

# Improving Health Narrowing the Divide

A joint annual report of the Directors of  
Public Health in South Yorkshire



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# Foreword

## Welcome to the Annual Report

In early 2002 the South Yorkshire Health Inequalities Atlas<sup>1</sup> was produced as we went into nine Primary Care Trusts (PCTs) from four Health Authorities. South Yorkshire has maintained a strong Public Health Network and it was agreed within the network to continue to work collaboratively. All PCTs agreed they would produce annual reports on a three year cycle; PCT based in year 1, health community based in year 2 and in the third year once again produce a combined annual report for South Yorkshire. This is that report.

We have maintained a focus on health inequalities as an important element within health improvement, but in particular we report on evolving work to focus interventions on neighbourhoods. We feel that this will be of particular interest to service professionals in health, social care and related sectors.

This report documents some major public health successes. There have not only been significant improvements in the overall health of our

population but there has been a reduction in the gap between the health of our most disadvantaged communities and the population of South Yorkshire as a whole. This will be in part attributable to the focused work of a variety of regeneration programmes and health services. Improving the health of our population is an important part of the economic and social renewal of South Yorkshire.

Coincidentally, this again comes at a time of structural change in the NHS, and we have based our analysis on Local Authority boundaries to reflect the newly proposed PCT boundary structure, as at the time of going to print.

### Reference

1 Bentley C, Birks D, Fryers MJ, Fryers PT, Radford J, Westlake L *et al* (2002). *South Yorkshire Health Inequalities Atlas: A report of the Directors of Public Health in Barnsley, Doncaster, Rotherham and Sheffield*. Rotherham: Rotherham Health Authority.



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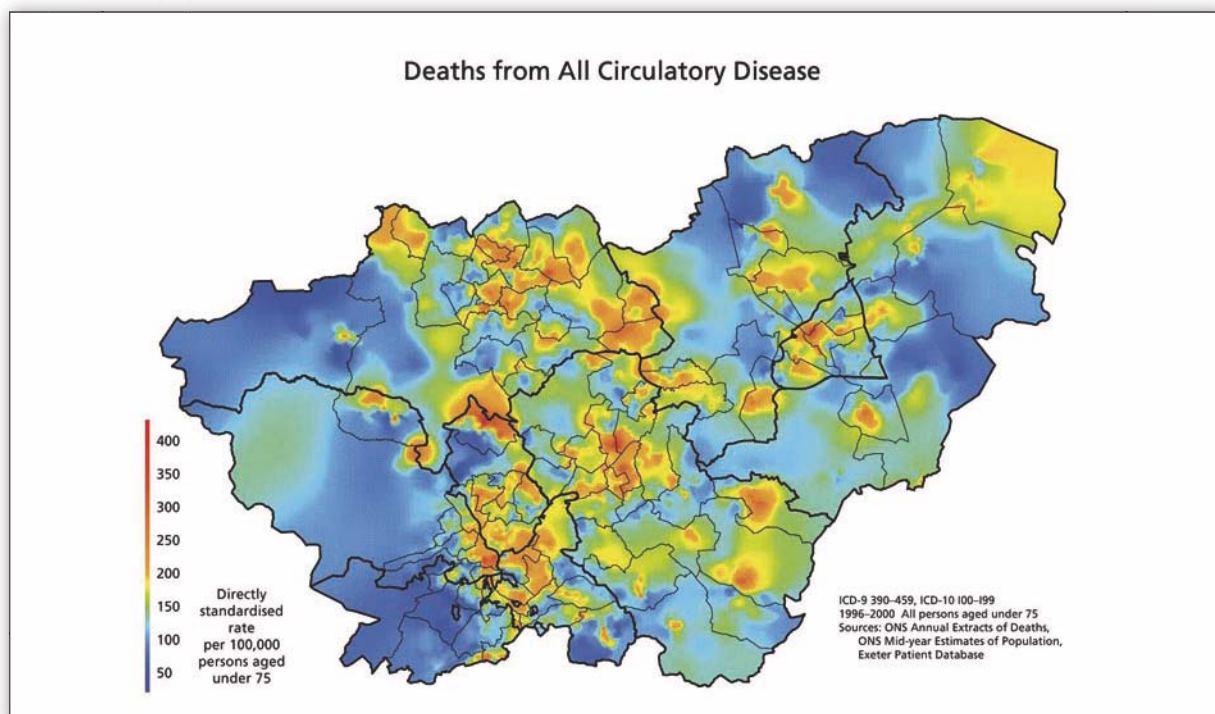
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# Introduction

In March 2002 the then four South Yorkshire Health Authorities jointly published a Health Inequalities Atlas. As well as highlighting differences between and within the newly forming Primary Care Trusts (PCTs) in terms of overall health and mortality from individual diseases, the mapping processes involved demonstrated a number of important issues about how we collect and analyse health information.

