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BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 8 December 2015
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

AGENDA

1 Declarations of Pecuniary and Non-Pecuniary Interests

2 Minutes of the Board Meeting held on 13th October, 2015 (HWB.08.12.2015/2) *(Pages 3 - 6)*

3 Minutes from the Children and Young People's Trust Executive Group held on 6 November, 2015 (HWB.08.12.2015/3) *(Pages 7 - 16)*

4 Minutes from the Barnsley Community Safety Partnership held on 11th November, 2015 (HWB.08.12.2015/4)

5 Notes from the Anti-Poverty Board held on 12th October, 2015 (HWB.08.12.2015/5) *(Pages 17 - 18)*

For Decision/Discussion

6 Adult Safeguarding Board - Annual Report (HWB.08.12.2015/6) *(Pages 19 - 94)*

7 Public Health Strategy (HWB.08.12.2015/7) *(Pages 95 - 128)*

8 Stronger Communities Partnership Presentation

Performance

9 Patient Flow (HWB.08.12.2015/9) *(Pages 129 - 140)*

10 BCF Update (HWB.08.12.2015/10) *(Pages 141 - 144)*

11 Development Session (HWB.08.12.2015/11) *(Pages 145 - 148)*

For Information

12 Sheffield City Region Devolution Deal Update (HWB.08.12.2015/12) *(Pages 149 - 182)*

To: Chair and Members of Health and Wellbeing Board:-

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Councillor Jim Andrews BEM, Deputy Leader
Councillor Margaret Bruff, Cabinet Spokesperson - People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson for Communities
Diana Terris, Chief Executive
Rachel Dickinson, Executive Director People
Wendy Lowder, Interim Executive Director Communities

Julia Burrows, Director Public Health
Nick Balac, NHS Barnsley Clinical Commissioning Group
Lesley Smith, NHS Barnsley Clinical Commissioning Group
Tim Innes, South Yorkshire Police
Emma Wilson, NHS England Area Team
Adrian England, HealthWatch Barnsley
Steven Michael OBE, South West Yorkshire Partnership NHS Foundation Trust
Richard Jenkins, Barnsley Hospital NHS Foundation Trust

Please contact Peter Mirfin on 01226 773147 or email governance@barnsley.gov.uk

Monday, 30 November 2015

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 13 October 2015
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

MINUTES

Present

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Councillor Jim Andrews BEM, Deputy Leader
Councillor Jenny Platts, Cabinet Spokesperson for Communities
Rachel Dickinson, Executive Director People
Wendy Lowder, Interim Executive Director Communities
Julia Burrows, Director Public Health
Nick Balac, NHS Barnsley Clinical Commissioning Group
Lesley Smith, NHS Barnsley Clinical Commissioning Group
Tim Innes, South Yorkshire Police
Adrian England, HealthWatch Barnsley
Richard Jenkins, Barnsley Hospital NHS Foundation Trust
Sean Rayner, South West Yorkshire Partnership Foundation Trust
Helen Jaggar, Chair, Provider Forum

12 Declarations of Pecuniary and Non-Pecuniary Interests

Cllr Platts declared a non-pecuniary interest in minute numbers 18 and 19 in her capacity as a Member of Barnsley Hospital NHS Foundation Trust Governing Body, insofar as the discussion referred to the Trust.

13 Minutes of the Board Meeting held on 11th August, 2015 (HWB.13.10.2015/2)

The meeting considered the minutes of the previous meeting held on 11th August, 2015.

RESOLVED that the minutes be approved as a true and correct record.

14 Minutes from the Barnsley Community Safety Partnership held on 13th August, 2015 (HWB.13.10.2015/3)

The meeting considered the minutes from the Community Safety Partnership held on 13th August, 2015. Members noted the recently revised Terms of Reference for the Partnership, set out in the appendix to the minutes.

RESOLVED
i) that the minutes be received;
ii) that, insofar as the Board is concerned, the revised terms of reference be confirmed.

15 Minutes from the Provider Forum held on 9th September, 2015 (HWB.13.10.2015/4)

The meeting considered the minutes from the Provider Forum meeting held on 9th September, 2015.

RESOLVED that the minutes be received.

16 Safeguarding Children Board Annual Report. (HWB.13.10.2015/5)

The report was introduced by Bob Dyson, independent Chair of the Barnsley Safeguarding Children Board. He made particular reference to the good engagement with partners on the Board in progressing the strategy and action plan. The meeting noted that the revised threshold for action had led to an increase in contacts with Children's Services that did not ultimately lead to formal referrals.

However, there had also been an increase in formal activity. Mr Dyson noted that efforts continued to secure a better return rate by primary school of the annual safeguarding survey.

RESOLVED that the Barnsley Safeguarding Children Board Annual Report 2014-15 be endorsed.

17 Female Genital Mutilation - FGM. (HWB.13.10.2015/9)

The Board received the report on female genital mutilation, identifying the action being taken in Barnsley to respond to this issue.

RESOLVED that the report and its implications for Members as providers and commissioners of services be noted.

18 Better Care Fund update, including financial position. (Sac.13.10.2015/6)

Members were reminded of the background to the Better Care Fund and its aim to transform health and social care.

The allocation of the fund was noted, and the extent to which a number of schemes had historically been funded from sources consolidated into the BCF, and the meeting discussed performance in relation to the fund. The meeting heard how attendance at A&E was stable and reducing, but non-elective admissions were increasing.

The meeting noted the schemes supported by the BCF, and other activity that contributed to achieving the performance targets, together with the assurance process to report to NHS England. It was important to understand why admissions were taking place in order to identify what could be done to improve performance levels.

RESOLVED that the update on the Better Care Fund be received, and SSDG undertake further work in order to improve performance as discussed.

19 Excess winter deaths. (HWB.13.10.2015/7)

The Public Health Principal-Place presented the Barnsley Excess Winter Deaths report. Attention was drawn to the findings contained within the Final Report on Excess Winter Deaths in Barnsley and its recommendations.

The meeting noted the key actions that were being pursued through existing networks and groups, particularly Voluntary & Community sector, to address the main factors contributing to excess winter deaths. The particular focus need to be on vaccination programmes, falls prevention and encouraging vulnerable groups to stay warm.

RESOLVED that the contents of the report and action being taken be noted.

20 Report from the Health and Wellbeing Board Development Session

The meeting reflected on the development session held on 23rd September in identifying key areas to forward the work of the Board. It was particularly important to focus on those areas where the Board would add value to work already being pursued by partner agencies. The need for a 'Health and Wellbeing Board strategy', as distinct from a 'Health and Wellbeing Strategy' was acknowledged.

RESOLVED that the report be noted, and SSDG be requested to pursue the actions agreed at the development session.

Chair

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Minutes of the Children and Young People's Trust Executive Group Meeting held on 6 November 2015

Present

Core Members

Rachel Dickinson (Chair)	BMBC, Executive Director: People
Bob Dyson	Independent Chair of the Barnsley Safeguarding Children Board
Tim Cheetham	Cabinet Member: People (Achieving Potential)
Cllr Margaret Bruff	Cabinet Member: People (Safeguarding)
Nigel Middlehurst	Voluntary Action Barnsley, External Services Manager
Dr Clare Bannon	Barnsley Local Medical Committee, GP representative
Dave Whitaker	Executive Headteacher, Representative of Secondary Headteachers
Margaret Libreri	BMBC, Service Director for Education, Early Start and Prevention
Mel John-Ross	BMBC, Service Director of Children's Social Care and Safeguarding
Brigid Reid	Barnsley CCG, Chief Nurse
Penny Greenwood	BMBC, Head of Public Health

Deputy Members

Dave Ramsay	South West Yorkshire Partnership Foundation Trust (SWYPFT), Deputy Director of Operations (for Sean Rayner)
Katherine Clark	Hoyland Springwood Primary School Headteacher (for Gerry Foster-Wilson)
Sue Gibson	Barnsley Hospital NHS Foundation Trust, Head of Midwifery/ Nursing (for Heather McNair)
Phil Briscoe	Barnsley College, Vice Principal (for Jenny Miccoli)

Advisers

Richard Lynch	BMBC, Head of Commissioning, Governance and Partnerships

In attendance

Julie Govan	BMBC, Integrated Systems & Strategy Manager (for item 8)
Jayne Hellowell	BMBC, Head of Locality Commissioning and Healthier Communities (for item 9)
Ben Finley	BMBC, Integrated Youth Support Services Manager (for item 13)
Denise Brown (Minutes)	BMBC, Governance, Partnerships and Projects Officer

			Action
1.	Apologies		
	Tim Innes	South Yorkshire Police Chief Superintendent (Barnsley Commander)	
	Deborah Mahmood	South Yorkshire Police	
	Anna Turner	BMBC, School Models and Governor Development Manager	
	Angela Kelly	BMBC, Targeted Youth Support Operations Manager	
	Julie Green	BMBC, Strategic Lead, Procurement and Partnerships	
	Gerry Foster-Wilson	Executive Headteacher, Representing the Barnsley Association of Headteachers of Primary, Special and Nursery Schools	
	Sean Rayner	SWYPFT District Director Barnsley/ Wakefield	

		Action
	Wendy Lowder — BMBC, Service Director for Stronger, Safer and Healthier Communities Catherine Warrener — BMBC, Workforce Development Strategy Officer (for item 7) Jenny Miccoli — Barnsley College, Vice Principal Teaching, Learning and Student Support	
2.	Identification of confidential reports and declarations of any conflict of interest Reports for agenda items 4 and 10, BSCB minutes and Short Breaks report, are to be treated as confidential and are not for further distribution.	
3.	Minutes of the Trust Executive Group meeting held on 25 September 2015 The minutes of the meeting were approved as an accurate record.	
3.1	Action log/ matters arising • Item 5 – effective engagement with schools. A discussion was held regarding the necessity for schools to have a Safeguarding Lead, particularly primary schools as secondary schools tended to have a nominated safeguarding lead on their leadership team. It was suggested that each primary school may wish to make a small contribution towards a Safeguarding Lead post. Primary School representation on the BSCB continues to be an issue. It was noted that Ms Wilks, Headteacher at Kings Oak Primary Learning Centre, had undertaken to represent Primary Schools on the BSC Board. Margaret agreed to put an item on the next Schools Forum agenda regarding the need for effective strategic engagement with schools, particularly in relation to safeguarding. • Item 6(iii) – During the workshop when discussing 'improving education, achievement and employability' a number of issues were raised and Rachel had suggested that it might be helpful to hold a light touch learning event at some point. • Item 10 – Central Government's budget announcement and devolution agenda. This item had been removed from the agenda of this meeting as there had not yet been a budget announcement, however, it would continue to be a standard item for update on future agendas.	Margaret
4.	Minutes of the BSCB meeting held on 18 September 2015 – for information As highlights from the BSCB meeting held on 18 September had been recorded at the last meeting, the minutes were noted for information. There were no further comments. Bob informed the meeting that the Police and Crime Commissioner had invited Professor John Drew to lead an independent review into South Yorkshire Police's approach to child sexual exploitation, and that the BSCB had received an invitation to be part of that process.	

		Action
5.	Children and Young People's Plan - draft plan for 2016-19 (Richard Lynch) In preparing the review of the Children and Young People's Plan the results of the two workshops held at previous TEG meetings, and feedback from young people about the priorities in the Children and Young People's Plan had been taken into account. The comments from the workshop held at the joint TEG/BSCB meeting were yet to be assimilated to the draft plan. The following comments were noted: • There was a shared view that there needs to be a small number of actions where partnership effort can be aligned that will have the biggest impact and make a difference, i.e. 5 key things. • Need to consider which issues could be taken forward, and how best to drive those actions forward. • The plan on a page is intended to be a pithy document to be used as a guide to achieving the desired outcomes. 'Less is more'. • Some elements in the draft plan are still too long. Need something that can be extrapolated that is portable and can be shared with front line workers. The priorities of the partnership need to align with front line priorities. • The CYP Plan needs to tell the story of the key issues and the value of having a partnership approach. • A key driver of the CYP Plan is the work of the Anti-poverty Board and also early help, and that part of the plan needs to be populated. • At the next TEG meeting would like a draft that can be signed off. Members were asked to submit outstanding information that had been requested in relation to the progress update against the last set of priorities on page 13 of the draft plan, as well as setting priorities for 2016-19 for the revised plan on a page. It was agreed that TEG champions would be nominated for each identified priority to drive the actions, gather evidence of achievement and highlight any barriers: • Keeping children and young people safe: Bob Dyson & Mel John-Ross • Improving education, achievement and employability: Margaret Libreri • Tackling child poverty and improving family life: It was agreed that the vehicle for addressing this is early help and that this has strong links with the Communities Directorate. A TEG champion needs to be nominated for this area of work • Supporting all children, young people and families to make healthy lifestyle choices: Penny Greenwood • Encouraging positive relationships and strengthening emotional health: Brigid Reid • Improving staff skills to deliver quality services: Champion to be nominated.	Members
6.	Progress report on the Child and Adolescent Mental Health Service Performance and Improvement Task and Finish Group (Brigid Reid) The report highlighted the following points: • Current average waiting times to the initial appointment is now 10 weeks, which is an improvement. The aim is to reduce this to 5 weeks by March 2016 and Dave Ramsay gave assurance that this target would be met.	

