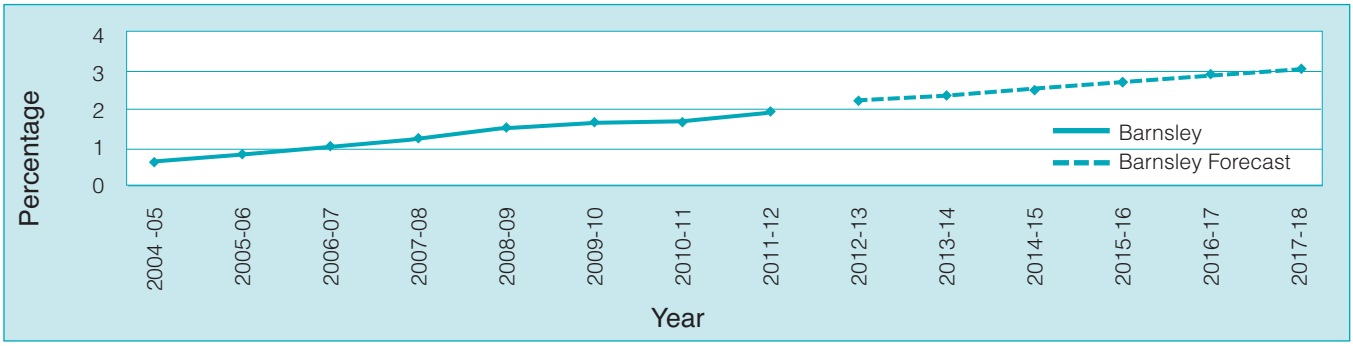


Significantly higher than the Barnsley average
Not significantly different to Barnsley average
Significantly lower than the Barnsley average

Cancer

Barnsley's 2011/12 cancer prevalence rate was 1.9%. The predicted prevalence of cancer in Barnsley is modelled to rise to 2.9% by 2017/18.

Cancer Prevalence 2004/05 to 2011/12 with projections to 2017/18 Barnsley



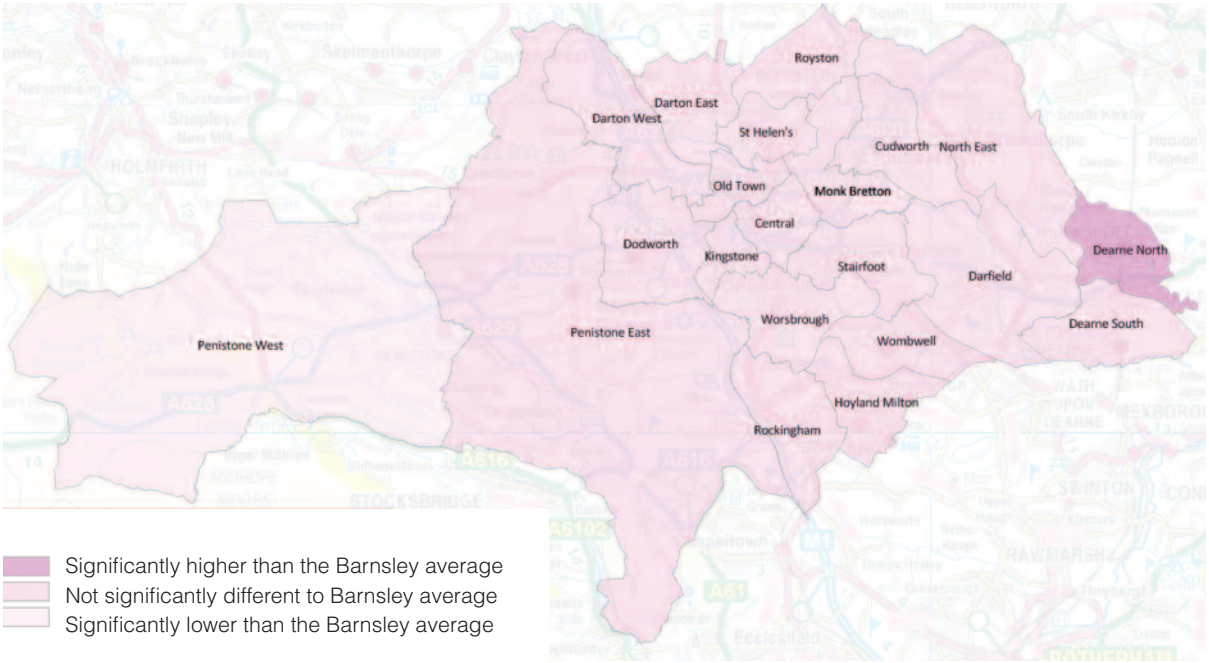
Source: Health and Social Care Information Centre and Public Health Intelligence Team, Barnsley Metropolitan Borough Council

There are approximately 353 deaths each year in those aged under 75 from cancer. In 2009-11 the under 75 mortality rate from cancer in Barnsley was 127.0 per 100,000 which was significantly higher than the national average.

Lung cancer is the main cause of cancer deaths in Barnsley; 26% of cancer deaths between 2009 and 2011 were due to lung cancer, 7.7% to bowel cancer, and 5.8% to breast cancer. Smoking is the main cause of lung cancer and associated with other cancer types.

There is wide variation in cancer mortality within Barnsley at ward level, people living in Dearne North have a statistically significantly higher cancer mortality rate in the under 75s than the Barnsley average.

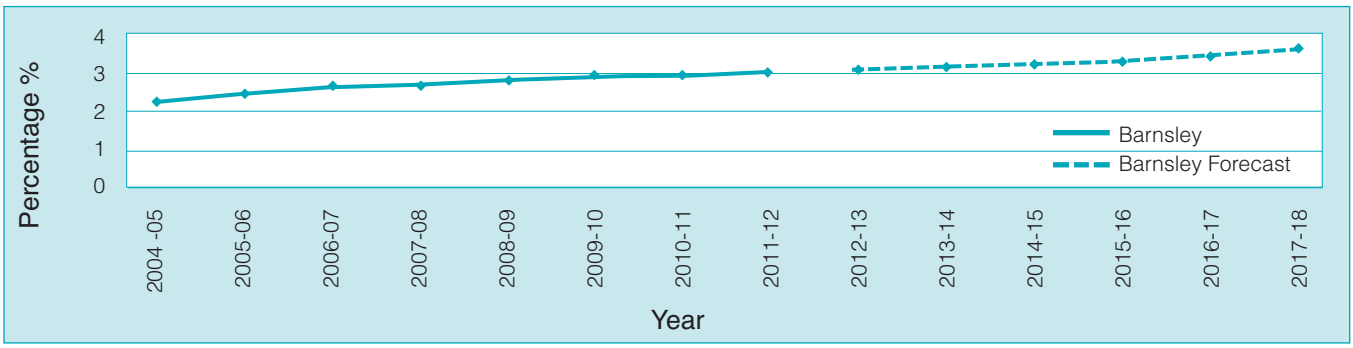
Barnsley Electoral Ward Under 75 Mortality Rate from Cancer Directly Age Standardised Rate 2007 - 2011



Respiratory Disease

Chronic Obstructive Pulmonary Disease (COPD) is the main cause of respiratory deaths in Barnsley. The prevalence rate for COPD in Barnsley is 3.02% which is significantly higher than the England average of 1.69%.

COPD Prevalence 2004/05 to 2011/12 with projections to 2017/18 Barnsley

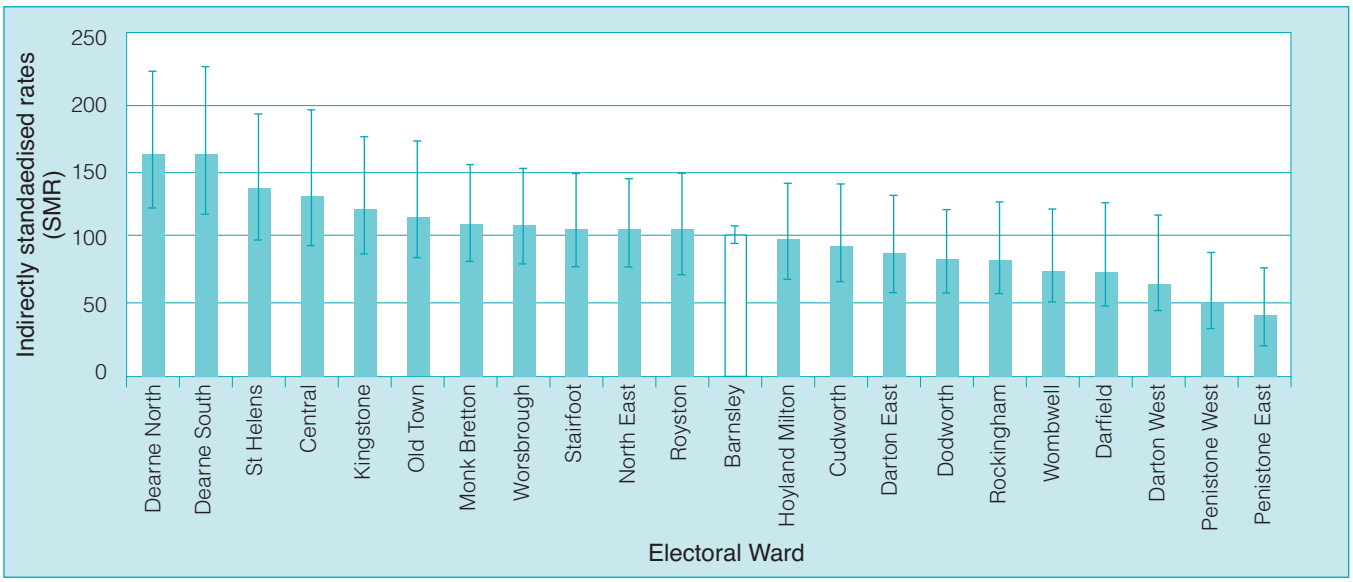


Source: Health and Social Care Information Centre and Public Health Intelligence Team, Barnsley Metropolitan Borough Council

There are approximately 87 deaths each year in those aged under 75 from respiratory disease. In 2009-11, the under 75 mortality rate from respiratory disease in Barnsley was significantly higher than the national average. Smoking is the main cause of COPD which accounts for majority of respiratory deaths.

There is some variation in COPD mortality within Barnsley at ward level, with Dearne North and Dearne South wards experiencing significantly higher COPD mortality rates compared to the Barnsley average.

Premature deaths from COPD, Barnsley wards, 2005-09



Source: Public Health Intelligence, NHS Barnsley, 2011

Addressing Population Health and Health Inequalities in Barnsley

Recognition in Barnsley that prevalence of disease and death rates were higher in Barnsley when compared with England was highlighted in 2003 when the first Barnsley Health Inequalities strategy : Fit For the Future was published.

Funding from the Neighbourhood Renewal Fund and Primary Care Trust (PCT) health inequalities fund was used to implement a 30 year programme to target work on prevention and improvements in healthcare in deprived areas in Barnsley experiencing the worst health outcomes.

The Department of Health policy " Choosing Health" allocated money from 2004 onwards to local PCT's to address health inequalities. Intervention programmes such as detecting early disease and lifestyle prevention were promoted by the Health Inequalities National Support Teams (HINST) from 2007 onwards. Barnsley was scrutinised by the HINST team on its activities in 2009 with recommendations from the team to step up work to achieve the 2010 Life Expectancy target.