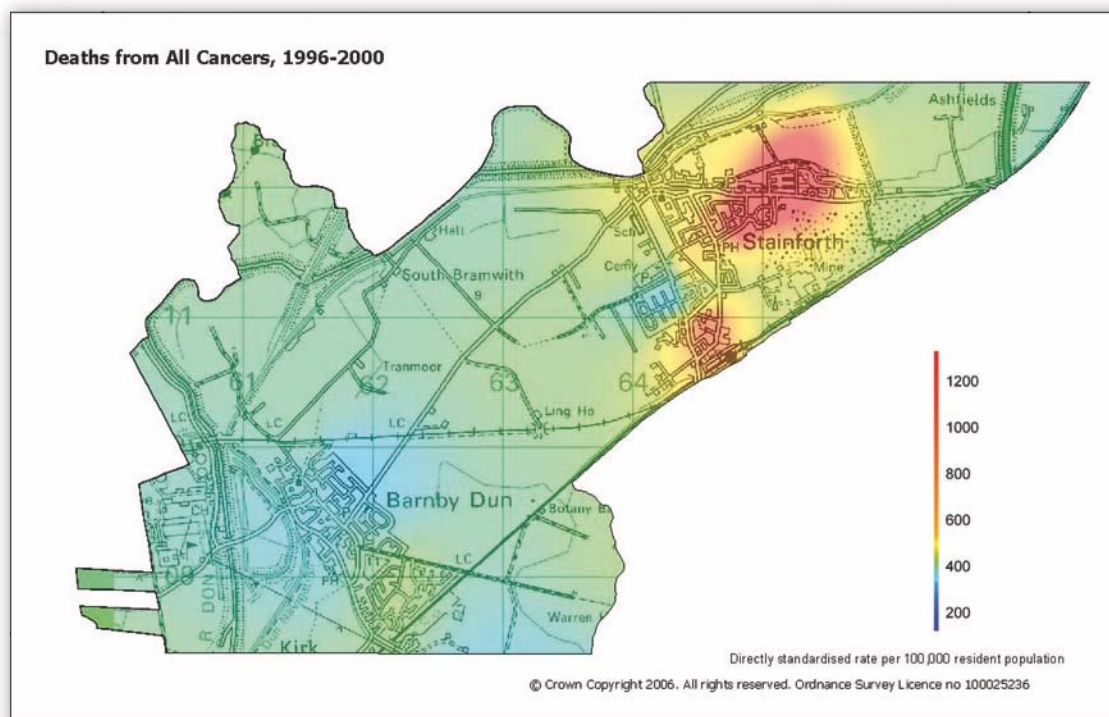
The maps, such as that for Circulatory Disease shown in Figure 1, illustrate one of the most important issues. It is clear that 'hotspots' of circulatory disease mortality in many cases cut across the administrative 'ward' boundaries.

Figure 1



Further analysis, examining the boundaries of these hotspots, illustrated how wards can encompass a number of different communities. In many cases in South Yorkshire, quite severely deprived areas can sit right alongside relatively affluent communities (see Figure 2). The averaging effect, if wards are used for collecting information, can therefore mask important pockets of deprivation.

**Figure 2**  
**Part of Stainforth ward, Doncaster**




Thinking provoked by the Atlas, linked with the Neighbourhood Renewal Programme in local Strategic Partnerships and locality based working in PCTs, prompted a range of initiatives across South Yorkshire to focus analysis and action on the concept of neighbourhoods. The processes involved, including the political negotiation necessary to agree community boundaries accepted by local people, local authorities and the health sector are described in Chapter 3.