		Action
	• Barnsley's Local Transformation Action Plan is focused on ensuring that children, young people and families can be effectively supported to meet their emotional health and wellbeing needs before they get to the stage of needing CAMHS services, in particular by increasing support to schools. The action plan is almost at a stage when it can be shared. • A Governing Body development session focusing on CAMHS had been held on 29 October which had been helpful. Brigid stated that a rejected referral from a GP had been brought to her attention, which had described a parent taking their child to the GP on the school's insistence due to behavioural issues. It was noted that there had been insufficient detail for the CAMHS team. The importance of input from the School Nurse was reiterated. Clare stated that there are still issues for GPs around thresholds and the gap in service provision below Tier 3. Brigid pointed out that one of the objectives of the Local Transformation Action Plan is to create capacity and capability in the system. All Schools have an identified School Nurse, and it is important for GPs to contact the School Nurse in the first instance if the parents claim that the school has sent them, and to ensure that referrals are made with the involvement of the School Nurse. It was confirmed that school nurses can refer directly to CAMHS. Clare queried whether the wait for treatment had been impacted on as a result of the shorter waiting times to initial appointment, and Dave Ramsay stated that data regarding waiting times would be available at the end of the calendar year. Rachel pointed out that it is important to monitor waiting times for a service, not only to initial appointment, to identify where the system is not working adequately. **It was agreed that:** • A notice would be included in the next Schools Bulletin to reiterate the role of the School Nurse in terms of referrals. • An update would be given at the next meeting on the Local Transformation Action Plan. • Dave would circulate invitations to TEG members to attend the official opening of the newly refurbished New Street Health Centre on 7 December, taking place from 6 – 7.30pm.	Margaret Libreri Brigid Reid Dave Ramsay
7.	<u>Children's Workforce Development update</u> (Catherine Warrener) The report provided a helpful review of the Children's Service Learning and Development Activity between April – October 2015, and the Workforce Development Training Plan for 2015/16. It was agreed that as Catherine had been unable to attend this meeting members would send any comments to Denise, and that this item would be deferred to the next meeting.	Members/ Denise/ Catherine
8.	<u>Continuous Service Improvement Plan/ Framework</u> (Rachel Dickinson/ Julie Govan) The CSI Framework has been amended following the feedback received at the joint TEG/BSCB meeting.	

		Action
	It was noted that: • There are no red flags against any performance action. • The 'front door' is still a priority. • Outcomes for care leavers are still being considered. At the joint meeting it had been agreed that themed discussions would be helpful when reviewing the CSI plan, however, areas of concern must be raised by the Officer Group immediately and not wait until that particular theme is discussed. *(Julie Govan left the meeting at this point)*	
9.	<u>Stronger Communities Partnership update</u> (Jayne Hellowell) The first meeting of the Stronger Communities Partnership (SCP) will be held on 9 November 2015, Chaired by Councillor Chris Lamb. Priorities will be progressed through three Delivery Groups: 1. Delivery Group One - Resilient and Healthy Communities. 2. Delivery Group Two - Early Help and Prevention. 3. Delivery Group Three - Anti-Poverty. The following comments were made: • Rachel explained that during the Council's re-structure it had been agreed that the work around 'early help' and 'think family' would be driven by the Communities Directorate, however, accountability remains with the Executive Director for People Directorate as the DCS, and it is therefore important for both the Children and Young People's Trust and the Barnsley Safeguarding Children Board remain sighted on, and be able to challenge, progress. • The Stronger Communities Partnership (SCP) will provide a strategic focus, strengthening areas where necessary, and will ensure that there is no duplication of effort. • Clare pointed out that the membership included a representative of the GP Federation, which is not inclusive of all GPs as membership is optional, whereas all GPs are members of the Local Medical Committee. Jayne undertook to raise this with Wendy Lowder. • The Thresholds Group needs to be reviewed but will continue as a separate group. • An action plan would be submitted to future TEG and BSCB meetings. *(Jayne left the meeting at this point)*	Jayne Jayne
10.	<u>Provision of short breaks for children and young people with a disability in Barnsley – confidential</u> (Richard Lynch) The draft Short Breaks Strategy was presented for consultation and the report provided an update on progress in relation to the programme of work in the commissioning plan. The following comments were noted: • The draft strategy is to be treated as confidential and not for wider sharing with the workforce at this stage. • It was noted that further consultation with stakeholders would take place at the Disabled Children's Programme Board.	

		Action
	• A key element of the strategy is an increased focus on personalisation. • Brigid stated that there is a strong theme in the CQC regarding children in transition into adult services, and there is a lot of work to be done around strengthening independence. • Members were asked to let Richard have comments on the draft strategy by the end of November 2015, particularly in relation to independence and use of personal health budgets. • The final version of the strategy will be considered at the Executive Commissioning Group Meeting on 11 January 2016.	Members Richard/ Denise
11.	<u>0-19 Healthy Child Programme – update report</u> (Penny Greenwood) From 1 October 2015 the Council became responsible for commissioning School Nursing, Health Visiting and Family Nurse Partnership Services for children and young people aged 0-19 years. The Contracts for Health Visitors and Family Nurse Partnership expire at the end of March 2016, and the School Nursing Service contract expires at the end of May 2016. From June 2016 these services will be commissioned through the 0-19 Healthy Child Programme and bids were invited through the YOR Tender procurement system. Since the last TEG meeting, however, it had been decided not to award the contract for the 0-19 Healthy Child Programme as it was felt that the bids were not appropriate. Work is taking place with partners and colleagues regarding the next steps. Regular updates will be communicated through the website so that everyone is involved and aware of progress. The risks and challenges would be considered by the Executive Commissioning Group. It was acknowledged that concern is shared across the partnership. It is important to reiterate, and communicate with stakeholders and partners, that the services will continue to be provided.	Penny/ Denise Julia
12.	<u>Performance: Escalated items from other theme leads</u> No items were escalated. Rachel requested that this item remain on the agenda to allow for any issues of particular concern to be raised.	
13.1	<u>Action focused discussion - persistent absence from school</u> (Margaret Libreri) A presentation was circulated highlighting the issues in relation to persistent absence in Barnsley, and the difference between those who are disadvantaged (receiving pupil premium) and those who are not. Persistent absence in Barnsley is higher than the national average for both primary and secondary schools, and more disadvantaged children are persistently absent when compared with their peers. The current definition of 'persistent absence' is a child who misses a month of school lessons in a year, 15% of the number of sessions a child should attend. The new definition takes into account the actual number of sessions available to a young person in whatever school they attend, and the threshold will be reduced to 10% with the aim that schools will take action	

		Action
	sooner. This is a helpful change as it will identify young people who were not previously identified as persistently absent if they had moved schools. It was noted that schools converting to academies would have started with a nil balance and Margaret undertook to do a deep dive into individual school details. An anonymised case study of a family of four children who were not attending school was discussed and the following points were raised: • It was acknowledged that in some cases non-attendance of school is condoned and is culturally acceptable. Despite fines being issued, taking holidays during the school term continues to be a massive problem. • For some young people school is not an attractive place to be and it is important to get behind the reasons for young people not wanting to attend school. • It is also important to help parents to understand the consequences of non-attendance for their children, emphasising the parental responsibilities of both parents. • There is a concern regarding the quality of education for those children who are educated at home. • It was suggested that a communications strategy be developed to convey the importance of school attendance and the responsibility of parents, including stories in the media of how families have been helped to overcome barriers. This would include a parallel piece of work around social marketing. • Positive reinforcement is important to recognise progress made. Of the 121 cases taken to an attendance panel, half achieved improved attendance. • It is important for GPs and other service providers to challenge the parents of young people who attend appointments during the school day, and it was suggested that truancy sweeps be carried out to challenge adults with young people who should be in school, and publish the results. • When young people are not in school it raises a potential safeguarding issue regarding where they are and who they are with. Improving school attendance for children who are on a child protection plan needs to be a priority. • If a school identifies a child who is persistently absent they would be expected to put in place a range of support to ensure attendance and engagement. • Closer links between GPs and the School Nurse would be helpful in some instances, i.e. if there are any medical concerns regarding the parents or the children e.g. if the Mum is believed to have mental health issues. • Margaret stated that the Behaviour and Attendance Group, which is a sub-group of the Barnsley Alliance Board, is currently exploring the reasons behind persistent pupil absence. The Behaviour and Attendance Group includes representation from schools; Educational Psychology; the Head of Early Start, Prevention and Sufficiency; and Education Welfare. It was suggested that representatives for PCSO's and SWYPFT are also invited to attend this group. • It was suggested that it would be helpful to identify a school to run a pilot and to put a team around a school, using early help methodology to understand the reasons behind persistent absence. Bob suggested	Margaret Libreri

		Action
	further investigation in both a primary and secondary school, particularly if any siblings are attending a secondary school. It was agreed that: • Partners would raise the profile of persistent absence in their respective organisations, and to consider how a joint approach across the children's workforce might improve school attendance. Suggestions included GPs booking appointments after hours rather than during the school day; having CAMHS appointments on the school premises; improved support for schools with EAL learners. • Consideration would be given to developing a Communications Strategy to emphasise in the media the importance of school attendance and the impact on non-attendance. • Truancy sweeps would be undertaken, particularly on market days, and publicise the results • A 10 minute update would be given at the next TEG meeting.	All partners Margaret Libreri
13.2	<u>School exclusions</u> (David Whitaker) The report provided information on the number of secondary school fixed term exclusions for the first half term of the academic year 2015/16, and the number of permanent exclusions in Barnsley secondary schools. The data also showed the fixed term exclusions for the whole of the last academic year. Fixed term exclusions remain high in a number of Barnsley secondary schools, and are increasing in schools with previously low exclusion rates. Dave pointed out that the available space at Springwell Alternative Academy had reduced to 20 since this appendix had been circulated, and that there were no Primary PRU places available. During the discussion the following points were noted: • Consideration needs to be given to whether fixed term exclusions have achieved a change in behaviour, and it is therefore important to track the outcomes of those young people who had received fixed term exclusions, particularly in Carlton and Shafton Schools. Margaret Libreri undertook to obtain that data. • The data does not show the movement of young people with behaviour issues to another school. • Dave stated that Springwell Academy receives a lot of enquiries from other Headteachers who are working with young people with challenging behaviour. Their choices appear to be phone Springwell for advice/ exclude the pupil/ refer the pupil to CAMHS. • It was suggested that the thresholds being used by schools for excluding pupils may need to be considered, as well as the skills of staff to manage challenging behaviour. • Schools need to get better at looking at the reasons behind the poor behaviour. Examples were given of young people who may be excluded for being asked to deliver something that they are not capable of delivering, and not being able to read. There is also an issue around teaching young people how to manage their behaviour and to exercise self-control. • Margaret Libreri stated that it had recently been agreed that these issues also need to be discussed at Primary School level.	

		Action
	• It was noted that a link needs to be made with the Local Transformation Plan. **It was agreed that:** • Margaret would obtain details about the young people excluded from Carlton and Shafton Schools for further investigation. • An update would be brought to a future TEG meeting in the next term to discuss the issues raised further.	Margaret Libreri Dave Whitaker
13.3	<u>Analysis of school attendance and attainment data for MST cases successfully closing 01/04/15 - 30/09/15</u> (Ben Finley) The report provided further analysis of the attendance and attainment levels of young people that MST had worked with, and concluded that young people had achieved an improved rate of attendance, and there had been a reduction in the use of fixed term exclusions, for the 4 weeks prior to closure with MST compared to the year prior to MST involvement. The report concludes that overall most young people worked with were achieving and sustaining better educational outcomes in the half term after MST had closed. It was acknowledged that whilst performance is positive there is still room for improvement, which there is commitment to achieve. The following points were noted: • Dave Whitaker stated that he would welcome a review of the service level agreement with Springwell to achieve a more joined up approach. • It is important to achieve sustainability of good attendance not only during the life of MST but afterwards, and to work on what can be done to support sustainable change. **It was agreed that MST would:** • Review the SLA with Springwell in January 2016 and consider its use more broadly with educational partners. • Continue to refine its internal procedures and develop its work alongside schools. • Provide contextual data in reporting outcomes for young people in education.	
14.	<u>Proposed agenda items for the next meeting</u> 18 December 2015: • Supporting children, young people and families to make healthy lifestyle choices/ Child Health Programme Board (Penny Greenwood) • Early Support Pathway for children with additional/ complex needs (Carol Ward and John Rooke) • Public Health and Wellbeing survey for children and young people – results (Penny Greenwood) • Continuous Service Improvement Plan/ Framework (Rachel Dickinson/ Julie Govan) • Stronger Communities Partnership (Wendy Lowder) • Draft CYP Plan 2016-19	

		Action
	• Children's Workforce Development update • Local Transformation Action Plan It was agreed that it had been more productive to have a presentation rather than a report around the agreed action focused discussion and that this practice should be continued in future.	