The 2011 Director of Public Health's Annual Report- A Call to Action described detailed information and analysis on the widening health inequality gap between Barnsley and England in terms of life expectancy and recommendations on what interventions to put in place.

Work since 2011 led by NHS Barnsley and Barnsley Metropolitan Borough Council through the joint Public Health directorate has focused on targeting services and prevention initiatives on cardiovascular disease, cancer and other key health issues to try to reduce the gap in life expectancy between Barnsley and England and also between wards within Barnsley.

The Barnsley Health and Wellbeing Board has identified priorities and programme of work that will continue work on the major diseases and lifestyle issues such as alcohol and the wider and social determinants of health. This work will contribute to improvements in population health and reductions in health inequalities.

Screening

Screening of the population is also a key public health intervention that can detect illness in its early stage when health outcomes can be maximised.

The NHS Healthchecks programme, now in its fifth year in Barnsley, has risk assessed over 65,000 people aged 40-75 to identify early heart disease. Many people are now on high blood pressure and statin therapy as a direct result of this programme leading to fewer deaths from cardiovascular diseases.

Cancer screening and ante-natal and newborn screening programmes from April 1st 2013 became the responsibility of Public Health England. BMBC Public Health will play a key role in ensuring uptake of cervical, breast and bowel screening is good across all of Barnsley so that variations in uptake are minimised.

Protection

Diseases such as measles, sexually transmitted infections and other common infectious diseases, form part of population health amenable to health protection measures such as immunisation and contact tracing.

Conclusions

The population in Barnsley has increased over the ages and continues to increase with an ever ageing population. The prevalence of major diseases is rising and although life expectancy in Barnsley is improving, the pace of improvement is slower when compared to England. Health inequalities persist within the Borough with marked differences between the east and west.

Recommendations

The following programmes of work over the short, medium and long term, if resourced sufficiently and delivered effectively, will reduce premature deaths under 75 years and reduce health inequalities in the Borough.

Short Term Actions in the next 1-3 years

395 deaths each year potentially saved through the following actions:

- Aim for 100% of eligible people receiving NHS Health Check (and effective treatment)
- Raising awareness of risk factors for cancer, cancer early signs and symptoms, encouraging people to attend for screening
- Focus on reducing prevalance of smoking alongside helping people to stop smoking
- Work with the NHS to increase access to and take up of seasonal flu and pneumococcal immunisation

Medium Term Actions in the next 1-10 years

Work to promote healthier lifestyle choices and behaviour change:

- Smoking and tobacco control programmes
- Food programmes to increase access to healthy food and cooking skills
- Physical activity programmes
- Improving emotional resilience
- Drug and alcohol programme
- Improving sexual health & reducing teenage pregnancies
- Empowering and supporting people to take more responsibility for their own health

Longer Term Actions in the next 1-20 years

- Increasing levels of community engagement and empowering local communities
- Tackling crime and the fear of crime
- Promoting a healthier environment- waste, green space, transport facilities
- Improving the local economy and increasing employment
- Housing - access to and quality
- Education and life-long learning

Lifestyle determinants of HEALTH

Introduction

Many people think public health is about lifestyle issues, such as smoking, physical activity and alcohol use. Elsewhere in this report a picture is painted of the wider and social determinants of health. These are the underlying factors that can limit the health that people can achieve. There is also a description of the population and the health conditions that are faced by Barnsley people. In between these are our lifestyles and the behaviours that we adopt. In general, most people are aware of what constitutes a healthy lifestyle. Smoking is bad for your health - and yet people smoke. Drinking alcohol to excess is bad for your health and yet many people have a problem with alcohol. We all know that exercise is good for you - and yet many do not exercise sufficiently. It is clear that knowledge alone is insufficient.

In Public Health we work towards a holistic understanding of health. We accept that people live complex lives and are subject to a huge range of influences; from friends, families and community norms to media and advertising. Public Health commissions a range of services to help support those people who are ready to make lifestyle changes, such as our Stop Smoking Service, our Health Trainer service and our Integrated Weight Management Service.

As we have moved into Barnsley Metropolitan Borough Council we are beginning to look again at these services. We are at the start of a journey to review these services to provide the people of Barnsley with a more comprehensive, simpler and holistic service to support lifestyle changes.

This chapter examines some of the lifestyle issues and the work we have been undertaking to take these services forward.

Alcohol

Alcohol misuse has become a serious and worsening public health problem in the UK. The misuse of alcohol - whether as chronically heavy drinking, binge-drinking or even moderate drinking in inappropriate circumstances (e.g. operating machinery, on medication) - not only poses a threat to the health and well-being of the drinker, but also to family, friends, communities and wider society through such problems as crime, anti-social behaviour and loss of productivity. It is also directly linked to a range of health issues such as high blood pressure, mental ill-health, accidental injury, violence, liver disease and sexually transmitted infection (FPH, 2008).

Marmot (2010, p57) points out that the social gradient in alcohol use is different to most healthy lifestyle issues with alcohol use rising with income levels. Problematic use and dependence on alcohol, however, is associated with lower socioeconomic status.

Evidence suggests that measures to increase the price of alcohol and decrease availability, as well as targeting groups who are vulnerable or disadvantaged where the risk of harm may be greatest, would have the most effect (WHO, 2007).

Barnsley's rate for alcohol-specific admissions in under 18s (87.8 per 100,000) is significantly higher than the England average of 55.8 per 100,000 and is the highest rate in South Yorkshire (Public Health England). Focused work needs to be undertaken aimed at specific risk groups such as young binge-drinkers, in addition to effective partnership working to ensure implementation of existing laws on sales of alcohol to those underage, and supported by the introduction of education on alcohol-related issues at a younger age.

Barnsley's worse than average figure has led to a range of organisations joining forces to work collaboratively to reduce morbidity and mortality rates across Barnsley due to overconsumption of alcohol. Alcohol is one of the priorities for the Health and Wellbeing Board and has been written into the first Health and Wellbeing Strategy.

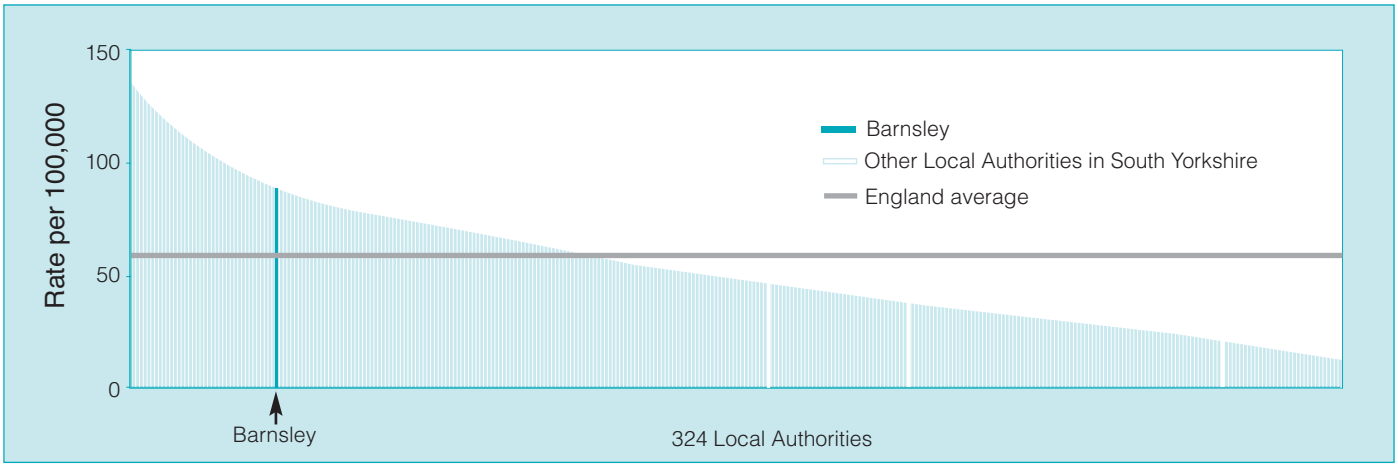
Locally, many Public Health funded interventions are commissioned by The Barnsley Drug and Alcohol Action Team (DAAT) in partnership with children's services. These include:

- Alcohol awareness in schools,
- 'Young Addaction' (a referral programme for young people with alcohol issues).
- The Immortals - a group of young people who are keen to promote alternative nights out for young people in Barnsley aged 10-18 years of age; these are alcohol and drug free events that are led and developed by the young people themselves and have been well attended and are gaining in popularity amongst the target age group.
- Partnerships with local pubs and clubs, particularly within the town centre, to encourage responsible drinking. Initiatives such as 'Best Bar None' and 'Challenge 21' have been implemented.
- A large amount of work has been done across Barnsley in order to reduce the incidence of anti-social behaviour induced by excess alcohol consumption amongst young people.

The work of the DAAT has in recent years been funded by NHS Barnsley, Barnsley Metropolitan Borough Council and South Yorkshire Police. These arrangements have changed. The new arrangements involve Public Health in the local authority, NHS Barnsley Clinical Commissioning Group and the Police and Crime Commissioner.

We will need to work closely within these new arrangements to tackle the alcohol agenda in a comprehensive manner.

Alcohol Specific Admissions in under 18's (2008/09 to 2010/11)



Source: Public Health England

Physical Activity

A great deal of debate has been had over one of the major public health issues of our time, obesity. The rise in levels of obesity is a serious concern and is an outcome of unhealthy lifestyles and an environment that actively encourages sedentary lifestyles and a poor relationship with food.

Being overweight is fast becoming a normal condition, and we are now becoming an obese society. But this transition has been at least three decades in the making. The research commissioned by Foresight (2007) reveals that the causes of obesity are embedded in a complex biological system, set within an equally complex societal framework. It will take several decades to reverse the factors that are driving current obesity trends.

The emphasis should be on influencing the wider environment and encouraging healthy lifestyles, particularly around physical activity and food.

This section primarily concerns itself with physical activity.

Current physical activity recommendations are for adults to participate in 150 minutes per week of moderate intensity activity (DH, 2011a). This can comprise of 30 minutes on 5 days, which in turn can be broken down into three 10 minute sessions. This then makes the intervention achievable for most people. Moderate intensity activity should be activities that involve getting slightly out of breath, but still able to hold a conversation. This recommendation is different for children, who should do 60 minutes of activity each day and the activities should include jumping, running, hopping and skipping types of activities. Children under 5 should be active for 3 hours each day once they can walk.

Unfortunately, only a small percentage of the population say they meet these recommendations. 12% of Barnsley adults exercise 3 times a week (DH, 2012), despite the fact that physical inactivity has an impact on health comparable to that of smoking. Regular physical activity reduces the risk of several serious health conditions, including:

- Coronary heart disease (CHD) and stroke
- Type 2 diabetes
- Colon cancer
- Breast cancer
- Hip fracture
- Depression
- Alzheimer's disease

Regular physical activity helps:

- Increase life expectancy
- Improve strength of muscles and bones
- Reduce blood pressure
- Increase levels of 'good' cholesterol (HDL)
- Control weight

Improving health and well-being through physical activity

Being active promotes mental health and well-being, improving self-perception and self-esteem, mood and sleep quality and reducing stress, anxiety and fatigue.