Once the 'real' communities had been defined, it was then possible to more tightly define a meaningful most deprived quintile (20%) of the population. This process mimicked the national definitions of a 'Spearhead' group (nationally 20% of local authorities; locally 20% of neighbourhoods). The Government's Public Sector Agreement (PSA) target requires there to be a 10% improvement in life expectancy at birth of the Spearhead group of authorities compared to the national average. This could be achieved most easily in Spearhead communities by rapidly further improving the health of their own more affluent population, who have more lifestyle options, better education and more resources. This may, therefore, lead to a further widening even of the local inequalities gap.

The strategy of developing a set of local Spearhead neighbourhoods in each borough helps to guard against this. If separately measured, the local inequalities gap can be monitored. Also the Spearhead neighbourhoods can become the focus for strategic and tactical action to ensure that those living in the most deprived circumstances receive full attention, not to the exclusion of others, but preferentially.

Once neighbourhoods are defined, it becomes very apparent that, even amongst the most deprived Spearhead group, there is a huge variety of different types of community. Deprivation is not the result of a single set of circumstances. A given deprivation ranking can apply equally to an ex-coal mining village, an area with a high



proportion of poor families from ethnic minorities, or a largely Caucasian population on a large housing estate with high unemployment. In each case, the interventions and actions, which might help, may be different, or require delivery in different ways.

Because of this, the Public Health Network in South Yorkshire has developed a quite sophisticated classification or 'taxonomy' of neighbourhoods. This applies to all local neighbourhoods, not just the most deprived. It allows comparison of like with like on the basis of a range of structural characteristics. This is to be used as the basis for targeting and studying the impact of all interventions to tackle health deprivation across South Yorkshire. The process of developing the taxonomy is shown in Chapter 4, and detail of the results in the Appendices.

The first results of analysis made possible by the work on neighbourhoods described, are included in this report, particularly in Chapter 1. These results are particularly exciting. Straightforwardly, the results show that life expectancy for both sexes has improved significantly over a five-year period between 1998 and 2003 for nearly all the South Yorkshire communities. The greatest improvement has been a remarkable two years in average life expectancy for men in Sheffield.

Equally remarkable are the results for life expectancy in the worst quintile of populations in each community. For most there has been an apparent narrowing of the gap. While not statistically significant in all cases, in no case does the trend suggest that the local gap is widening.

For the individual major killers the picture is mixed. Cardiovascular disease (heart disease and strokes) deaths are falling dramatically. At the current rate of decline, South Yorkshire could show a lower death rate by 2010 than the England and Wales average, a remarkable change from the dire situation ten years ago. Even more remarkable are the apparent reductions in the inequalities gap between the Spearhead neighbourhoods and the rest, in some parts of South Yorkshire.

For cancer the picture is not as encouraging. While in some communities the inequalities gap in death rates has reduced substantially, communities other than Sheffield are not making progress relative to England and Wales, although death rates are still falling quite fast.

Chapter 2 examines trends in other important areas of health, giving a best five and worst five sets of trends.