Anti-Poverty Board: Note of meeting 12th October 2015	Action in Action Log
Present: Cllr Platts (Chair),Wendy Lowder , Jordan Roberts, Tom Smith, Michelle Kaye, Nigel Middlehurst, Joanne Dearnley, Dave Fullen, Jayne Hellowell, Anita McCrum, Emma White, Jo Clark, Andrea Hoyland	
In Attendance: Mark Wood, Eleanor Dearle	
Apologies: Lisa Smith, Gary Stott, Sarah Cartwright	
1. From Previous Board Meeting	
The Action Log from the last meeting (20th July) was agreed as a true and accurate record. All actions had been completed or were on the agenda.	
2. Matters Arising	
There were no additional matters arising.	
3. Presentation from BMBC Business Intelligence Service	
Mark Wood provided a presentation using the Experian Mosaic Poverty data which illustrated the numbers of households in poverty across the borough based on income. It was suggested that the data could provide a useful benchmark for future comparison.	
4. **Universal Credit & Welfare Review Updates**	
Joanne Dearnley and Michelle Kaye provided an update on Universal Credit.(UC) There were 700 clients on Universal credit at that point, mainly single, non-householders who were fit for work. The start of the full roll out is estimated to be mid 2017 at the earliest. Possible size of cohort is estimated at 3.5k JSA, 13k ESA, 200 Lone Parent Benefit plus working tax credit clients. Michelle told the Board about the work that Council is undertaking to support client readiness for their transfer to UC.	
5. Stronger Communities Partnership –new governance arrangements	
Jayne Hellowell provided a briefing and papers to illustrate the proposed governance arrangements to include the transition of the Anti-Poverty Board to the Anti-Poverty Delivery Group which would be a subgroup of the Stronger Communities Partnership. Wendy Lowder further outlined the ambition of the Stronger Communities Partnership and the activity to take place at the first meeting on 19th November. Wendy detailed the activities expected of the Delivery Group, which will include it being a 'doing' group that will monitor delivery of partners against their actions in the Anti-Poverty Action Plan. The Board agreed to the transition and agreed that the first meeting of the new Anti-Poverty Delivery Group would take place on the next scheduled date of the current Board. (23rd November).	
6. Anti-Poverty Action Plan Update	
Andrea Hoyland provided a brief update on the development of the Anti-Poverty Action Plan. The draft plan has been developed from the workshop which included Board members and wider partners and is shaped around the 5 agreed challenge areas. The Plan brings together the activities of the Council and partners that combat and tackle poverty and low income affecting residents and includes actions from the relevant	

strategies and plans that contribute to this outcome. Colleagues agreed to return any comments or actions to be included in the Action Plan to Andrea by 2nd November. Details required include any relevant actions that contribute to poverty reduction, a named lead for each action, and projected deadline for completion. Wendy emphasised the need for specific and measurable outcomes and any metrics attached to the actions and Cllr Platts reiterated the check and challenge role of the Delivery Group that it would monitor the actions in the Plan to ensure that activities are targeted in areas of most need . Colleagues were also asked to submit details of who they felt should be part of the Delivery Group. A revised Plan will be brought to the first meeting of the Delivery Group.	**ALL by 2.11.2015** **Andrea Hoyland**
7. Any Other Business	
Eleanor Dearle gave information about ESF funding available to support activities targeted on social inclusion and progress to work. Eleanor said that she would revisit the information available with a view to providing further details.	**Eleanor Dearle**
8. Date and time of next meeting The next meeting will be the inaugural meeting of the Anti-Poverty Delivery Group will be on 23rd November from 2pm-4pm at Gateway Plaza, Level 4 Boardroom. Future meetings TBA	

BARNSLEY METROPOLITAN BOROUGH COUNCIL

This matter is not a Key Decision within the Council's definition and has not been included in the relevant Forward Plan

Report of the Executive Director (People) to Cabinet (18th November 2015)

SAFEGUARDING ADULTS BOARD: 8th ANNUAL REPORT 2014 - 2015

1. Purpose of Report

1.1 To inform the Cabinet of the work of the Barnsley Safeguarding Adults Board (SAB) the contributions made by multi-agency partners, including Barnsley MBC towards progress, during 2014 -2015, and to note future policy and legislative developments that impact on the Safeguarding Adults agenda.

2. Recommendations

2.1 **Cabinet Members are requested to note:-**

1) **The contents of the Safeguarding Adults Board Annual Report 2014 - 2015 attached Executive Summary.**
2) **The future policy and legislative changes and the ways in which these impact on the Safeguarding of Vulnerable Adults.**
3) **The progress made in 2014 – 2015 by the Safeguarding Adults Board.**

3. Introduction

3.1 In March 2000, the Department of Health document 'No Secrets' required the setting up of an inter-agency framework for Adult Protection to include all partners in order to achieve effective inter-agency working. After a review of 'No Secrets' and following the Law Commission's 3-year report on Adult Social Care (May 2011), the Care Act 2014 entered the statute books to be implemented in April 2015.

3.2 The Care Act establishes the first statutory framework for adult safeguarding. It sets out local authorities' responsibilities, and those of local partners, to protect adults at risk of abuse or neglect. These responsibilities include a core

membership of the Safeguarding Adults Board to consist of the local authority, the Clinical Commissioning Group (CCG) and a Chief Officer of the police. The Board will be required to publish a strategic safeguarding plan and report annually on its progress, to ensure that partner agencies' activities are effectively co-ordinated. The Board will also be required to establish and arrange for a Safeguarding Adult Review (SAR) to take place where there is reasonable cause for concern about how the Board, its members or other persons with relevant functions worked together to safeguard the adult. Such reviews will focus on learning from experience and improving services.

3.3 The annual report provides a discussion of the key drivers and gives some indication of expected future service development. Partner agencies also report on individual progress made this year. The annual report also contains the 2014-2015 Performance Management and Quality Assurance report which gives a simple analysis of the safeguarding adults data collected for each quarter of the year and the end of year data totals.

3.4 **Performance Summary 2014-2015**

This Performance Management and Quality Assurance Statistical Report (included in the Annual Report 2014 – 2015) makes use of the data provided by the Safeguarding Adults Return (SAR) data collection to the Information Centre for Health and Social Care, for the period 1st April 2014 to 31st March 2015.

3.5 At the year end 31st March 2015, the number of alerts received into the service was 951 and of those, 361 progressed to a safeguarding referral. The highest number of cases on file were categorised as 'neglect' (226) followed by 'physical abuse' (91). and 'financial abuse' (37). Out of the 361 referrals 226 were with respect to female clients and 135 were male. The age group 65+ years with 76% (275 cases) continues to provide the majority of cases to the Safeguarding Adults service.

3.6 **Safeguarding Adults Service and Partner Agencies' Achievements**

- BMBC and the Barnsley Clinical Commissioning Group (CCG), NHS England, the Barnsley Hospital NHS Foundation Trust (BHNFT) and the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) have all delivered extensive staff training this year in issues related to the safeguarding of vulnerable adults demonstrating an all-round commitment to the safeguarding of adults in their care.

- The Mental Capacity Act 2005 continues to provide a legal framework for

acting and making decisions on behalf of an individual who lack the mental capacity to make a particular decision for themselves. From April 2013 the Local Authority has held full responsibility for the administration and implementation of the Deprivation of Liberty Safeguards (MCA/DoLS).

Following a landmark judgment made in the Court of Protection there is now a straightforward 'acid test' to determine whether or not a person is being deprived of their liberty. This has resulted in a seven-fold rise in the number of requests for DoLS Standard Authorisations so that whereas in previous years the local authority received around 100 assessments each year, between April 2014 and March 2015 the service has received over 750 requests. In order to mitigate the risks associated with this increase, the DoLS pilot, whereby we have a dedicated team of Best Interest Assessors working full-time on DoLS assessments, has been extended.

- A Local Government Association (LGA) study into the effect of focussing safeguarding adults work on person-centred, outcome-based principles has paved the way for the implementation of the principles of Making Safeguarding Personal (MSP). Work has taken place within a number of local authorities, Barnsley included, to implement the principles of MSP. This approach to the safeguarding of vulnerable people has been further endorsed, and has become a statutory requirement through the implementation of the Care Act 2014.

- The South Yorkshire Consortium of local authorities, Barnsley , Rotherham, Sheffield and Doncaster have developed and reviewed the Safeguarding Adults Procedures for South Yorkshire and following consultation in May 2015, are expected to be fully implemented throughout the Safeguarding Partnership in the summer of 2015.

- The Counter-Terrorism and Security Act 2015, brings into force the requirement that local authorities must put in place and chair a multi-agency panel of members with the function of developing an appropriate support package to safeguard those at risk of being drawn into terrorism based upon an assessment of their vulnerability.

- The Safeguarding Adults Board has undertaken internal various audits the most recent being the Safer Recruitment Audit which is due to report in Spring 2015. This will enable recommendations to be included in the Safeguarding Adults Board Business plan 2015 -16.

- The SAB MCA/DoLS Mental Capacity Act/Deprivation of Liberty Safeguards Training Sub Group has continued to meet bi-monthly to identify, develop

and maintain safeguarding training processes for statutory, independent and voluntary sectors. March 2014 bespoke MCA Compliant Record Keeping training was developed for all providers which incorporates the Principals of the Care Act 2014.

- During the year Berneslai Homes have carried out over 1500 visits to vulnerable individuals affected by the advent of Universal Credit and continued to support those affected by welfare reform. Its Family Intervention Service (FIS) provides intensive family support to families with multiple and complex needs. The FIS has continued to make significant progress in achieving positive outcomes for families under the Troubled Families Programme supporting over 200 families with multiple and complex needs during the last year.

- Following the implementation of the Health and Social Care Act (2012), public health responsibilities and functions returned to local authorities from the NHS. Throughout this transition period Public Health have continued to commission and work with partners on a broad spectrum of programmes which impact on the health, wellbeing and safeguarding of the population across the life course.

- Healthwatch Barnsley is one of 152 local Healthwatch organisations, supported by a national organisation called Healthwatch England. Healthwatch Barnsley has a representative on the Safeguarding Adults Board. It is a member of the Health and Social Care Intelligence Sharing Meetings and is represented on the Regional Quality Surveillance Group for South Yorkshire and Bassetlaw.

- In September 2014 the Clinical Commissioning Group (CCG) created a senior safeguarding and patient experience Designated Nurse post to enable dedicated strategic oversight of Adult Safeguarding. This new post will enable the CCG to provide strengthened leadership to the Adult Safeguarding Operational Management Sub group in order to support the Board in the delivery of its work streams.

- During 2014-2015 the Barnsley Hospital NHS Foundation Trust had 1,210 formal and informal safeguarding alerts. Of this total 351 met the threshold for formal investigation with 262 referrals being made to district teams via the Barnsley Safeguarding Adults Office and 89 referrals leading to internal investigations.

- This year the South West Yorkshire Partnership (NHS) Trust (SWYFT) has implemented a variety of training for staff and volunteers including adult abuse awareness, Prevention of radicalisation, and awareness of domestic

abuse. Trust staff and partners have had access to workshops around complex issues such as Human Trafficking, presented by Hope for Justice and the prevention of radicalisation presented by West Yorkshire Police.

- This year South Yorkshire Police has increased its staffing and resourcing of the Barnsley Public Protection Unit (PPU), based at Wombwell Police Station. It has seen additional staff provided in the form of a dedicated Safeguarding Adults Officer and additional staff to support adult safeguarding investigations and domestic violence.

- South Yorkshire Fire & Rescue's (SYFR) total for April 2014 – March 2015 for all Adult Safeguarding Alerts across South Yorkshire was 94. This represents a considerable increase from 54 cases in the same period last year. The majority of the alerts were received as a result of a Home Fire Safety check with some being received from fire incidents. This year SYFR staff received introductory and/or refresher safeguarding training.

4.0 Priorities 2015 – 2016

4.1 Key priorities for the Safeguarding Adults Board for the coming year 2015 – 2016 are:-

- The Safeguarding Adults Board (SAB) to maintain a clear vision of the outcomes it wants to achieve during 2015 – 2016 through its Safeguarding Adults Strategic Plan.

- To continue effective joint working between the Safeguarding Adults Board (SAB), the Safeguarding Children Board (SCB) and local strategic partners.

- To ensure partner agencies understand their leadership roles, responsibilities and their contributions towards the Safeguarding Adults Board's Strategic plan.

- To ensure full implementation of the requirements of the Care Act 2014 in relation to Making Safeguarding Personal (MSP).

- Ensure the new Safeguarding Adults Procedures for South Yorkshire are implemented across all partner agencies in order to ensure the safety and protection of vulnerable adults.

- To ensure that systems are in place, including a clear strategy that incorporates service user and carer involvement in the safeguarding of vulnerable adults.

- To highlight areas of concern through sub group analysis and produce learning outcomes for additional training sessions as required.

- Continue to participate fully in the PREVENT agenda for those who are vulnerable to messages of violent extremism. and that all front-line workers are trained to recognise when a person might be susceptible to the messages of violent extremism and radicalisation and how to report this.

- Encourage multi-agency participation in Domestic Homicide Reviews (DHRs) and Safeguarding Adults Reviews (SARs).

- To ensure the Safeguarding Adults Board uses the experiences of those using safeguarding services to drive improvements in services and to provide for quality assurance through the use of regular audits of safeguarding activity and the quality of the work undertaken.

- To ensure the Safeguarding Adults Board drives quality assurance forward through its Performance Management and Quality Assurance Sub-group and ensure there is appropriate evidence that this leads to service improvement.

- Ensure the Safeguarding Adults Board has effective arrangements to identify and secure financial resources to deliver its vision and strategy.

- To maintain liaison with regional partners to maintain networks in order to share and disseminate good practice across South Yorkshire.

5.0 Consideration of Alternative Approaches

5.1 Not applicable to this report.

6.0 Proposal and Justification

6.1 The purpose of this report is to inform Cabinet of the work of the Safeguarding Adults Board, including the contribution of the Council as a partner, together with the National developments impacting on the Safeguarding Adults agenda.

6.2 It is proposed that Cabinet note the Annual Safeguarding Board Report Executive Summary and the progress and achievements made in the protection of vulnerable adults in Barnsley through a proactive Safeguarding Adults service.

7.0 Implications for local people / service users

7.1 The operation of the Safeguarding Adults service impacts upon the wellbeing of all citizens and in particular the protection of vulnerable adults.

8.0 Financial Implications

8.1 There are no direct financial implications arising from this report. South Yorkshire Police and the Barnsley Clinical Commissioning Group (CCG) have provided a financial contribution to the Safeguarding Adults Board and its processes. Funding from the CCG and police has been secured for the coming financial year. Funding beyond the coming financial year is under discussion with partner agencies.

9.0 Employee Implications

9.1 There are no employee implications.

10.0 Consultations

The Council's Senior Management Team has been consulted on this report.

11.0 Risk Management Issues

11.1 At present the Safeguarding Adults Board is not placed on a statutory footing. Whilst this is due to change with the introduction of the Care Act 2014, the current financial climate affecting all member organisations and changes in organisational structures pose a potential risk to the commitment of agencies to the SAB. This is mitigated by the sign up of all partners to the Safeguarding Adults Board Memorandum of Understanding and the South Yorkshire Safeguarding Adults Procedures.

11.2 The Safeguarding Adults Board maintains a risk register which is regularly reviewed, updated and monitored by the Safeguarding Adults Board.

12.0 Compatibility with the European Convention on Human Rights

12.1 The contents of this report do not contravene the European Convention on Human Rights.

13.0 Promoting Equality & Diversity and Social Inclusion

13.1 The Safeguarding Adults service promotes the social inclusion of vulnerable adults. The service seeks to ensure that no person or persons are discriminated against due to their race, religion, culture, sexuality, disability, or age.