Across Barnsley there are a number of activities available aimed at improving health through physical activity. These include:

- Health walks
- Allotment re-engagement projects
- School sports
- Sports clubs
- Leisure centres
- FitMums
- FitReds – Barnsley Football Club intervention aimed at males
- Falls prevention classes
- Community based exercise classes
- Workplace interventions

In addition to the above, the Barnsley Sport and Active Lifestyles Partnership (BSALP) are currently finalising the 'Everybody Active - A Strategy for Sport and Active Lifestyles in Barnsley 2011-2016'. The fundamental principle of the strategy is the importance of providing opportunities and encouraging people to be physically active because of the health and social benefits that this brings to individuals and communities.

The overall vision of the Strategy is '*to increase participation in sport and active lifestyles and by doing so improve the quality of life for all in Barnsley with a focus on narrowing the gap in participation in five target groups: older people; women and girls; people with a disability; people on low incomes; identified areas of the Borough with low participation'*. By 2016, the strategy aims to have achieved the following: More people in Barnsley:

- Aspiring to be active
- Take part in sport and active recreation
- Choosing to walk or cycle to get around the Borough
- Able to access good quality places and spaces to be active
- Volunteering to support opportunities for sport and active recreation in their local communities
- Able to live independent lives in later years

Despite the availability of many physical activity opportunities, participation still remains low amongst much of the population. Barriers identified include time and cost, and therefore Public Health are giving priority to developing opportunities that utilise the existing environment. This may include increasing the numbers of people walking and cycling as part of their everyday lives – particularly utilising active travel for short journeys. In addition, work will be undertaken to encourage use of Barnsley's beautiful natural setting amongst green spaces and bordering the Peak District National Park; particularly encouraging families to play and spend their leisure time together.

This work cannot progress in isolation. As we develop this work we will have a close relationship with colleagues in Barnsley Council's Development, Environment and Culture Directorate, with local providers and with the NHS Barnsley Clinical Commissioning Group.

Smoking

A large proportion of smokers start in adolescence – and almost all before the age of 24 years. Very few start after 21 years. Individuals who start smoking before the age of 16 are twice as likely to continue using tobacco as those who start when they are older. They are also more likely to smoke heavily, find it harder to stop, and are three times more likely to die of smoking-related cancer than someone who has smoked since their mid-20s.

Children who live with parents or siblings who smoke are up to three times more likely to become smokers themselves than children from non-smoking households. According to the 2013 Year 10 Health and Lifestyle Survey, 41.2% of 14 and 15 year olds in Barnsley live with someone who smokes.

Child and adolescent smoking causes serious risks to respiratory health both in the short and long term. Children who smoke are two to six times more susceptible to coughs and increased phlegm, wheeziness and shortness of breath than those who do not smoke. Smoking impairs lung growth and initiates premature lung function decline which may lead to an increased risk of chronic obstructive lung disease later in life. The earlier children become regular smokers and persist in the habit as adults, the greater the risk of developing lung cancer or heart disease. Children are also more susceptible to the effects of passive smoking.

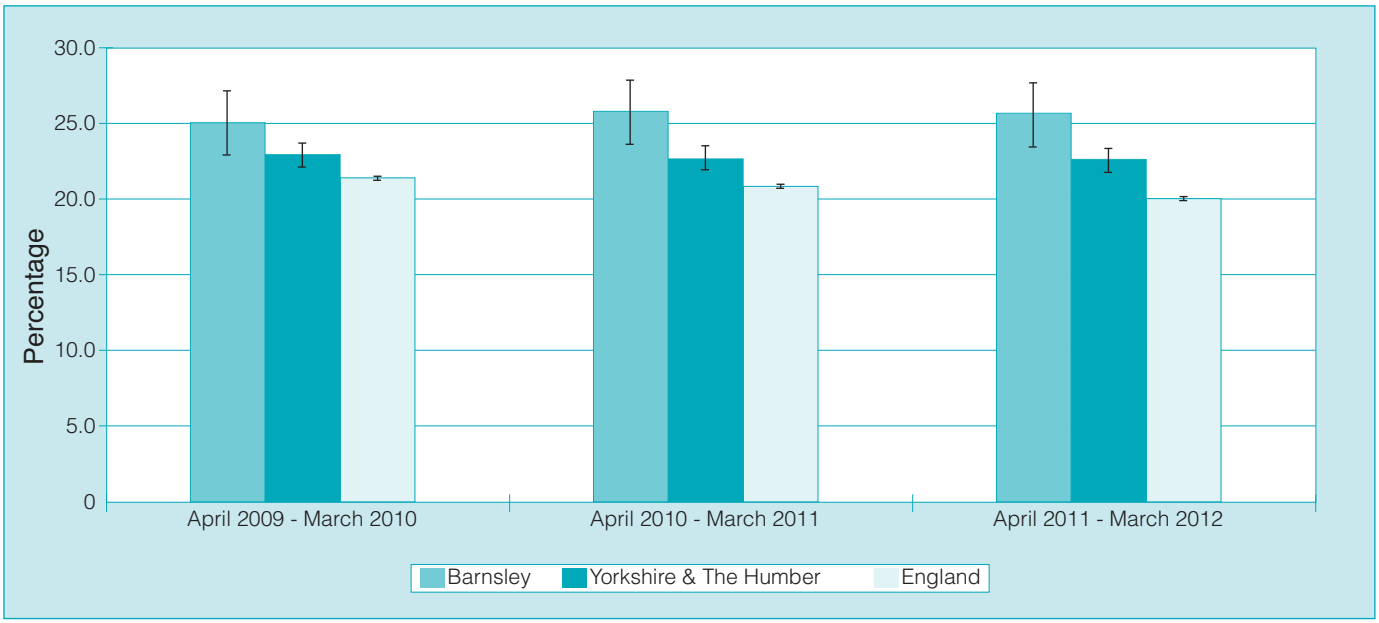
Bronchitis, pneumonia, asthma and sudden infant death syndrome (cot death) are significantly more common in infants and children who have one or two smoking parents.

Evidence clearly demonstrates that there is a social divide in smoking behaviour, with the most deprived young people taking up smoking. In addition, their ability to quit once they have started is greatly reduced. Further, risky behaviour such as drinking alcohol and taking drugs is also strongly associated with smoking.

Smoking is the single biggest cause of preventable death in Britain, claiming more lives each year than the next six most common risk factors combined. Tobacco use is a major cause of coronary heart disease, lung and other cancers, and respiratory diseases, particularly chronic obstructive pulmonary disease (COPD). In 2009, 81,400 people died in England alone as a result of smoking related illnesses. The estimated cost to the NHS that year of treating diseases caused by smoking was upwards of £5 billion.

Smoking is the leading modifiable risk factor for death in Barnsley. Smoking contributed to one in five deaths in the borough between 2008 and 2010 (Office for National Statistics, 2012).

Percentage of current smokers (aged 18+)
Barnsley, Yorkshire & The Humber and England



Source: Integrated Household Survey

Smoking prevalence is still high in Barnsley; the chart above illustrates that Barnsley's rates are significantly higher than the England average. This contributes to Barnsley's low life expectancy when compared to national and regional figures. It is also a major health inequality issue. Reducing Barnsley's smoking prevalence is vital to tackling health inequalities. Data shows for 2011/12 that Barnsley PCT had the 2nd highest number of successful smoking quitters per 100,000 population aged 16 and over in the Yorkshire and Humber region (1506 per 100,000).

Smoking in Pregnancy

Smoking during pregnancy is associated with multiple preventable health problems. These include:

- Complications during labour and increased risk of miscarriage
- Premature birth
- Stillbirth
- Low birth weight
- Sudden unexpected death of the infant
- Harmful impact on long-term physical growth and intellectual development

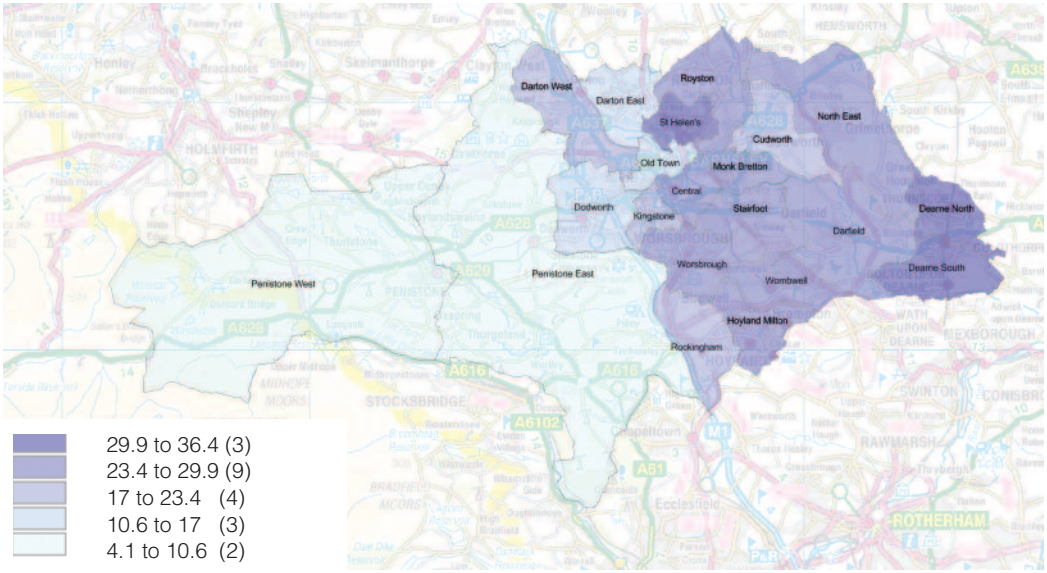
Smoking in pregnancy is measured by smoking at time of delivery. Although Barnsley's rates for women smoking at time of delivery have fallen from 26.4% in 2006/07, the 2012/13 rate of 21.9% is still higher than the Yorkshire and Humber and England rates of 16.5% and 12.7% respectively.

Tobacco use is particularly problematic amongst pregnant 15-19 year olds, of whom 42% are regular smokers. The estimated cost to Barnsley of caring for babies during their first year of life who develop health problems as a consequence of their mother's smoking is £207,484 for 2010/11 alone (Godfrey et al 2010).

Pregnant smokers are concentrated in the most deprived parts of the Borough. As illustrated in the map below, in 2010 to 2013, 36% of pregnant women living in the Dearne North ward smoked, compared to only 4% in Penistone East. This reflects the added pressures and challenges experienced by women living in some of the poorest areas of the Borough.

In 2011/12 only 35.2% of Barnsley's pregnant smokers successfully stopped smoking. This was significantly fewer than both the national and regional averages of 45% and 49% respectively, ranking Barnsley PCT 119th out of 149 PCTs nationally.

Smoking Status Time of Delivery, 2010-11 to 2012-13, Barnsley Electoral Wards



Source: Public Health Intelligence Team BMBC © Crown copyright and database rights (2013)
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Children and Young People

There is no robust estimate of the prevalence of smoking in the under 18's. In the Year 10 Health and Lifestyle survey 2013, 6.5% of males and 13.2% of females said they smoked often or daily; a significant decrease from 2010. This is a positive change; however it needs to be considered that this in part may be due to increasing numbers of young people using E-cigs or Shisha pens as an alternative to smoking cigarettes.

The price of tobacco is related to consumption. The World Bank states that a 10% increase in the price of tobacco would reduce prevalence by 4% in high income countries (World Health Bank 2000). Prevalence rates are highest amongst more deprived communities as is the use of illicit tobacco which helps to maintain these smokers in their habit and encourages the uptake amongst young people. The cost of tobacco is a key factor in any decision to start, quit or relapse.