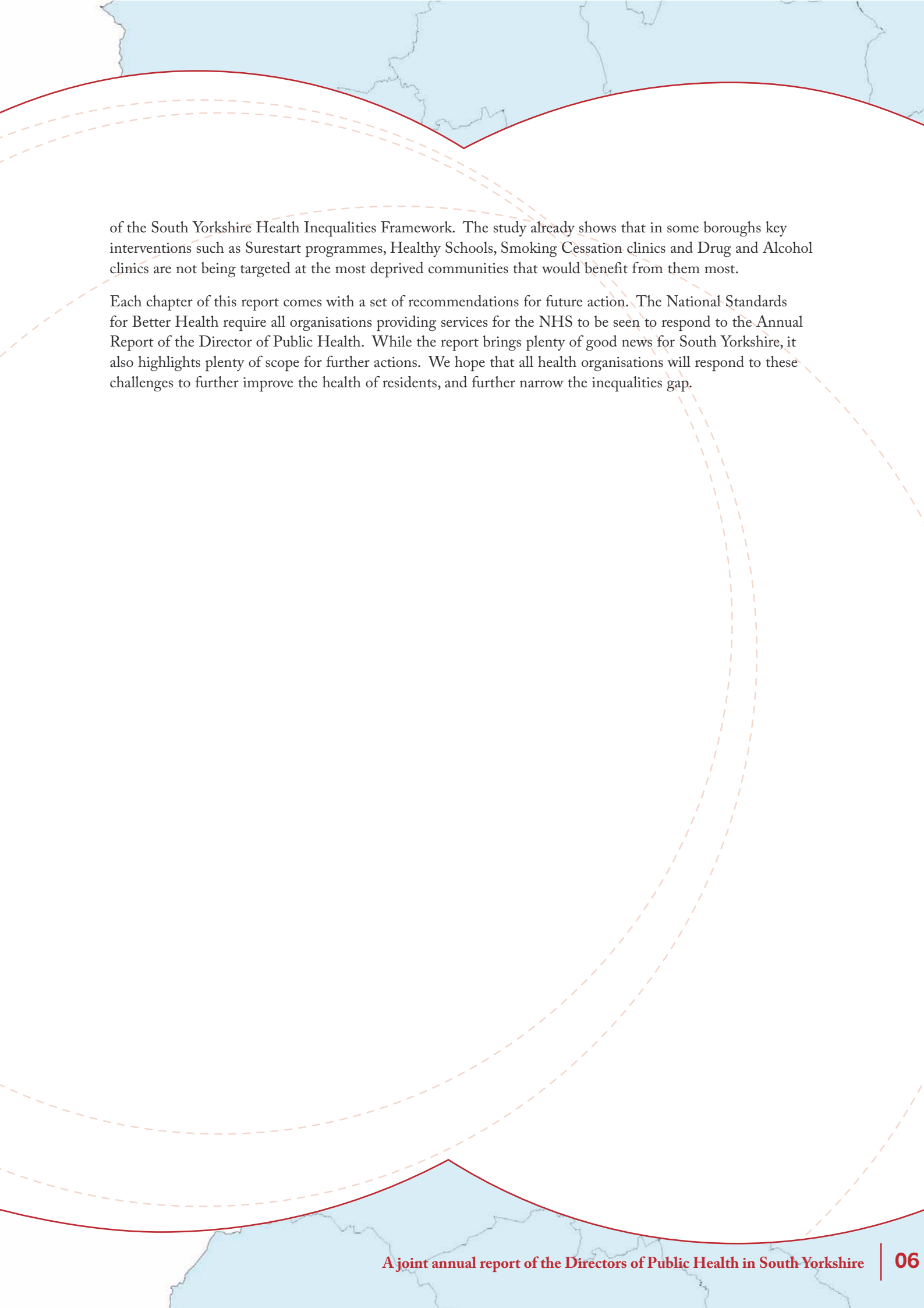
As well as heart disease and cancer, good news is highlighted in relation to multiple (antibiotic) resistant staphylococcus aureus (MRSA), 'the hospital killer bug', waiting time for operations and the Healthy Schools Programme.

On the other hand, the analysis shows a deteriorating situation in a number of important areas.

One of the most important is sexually transmitted infection. There is a resurgence of important conditions such as gonorrhoea and syphilis, and a growing threat from chlamydia. However, perhaps the most significant change is in HIV/AIDS. This is no longer primarily a disease of homosexual men. The main cause in South Yorkshire, where there has been a large increase in numbers of cases, is in sex between men and women, largely acquired outside the country.

Other problems include little improvement in deaths due to chest disease, deteriorating dental health and unchanging high levels of teenage pregnancy.

Chapter 5 gives the early results from a stocktake of the important evidence based interventions, and where they are being carried out in all Spearhead neighbourhoods. The checklist of interventions was established as part



of the South Yorkshire Health Inequalities Framework. The study already shows that in some boroughs key interventions such as Surestart programmes, Healthy Schools, Smoking Cessation clinics and Drug and Alcohol clinics are not being targeted at the most deprived communities that would benefit from them most.

Each chapter of this report comes with a set of recommendations for future action. The National Standards for Better Health require all organisations providing services for the NHS to be seen to respond to the Annual Report of the Director of Public Health. While the report brings plenty of good news for South Yorkshire, it also highlights plenty of scope for further actions. We hope that all health organisations will respond to these challenges to further improve the health of residents, and further narrow the inequalities gap.