14.0 Reduction of Crime & Disorder

14.1 In investigating the options set out in this report, the Council's duties under Section 17 of the Crime and Disorder Act have been considered.

15.0 List of Appendices

15.1 Appendix 1: Barnsley Safeguarding Adults Board Annual Report 2014 – 2015 Executive Summary.
Appendix 2: Barnsley Safeguarding Adults Board Annual Report 2014/15 (full version)

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Date: November 2015

People Directorate, Barnsley MBC

Financial Implications / Consultation ……
(To be signed by senior Financial Services officer where no financial implications)

Appendix 1

Barnsley Safeguarding Adults Board

ANNUAL REPORT 2014-2015

Executive Summary

Introduction

1. The Safeguarding Adults Board Annual Report outlines the progress made in the year 2014-2015 to safeguard and promote the welfare of vulnerable adults in Barnsley. The report identifies developments that have taken place over the last year and communicates key targets for the forthcoming year 2015 – 2016.

2. The Barnsley Safeguarding Adults partnership[1] has continued to work without a statutory framework. However, the Care Bill received Royal Assent in May 2014 and the Care Act, due to implemented in April 2015 establishes the first statutory framework for adult safeguarding. It sets out local authorities' responsibilities, and those of local partners, to protect adults at risk of abuse or neglect.

3. This Executive Summary provides an overview of the achievements of the Safeguarding Adults Board and its partner agencies. It outlines developments, both nationally and locally and describes what the Board has done in response to those developments.

4. The Safeguarding Adults Board has seen the appointment of Rachel Dickinson as The Executive Director, People and the Board is also looking forward to the appointment of Bob Dyson, an Independent Chair for the Safeguarding Adults Board in 2015.

National and Regional Developments

5. The single most far-reaching development in the protection of vulnerable adults has been the introduction of the Care Act 2014 which comes into force in April 2015 establishing a firm statutory framework for adult safeguarding. It makes the Local Authority the lead organisation and together with the Clinical Commissioning Group (CCG) and the Police, forms the core membership of the Safeguarding Adults Board onto which a number of other organisations are invited to become members. It also places in statute the need for a Safeguarding Adults Review (SAR) to be held where an adult was subject to abuse or neglect and subsequently died. (Prior to the Care Act these were referred to as Serious Case Reviews – but they were not statutorily required). The Care Act also requires that safeguarding processes are person-centred,

[1] Local and regional partners include: Barnsley Metropolitan Borough Council (BMBC), Berneslai Homes, NHS Barnsley Clinical Commissioning Group (CCG), Barnsley Hospital NHS Foundation Trust (BHNFT), Healthwatch Barnsley, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), NHS England, South Yorkshire Police and their Public Protection Unit (PPU), Yorkshire Ambulance Service NHS Trust (YAS) , South Yorkshire Fire and Rescue (SYFR), Barnsley College, Northern College

concentrating on an outcomes approach and at all times involving the person in decision-making and helping the person to manage risk. This is known as 'Making Safeguarding Personal' (MSP).

6. This year the local authority has received over 750 requests for Standard 'Deprivation of Liberty Safeguards' Authorisations. This represents an eight-fold rise over the previous year. The rise in requests is a product of the 'Cheshire West' ruling made by the Court of Protection in March 2014 which effectively broadened the category of those deemed to be deprived of their liberty. A dedicated team of Best Interest Assessors has been employed to alleviate the pressure created by the need to address the rise in requests.

7. In December 2014 the Chief Coroner confirmed that it was necessary to inform the coroner of any death that had occurred whilst a person was subject to the Deprivation of Liberty Safeguards (DoLS). It was the Chief Coroner's view that any person subject to a Deprivation of Liberty Authorisation was 'in state detention' for the purposes of the Coroners and Justice Act 2009 and the coroner should commence an investigation under section 1 of the 2009 Act.

8. The Multi-Agency Risk Assessment Conferences (MARAC) continues to meet twice monthly. The Barnsley Safeguarding Adults Board is represented on MARAC by the Safeguarding Adults Service Manager. The group make decisions regarding cases involving domestic violence. Partnership working is applied to work aimed at reducing domestic violence in Barnsley. Applied to domestic violence, effective partnership working increases safety and minimises risk. In Barnsley the Strategic Domestic Abuse and Sexual Violence Partnership oversees a multi-agency approach to reducing domestic violence in Barnsley.

9. This year has seen the first full reporting of the Safeguarding Adults Return (SAR) data. The SAR is the new safeguarding adults data collection implemented by the Health and Social Care Information Centre (hscic). The SAR data collection for this year (1st April 2014 – 31st March 2015) is reported in the annual Performance Management and Quality Assurance Report at Chapter 4 of the annual report.

10. The Counter-Terrorism and Security Act 2015, received Royal Assent on 12 February 2015 and introduced the requirement that local authorities must put in place a multi-agency panel of members with the function of developing an appropriate support package to safeguard those at risk of being drawn into terrorism based upon an assessment of their vulnerability. The Act also required that the local authority chair the multi-agency panel which will consist

of representatives of the local authority, a chief officer of police and other statutory partners.

11. Safeguarding Adults Leads of the regional Safeguarding Adults Consortium consisting of Barnsley, Doncaster, Rotherham and Sheffield, have continued to meet regularly to finalise the implementation of the new Safeguarding Adults Procedures for South Yorkshire. The new Procedures are expected to be launched in August 2015.

Local Developments and Achievements

12. The Safeguarding Adults Board, consisting of representatives from partner agencies receives quarterly reports from its Sub-groups:- the Operational Management Sub-group, the Safeguarding and MCA/DoLS (Mental Capacity Act and Deprivation of Liberty Safeguards) Training Sub-group, the Performance and Quality Assurance Sub-group and the Practice Learning Sub-group. Reports outlining the achievements and developments within local and regional partners are provided in the annual report.

13. Key developments this year are as follows:

- Berneslai Homes has carried out around 5000 support visits to Council properties to identify any support or people where issues of vulnerability exist. Over 1000 of these visits resulted in supportive interventions. During the year over 1500 visits to vulnerable individuals affected by the advent of Universal Credit and continued to support those affected by welfare reform have been carried out.

- Public Health responsibilities and functions have this year been returned to Local Authorities from the NHS. Throughout the transition period Public Health have continued to commission and work with partners on a broad spectrum of programmes which impact on the health, wellbeing and safeguarding of the population and to the prevention of people becoming susceptible to vulnerability.

- The Physical Activity Care Pathways (PACP) delivers an array of physical activity sessions across Barnsley for people with long term conditions such as diabetes, cancer, arthritis and many more. More than 1000 sessions have taken place since the launch of the programme in April 2014, with 330 referrals from a range of health professionals such as nurses, GPs, physiotherapists and dieticians. Service users over 65 years of age are also referred to postural stability classes which contribute to protecting against falls.

Raising participation in physical activity across the Borough is one part of the wide and varied portfolio of work which falls under the Public Health scope of responsibilities and demonstrates that safeguarding requires a multi-faceted approach helps to build self-esteem and personal resilience.

- Healthwatch Barnsley has gathered over 4000 comments about peoples' experiences of health and social care services in Barnsley. Healthwatch Barnsley is supported in its outreach and engagement activity by a team of volunteers called Healthwatch Champions. When undertaking outreach and Healthwatch Champions collect and collate comments from members of the public which help towards the identification of cases where concerns or issues need to be escalated to the service provider, commissioners, safeguarding, regulatory bodies, or the police.

- The Barnsley Clinical Commissioning Group (CCG) has continued to develop its role in Safeguarding Adults within Barnsley. The Chief Nurse at the CCG continues to take the lead for Safeguarding Adults for the CCG, providing statutory representation at the Safeguarding Adult Board. The Chief Nurse also sits on the CCG Governing Body; ensuring safeguarding is represented at the executive level of the CCG.

  A review audit was undertaken in accordance with the Public Sector Internal Audit Standards and completed in respect of the CCG's adult safeguarding systems and processes. The findings highlighted no concerns and a workshop was held to drive forward areas for development such as the CCG's role in ensuring safeguarding is an integral part of the commissioning cycle.

  The CCG have been instrumental in writing a strategy to support the implementation of the Deprivation of Liberty Authorisation work and has provided training to staff on the Mental Capacity Act and Deprivation of Liberty Safeguards.

- The Barnsley Hospital NHS Foundation Trust (BHNFT) has appointed a Safeguarding Adults Professional Lead to lead on the development of the Safeguarding Adults service including the *Prevent* initiative, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards scheme. BHNFT has embraced the Making Safeguarding Personal (MSP) initiative The Trust has also realigned the Trust Safeguarding Adults and Safeguarding Children Steering Groups into one integrated Safeguarding Steering Group under the direct leadership of the Director of Nursing and Quality and the Deputy Director of Nursing.

- The safeguarding of adults at risk from abuse or neglect remains a priority throughout South West Yorkshire Partnership (NHS) Trust. All staff attend the Safeguarding of Adults at Risk from Harm training on induction to the Trust and it is mandatory for staff to access the right level of training for their post with all staff attending refresher training on a three yearly basis.

  Trust policies have been refreshed in light of the Care Act and lessons learnt via adult case reviews and domestic homicide reviews. The Trust expects staff to complete an internal risk assessment each time a member of staff identifies and reports abuse. This year 276 safeguarding alerts were made Trust wide.

- NHS England provides assurance that the local health system, including Clinical Commissioning Groups (CCGs) and designated professionals, are working effectively to safeguard and promote the welfare of children and adults at risk. This role includes ensuring that CCGs are working with their directly commissioned providers to improve services as a result of learning from safeguarding incidents.

  NHS England has the responsibility for sharing learning from safeguarding serious incidents across Yorkshire and the Humber and not just within the services where the incident occurred. The NHS England South Yorkshire and Bassetlaw Safeguarding Forum have met on a bi-monthly basis throughout 2014-15 to facilitate this. Learning has also been shared across GP practices via the Clinical Commissioning Groups. A thematic report of lessons learned is provided on a quarterly basis to the Quality Surveillance Group.

- South Yorkshire police actively contributes to the governance of Barnsley's Adult Safeguarding partnership. The overall strategic lead is provided by the Chief Superintendent who is a member of the Adult Safeguarding Board. The operational groups are supported by other police managers and practitioners where appropriate.

  South Yorkshire Police continue to support the Adult Safeguarding Partnership and play a key role in Domestic Homicide Reviews when necessary. This work also builds on the work carried out around the Domestic Violence, MARAC and MAPPA processes.

- BMBC partners, the Barnsley Clinical Commissioning Group, NHS England, the Barnsley Hospital NHS Foundation Trust, the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and the police have all

delivered extensive staff training in issues related to the safeguarding of vulnerable adults demonstrating an all-round commitment to the safeguarding of adults in their care.

- South Yorkshire Fire and Rescue (SYFR) have carried out over 21,500 Home Safety Checks across South Yorkshire. More than 17,000 were for those considered to be most vulnerable - households where the occupants are very young or elderly, are disabled or have mobility problems. Over 4,000 referrals were made by SYFR partners and SYFR's Vulnerable Persons Advocate continues to deliver Fire Safety talks and presentations to professionals and service user groups.

Priorities 2015 – 2016

14. Key priorities for the Safeguarding Adults Board for the coming year 2015 – 2016 are:

- The Safeguarding Adults Board (SAB) to maintain a clear vision of the outcomes it wants to achieve during 2015 – 2016 through its Safeguarding Adults Strategic Plan.

- To continue effective joint working between the Safeguarding Adults Board (SAB), the Safeguarding Children Board (SCB) and local strategic partners.

- To ensure partner agencies understand their leadership roles, responsibilities and their contributions towards the Safeguarding Adults Board's Strategic plan.

- To ensure full implementation of the requirements of the Care Act 2014 in relation to Making Safeguarding Personal (MSP).

- To ensure full implementation of the requirements of the Care Act 2014 in relation to the production of an Annual Report and a Strategic Plan for each financial year.

- Ensuring the Communication Strategy and the Safeguarding Adults Board Action plan are reviewed and updated in light of the Care Act 2014.

- Ensuring Safeguarding Adults Procedures for South Yorkshire are being implemented across all partner agencies in order to ensure the safety and protection of vulnerable adults.

- To maintain liaison with regional partners to maintain networks in order to share and disseminate good practice across South Yorkshire.

- To ensure that systems are in place, including a clear strategy that incorporates service user and carer involvement in the safeguarding of vulnerable adults.

- To highlight areas of concern through sub group analysis and produce learning outcomes for additional training sessions as required.

- Continue to participate fully in the PREVENT agenda for those who are vulnerable to messages of violent extremism. The Counter-Terrorism and Security Act 2015 requires that all front-line workers are trained to recognise when a person might be susceptible to the messages of violent extremism and radicalisation.

- Encourage multi-agency participation in Domestic Homicide Reviews (DHRs) and Serious Case Reviews (SCRs), now known as Safeguarding Adults Reviews (SARs) and to provide appropriate levels of training to the multi-agency workforce that become involved with DHRs and SARs

- To ensure the Safeguarding Adults Board uses the experiences of those using safeguarding services to drive improvements in services and to provide for quality assurance through the use of regular audits of safeguarding activity and the quality of the work undertaken.

- To ensure the Safeguarding Adults Board drives quality assurance forward through its Performance Management and Quality Assurance Sub-group and ensure there is appropriate evidence that this leads to service improvement.

- Ensure the Safeguarding Adults Board has effective arrangements to identify and secure financial resources to deliver its vision and strategy.

- The Safeguarding Adults Board continues to ensure that a training strategy is in place to include all levels of safeguarding training from basic awareness to the chairing of complex safeguarding adults cases.