The Public Health Outcomes Framework 2013-2016 has indicators for smoking in relation to prevalence targets for over 18's, pregnant women's smoking status at delivery and 15 year olds.

Previously Local Authority areas had quit targets to meet, so activity had to focus on this. We are now looking at a different approach; based on the findings of research across South Yorkshire. In addition we have recently chosen to have our tobacco control programme audited as part of the CLeaR programme. A revised approach to tobacco control is a major priority for Public Health in the coming year and will need to involve a wide range of partners.

Recommendations

1. Work closely with the Drug and Alcohol Action Team to review alcohol services and prevention work.

2. Develop new programmes in partnership to promote increased use of cycling and walking.

3. Develop a revised approach to tobacco control and smoking based on local research and external reviews of the current programme.

4. Undertake an overarching review of lifestyle services to develop options for a new model of healthy lifestyle provision.

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Wider and social determinants of HEALTH

Introduction

This chapter is concerned with the wider and social determinants of health. The evidence is very clear. Living in poor social, economic and environmental conditions is bad for health at all stages of your life.

Factors such as poor housing, low levels of education, inadequate pensions, polluted environments and insecure employment are not equally distributed.

It is the unequal distribution of these factors that drive health inequalities. The health effects of these factors accumulate over time. Marmot and Wilkinson describe it thus;

'The longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age' (Marmot and Wilkinson, 2003, p.10).

This chapter describes some of the key wider and social determinants of health that we have been working on.

Environment and housing

The environment in which people live is a fundamental determinant of health. This section examines some of the recent work that has been undertaken in Public Health with the help of partners and Council colleagues on this important agenda.

The Barnsley environment bears the legacy of its industrial past. The industry of the past led to high levels of pollution and degradation. Legislative changes and the decline of industry have changed the landscape of Barnsley. Air quality is substantially improved and residents enjoy significant green spaces and other assets such as the Trans Pennine Trail.

Public Health is interested in continuing to improve the environment, both for the residents of today and of tomorrow and to make the most of the existing environment to benefit the health of Barnsley people.

The importance of this agenda is recognised in the Public Health Outcomes Framework. This framework includes a number of indicators that relate to the wider environmental agenda including:

- Fraction of mortality attributable to particulate air pollution
- Utilisation of outdoor space for exercise / health reasons (this is covered in the section on physical activity – see page 34)
- Statutory homelessness
- Fuel Poverty

Air quality

Air quality in Barnsley has improved over the years. The Public Health Outcomes Framework indicator relates to the number of deaths that can be attributed to the presence of fine particulate matter in the air. Barnsley's position on this indicator is similar to the national average.

Barnsley Metropolitan Borough Council monitors air quality across the Borough and has declared a number of Air Quality Management Areas (AQMAs). These are listed below and are a result of traffic pollution rather than industrial processes.

1. M1 Motorway, 100 metres either side of the central reservation within the Barnsley Borough
2. A628 Dodworth Road
3. Junction of A61 Wakefield Road and Burton Road
4. A61 Harborough Hill Road
5. Junction of A633 Rotherham Road and Burton Road
6. Langsett
7. A61 Sheffield Rd

Over the last year Public Health has been working with partners in Regulatory Services in BMBC to develop an air pollution model for Nitrogen Dioxide (NO2). This will enable various scenarios to be evaluated, such as what effect low emission vehicles would have on local air quality with the aim of influencing a wide range of council policies. The first phase of this process will focus on the A61 Wakefield Road and will be replicated on all major routes into the town in the next few years. We are also looking at supporting Regulatory Services in developing local information on PM2.5 (the fine particulate matter that the Public Health Outcomes Framework indicator is based on). This will assist in the development of a robust multi disciplinary air quality evidence base for the borough.

Location of AQMA's - April 2013

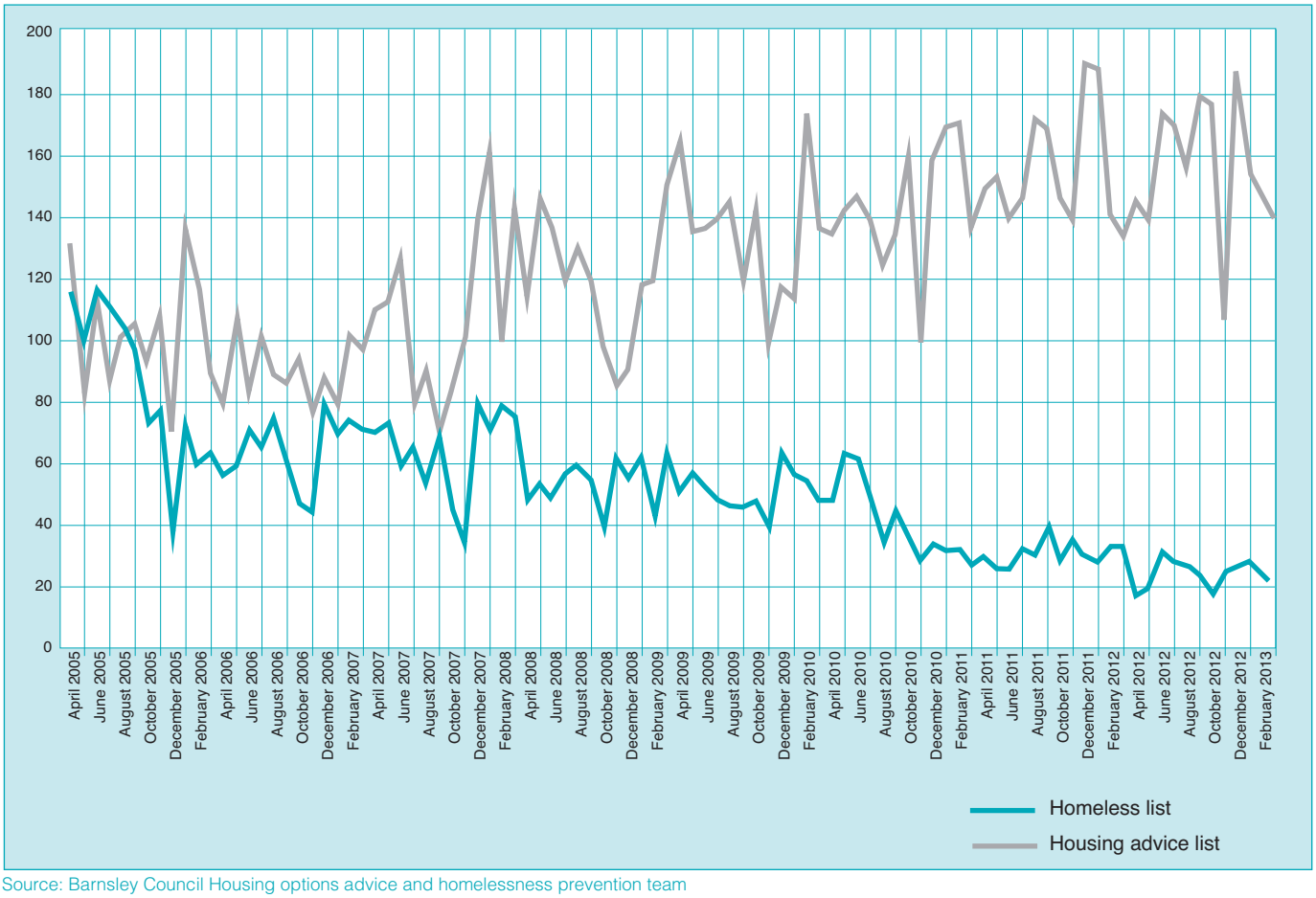
Source: BMBC Regulatory Services

Homelessness

Barnsley does not have a significant homelessness problem compared to the rest of the country. Barnsley Council has an excellent approach to managing homelessness, providing housing advice and intervening at an early stage in order that applications for statutory homelessness are minimised.

Since the 2002 Homelessness Act was introduced there has been an increase in individuals accessing housing advice. The Act required all local authorities to put into place preventative services, since which a drop in homeless applications has been notable in Barnsley.

The chart below provides summary historical information regarding the total approaches for both homeless and housing advice approaches from 1 April 2005 to present.



Source: Barnsley Council Housing options advice and homelessness prevention team

In 2012/13 1,845 housing advice applications were made, and only 341 actual homeless applications were made, suggesting that early intervention is helping to prevent homeless applications.

Of the 309 homeless applications where a decision has been reached, 123 were 'solved' through housing advice, preventing them from becoming homeless. Only 24 applications made in 2012/13 were successful (where the local authority accepts 'full duty').

The last five years has seen a 500% increase in housing advice for home owners, indicating that the recession is impacting on homelessness. Early evidence of the impact of recent welfare reform changes is beginning to emerge, with homeless applications been made by social housing tenants since reforms were introduced in April 2013.

Information about the impact of national welfare reform policies on homelessness is only just beginning to emerge, but suggests that the increased costs associated with the spare room subsidy for example are causing more households to seek housing advice. Keeping abreast of such policy changes will be important in anticipating issues causing homelessness, monitoring their impact, and arranging appropriate support services.

The Homelessness Team have begun to produce monthly, rather than quarterly, data on the reasons for homelessness, in order that new trends, such as eviction due to inability to afford increases in rent associated with the 'bedroom tax' are identified quickly. Further to this, the Team will need to work closely with partner agencies involved in the anti-poverty/welfare agenda to respond to need, as it is identified. For example, providing advice to households affected by the benefit cap, and encouraging take up of discretionary housing benefit where appropriate.

The team are likely to require assistance in setting up the right kind of advice and support to be made available at the planned Christmas Shelter.
More intelligence and work is required around the following two groups, who are judged to be at risk of homelessness:-

- Those that make a homeless application but then do not remain in touch, for which cases are eventually closed. This applied to 46 such applicants in 2012/13 (of the 355 who made an application).

- Prison leavers placed into accommodation which is inappropriate, for example too expensive, with no support for on-going needs.

Fuel Poverty and Excess Winter Deaths

In Barnsley between 2008 and 2011 there were an average of 116 excess elderly deaths in the winter.

In Yorkshire and Humber Barnsley has the second highest level of fuel poverty with over 18% of households being classed as "Fuel poor".

The extent of fuel poverty in Barnsley compared to the rest of the region is illustrated in a recent Government report on levels of fuel poverty (DECC, 2013): The summary below shows Barnsley has almost the highest level of fuel poverty in the region. Reducing and ultimately eradicating fuel poverty is a high priority in the Borough.

Percentage of fuel poor households, Yorkshire and Humber, 2011

LA Name	English region	All Households	Fuel Poor Households	Percent Fuel Poor
Barnsley	Yorkshire and the Humber	102,298	18,798	18.4%
Doncaster	Yorkshire and the Humber	127,619	23,535	18.4%
Rotherham	Yorkshire and the Humber	110,636	18,447	16.7%
Sheffield	Yorkshire and the Humber	234,605	41,215	17.6%
Bradford	Yorkshire and the Humber	198,766	35,662	17.9%
Calderdale	Yorkshire and the Humber	90,018	16,911	18.8%
Kirklees	Yorkshire and the Humber	175,184	30,783	17.6%
Leeds	Yorkshire and the Humber	336,974	55,050	16.3%
Wakefield	Yorkshire and the Humber	144,946	23,980	16.5%

Source: Department of Energy and Climate Change

Clearly, improving housing conditions can play a key role in reducing fuel poverty and a wider range of health related conditions.