Rachel Dickinson
Executive Director, People Business Unit
August 2015

Yvonne Butler
Safeguarding Adults Service Manager
August 2015

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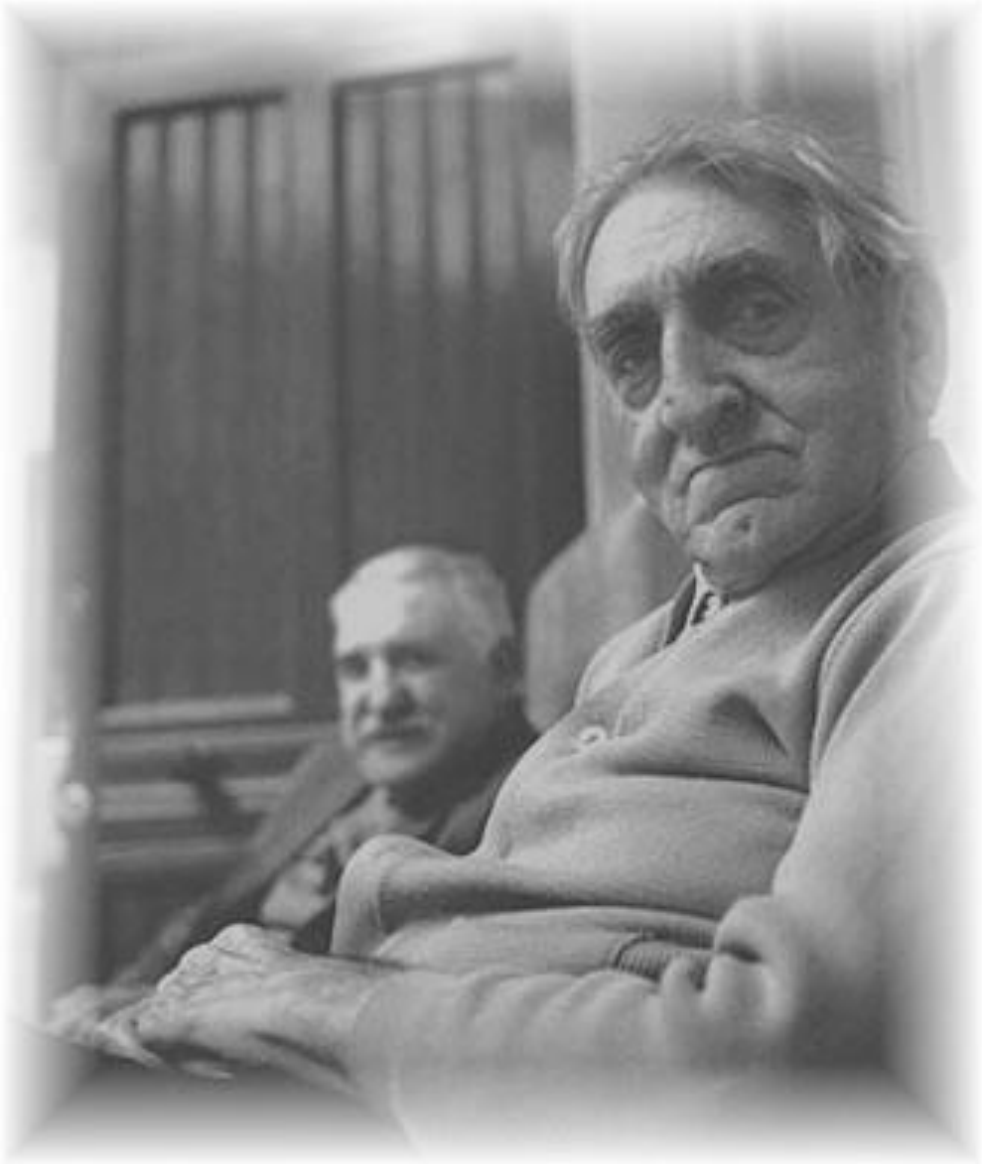
Appendix 2

Barnsley Safeguarding Adults Board

8th ANNUAL REPORT 2014-2015



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FOREWORD BY THE CHAIR

As Chair of the Barnsley Safeguarding Adults Board, I am delighted to commend this, the eighth annual report to you. The report outlines the progress made in 2014-2015 to safeguard and promote the welfare of vulnerable adults in Barnsley.

The Board exists to hold all agencies to account for the work they do to safeguard vulnerable adults in Barnsley. Safeguarding is a partnership activity which requires staff at all levels in all agencies, volunteers, members of the public, families to work together to ensure that adults regardless of their residence are protected from abuse.

The Care Act comes into force in April 2015. This legislation will put safeguarding adult's boards on a strong statutory basis, better placed both to prevent abuse and to respond to abuse when it occurs. Some of our board partners have faced continued change over the last year, and resources remain a challenge in all agencies. However, all partners have continued to remain committed to the safeguarding adult's agenda and partnership working.

The South Yorkshire Safeguarding Adults Consortium consisting of Barnsley, Doncaster, Rotherham and Sheffield, commissioned the re-write of the Safeguarding Adults Procedures for South Yorkshire. The consortium has continued to work on the production of the Procedures and we are expecting a draft for consultation in May 2015.

The Board has continued to work closely with a number of key statutory organisations such as the Clinical Commissioning Group (CCG), the Police, NHS England, Healthwatch and the Care Quality Commission (CQC).
This year the safeguarding service has received a total of 951 safeguarding alerts and of these, 361 alerts progressed to safeguarding referral. This contrasts with the previous year when the service received 700 alerts of which, 367 progressed to referrals.

Of the 361 referrals processed this year, 135 were with respect to male victims and 226 were in respect of female victims.

The Care Act (2014) will place the Safeguarding Adults Board on a statutory footing and the legislation recommends the appointment of an Independent Board Chair. 2013 – 2014 was to be my last year as Chair of the Barnsley Safeguarding Adults Board. I continued to support the Board as Chair until an Independent Chair had been appointed.

I would also like to welcome Bob Dyson, the newly appointed Independent Chair of the Safeguarding Adults Board.

I would like to take this opportunity to thank my deputy chair Councillor Morgan for her continued commitment to Safeguarding and everyone who works within safeguarding adults for their hard work and support throughout my time as Chair.

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CouncillorJenny Platts
Chair of the Safeguarding Adults Board

INTRODUCTION BY THE EXECUTIVE DIRECTOR PEOPLE

The Annual Report for Barnsley Safeguarding Adults Board (SAB) for the period April 2014 to March 2015 outlines progress made against the objectives and plan, providing details of the key achievements, plus looks forward and sets out the challenges and actions planned for the forthcoming year.

With the introduction of the Care Act 2014, to be implemented in April 2015, partnership working is subject to a number of legislative changes. The Care Act will place the safeguarding of vulnerable adults on a statutory footing. New guidance and the re-writing of the Safeguarding Adults Procedures for South Yorkshire, working together with multi-agency partners and in the context of Making Safeguarding Personal (MSP) is more important than ever in ensuring that risk is managed across the sector and that the resources we have are put to best use.

The annual development day, held in conjunction with the Barnsley Safeguarding Children's Board, has again been highly successful as it was well attended by a broad range of stakeholders. Continuing to reinforce and develop more integrated working between Adult and Children's services, to promote the safety and wellbeing of all those who may be vulnerable across the borough, all sectors and agencies. Next year we will see a further integration with Safeguarding Adults and Safeguarding Children operating within a single Business Unit.

The recent appointment of an Independent Chair for the Safeguarding Adults Board will help in underlining the independence of the Board and promote an additional focus to the demands enshrined in the legislative requirements of the Care Act. However, on behalf of Board and all the partner agency members I would like to extend my thanks and appreciation of the hard work and commitment of the outgoing Chair, Councillor Jenny Platts.

Rachel Dickinson
Executive Director People

1 Developments in Safeguarding Adults Work

Developments over the year 2014-2015 in work related to the safeguarding of vulnerable adults are outlined in this section. First, developments at a National level are reported followed by developments at both a regional level and local level are discussed.

The Care Act 2014

The Care Bill became an Act of Parliament after receiving Royal Assent on 14 May 2014. The Care Act 2014 modernises and consolidates the law on adult care in England into one statute and has been described as the biggest change to the law in 60 years. The Act comes into force on 1 April 2015 and sets out how local authorities protect adults at risk of abuse or neglect. Local authorities have new safeguarding duties. The local authority must:

- *Make enquiries*, or cause others to do so, if it believes an adult is experiencing, or is at risk of abuse or neglect. An *enquiry* should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

- *Co-operate* with each of its relevant partners in order to protect the adult. In their turn each relevant partner must also *co-operate* with the local authority.

- *Co-operate* with such other agencies or bodies as it considers appropriate in the exercise of its adult safeguarding functions. These might include general practitioners, dentists, pharmacists, NHS hospitals, housing, health and social care providers.

The Care Act also requires that the safeguarding processes are person-centred, concentrating on an outcomes approach and at all times involving the person in decision-making and helping the person to manage risk. This is known as 'Making Safeguarding Personal' (MSP).

The Act places a duty on the local authority to ensure they establish a Safeguarding Adults Board. It specifies a core membership for the Board and it requires an annual report to be produced which describes the Board's achievements and it also requires that a Strategic Plan is produced for each financial year.

Care Quality Commission (CQC)

The Care Quality Commission (CQC) inspects all health and social care services including hospitals, care homes and dentists. The CQC maintains registers of people eligible to work in care settings as well as care organisations that provide 'regulated services'. In June 2014 the CQC closed its consultation with the public and its partners on a proposed 'new approach' to monitoring and inspection. As a result of the consultation in October 2014 the CQC published a number of 'provider' handbooks which explain how the monitoring and inspection of services will operate.

The main changes to the processes carried out by the CQC were:

- Introducing new ways to inspect services, with Chief Inspectors and more specialist teams that include members of the public.
- Using a new system of intelligent monitoring to help the CQC decide when, where and what to inspect.
- Listening to people's experiences of care and using the best information across the CQC's monitoring system.

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act 2005 (MCA) continues to provide a legal framework for acting and making decisions on behalf of an individual (adults aged over 16 years) who lack the mental capacity to make a particular decision for themselves. Everyone working with or caring for an adult who may lack capacity to make decisions must comply with this Act.

The Deprivation of Liberty Safeguards (MCA/DoLS) was introduced into the Mental Capacity Act 2005 by the Mental Health Act 2007. Full implementation of the safeguards came into effect on 1 April 2009 providing protection for vulnerable adults who lack capacity.

From April 2013 the Local Authority has held full responsibility for the administration and implementation of the Deprivation of Liberty Safeguards.

The main issue regarding DoLS, is that on 19 March 2014, a landmark judgment was made in the Court of Protection which has had an immense impact on this area.

Previously the factors that rendered someone deprived of their liberty in a care home or hospital were many and complex, there was no simple answer to the question of whether any individual was deprived or not. This case, 'Cheshire West' changed everything, in that there is now a straightforward 'acid test' as to whether or not a person is deprived.

The case also broadened the category of those deemed deprived of their liberty, so that whereas in previous years the local authority received around 100 assessments each year, between April 2014 and March 2015 we have received over 750 requests and for the first time have a backlog of referrals, which poses a considerable legal risk. To try to mitigate this, we have extended the DoLS pilot, whereby we have a dedicated team of Best Interest Assessors working full-time on DoLS assessments.

Nationally the picture is similar, and there appears to be no area that has been able to summon the resources to deal with this unprecedented pressure on local authorities. Given that every assessment takes around 10 hours to complete, this continues to be an ongoing problem, with little sign that central government are prepared to address the resource problems.

There is also increased activity in terms of applications to the Court of Protection, for situations in which an individual may be deprived of their liberty, but is not in a CQC-registered resource. This may include young adults in residential schools after the age of 18, Shared Lives or Supported Living.

We have developed a Mental Capacity Act/DoLS strategy and action plan, which is reviewed on a monthly basis. Regular training on the MCA is being provided across all sectors.

DOLS applications, including reviews for the past four years, are shown:

- 2010-11 there were 105 applications
- 2011-12 there were 77 applications
- 2012-13 there were 80 applications
- 2013-14 there were 92 applications

The total number of requests received from various managing authorities for DoLS assessments this year (2014 to 2015) was 750.

As of 1 April 2015 Barnsley has 25 active Best Interest Assessors. Additional statistics in respect of DoLS applications are shown:-

- No. of authorisations granted – 400
- No. of authorisations not granted – 46
- No. of referrals withdrawn – 89

- No. of DoLS referrals resulting in a referral to safeguarding -1
- No. of stacked cases – 185
- No. of cases undertaken for other local authorities – 2
- No. of referrals in progress as at 31 March 2015 – 28

Chief Coroner's Guidance (DoLS)

In December 2014 the Chief Coroner published guidance referring to the question of whether an inquest into a person's death should be held if that person was subject to a Deprivation of Liberty. The Chief Coroner's view was that any person subject to a DoL is 'in state detention' for the purposes of the Coroners and Justice Act 2009. Therefore the death of such a person should be reported to the coroner and the coroner should commence an investigation under section 1 of the 2009 Act.

Domestic Abuse and Domestic Homicide Reviews

A new Home Office definition of domestic abuse was endorsed by the Association of Chief Police Officers in March 2013 and was effective in England and Wales from that date. The definition is inclusive for male and females. It states that;

"any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Revised multi-agency statutory guidance published by the Home Office in June 2013 states that the local authority must hold a domestic homicide review (DHR) when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person who was related to or had been in an intimate personal relationship with the deceased or who is a member of the same household as the deceased".

The purpose of a DHR is to establish what lessons are to be learned regarding the way in which local professionals and organisations work individually and together to safeguard victims and to identify what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

There have been no new Domestic Homicide Reviews undertaken for the period 2014-2015.

Health and Social Care Information Centre:- The Safeguarding Adults Return (SAR)

This year has seen the first full reporting of the Safeguarding Adults Return (SAR) data. Implemented by the Health and Social Care Information Centre (HSCIC) in April 2013, the SAR records information about safeguarding referrals and the Deprivation of Liberty Safeguards (DoLS) reported to it nationally by local authorities.

The SAR data collection is designed to support local authorities to identify areas for improvement.

The SAR data collection for this year (1 April 2014 – 31 March 2015), together with other data related to the performance of the safeguarding service is reported in the annual Performance Management and Quality Assurance Report at Chapter 4 of this report.

Making Safeguarding Personal (MSP)

In March 2014 the Local Government Association (LGA) in conjunction with the Association of Directors of Adults Social Services (ADASS) published the findings of a study into the effect of focussing safeguarding adults work on person-centred, outcome-based principles.

Since that time work has taken place within a number of local authorities, Barnsley included, implementing the principles of MSP.

This approach to the safeguarding of vulnerable people has been further endorsed, and has become a statutory requirement through the implementation of the Care Act 2014.

The *Prevent* Strategy and *Channel*

In October 2012 the government published guidance on how local partnerships should deliver *Channel* projects designed to combat violent extremism and radicalisation. *Channel* is a key element of the Government's *Prevent* Strategy which purposes to stop people becoming terrorists or supporting terrorism**.** *Channel* is a multi-agency approach to protect people at risk from radicalisation. It relies on coordinated activity at a local level and uses existing collaboration between local authorities, the police, statutory partners (such as education and health sectors and social services) and the local community.

The Counter-Terrorism and Security Act 2015, which received Royal Assent on 12 February 2015 brought into force the requirement that local authorities must put in place a multi-agency panel of members with the function of developing an appropriate support package to safeguard those at risk of being drawn into terrorism based upon an assessment of their vulnerability. The panel is responsible for managing the safeguarding risk which is in line with other multi-agency panels where risk is managed, such as Adult Safeguarding panels and Multi-Agency Public Protection Arrangements (MAPPA).

It is also a requirement of the Act that the local authority chair the multi-agency panel which will consist of representatives of the local authority, a chief officer of police and other statutory partners as the local authority deems appropriate.

Multi-Agency Public Protection Arrangements (MAPPA) & Multi-Agency Risk Assessment Conferences (MARAC)

The South Yorkshire Consortium consisting of Barnsley, Doncaster, Sheffield and Rotherham continue to hold monthly multi-agency public protection arrangements (MAPPA) meetings led by the police, to discuss individual cases where persons are deemed to present as a high risk.

The Multi-Agency Risk Assessment Conferences (MARAC) continues to meet twice monthly. The Barnsley Safeguarding Adults Board is represented on MARAC by the Safeguarding Adults Service Manager. The group make decisions regarding cases involving domestic violence.

Partnership working means individuals and organisations working together for a common purpose. Working together brings many benefits including pooling valuable resources and providing more co-ordinated services. Applied to domestic violence, effective partnership working increases safety and minimises risk. In Barnsley the Strategic Domestic Abuse and Sexual Violence Partnership oversees a multi-agency approach to reducing domestic violence in Barnsley.

2 The Safeguarding Adults Board Operational Management Group

The Operational Management Group (OMG)

The Safeguarding Adults Board Operational Management Group (OMG) exists to operationally oversee the work of the Safeguarding Adults Board (SAB) Sub-groups and feeds back progress on each group's action plan and any areas for concern to the Strategic Board (the SAB). The OMG has concentrated its efforts on care homes and nursing homes. The reporting of Low Level Concerns was developed into a pilot taking place throughout the year. The pilot was reviewed with Commissioners and Providers and the system updated following the review. Professionals going into care homes and nursing homes will be alert to identify areas of good practice in the homes as well as identifying areas that need development. Professionals identifying issues will give feedback to the care home manger and the same information will be provided to the Commissioning Team monitoring the contracts. Early feedback suggests that the process is much improved and that there is learning for providers to share.

Other priorities have been focused on Assurance processes. The Safeguarding Adults Board (SAB) last completed a full audit of the Board and its functions in 2009 and on completion of the resulting action plan, the Barnsley Safeguarding Adults Board compared favourably with its regional comparators. Since that time the SAB has undertaken various audits the most recent being the Safer Recruitment Audit currently in progress and due to report in Spring 2015. This will enable recommendations to be included in the Safeguarding Board Action plan 2015 -16.

The OMG reviewed an Assurance/Audit tool that had been developed by the Department of Health and draws on existing standards & inspection frameworks including the Care Quality Commission (CQC) Essential Standards for Quality & Safety, the Association of Directors of Adults Social Services (ADASS) Standards for Adult Protection & the NHS Outcomes Framework. The tool aims to ensure that there is a common purpose to safeguard adults whose circumstances place them at risk and to protect them from avoidable harm across the different sectors in Barnsley, which includes health, the police and local authorities.

Safeguarding MCA/DoLS Training Sub Group

The SAB MCA/DoLS (Mental Capacity Act/Deprivation of Liberty Safeguards) Training Sub Group meets bi-monthly to identify, develop and maintain safeguarding training processes for statutory, independent and voluntary sectors. The Training Sub Group considers a training strategy which meets the needs of all partner agencies working collaboratively across South Yorkshire. In March 2014 bespoke MCA Compliant Record Keeping training was developed for all providers, this incorporates the Principals of the Care Act 2014. An evaluation audit will be developed to record the effectiveness of the training in practice. The Sub Group reports training attendance figures to the Safeguarding Adults Board quarterly and annually.

3 Reports from Local and Regional Partners

Berneslai Homes

Berneslai Homes' primary contribution to Safeguarding is via our established Vulnerability Strategy: 'Something Doesn't Look Right'. Through this approach, we provide practical support and interventions to address identified issues which, without our contribution could escalate to other services for example social care or the police. Our strategy aims to ensure the early intervention of risks during routine visits to thousands of homes within the Borough, at the start of tenancies and at various times throughout them. For example, we are able to provide practical support, make referrals to other appropriate support providers and carry out housing application assessments as part of our response to the early identification and intervention with our tenants in need.

Berneslai Homes continue to undertake proactive visits to Council properties specifically to identify any support or vulnerability issues early. During the last year we carried out 5000 support visits, 1000 of which resulted in supportive interventions. This includes over 300 for families, 12 of which there were concerns around the safety of children. During the year we have carried out over 1500 visits to vulnerable individuals affected by the advent of Universal Credit and continued to support those affected by welfare reform.

Berneslai Homes Family Intervention Service (FIS) provides cross tenure intensive family support to families with multiple and complex needs. The FIS continues to make significant progress in achieving positive outcomes for families under the Troubled Families Programme; supporting over 200 families with multiple and complex needs during the last year. The primary aim is to secure and sustain clear behavioural change, thus reducing the effect of a family on the surrounding community. Positive changes are evidenced through reduced antisocial behaviour and criminality, addressing worklessness and improving progress to work, and improved opportunities for children through better school attendance. Families are allocated dedicated keyworkers, delivering an evidence based approach of early intervention/prevention, non-negotiable support and enforcement in order to provide families with a positive incentive to change.

Public Health (BMBC)

Following Royal Accent of The Health and Social Care Act (2012) Public Health responsibilities and functions returned to Local Authorities from the NHS. Throughout this transition period Public Health have continued to commission and work with partners on a broad spectrum of programmes which impact on the health, wellbeing and safeguarding of the population across the life course. The diverse programmes of work which make up the Public Health contribution to the prevention of people becoming susceptible to vulnerability include:

- Commissioning of 0-19 years Healthy Child Programme
- Administration and chairing of the Child Death Overview Panel
- Emergency preparedness and resilience
- Health Checks
- Health Protection
- Oral Health Promotion
- Safeguarding
- Commissioning integrated sexual health services

BMBC Public Health will focus on physical activity public health initiatives which contribute to the welfare of our population, demonstrating a wider community approach to reducing the number of vulnerable adults within our Borough.

During 2014/15 Barnsley played host to part of the world famous Tour de France which was a great influence on raising physical activity levels across our population, this has been recognised as a key tool to tackle a range of challenges facing individuals across the Borough. Leading a physically active lifestyle offers the potential to improve both physical and mental health and improve life expectancy (Chief Medical Officer 2011). Public Health BMBC has provided expertise and guidance on a number of agendas to improve and increase opportunities for people to lead active lifestyles. Outlined below are some key pieces of work which demonstrate Public Health outcomes on reducing health inequalities which impact on the most vulnerable people in our community.

Tour de France (TdF) Legacy Group

Over the last 12 months through our TdF legacy group we have delivered a wide variety of cycling related, events, training and infrastructural improvements – below are some headline outcomes:

- Made 345 local cycling opportunities available for local people to take part in.
- Provided 280 adult cycle training courses - 496 adults took part.
- 182 residents and employees loan a bike through Barnsley's Cycleboost scheme.
- Installed 128 Sheffield Cycle Stands in business across the Borough.
- Installed 2 community bike pumps.
- Made 16 adaptive bikes more accessible by organising the transfer of these bikes from Barnsley FC to Cycle Penistone.
- Delivered 20 Sky Ride Local Rides – attracting 123 participants with a campaign reach of 1800.
- Over 30 volunteers have been involved in the project - donating over 10,000 hours of time.

We have delivered 2 major cycling events:

- The Tour de France 2014 – 60,000 spectators line the route through Barnsley Borough.
- Town Centre Criterium Race in 2014 – attracted 160 participants and over 2000 spectators.

In order to deliver services, Public Health work in synergy with a wide range of partners both internal and external to the council, these include:

- Barnsley Clinical Commissioning Group
- South West Yorkshire Partnership Foundation Trust
- Team Activ
- Active Barnsley
- Health Trainer Service
- Cycle Yorkshire
- Barnsley Premier Leisure
- Barnsley Football Club
- Barnsley College
- South Yorkshire Sport
- Shaw Lane Community Sports Centre
- BMBC – Education, Children and Young People, highways, transport
- Barnsley Health and Wellbeing Board
- Racescene
- Planet X

The commitment from partner organisations demonstrates the extent to which value is

placed on the health, wellbeing and reducing the number of vulnerable people within our population.

Inspiring Volunteering

As well as the volunteers who played a vital part in the success of the 'Barnsley leg' of the TdF, Public Health BMBC have been working alongside Voluntary Action Barnsley to develop a model to reduce social isolation in older adults using volunteers. Workshops have been planned to scope out how a model would work in practice and to develop pathways to support delivery. The forward plan is to identify the 'pinch points' when our residents are more likely to feel socially isolated and vulnerable, such as discharge from secondary care and following bereavement.

Physical Activity Care Pathways (PACP)

For our population who may find it difficult to take part in conventional exercise, the PACP delivers an array of physical activity sessions across Barnsley for people with long term conditions such as diabetes, cancer, arthritis and many more. It runs over 25 sessions a week, totalling over a 1000 sessions since the launch of the programme in April 2014. We have had 330 referrals from a range of health professionals such as nurses, GPs, physiotherapists and dieticians. The activities on offer range from community walking groups, tai chi classes and even gym based activity to help patients improve their health and help with self-management of their conditions. Service users over 65 years of age are also referred to postural stability classes which contribute to protecting against falls.

Raising participation in physical activity across the Borough is one part of the wide and varied portfolio of work which falls under the Public Health scope of responsibilities. This demonstrates that safeguarding requires a multi-faceted approach and that the acquisition of social capital, taking part in team activities and volunteering to help others helps to build self-esteem and personal resilience.

Healthwatch Barnsley

During the past 24 months Healthwatch Barnsley has engaged with 8,800 individuals including Children and Young People and through this activity have gathered over 4000 comments about their experiences of health and social care services.

Healthwatch Barnsley is supported in its outreach and engagement activity by a team of volunteers called Healthwatch Champions. Each of our champions is at different levels of involvement and development, due to the date they joined with us.

The training they are able to access includes:

- Enter and View.
- Adult Safeguarding.
- Children's Safeguarding.
- Mental Capacity Act and Deprivation of Liberty Safeguards.
- Equality and Diversity.

We also look for training that will support member's awareness of a range of subjects for example:

- Sensory Awareness Training.
- Dementia Awareness Training.

When doing outreach and engagement activity Healthwatch Champions support us in collating comments from members of the public.

Each comment received by the Healthwatch team will be checked and analysed for concerns affecting a person's:

- Dignity
- Discrimination

- Safety
- Neglect

This helps us to identify when a comment, experience, concern or issue requires escalation, to the service provider, commissioners, safeguarding, regulatory bodies, and the police.

Feeding In Your Views

Healthwatch Barnsley has a number of ways in which we can feed in your views.

Firstly if you wish to submit a complaint we can provide you with the information you need to do this directly with the provider or we can signpost you to a local organisation with whom we work closely.

DIAL holds the NHS and Social Care Complaints Advocacy Service here in Barnsley, and will support you to navigate NHS and Social Care complaints systems.

Healthwatch Barnsley collates information and signposts but does not support with individual complaints.

Healthwatch gathers information and detail to form trends, and meets on a regular basis with the quality leads from health and social care organisations. At these meetings we are able to find out what is happening with providers and commissioners as well as feed in your views and any trends being identified to encourage change.

Healthwatch Barnsley have a seat on the Local Adult Safeguarding Board, Health and Social Care Intelligence Sharing Meetings and on the Regional Quality Surveillance Group for South Yorkshire and Bassetlaw, meaning that we have an in depth view of what is happening to maintain safety and quality at a local and regional level and have opportunity to feed patient view into these processes.

Not forgetting that Healthwatch Barnsley is part of a network of 152 local Healthwatch organisations, supported by a national organisation called Healthwatch England. Healthwatch England analyses the information we collate and escalates issues at a national level to identify national trends and inform government policy.

BARNSLEY Clinical Commissioning Group (CCG)

Since becoming formally responsible for buying and developing health services for local people, Barnsley Clinical Commissioning Group (CCG) has continued to develop its role in Safeguarding Adults within Barnsley. The Chief Nurse at the CCG continues to take the lead for Safeguarding Adults for the CCG, providing statutory representation at the Safeguarding Adult Board. The Chief Nurse also sits on the CCG Governing Body; ensuring safeguarding is represented at the executive level of the CCG. The Named General Practitioner for Adult Safeguarding is employed by the CCG and attends the Safeguarding Adult Board.