The Marmot Review, 'Fair Society Healthy Lives' 2010 set out the consequences of poor housing on health and nowhere is this more starkly illustrated than in regard to excess winter deaths that are directly linked to fuel poverty. This was further reinforced by the Marmot Review Team in the report (2011,p5) "Cold housing and fuel poverty can be successfully tackled through policies and interventions if there is a will to do so. There is a social gradient in fuel poverty: the lower your income the more likely you are to be at risk of fuel poverty. Inequalities that are avoidable are fundamentally unfair - fuel poverty is avoidable and it contributes to social and health inequalities."

The 2010 Barnsley private sector housing stock condition survey found that 24.8% of houses in this sector failed to meet the thermal comfort criterion of the decent homes standard and this in turn is likely to lead to significant levels of fuel poverty, especially amongst vulnerable households living at the bottom end of the private rented sector. This equates to approximately 23,000 dwellings and it is likely that most of these houses will still be standing in 2050.

The extent of fuel poverty at a local level is further illustrated by the Barnsley MBC Private Sector House Condition Survey (2010). This shows the extent of the problem in both owner occupied and private rented sectors.

An indication of the extent to which owner occupied properties are below standard came from a 98 yr old couple living in an owner occupied property and who received a Winter Survival Kit as part of the Public Health Warm Homes, Healthy People campaign:

"Thank you for all the lovely warm things like scarves, gloves, stockings etc. We particularly like the huge blanket" .

Tenure	Owner Occupied		Private Rented	
	Number	%	Number	%
Households in Fuel Poverty	9600	13.4	1800	17.2
Non-decent Homes	25950	36.3	4850	45.7

Warm Homes Healthy People (WHHP)

Having previously run a WHHP project in 2011/12 Barnsley's Public Health Directorate decided to submit a further bid for a range of initiatives to be implemented during the winter of 2012/13. This bid was successful and the Department of Health awarded £254,000. Additional funds were provided by the local Clinical Commissioning Group and the local Public Health budget.

Our aim was to reduce excess illness and deaths caused as a result of vulnerable people living in cold housing. Currently, there are at least 10,000 Barnsley pensioners living in some of the most deprived areas in the country, and 23.9% of the Borough's 42,700 children live in poverty.

The 2012/13 WHHP programme consisted of a number of strands that included the following:

The Winter Survival Kits (WiSK's)

Targeted at the most vulnerable people, particularly the elderly and struggling families (2,000 kits were distributed to the elderly, 1,000 kits to families with children under 4 and 1,000 kits to families with infants under 1). The packs were procured locally through Norfolk Property Services (NPS), packed by around 50 volunteers, recruited and managed by VAB, who then distributed them to the most vulnerable members of the community.

Free Home Energy Efficiency Checks

Were carried out by Groundwork UK "Green Doctors". The Green Doctors will make a contribution to improving energy efficiency and provide an opportunity to reduce fuel poverty.

A number of clients who have received support from the WHHP programmes have expressed thanks for various initiatives which have resulted in the individuals' homes being a great deal warmer in winter with little or no outlay from the tenant/owner.

- *"lived in this house near Cemetery Rd for 30 yrs and never been as warm" and*
- *"The two Green Doctors were really helpful. Offering me advice how to keep my house warm and keep my bills down".*

An external evaluation of the programme is being carried out. The past two winter campaigns have received external funding and there are no guarantees that we will be able to continue in the same vein. Public Health is therefore organising a partnership event to look at how we can continue to support the eradication of excess winter deaths.

Workplace Health

In general, having a job is better for health than having no job. But, the social organisation (sic) of work, management styles and social relationships in the workplace all matter for health.' (Marmot and Wilkinson, 2003, p.18).

In recent years the nature of work has changed considerably with many more sedentary, office based jobs and less active manufacturing or industrial jobs. At the same time the population is changing, people are living longer and the workforce is becoming on average older with people retiring later.

With higher levels of chronic disease there is an important role for health promotion within the workplace to keep people healthier and reduce the negative impact of factors such as lack of exercise, smoking and drinking.

Particularly in the last ten years there has been a shift in attitudes and recognition by employers of the business benefits of investing in employee health and wellbeing. The Black Report (Black, 2008) has been instrumental in raising awareness at public policy level of how the way we are treated at work and the nature of the work that we do affects our wellbeing and our levels of performance.

Employers are recognising the link between work and employees' health and wellbeing and that they have a responsibility to encourage employees to be physically and mentally healthy. This was highlighted in a Department of Work and Pensions survey of employers (Young, C and Bhaumik, C, 2011). The main challenges identified being to transfer the good health and wellbeing practices taking place in larger organisations to small and medium enterprises, as these were less able to invest in health and wellbeing.

Employers were also recognising the aspects of work such as people management, leadership, job design organisational culture, autonomy and support as being central to employee wellbeing.

The pace of work has altered and work has intensified. There has been technological advances, companies have become 'more lean' with increased pressures to be competitive, customer focused with constricted budgets. There is also a greater expectation for people to do too much in less time which has led to a blurring of 'work' and 'home' life, impacting on mental and emotional wellbeing.

So whilst work is much safer now and employers are introducing policies that offer more flexibility for employees allowing a greater balance between work and home life, work is also more complex with employees suffering from higher levels of stress and mental health problems.

Health at work is a priority for Public Health and whilst knowledge of what businesses are doing in terms of health and wellbeing across the borough is currently limited, in general the trend is that employers are recognising the benefits of investing in employee health and wellbeing.

The start of the initial engagement with employers across Barnsley was through a health at work conference held in January 2013. This event was organised with colleagues in Rotherham and the Barnsley and Rotherham Chamber of Commerce. The outcomes of the event have led to follow up support with a number of businesses.

A local group chaired and organised by Public Health is meeting quarterly to share good practice. Feedback from the local group is that employers are raising awareness of lifestyle factors affecting health and wellbeing and are bringing in benefits such as cycle to work schemes and reduced cost gym membership to encourage their employees to be more physically active.

The workplace is a key setting and infrastructure to support the promotion of health to a large group of individuals and for the Government to influence how health and wellbeing is managed for those who are in work, those who risk dropping out of employment and those who wish to return to work.

The fit note has forced employers to look more seriously at helping employees back to work more swiftly. More recently the announcement of the New Occupational Health Advisory Service will provide support for employers and put measures in place to help employees off from work on long term sickness to return to work quicker.

Public Health will be assessing the heath and wellbeing needs of businesses across the Borough and encouraging businesses to put measures in place to improve the health and wellbeing of their employees.

Unemployment and poverty

There is evidence that unemployment is harmful to health. Those unemployed have generally poorer health, long standing illness, poor mental health and higher medical consultation.

In the short term unemployment in Barnsley is unlikely to decrease, it will be for Public Health to work with partner organisations and to try and mitigate the effects that the recession and welfare reforms have had and will have on the communities within the borough.

The chart shows that since the credit crunch in 2008 increasing numbers of Barnsley residents have been out of work and actively looking for work. The rate of people claiming Job Seeker Allowances has risen higher and faster than for the country as a whole.

Percentage of population (aged 16-64) claiming Job Seekers Allowance, Barnsley and Great Britain. August 1999 - November 2012.

Source: NOMIS

The impact of the welfare reforms will be significant on the citizens and communities of Barnsley as there are a high proportion of residents in receipt of benefits. This in turn will have an economic impact on the prosperity of the town, falling on the most vulnerable within our communities (particularly those on benefits who may receive a reduced level) such as lone parents, workless families, families with children and people with disabilities.

Mental Health and Wellbeing

Mental health is as important to Public Health as physical health. The two are inextricably linked. For example, on average people with mental illness die 5 – 10 years younger than the general population. Improved mental health is associated with a range of better outcomes including improved physical health, better educational achievement, increased skills, reduced health risk behaviours such as smoking and drinking alcohol and reduced criminality.

It is essential to tackle the stigma and discrimination of mental illness that is all too often experienced. The National Mental Health Strategy, No Health without Mental Health (DH, 2011) cites this as a key area for action. Adults with mental health problems are one of the most socially excluded groups in society.

The mental health agenda is very broad ranging from suicide and suicide prevention on one extreme to promoting and encouraging good mental health and emotional resilience.

A new Suicide Audit is currently underway to analyse reported deaths between 2009 and 2013. This audit should inform future strategies building on the Government's recently published Suicide Prevention strategy.

Public Health has been financially supporting and championing a local programme of Arts on Referral for a number of years. This is an innovative scheme run by local providers to provide help for people with low levels of stress, anxiety and depression. The scheme uses a number of artistic approaches to provide help, strategies and confidence.

Initiatives embedded within the scheme include:

- Creative wellbeing
- Tickets on referral
- Live Arts Café
- Uplift Army

The sessions continue to attract good numbers and evaluations are positive with participants recording a positive change in their wellbeing since engaging in the programme.

Quotes from participants

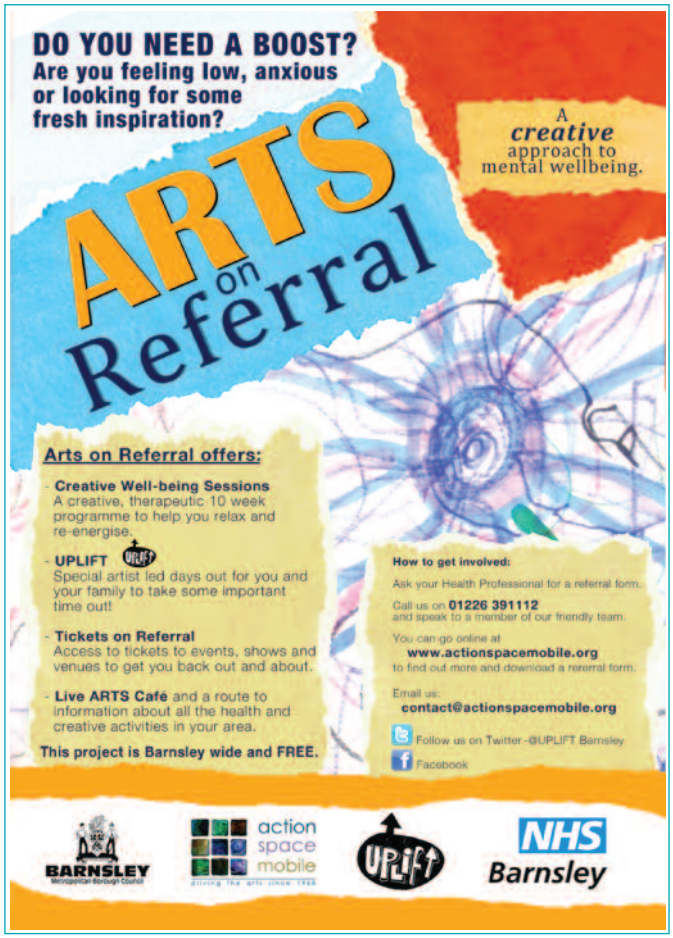
"I was isolated & it got me out & about a bit. It was a good thing to sign up & get me out & about. Gives you a purpose, something to get up for. Travelling is an achievement; started using public transport motivated me to get over nervousness. Got me more motivated than I was. I had low self-esteem & motivation. I choose the ones I want - before I went to stuff because I had to."

"I think more people should be able to come to classes like this…its very therapeutic"

"Not one session has disappointed me yet!"

'UPLIFT has helped me to cope better, to see new avenues and explore what I might want to do in the future. …. I have definitely improved. I now make sure that I have stuff to look forward to and that means I have the strength to carry on, I don't contemplate suicide now. The UPLIFTs have been a reward for keeping going.

Compared to last year I'm 75% better. This is due to getting out and meeting people, talking and trying new things. I recommend it to anyone who is feeling grey and who can't see a future. I'm now making sculptures in my own time; I've started attending courses at Northern College. I think I'm worth it!



Arts on referral poster

A key challenge for the Council is to change the relationship it has with the community. Communities will need to be self-reliant and will need to come together to co-produce solutions to the problems that they face.

The Arts on Referral programme is valuable to this agenda as it not only builds resilience in individuals, families and communities but it also demonstrates the creativity that exists in Barnsley communities. And creative approaches to difficult issues will be important in the coming years.

Recommendations

1. Continue to work in partnership with regulatory services in the council and Public Health England to ensure that the population of Barnsley is protected from preventable environmental and pollution health threats.

2. Work with partner agencies to develop a joint approach to eradicating preventable excess winter death in Barnsley.

3. Develop a workplace health programme and engage with businesses across the borough to promote workplace health.

4. Continue to promote creative approaches to improving mental wellbeing.

5. Support work through the Anti-poverty Board to monitor, understand and mitigate the effects of welfare reform on the health of Barnsley residents.

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Health PROTECTION

Health Protection is a term used to encompass a set of activities within the public health function. It involves;

- Ensuring the safety and quality of food, water, air and the general environment
- Preventing the transmission of communicable diseases
- Managing outbreaks and the other incidents which threaten the public's health.

The profile of Health Protection has increased significantly in recent years with issues such as immunisation, food borne infections, pandemic flu, healthcare associated infection and communicable diseases regularly in the public eye. All of us have a role to play in some way in protecting ourselves and others against infections.

In the mid 1990's, the European level of cooperation against infectious disease interested no more than a few dozen experts. Nowadays, there is a completely different outlook, with the World Health Organisation International Health Regulations having a prominent role in the public health response to the control of infectious diseases (Hawker et al, 2011).

This chapter does not attempt to cover every area of health protection. The main focus is around specific infectious diseases. The aim is to be clear about the extent of the problems we face and to explain what is already being done here in Barnsley. It also sets out what else is needed, who we need to work with to improve the problems we face, and how we will monitor those problems to make sure that things are improving.

Healthcare Associated Infections

Infections that occur following healthcare interventions in hospital and community settings represent a significant burden of disease. Despite major improvements to infection control, protecting people from healthcare associated infections (HCAIs) remains a challenge. This has been exacerbated by the increase in bacteria that are resistant to important antibiotics.

Cases of healthcare associated infections (HCAIs) remain low across Barnsley, and across the country, in recent years. The incidence of one of the most important infections, MRSA (Methicillin Resistant Staphylococcus Aureus) in the hospital trusts in Barnsley over the three years to March 2013 remains consistently low.

Despite this, HCAIs continue to be one of the biggest challenges the health service faces. This is because, while we are doing much better, national targets are becoming ever more challenging. The organisms that cause healthcare associated infections evolve, as does all life, to meet the changing environment they face. For the bacteria that cause HCAIs, this includes adapting, if they can, to resist the antibiotics used to treat the infections they cause.

Infection prevention and control (IPC) is a key objective for Barnsley. The focus for HCAIs has historically been on infections acquired in hospitals. While that remains crucial, our approach has evolved to include HCAIs acquired in the community which, in the complex modern healthcare environment, is often a shared problem between hospital and community healthcare providers, for example a wide range of health services in the community, including care homes, dentists and GPs.

The recommendations below are the key actions that will be needed to maintain and improve our performance on healthcare associated infections.

- Continue to work collaboratively to ensure there are no avoidable infections associated with the healthcare provided locally.
- Continue to monitor closely the number of healthcare associated infections locally and hold health providers to account when targets are not met.
- Continue to strengthen our work on infection prevention and control, working collaboratively with health and social care providers and ensuring oversight of HCAIs.

Tuberculosis

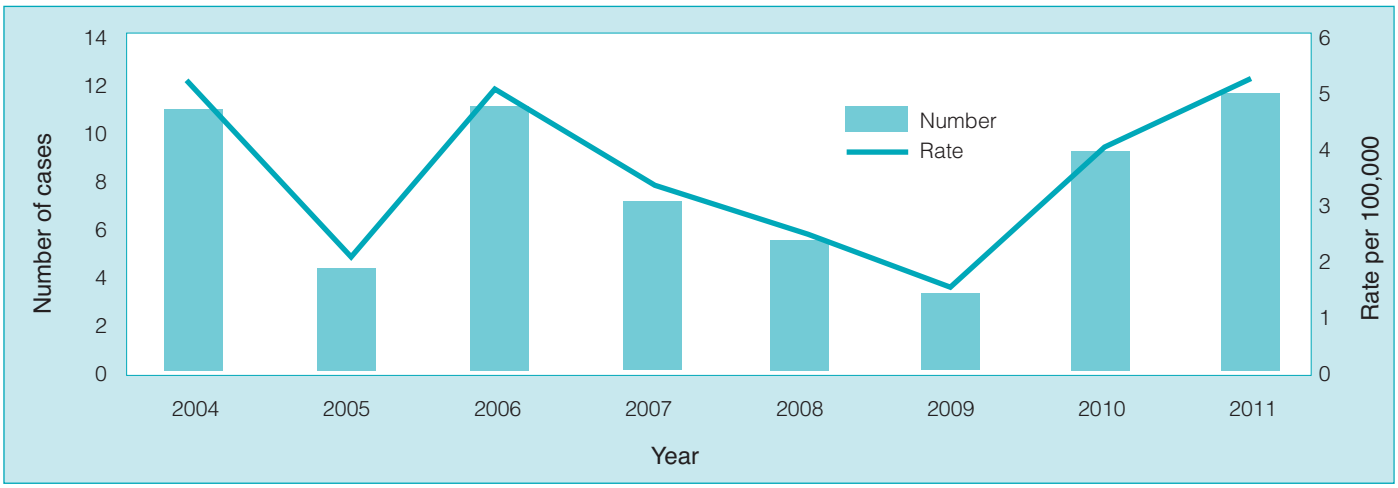
Tuberculosis (TB) is a potentially fatal contagious disease that can affect almost any part of the body but is mainly an infection of the lungs. It is caused by a bacterial microorganism, the tubercle bacillus or Mycobacterium tuberculosis. Although TB can be treated, cured and prevented through certain drugs taken by at risk persons, scientists have never come close to wiping it out.

Current status of TB in Barnsley

An average of 1 to 2 people die each year from TB in Barnsley, even though the local incidence has been historically low, 3.98 per 100,000 in 2010 (HPA, 2012). With recent demographic changes, Barnsley is becoming more multicultural. There is a rise in the number of people from high incidence countries living within the town and although there has been less than 1 TB case per year of multi-drug resistance these can be complex and costly to manage.

Therefore, it is still critical that TB (including suspected TB) is investigated and managed by individuals who have comprehensive experience of the condition and who have ready access to multidisciplinary services and necessary skills. Health and social care professionals will require updates on signs and symptoms of TB and information regarding which countries are classified as high risk (NICE, 2011).

Tuberculosis Case Reports and Rates per 100,000, 2004-2011, Barnsley



Source: Tuberculosis in Yorkshire and the Humber Agency (2012). 2011. ETS July 2012.

Measures to tackle TB in Barnsley

There are three principal steps in the prevention and control of TB:

- Preventing transmission through early detection and treatment,
- Preventing disease in exposed individuals through identification of contacts and chemoprophylaxis and;
- Immunisation of ''at risk'' individuals with BCG (Bacillus Calmette-Guérin) vaccine.

On-going awareness of the signs and symptoms of TB is an important aspect of the first key intervention, the prompt early recognition and appropriate treatment of the minority of people who develop active TB disease. This needs to happen promptly to reduce the possible transmission of TB infection. We need to encourage those at risk to recognise the symptoms of TB and to go to their doctor if they develop symptoms. As most individual GPs do not see TB cases, they may not always suspect TB, so training for primary health care professionals is also needed. The clinician responsible for care should refer the person to an expert physician with training in, and experience of, the specialised care of people with TB (NICE, 2011).

After the diagnosis of TB is confirmed, contact tracing of family members and close friends is undertaken to check if anyone else close to the patient also has TB (second key point). Sometimes contact tracing has to be extended to wider groups, although finding TB cases in more casual contacts is unusual. It is particularly important to ensure that people treated for TB complete their treatment.

Prevention measures include; improving the identification of cases through enhanced active surveillance and consistent management, follow up of cases and contacts, raising awareness of TB as an important Public Health issue and ensuring there are contingency plans in place to control an outbreak, e.g. in schools and hospitals (NICE, 2011).

Despite treatment being free, diagnosis and treatment can have financial implications for vulnerable groups and there may be a lack of clarity over entitlement/ eligibility for NHS treatment. It is recognised that there needs to be a proactive approach to helping people from hard-to-reach groups with strong links between social care, community and voluntary organisations and secondary and acute services (NICE, 2012).

Summary

Detecting TB , preventing the risk of the spread of infection and effective treatment are crucial in avoiding late diagnosis, poor management and the emergence of drug resistant cases which can be costly in the long term (NICE, 2011).

Best practice suggests;

- Active and comprehensive contact tracing.
- Reliable, high-quality diagnostic services, microbiology laboratories.
- Management of TB cases carried out in conjunction and discussion with local peers and regional experts.
- Shared management with paediatric colleagues for children with TB.
- Shared management of TB with HIV specialists when a patient is found to be co-infected with HIV(NICE, 2011).

The Public Health Outcomes Framework to improve life expectancy and reduce inequalities has 'TB Completion rates' as one of its indicators (DH 2011).

Recommendations

1. Continue to promote delivery of high quality effective services for the prevention, diagnosis, clinical management and control of TB e.g. through the development of integrated care pathways with links to HIV testing and substance misuse services.

Immunisation and Vaccination Programmes

Infectious diseases remain a global threat to health, and vaccination continues to be an effective tool in protecting the population. Vaccination is also a major factor in reducing health inequalities and without vaccination, epidemics may occur. Despite the success of our national vaccination programme, vaccine-preventable diseases such as measles, whooping cough and tuberculosis (TB) still occur. In Barnsley we maintain a high uptake of routine childhood vaccinations to ensure community-wide (herd) immunity.

Public health programmes that ensure high rates of vaccination and immunisation uptake are essential components of a safe and effective community health system. For readers who would like further information about vaccination programmes offered please visit:

www.nhs.uk/Conditions/vaccinations/Pages/vaccination-schedule-age-checklist.aspx

www.nhs.uk/Conditions/vaccinations/Pages/myths-truths-kids-vaccines.aspx

These diseases are ready to resurge should our guard on vaccination slip, as the national measles outbreak has demonstrated. Figure 1 shows the number and rate of measles cases by year and local authority (2009-2011).