In September 2014 the CCG restructured its Quality Team, creating a senior safeguarding and patient experience Designated Nurse post to enable dedicated strategic oversight of Adult Safeguarding going forward. This new post will enable the CCG to provide strengthened leadership to the Adult Safeguarding Operational Management Sub group in order to support the Board in the delivery of its work streams.

The CCG is responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards adults at risk of abuse or neglect. The assurance required from organisations is gained using a variety of methods, including assurance visits, contract monitoring and Key Performance Indicators. Any concerns are addressed through contract review meetings.

The CCG becomes involved in safeguarding process where it is perceived that there is a need for oversight in relation to health care issues. This involvement and clinical leadership provides assurance to both adults at risk and healthcare providers that the process is supportive, effective robust and impartial. The future challenge is to ensure that the CCGs skills and knowledge are used effectively to support change and improvement where it is required.

The CCG maintain effective oversight of safeguarding issues in Continuing Health Care placements. The Continuing Health Care Team performs 'safe and well checks' when concerns are raised in relation to the quality of care provided for people with a primary health need.

A review audit has been completed in respect of the CCG's adult safeguarding systems and processes. The review examined the effectiveness of the controls in place and was undertaken in accordance with the Public Sector Internal Audit Standards. The CCG demonstrated that is has appropriate systems for discharging responsibilities in respect of safeguarding. The findings highlighted no concerns and a workshop was held to define and drive forward areas for development such as the CCG's role in ensuring safeguarding is an integral part of the commissioning cycle.

The CCG hosts intelligence sharing meetings with Healthwatch about commissioned providers, the intelligence is utilised to triangulate all available information and to note any developing lines of enquiry that need to be pursued. Where appropriate this is also shared at the wider intelligence sharing meeting held by the Local Authority and also attended by the Care Quality Commission. The CCG Adult Safeguarding Designated Nurse attends the safeguarding steering groups of the two main commissioned providers (Barnsley Hospital NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust). This enables the CCG to drive forward the adult safeguarding agenda, discuss and escalate any concerns.

The CCG networks on a regional level through attendance at forums and meetings enabling a sharing of learning, experience and best practice with both providers and other CCGs across Yorkshire and the Humber.

In conjunction with NHS England the CCG has a role in supporting the development of safeguarding in Primary Care. Over the past year the CCG provided Adult Safeguarding training to 104 GPs and this work will continue going forward. 100% of CCG staff received level one adult safeguarding training this year, together with bespoke training for the Governing Body members.

The CCG have been instrumental in writing a strategy to support the implementation of the Deprivation of Liberty Authorisation work and has provided training to staff on the Mental Capacity Act and Deprivation of Liberty Safeguards.

The CCG's key responsibility for safeguarding adults can be summarised as assurance, leadership and partnership. These areas mean that safeguarding adults and the prevention of harm to vulnerable adults and the intelligent use of the Mental Capacity Act continue to be a priority for the CCG.

Barnsley Hospital NHS Foundation Trust (BHNFT)

Barnsley Hospital NHS Foundation trust (BHNFT) continues to be committed to safeguarding vulnerable adults and has made significant improvements to systems and processes that enable the Trust to identify vulnerabilities in adults who access the Trust services.

The Trust is committed to the Making Safeguarding Personal initiative and engagement with prevention, early recognition of vulnerabilities and learning from Safeguarding Adult enquiries arising from concerns raised.

Supporting this approach is the commitment to increase safeguarding adult awareness and knowledge in all Trust staff by delivery of Safeguarding Adult mandatory training and additional learning approaches to meet the diverse needs of clinical areas and staff profiles.

Developments

- The appointment of a Safeguarding Adults Professional Lead to lead on the development of the Safeguarding Adults service which includes the Prevent initiative, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards scheme, and the performance of the Mental Health Act 1983.
- The notification of internal Safeguarding Adults cause for concerns onto the Trust Datix system which is open to audit by the Risk Management Team.
- Engagement with the Making Safeguarding Personal initiative and the implementation of the Care Act 2014 with particular reference with the Chapter 14 requirements of the Care and Support Statutory Guidance.
- Realignment of the Trust Safeguarding Adults and Safeguarding Children Steering Groups into one integrated Safeguarding Steering Group which sits within the corporate nursing team under the direct leadership of the Director of Nursing and Quality and the Deputy Director of Nursing.
- The Safeguarding Steering Group now reports directly into the Quality and Governance Committee which is a sub-committee of the Trust Board which is chaired by a Non-Executive Director and has Executive representation.

Safeguarding Assurance

- The Trust is developing its process for performance monitoring and quality assurance on Safeguarding Adults activity and the learning from safeguarding enquiries.
- The Trust has evidenced its compliance with quality assurance through the submission in June 2014 of the CQC Provider Compliance Assessment Exception Report in accordance with Outcome 7, Regulation 11 – Safeguarding people who use services from abuse.
- The Trust is working closely with the Performance & Quality Assurance sub-group of the Barnsley Safeguarding Adults Board to improve quality on assurance reporting and inter-agency strength.

Safeguarding Partnership Working

The Director of Nursing and Quality is the Trust executive lead for Safeguarding Adults.

The Deputy Director of Nursing is the Trust strategic lead for Safeguarding Adults and represents the Trust on the Barnsley Safeguarding Adults Board.

The operational lead within the Trust is the Lead Professional Safeguarding Adults and the post-holder represents the Trust on the sub-groups of the Board.

The Lead Professional Safeguarding Adults is supported by the Learning Disability Liaison Nurse whose primary responsibility is to deliver a learning disability service across all areas of the Trust.

Safeguarding Adults Activity

During 2014-2015 there were 1,210 formal and informal safeguarding alerts. Of this total 351 met the threshold for formal investigation with 262 referrals being made to district teams via the Barnsley Safeguarding Adults Office and 89 referrals leading to internal investigations.

Mental Capacity Act 2005 & Deprivation of Liberty Safeguards scheme Activity

During the year 2014-2015, 71 Urgent Authorisations were awarded under the DoLS scheme. In addition there were 40 DoLS related queries which did not warrant use of the DoLS scheme. There were 26 Best Interests Decision Meetings facilitated.

The year has also evidenced a marked increase in requests for advice and guidance relating to issues of consent to treatment, the assessment of mental capacity regarding decision making, the formulation of best interest's decision making, and the use of positive and proactive care requiring the use of restraint and restriction.

The Trust is fully compliant with the Care Quality Commission (Registration) Regulations 2009: Regulation 18(2) Notification about an application to deprive a person of their liberty.

Deprivation of Liberty Safeguards	**2013–2014**	**2014–2015**
Urgent Authorisations awarded (Data does not include extensions and Standard Authorisations) The numbers of DoLS applications have steadily continued to rise following the Cheshire West judgment in March 2014, across the country. In Barnsley we have undertaken extensive training in both healthcare and residential settings. This has resulted in agencies being made more aware of their legal obligations and hence the no. of urgent DoLS has significantly increased. We are now averaging around 80 DoLS referrals per month- prior to Cheshire West we carried out just over 100 assessments per year. Barnsley's situation is not out of the ordinary.	**19**	**71**
DoLS queries (Not necessarily leading to an Authorisation being awarded)	**N/A**	**40**
Best Interests Decision Meetings facilitated	**N/A**	**26**

Mental Health Act 1983 Activity

During the year 2014-2015 the Trust has developed its role within the Service Level Agreement developed with the South West Yorkshire Partnership Trust, Barnsley Business Delivery Unit, to provide performance of the Act within the hospital.

The Trust was subject to a themed mental health crisis care pathway CQC inspection in February 2015.

Prevent Activity

During 2014-2015 the Trust has fully engaged with the Prevent initiative and has assimilated the statutory requirements of the Counter-Terrorism and Security Act 2015.

The Trust has reported its activity to the Prevent Regional Coordinator on a monthly basis as required and is an active participant of the Regional Prevent Group.

Learning Disability Activity and Training

During the year 2014-2015 the Learning Disability Liaison Nurse (LDLN) has continued to develop close working relationships with the Community Learning Disability Services and has led on behalf of the Trust on the Learning Disability Commissioning for Quality and Innovation (CQIN) payment. Progress in these areas is reported to the Safeguarding Steering Group. Key drivers include:

- Compliance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards scheme.
- Compliance with the Equality Act 2010.
- The making of reasonable adjustments.
- Reduction in the length of stay for patients with learning disabilities and improving the patient experience.
- Coding and identification of patients with learning disabilities through the use of alerts on the Lorenzo system.
- Improving the care pathway of patients with learning disabilities.
- Development of the 'All About Me' patient document.
- Delivery of mandatory, induction, and speciality training.

Current and Projected Developments for 2015-2016:

Safeguarding Adults

- Delivery on the Chapter 14 provisions of the Care Act 2014.
- Consolidate the Making Safeguarding Personal initiative into practice.
- Incorporation of the Prevent strategy is embedded into Safeguarding Adults processes.
- Ensure the Trust Safeguarding Adults Policy reflects the provisions of the Care Act 2014, Making Safeguarding Personal, and the revised Safeguarding Adults Procedures for South Yorkshire.
- Audit of the 89 formal Safeguarding Adults referrals investigated within the Trust to learn the lessons and report these back to the CBUs and professionals affected.
- Development of the Trust internet and intranet sites to provide a platform of guidance and support across Safeguarding Adults, Mental Capacity Act and the Deprivation of Liberty Safeguards scheme.
- Development of 'Fingertip Fact' sheets to support safe, sound and informed

practice across Safeguarding Adults, Mental Capacity Act and the Deprivation of Liberty Safeguards scheme.

- Strengthening the links between Safeguarding Adults and complaints and incident investigations.
- Build on developments to the Datix system and systemised methods of capturing data on safeguarding adults activity.
- Support for the sub-groups of the Safeguarding Adults Board.
- Support to the MAPPA, MARAC and Channel multi-agency working groups.

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

Last year a review of the group's function took place resulting in a Safeguarding Adult Board report and discussion regarding the group's future direction. It was agreed to link the practice learning element with the existing Safeguarding Adult Peer Support Network, currently led by SWYFT, and develop a new multi-agency group which will focus on communication issues and public awareness of adult safeguarding.

The resulting group will be developed to look at

- National and local cases for Safeguarding and MCA/DOLS, strengthening the link to learning from DOLS cases.
- Discuss policy and procedure issues.
- Learning from audit recommendations.

Due to unforeseen circumstances there was a delay in fully launching this group. A new chair was recently appointed and the group will re launch in May 2015.

Safeguarding of adults at risk from abuse or neglect remains a priority throughout South West Yorkshire Partnership (NHS) Trust. The Trust has a variety of training available for staff and volunteers which includes abuse awareness, prevention of radicalisation, and awareness of domestic abuse. All staff attend the Safeguarding of Adults at Risk from Harm training on induction to the Trust and it is mandatory for staff to access the right level of training for their post. All staff attend refresher training on a three yearly basis. This year the percentage of staff up to date with safeguarding training is in excess of 80%.

Trust staff and partners have had access to workshops around complex issues such as Human Trafficking, presented by Hope for Justice and the prevention of radicalisation presented by West Yorkshire Police.

Trust policies have been refreshed in light of the Care Act and lessons learnt via adult case reviews and domestic homicide reviews. Staff work within the multi-agency Safeguarding Policy and Procedures and easy access to Policies and safeguarding information is available through the Trust intranet. The Trust expects staff to complete an internal risk assessment each time a member of staff identifies and reports abuse. This year 276 alerts were made Trust wide.

Safeguarding team activity has been reviewed by an independent author and the staff compliment has been extended to include a safeguarding adults adviser.

Priorities for next year include continuing to deliver support to services around the whole Trust agenda ensuring that adults at risk remain the priority. The Safeguarding Adults and Children's team will be working to promote the Prevent agenda and ensure staff are well informed in relation to Female Genital Mutilation.

NHS England

The overall responsibilities of NHS England in relation to safeguarding

NHS England was established on 1 April 2013 and has an assurance role for local health systems and directly commissions some services. NHS England has worked with Clinical Commissioning Groups (CCGs) to ensure their commissioned providers take all reasonable steps to reduce serious incidents. NHS England provides assurance that the local health system, including (CCGs) and designated professionals, are working effectively to safeguard and promote the welfare of children and adults at risk. *(Safeguarding Vulnerable People Accountability and Assurance Framework, NHS England 2013).* This role includes ensuring that CCGs are working with their directly commissioned providers to improve services as a result of learning from safeguarding incidents. These services include acute, community, mental health and ambulance care.

NHS England responsibilities in relation to direct commissioned services

NHS England is responsible for driving up the quality of safeguarding in its directly commissioned services and for holding these providers to account for their responses to serious safeguarding incidents, ensuring that safeguarding practice and processes are optimal within these services. In Yorkshire and Humber, this includes all GP practices, dental practices, pharmacies, optometrists, health and justice services and the following public health services:-

- National immunisation programmes.
- National screening programmes.
- Public health services for offenders in custody.
- Sexual Assault Referral Centres.
- Public health services for children aged 0-5 years (including health visiting, family nurse partnerships and much of the healthy child programme).
- Child health information systems.

From April 2015 onwards, NHS England will commence a programme of transferring responsibility for GP practices (and eventually all other primary care providers) to CCGs with delegated powers of co-commissioning.

NHS England has worked in partnership with local Safeguarding Boards to ensure that the NHS contribution is fit for purpose and that there is no unnecessary duplication of requests for safeguarding reviews to be undertaken. NHS England also has its own assurance processes in place concerning NHS safeguarding reviews, learning and improvements.

Sharing learning from safeguarding reports

In order to continuously improve local health services, NHS England has responsibility for sharing learning from safeguarding serious incidents across Yorkshire and the Humber and more widely, making sure that improvements are made across the local NHS, not just within the services where the incident occurred. The NHS England South Yorkshire and Bassetlaw Safeguarding Forum have met on a bi-monthly basis throughout 2014-15 to facilitate this. Learning has also been shared across GP practices via the Clinical Commissioning Groups. A thematic report of lessons learned is provided on a quarterly basis to the Quality Surveillance Group.