Number and rate of measles cases by year and local authority (2009-2011)

Unit	Local Authority	Number Confirmed (Rate)			Number Reported (Rate)		
		09	10	11	09	10	11
West Yorkshire	Bradford District	0 (0)	5 (0.8)	2 (0.39)	23 (4.49)	23 (4.49)	39 (7.6)
	Calderdale District	0 (0)	1 (0.49)	7 (3.45)	7 (3.45)	7 (3.45)	22 (10.9)
	Kirklees district	0 (0)	0 (0)	0 (0)	27 (6.59)	11 (2.68)	23 (5.6)
	Leeds District	6 (0.75)	0 (0)	47 (5.9)	68 (8.51)	46 (5.76)	132 (16.5)
	Wakefield District	12 (3.7)	12 (3.7)	0 (0)	32 (9.83)	26 (7.99)	19 (5.8)
South Yorkshire	Barnsley District	0 (0)	1 (0.44)	1 (0.44)	20 (8.79)	12 (5.72)	13 (5.7)
	Doncaster District	9 (3.1)	9 (3.10	0 (0)	32 (11)	25 (8.6)	9 (3.1)
	Rotherham District	1 (0.39)	1 (0.39)	1 (0.39)	23 (9.03)	6 (2.36)	16 (6.3)
	Sheffield District	11 (2.0)	2 (0.36)	10 (1.8)	36 (6.48)	17 (3.06)	28 (5.0)
North Yorkshire and the Humber	Kingstone upon Hull	1 (0.38)	2 (0.76)	0 (0)	18 (6.82)	17 (6.44)	12 (4.6)
	East Riding of Yorkshire	1 (0.3)	2 (0.59)	0 (0)	16 (4.72)	9 (2.66)	9 (2.66)
	North East Lincolnshire	1 (0.64)	0 (0)	0 (0)	6 (3.81)	7 (4.45)	6 (3.81)
	North Lincolnshire	0 (0)	0 (0)	0 (0)	5 (3.1)	3 (1.86)	5 (3.1)
	North Yorkshire	9 (1.5)	1 (0.16)	2 (0.33)	37 (6.19)	21 (3.5)	21 (3.5)
	York	1 (0.49)	0 (0)	0(0)	9 (4.45)	6 (2.96)	5 (2.47)
Yorkshire and the Humber		52 (0.98)	36 (0.68)	70 (1.32)	359 (6.77)	236 (4.45)	359 (6.77)
England and Wales (Rates)		1.93	0.66	1.8	-	-	-

Higher than regional rate
Higher than national rate

Source: HPU/HPZone data and oral fluid IgM antibody, PCR and other laboratory reported cases

We know that vaccination coverage levels in Barnsley compare favourably with other areas across the Yorkshire and Humber region.

Although mumps, measles and rubella (MMR) vaccination coverage has increased across the country, Barnsley rates remain consistently over 90%. The Yorkshire and Humber regional figure was below 90% with our neighbouring areas achieving lower rates.

Quarterly MMR second dose coverage at five years of age. (January-March 2009 to October-December 2011).

PCT	Jan - Mar 09	Apr - Jun 09	Jul - Sep 09	Oct - Dec 09	Jan - Mar 10	Apr - Jun 10	Jul - Sep 10	Oct - Dec 10	Jan - Mar 11	Apr - Jun 11	Jul - Sep 11	Oct - Dec 11
Barnsley	92.2	92.6	93.5	92.3	94.3	92.7	93.8	93.8	91.2	93.5	93.1	93.6
Bradford & Airedale	84	83.6	83.6	84.4	83.2	84.2	84.8	86.6	87	87.7	88.5	89.9
Calderdale	82.8	84.7	84.2	82.7	81.2	82	83	80.9	81	82.8	85.5	85.9
Doncaster	78.7	77.8	83.5	85.1	86.5	87.1	87.2	87.9	89.2	85.9	87.8	87
East Riding	86.6	86.7	90	89.9	87.6	90.3	89.8	88.8	88.5	90.5	90.8	91.2
Hull	83.9	83.9	87.2	87.3	88.3	87.3	88	85.7	88.3	89.5	91.2	88.6
Kirklees	85.9	87	90.3	89.8	89.2	90.2	88.9	88.5	90.4	92.2	91.8	93
Leeds	73.2	77.9	78.5	81	80.7	81.3	85.2	84.8	85.5	87.7	88.3	90.3
North East Lincolnshire	84.4	89.4	88.2	88.1	91.1	86.4	87.2	87.7	85	88.2	87.3	92.6
North Lincolnshire	82.4	82	83.8	84.4	85.1	83.1	84.1	86.5	84.2	83.2	86.7	86.9
North Yorkshire & York	84.5	85.4	84.6	86.6	85	86	87.9	87.9	87.4	87.2	87.6	86.3
Rotherham	84.3	79.7	84.2	85	88	89.6	88.4	89.6	90.8	89.5	90	89.2
Sheffield	80.4	82.1	83.5	85.3	86.1	88.4	84.6	85.4	85.6	89.5	85.7	87
Wakefield District	85.5	85.6	88.4	89.7	88.5	89.9	92.1	89.5	89	89.4	89.8	90.5
Yorkshire & the Humber	82.5	83.5	85	85.9	85.8	86.5	87.1	87	87.3	88.5	88.7	89.3
England	80	81.8	81.9	82	82.9	83.3	83.7	84	84.5	84.5	85.4	86.2

Over 90% uptake

Source: COVER data

The above data demonstrates the direct correlation between cases of measles and the uptake of MMR vaccination across the region.

Barnsley has historically and continues to have, one of the highest MMR vaccination uptake rates across the region and nationally. The estimated herd immunity threshold for measles is 92-94% uptake of the vaccine in the population. Herd immunity occurs when the vaccination of the population reaches this threshold. This ensures that the public health policy of herd immunity is maintained which reduces the spread of an illness and provides a level of protection to vulnerable and unvaccinated people.

Seasonal Flu

Each year the Department of Health (DH) and the NHS prepare for the unpredictability of seasonal flu. For most healthy people seasonal flu is an unpleasant but usually self-limiting disease with recovery within a week. However, older people, pregnant women and those with and underlying disease, particularly chronic respiratory or cardiac disease, or those who are immuno-suppressed, are particularly at risk of severe illness if they catch flu. It is estimated that the risk of serious illness or death from seasonal flu is 15 times greater for people with a clinical risk than healthy people.

The impact of flu on the population can vary from year to year and is influenced by changes in the virus which, in turn, influence the proportion of the population that may be susceptible to infection and the severity of the illness it causes. The proportion of the population susceptible to infection depends on how many people have been exposed to the same or similar strains in the past and consequently have some immunity and how many have been vaccinated against the circulating strains.

By the end of the 2011/12 flu vaccination season, nationally approximately 74% of people over the age of 65 years had been vaccinated against seasonal flu. The uptake amongst the at risk groups and those under the age of 65 years was in the region of 51.4% and for all pregnant women approximately 26.4% were vaccinated.

At the start of the 2012/13 flu vaccination season the Chief Medical Officer advised the NHS to plan to reach or exceed a target of 75% uptake in people aged 65 years or over and a 70% uptake in people below the age of 65 with an underlying medical condition and pregnant women, with a trajectory set to achieve 75% across all at 'risk groups' in the 2013/14 season.

Frontline health care workers

Increasing vaccination rates for frontline health and social care workers reduces the risk of transmission of the flu virus to vulnerable clients. Significantly improving uptake amongst frontline health care workers has posed a challenge locally. This challenge has been met through targeted awareness raising sessions and 'myth busting' amongst professionals.

Historically there has been some discussion as to how robust the denominator for frontline staff has been derived. National guidance provided clarity to GP and Dental practices in demonstrating a breakdown of their staff and an overall denominator. The uptake in the 2011/12 flu season for frontline health care workers was 38.3% in Barnsley. Through rigorous reporting and Public Health support the uptake for 2012/13 has risen significantly to 47.8%.

Pregnant Women

The Chief Medical Officer (CMO) recommended that during the 2012/13 seasonal flu vaccination programme 70% of all pregnant women should receive a flu vaccination. Pregnant women are at risk of contracting flu and developing complications not only for themselves but for the foetus. Uptake of flu vaccination has been historically low in this group both nationally and locally. However, following the introduction in 2011/12 flu season of the local initiative to vaccinate pregnant women in antenatal clinic, the percentage of pregnant women receiving the vaccination has risen.

During the 2012/13 seasonal flu period (1st October – 31st January) NHS Barnsley commissioned a Midwife to administer the flu vaccination to pregnant women. The project was supported by all maternity staff to promote the vaccine and signpost women either to the antenatal clinic or their own GP.

The uptake for seasonal flu vaccination amongst eligible children in Barnsley is below the CMO target and varies amongst GP practices. A decision was taken to commission the School Nursing Service to undertake vaccinations within the school. This gave parents a choice of either attending their own GP practice with their child or consenting for their child to be vaccinated at school.

Conclusion

The strenuous efforts to improve the uptake of seasonal flu vaccination have been successful in achieving this overall. It will be important to continue to build on this good work in future years to ensure the at risk population is protected.

Recommendations for Immunisation and Vaccination Programmes

The Director of Public Health has a responsibility for the vaccination coverage of the population of Barnsley. To discharge this duty of care Public Health will:

1. Work alongside Public Health England and the NHS to ensure that coverage reaches Department of Health vaccination targets.

2. Respond in a timely and effective way to any disease outbreaks.

3. Promote the uptake of vaccinations through partnership working.

Sexual Health

Our sexual health affects our physical and psychological wellbeing and is central to some of the most important and lasting relationships in our lives. The World Health Organisation (2011) defines sexual health as a "state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence." The wider aim of working towards good sexual health for all includes reducing unintended teenage pregnancies, prevention of HIV and other Sexually Transmitted Infections (STIs), the promotion of positive satisfying relationships and the provision of excellent Sex and Relationships Education (SRE).

We continue to place sexual health and wellbeing as a major public health priority in Barnsley. Barnsley Sexual Health and Wellbeing Strategy, approved by Barnsley Council and its partners in April 2013, has been produced to inform our approach to improving the sexual health of the local population, and to reduce sexual health inequalities between the general population and defined vulnerable groups.

Education and access to good quality information - It is extremely important that good quality information is available to everyone, including young people in school settings. Health promotion colleagues work on a range of awareness raising activities to support key massages such as; condom use, the importance of chlamydia screening for 15-24 year olds and World Aids Day. Public Health continues to monitor and review availability of these information services, particularly in the light of recent financial and organisational restructuring.

Sexually Transmitted Infections (STIs) - Affect all age groups, ethnicities and sexual orientations. Rates of STIs have been increasing for the last decade with viral infections being the cause of most newly diagnosed infections and Gonorrhoea and Syphilis (bacterial Venereal Diseases), stabilising. However, nationally although numbers are relatively low, Syphilis has started to increase again. The age profile of newly diagnosed STIs has also changed over the years with more infections occurring at a younger age.

Measures to tackle STIs

The age and gender structure of the population has important implications for sexual health and maternity services. Although sexual health affects all ages in the population, the burden is not evenly distributed across society, as young people, black and minority ethnic communities, men who have sex with men and people who are recently divorced or separated, can be disproportionately affected by STIs.

Services in Barnsley have established and maintained a range of provision and interventions, which are focused on helping people to maximise their sexual health and reduce inequalities by;

- Targeting those communities which need sexual health services the most.
- The use of care pathways across NHS providers (including GP practices and community pharmacies), local authority, community and voluntary sector.
- Ensuring good access to sexual health and contraception information and advice through a variety of mediums.
- Providing easy access to STI testing, the full range of contraceptive provision and other clinical services
- Supporting the promotion of testing for HIV infection and recognition of HIV as a long term manageable condition.
- Being staffed by appropriately trained and competent health and social care professionals to ensure equity of service provision.
- Being linked with other health and well-being initiatives such as alcohol and drug education programmes.

Current status

Sexually Transmitted Infections (STIs) continue to rise with more than 1.5 million episodes of STIs seen in UK clinics every year and whilst there has been a steady national decline every year since 1998, teenage pregnancy rates remain high compared to other European countries (ONS,2009, HPA,2009).

There are currently a wide range of settings in Barnsley where sexual health services can be accessed, providing professional and clinical support. These may be co-located offering a more holistic integrated approach; available outside normal working hours and in or near educational settings. Non face to face and health promotion interventions are also being utilised to provide maximum reach and especially for people who initially seek information via the internet or through social networking.

Summary

Sexual health and wellbeing is not just about STIs and unintended or unwanted pregnancies. Instead it can be seen as a complex and sensitive issue influenced by culture, religion, poverty, deprivation and the wider structures of society. The challenges faced are considerable and it is recognised that many of the changes required to improve sexual health outcomes are complex and may take years to achieve.

It is important that, despite the national reforms to the commissioning landscape for sexual health services and increasing constraints on public sector funding, we continue to work together to address our priorities, improve productivity and performance, drive up quality and meet performance targets. Barnsley has a long history of partnership working on improving sexual health services. These partnerships will be crucial to ensure that we effectively use our resources to target our priorities and to meet the needs within the Borough.

Recommendations

1. Lead on the partnership work with commissioners and providers of sexual health services to ensure service improvements deliver better outcomes for the people in Barnsley.

2. Maintain a strong emphasis on evidence based initiatives to promote the effective delivery of sexual health services through integrated care pathways which support the identification, management and control of STIs (including HIV).

Chlamydia Screening Programme

Chlamydia is the most common bacterial sexually transmitted infection, with sexually active young people at the highest risk. As chlamydia often has no symptoms and can have serious health consequences (e.g. pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility) screening and testing is an essential element of good quality sexual health services for young adults.

Concrete plans for a major long term public health programme, the National Chlamydia Screening Programme (NCSP), gained momentum with the publication of the English National Strategy for Sexual Health and HIV, in July 2001. This clearly outlined the government's commitment to a national roll-out of chlamydia screening. Its aim being to control chlamydia through early detection and treatment of asymptomatic infection, so reducing onward transmission and the consequences of untreated infection (DH, 2001). Initially introduced in over 300 screening sites across England, it showed a significant disease burden with 10.1% positivity among women and 13.3% among men aged 15-24 years old (consistent with the pilot studies) (La Montagne, 2004).

Without this programme, many of the young people who tested positive and their partners would not necessarily have found out that they had chlamydial infection.

Measures to tackle Chlamydia in Barnsley

The National Chlamydia Screening Programme (NCSP) advocated that chlamydia screening should be delivered as an integrated part of a holistic sexual health offer for young people, including embedding screening and treatment within core primary care, sexual health and specialist sexual health and reproductive services. A shift from measuring progress against an operating target (coverage) to a population outcomes indicator (diagnosis rate) has accompanied this, as set out in the Public Health Outcomes Framework 2013-16.

There are currently over sixty sites in Barnsley where chlamydia screening can be accessed (providing professional and clinical support) working proactively with sexually active 15-24 year olds and their partners in a range of settings and embedding screening into routine sexual health and reproductive health provision. In addition, drop-off and post kits, specific health promotion events and tests requested through a website are utilised to gain maximum reach.

There is evidence to suggest which population groups are most at risk, for instance;

- Sexual partners of chlamydia–positive individuals
- Sexual partners of those with suspected but undiagnosed chlamydial infection
- Those who have been diagnosed with an STI in the previous 12 months
- Those who have had two or more partners in the last 12 months
- Women aged 15-24
- All women undergoing terminations
- Men aged 20-24
- All Patients attending GUM clinics (DH/HPA, 2012)

Summary

The impact of the NCSP in England suggests 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. Nationally, several different approaches are currently being taken to try to estimate and monitor prevalence to determine the extent of controlling chlamydia in the community.

The commitment from the Department of Health to continue a Chlamydia Screening Programme remains, and amidst the current changes it is vital that young people continue to have access to quality services for chlamydia testing and treatment. Between April 2011 until March 2012, Barnsley successfully managed to deliver a positivity rate of over 9% with a 28% coverage, one of the highest in Yorkshire and Humber and continued to be a high performing Borough over 2012/13.

Recommendations

1. To continue to deliver a screening programme that meets the NCSP quality standards, is value for money, is sustainable by integrating it with core sexual health services and which will enable us to meet the new outcome indicator based on the rates of positive diagnoses.

2. Commissioners and providers of sexual health services work together to ensure that there are evidence based initiatives in place, to promote good sexual health and develop integrated care pathways to support the identification, management and control of STIs including chlamydia.

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Progress on RECOMMENDATIONS

from 2012 Director of Public Health Annual Report

Last year my report focused on reducing the smoking prevalence in Barnsley and a number of recommendations were made to ensure a continued focus on smoking as an important public health priority. The table below shows the progress that is being made to meet these recommendations.

Recommendation	Progress
1. That the Health and Wellbeing Board recognise the continued importance of smoking as a major public health issue for Barnsley and that this is reflected in the Joint Health and Wellbeing Strategy.	The Barnsley Health and Wellbeing Board was formally established on the 1st April 2013. The Joint Health and Wellbeing Strategy does include action on smoking as a priority and recognises that continued high levels of smoking in Barnsley is an important factor in premature deaths from cancers, heart disease and respiratory disease.
2. That a new model and commissioning plan for tobacco control / stop smoking services is developed that fits with the new emphasis on prevalence reduction and wider strategic developments across Barnsley Metropolitan Borough Council and the Barnsley Clinical Commissioning Group.	The responsibility for commissioning tobacco / stop smoking services transferred to Barnsley Council on the 1st April 2013. Work is already underway on developing new commissioning plans from 2014/2015 onwards in discussion with the Barnsley CCG. In the meantime, additional investment has been put into strengthening capacity to tackle illegal sales of tobacco products and enforce stop smoking legislation.
3. That a review of the Terms of Reference of the Smoke Free Barnsley Tobacco Control Alliance is undertaken to create strong, effective decision making with powers to drive through changes in commissioning.	Public Health has commissioned an independent review of the effectiveness of the Barnsley Tobacco Control Alliance in influencing local commissioning decisions. The Terms of Reference and membership will be reviewed after considering the recommendations of the review.
4. That a service is designed and commissioned, based on local need and national evidence, that will provide improved levels of support for pregnant women who smoke.	A new pilot programme called 'Fit Mums' has been commissioned in partnership with local services, including the midwifery service, with a focus on helping pregnant women to quit smoking. The evaluation of this programme will help inform the future model of service provision.

Looking to THE FUTURE

2012 has been a year of significant transition for Public Health. It has also been a significant year of change right across the whole Health and Social Care landscape. One of the most significant changes is the establishment of the Barnsley Health and Wellbeing Board as a statutory partnership on the 1st of April 2013.

The Health and Wellbeing Board is required to produce a Joint Health and Wellbeing Strategy which is informed by the Joint Strategic Needs Assessment (JSNA). The JSNA is our analysis of the health needs of the population of Barnsley. It is intended to inform and guide the commissioning of health, wellbeing and social care services in Barnsley to improve the health and wellbeing of the local population.

The 2013 JSNA is being developed as an online tool to allow the material to be revised and expanded on a continual basis. The 2013 JSNA will also include the publication of Area Public Health Profiles which will be posted to the website.

Future Director of Public Health Annual Reports will be produced to complement the online JSNA by providing a written summary of the JSNA, focusing on topics worthy of more in-depth investigation.

It is clear that the new system will need time to embed and to deliver results. It will do this against a backdrop of changing need. Future need, at least in the immediate future, will be driven by the difficult economic climate and the impact of welfare reform. The response to this need will not be easy or straightforward. The local authority specifically and the public sector in general are facing a long and severe period of austerity.

Traditional responses to difficult times will no longer provide an answer. The issues are complex. It is clear, however, that an emphasis will need to be on individuals, families and communities creating their own solutions to their issues as they seek to reach their true potential.

The Council, in its corporate plan, has set out three priorities for the next few years and Public Health must, and will, play a part in delivering all of these. As part of the corporate plan we have agreed two significant outcomes.

These are:

- We will make the improvement of people's health and wellbeing everybody's business, with an emphasis on prevention and the contribution that all services can make.

- We will prioritise the reduction of health inequalities between different parts of the Borough, and the Borough and the rest of the country.

As we begin our journey back in local government it is clear that we will need to stay committed to public health principles whilst being open to new challenges and new approaches. The agreement of these two outcomes will make sure that we are focused on the matters of most importance and the contribution that Council colleagues and other partners can make.

Glossary of TERMS

Acheson Report - *Independent Inquiry into Inequalities in Health Report,* was a report published in 1998. The Acheson report demonstrates the existence of health disparities and their relationship to social class.

BCG - Bacillus Calmette-Guérin, a vaccine for tuberculosis.

Beeching Report - the *Reshaping of British Railways* was published in 1963 written by Dr Richard Beeching was a report identifying 2,363 stations and 5000 miles of railway line for closure during a period of increasing competition from road transport.

Best Bar None - the national award scheme aimed at promoting responsible management and operation of alcohol licensed premises, supported by the Home Office to acknowledge premises for the services they provide.

Challenge 21 - national campaign to challenge anyone who looks under 21 for valid identification for the purchase of alcohol and other age restricted products.

Chronic Obstructive Pulmonary Disease - a lung disease defined by persistently poor airflow as a result of breakdown of lung tissue (known as emphysema) and dysfunction of the small airways.

CLeaR - stands for: Challenge of existing tobacco control services, Local Leadership for comprehensive action to tackle tobacco, Results demonstrated by the outcomes delivered against national and local priorities.

DAAT - BMBC's Drug and Alcohol Action Team.

Determinants of Health - the many factors combined together that affect an individual's and a communities health.

Health Action Zone - Government identified areas where there was a need to address the health inequalities.

Health Inequalities - differences in health status or in the distribution of health determinants between different population groups.

HPV - Human Papillona Virus is associated with cervical cancer. HPV vaccine offered to girls aged 12-13 provides protection for at least eight years after completion of a three dose course.

NHS Health Checks - programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dimentia. The programme aims to check everyone between age 40-75 who have not already been diagnosed with one of these conditions or other risk factors.

NICE - National Institute for Health and Care Excellence.

Public Health Outcomes Framework - the Public Health outcomes framework sets out desired outcomes for public health - and how outcomes will be measured.

The Black Report 1979 - a report by the Department of Health and Social Security, chaired by Sir Douglas Black. It demonstrated that although overall health had improved since the introduction of the welfare state, there were widespread health inequalities. It also found that the main cause of these inequalities was economic inequality.

The Health and Social Care act 2012 - National Legislation leading to the reorganising of the Public Health Service.

WHO - World Health Organisation.

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Nëse j'u nevojitet ndihmë për të kuptuar këtë dokument, j'u lutemi n'a kontaktoni.

若您需要幫助來理解本檔，請與我們聯繫。

यदि आप को इस दस्तावेज़ को समझने के लिए सहायता की आवश्यकता है तो कृपया हम से संपर्क करें

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Обратитесь к нам, если для того, чтобы понять этот документ, вам нужна помощь

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if you need help understanding this document please contact the Public Health Directorate on 01226 787440.

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