Training programme for general practice

Designated safeguarding professionals are jointly accountable to Clinical Commissioning Groups and NHS England. They have overseen the provision of level 3 training for primary care medical services. Training sessions have been provided on a locality

basis rather than to individual practices. The main source of training for other primary care independent contractors has been via E-learning training packages.

Key Performance Indicators

On behalf of the NHS England South Yorkshire and Bassetlaw Safeguarding Forum, the Adult Safeguarding Nurses across South Yorkshire and Bassetlaw have developed a set of Key Performance Indicators (KPIs) that have been incorporated into all the acute and secondary care provider contracts for 2014/15.

MCA/DOLS

NHS England South Yorkshire and Bassetlaw have provided funding for the Clinical Commissioning Groups (CCGs) to commission the local acute and mental health hospital Trust providers to undertake a self-assessment against the "MCA a guide for CCGs and other commissioners of healthcare services on commissioning for compliance" (April 2014). The providers have been asked to produce an action plan to address gaps identified and a plan as to how they will provide future assurance to their CCGs in 2015/16.

NHS England South Yorkshire and Bassetlaw have also provided the CCGs with funding to hold MCA/DOLS awareness raising workshops with Primary Care staff (GPs, nurses, Practice Managers & reception staff).

Child Sexual Exploitation

The Designated Nurses supported by NHS England, South Yorkshire and Bassetlaw hosted a national learning event on 18 September 2014 in Sheffield - 'Exploring Exploitation and Sexual Abuse'. The conference was aimed at providing level 4 and 5 training for safeguarding leads to enable them to provide specialist advice to practitioners and colleagues within provision or commissioning. The object of the day was to have increased understanding of the potential, personal impact when working with victims of sexual exploitation and sexual abuse, to understand the mind-set of perpetrators and work more effectively with safeguarding partners to plan, design and deliver local training on sexual exploitation.

South Yorkshire Police

South Yorkshire Police actively contributes to the governance of Barnsley's Adult Safeguarding partnership. The overall strategic lead is provided by Chief Superintendent, the Barnsley Local Polling Unit Commander who is a member of the Adult Safeguarding Board. The operational groups are supported by other police managers and practitioners where appropriate.

Within the period of 2013 to this current year South Yorkshire Police has seen an increased investment in the staffing and resources of their Public Protection Units (PPU), linked to one of their three strategic objectives namely Protecting Vulnerable People. Barnsley PPU, based at Wombwell Police Station has seen additional staff provided in the form of a dedicated Safeguarding Adults Officer and additional staff to support adult safeguarding investigations and domestic violence. The South Yorkshire Police PPU structure has moved to become a centrally managed and locally delivered system with central management providing policy guidance,

strategic direction and specialist advice. However local delivery of service is maintained through daily partnership work with Barnsley Safeguarding Partnerships and Social Care.

South Yorkshire Police continue to support the Adult Safeguarding Partnership and play a key role in Domestic Homicide Reviews when carried out, these lead to increased learning and the development of policies and processes to ensure vulnerable adults are protected. This work also builds on the good work carried out around Domestic Violence, MARAC and MAPPA processes.

Summer 2015 - a dedicated Safeguarding Adults Team will be established at Barnsley that will incorporate Adult Safeguarding Investigators. This unit will be part of Barnsley PPU but will focus on Adult Safeguarding including vulnerable adults and domestic violence. This unit will be managed by an additional Detective Inspector.

Headquarters PPU and Crime Training provide training on adult safeguarding on a force-wide basis. South Yorkshire Police have delivered training to all front line staff around Adult Protection, Mental Health Issues and the Mental Capacity Act via the Street Skills Training Programme. Internal policies and guidance documents have been amended/developed to reflect new legislation and emerging best practice providing continuous guidance to staff. The College of Policing who are responsible for all aspects of continuing police training and development are in the process of developing Authorised Professional Practice for all areas of Public Protection, Adult Protection being such an area of business. Once this training has been provided to all forces it will be rolled out to all relevant staff.

A dedicated Mental Health section has been created and is available to all staff via the forces Intranet site, providing guidance and advice together with contact details for specialist support. Additionally the force has established dedicated posts both at a force level and also local levels to address and promote the Adult Protection and Mental Health Agenda. A Force Lead has been identified together with a dedicated Force Mental Health and Integrated Offender Manager at Inspector level and a Force Mental Health Coordinator, Police Constable, linking into District Mental Health Single Point of Contact (SPOC's) to manage and drive forward work around Adult Protection and Mental Health.

Barnsley Police and South West Yorkshire Partnership Foundation Trust (SWYPFT) are currently piloting a mental health triage response vehicle to respond to calls for help to the police from individuals suffering a mental health crisis. The mental health triage response utilises a dedicated police officer and mental

health nurse, working together to respond to incidents and assess the needs of the individual in crisis. They can provide immediate support, advice, signposting and if needed a full mental health assessment. This has been successful in reducing the unnecessary use of section 136 Mental Health Detentions, reduced the use of A&E, police custody and ambulances for people suffering mental health issues. The main benefit is that the person in crisis receives the best possible care from a heath care professional as soon as possible.

South Yorkshire Fire & Rescue

[Note: The South Yorkshire Fire and Rescue's (SYFR) report necessarily refers to all localities, Barnsley, Doncaster, Rotherham and Sheffield].

Strategy
The SYFR 2013 – 2014 Prevention & Protection Strategy included cross cutting themes related to inclusion, partnerships, safeguarding and education. The focus is on developing best practice in targeting the most vulnerable to reduce the numbers of fire related deaths and injuries.

Policy
The Safeguarding Guidance & Procedures have been reviewed and rewritten in a format that will make it easier for the reader to follow.

In response to the increasing number of cases where a high risk of fire is identified a new guidance document has been drafted to provide an agreed process for the "Management and Coordination of High Fire Risk Home Safety Checks". This will require a multi-agency approach and joint ownership with relevant partners to manage the risk to the individual and particularly where there is a risk to others.

Fire Safety
A total of 21,544 Home Safety Checks were carried out across South Yorkshire, 17,384 were for those considered to be most vulnerable e.g. households where the occupants are very young or elderly, are disabled, have mobility problems and/or lifestyle increases the risk of fire. 4,182 referrals for the latter came from our partners and our Vulnerable Persons Advocate continues to deliver Fire Safety talks and presentations to professionals and service user groups e.g. Falls Prevention Group.

Fire Fatalities
SYFR has now established an internal process for responding to and learning lessons following a Fire Death or Serious Injury. A number of cases over the last 2 years have been subject to a Serious Case Review and recommendations from Internal Management Reviews have led to significant improvement in the way our fire risk assessments are carried out.

Adult Safeguarding Alerts & Referrals
Our annual total for April 2014 – March 2015 for all Adult Safeguarding Alerts across South Yorkshire was 94, a considerable increase from 54 cases in April 2013 – March 2014. The majority of these were as a result of a Home Fire Safety check, but some were from fire incidents. Many cases were linked to self-neglect and/or hoarding and for some of those in Sheffield the Vulnerable Adults Risk Management Meeting (VARMM) process was initiated. In 6 cases a perpetrator was identified and a Safeguarding Alert/Referral processed (e.g. theft). Some of the remaining cases were related to: -

- Alcohol intoxication
- Physical disability/mobility problems
- Mental Capacity/ Dementia
- Learning Disability

For these, support from other services was requested

Safeguarding Training
In 2014 – 2015 SYFR staff received Safeguarding Training as follows: -

- Induction = 42 (plus 30 Volunteers)
- Introductory = 22
- Refresher = 71

A programme of Safeguarding Update & Refresher training has been piloted with Community Safety staff and is currently being rolled out to Operational Fire Fighters throughout 2015 – 2016.

Northern College

(August 2013 to July 2014 – Educational Year)

Safeguarding Arrangements in Northern College

Northern College have a designated person responsible for safeguarding at the college. The college also has a designated Safeguarding Children's Officer to link with transitions to Adult Services.

A safeguarding group, comprising the designated people, the Personnel Manager, Head of Library, Learning Technologies and Student Support, Student Services Coordinator, two members of the teaching staff and a student representative, meets termly.

Summary of Safeguarding Training
All staff have been directed to undertake safeguarding training via LSIS (the Learning and Skills Improvement Service). All staff have been asked to undertake introductory modules on safeguarding and in addition staff involved in staff and student recruitment have been asked to undertake modules on safeguarding and safer recruitment. The training is carried out through online modules or in facilitated sessions on campus. After three years staff are required to undertake refresher training via the online modules.

In the period August 2013 to July 2014 a total of 72 staff have undertaken this training, including 23 sessional tutors. All full and part-time staff are up to date with their training.

Single Central Record of Recruitment and Vetting Checks
The single central record was inspected by Ofsted as part of the college's June inspection. The record was found to be up to date and compliant with requirements. The inspection report stated that:

"The college meets its statutory requirements for safeguarding students. Safeguarding is promoted well to students, staff and visitors through posters and quick reference guides attached to identity badges. Students feel safe on college premises."

Number of incidents recorded
In the period ending 31 July 2014 a total of nine potential safeguarding incidents were referred to a designated person. This compares with five in the previous year. Of the nine referrals two involved seeking the advice of external agencies. In all of these cases the College liaised closely with the relevant social services assessment team or the police as appropriate.

Carer Involvement with the Safeguarding Adults Board

Margaret B, who has been a carer for many years, has continued in her role of Carers Representative on the Safeguarding Adults Board (SAB). Margaret has always recognised that the safeguarding of vulnerable adults is not just a reactive service but its main focus is on the prevention of abuse.

Margaret continues to work above and beyond her considerable caring duties showing a real dedication to representing Barnsley carers on the Barnsley Safeguarding Adults Board.

Barnsley Safeguarding Adults

Performance Management & Quality Assurance Sub-group

Annual Performance Report: April – March

2014/15

Introduction

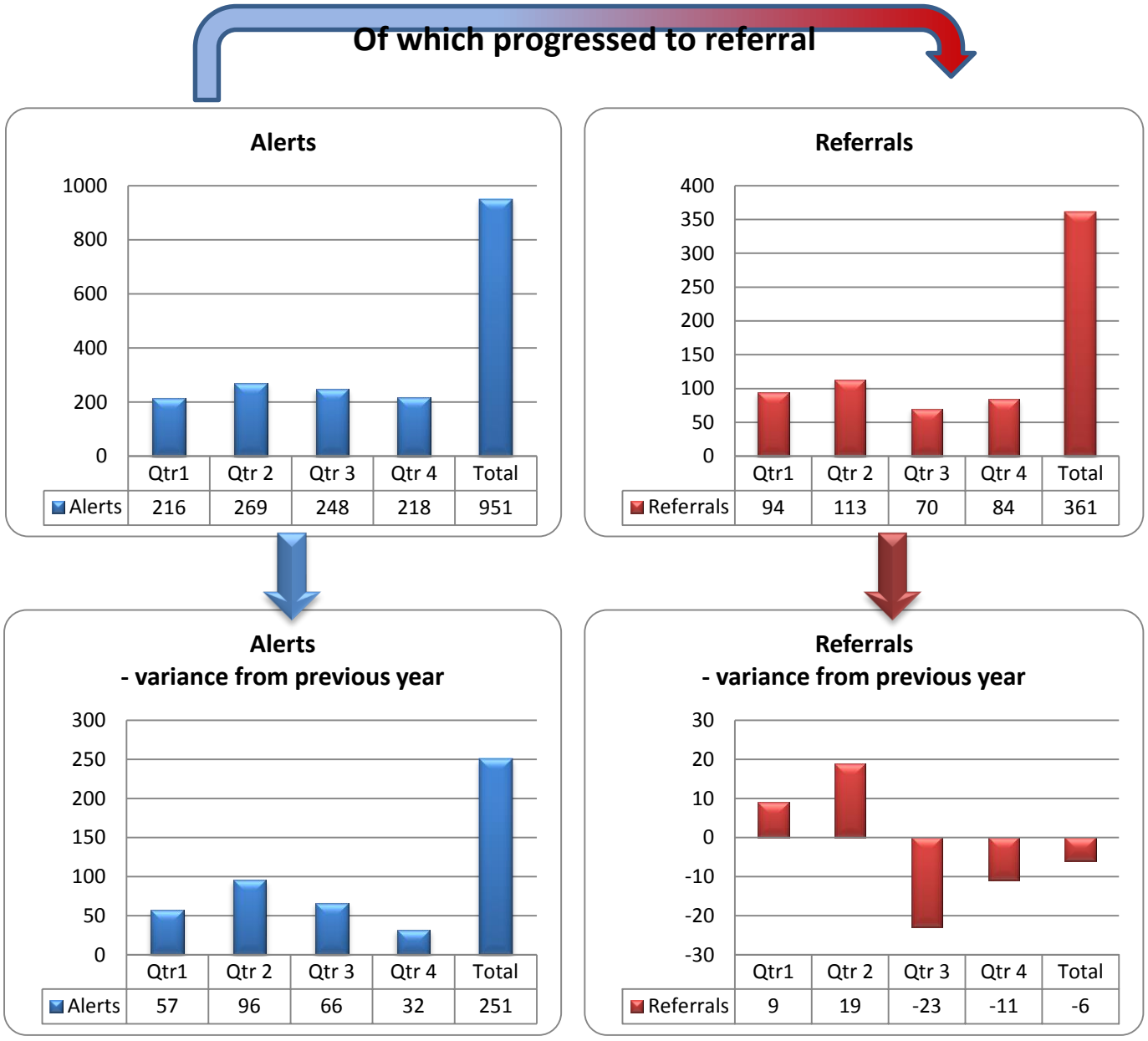
The safeguarding information contained within sections 1 to 4 of this report relate to new safeguarding incidents that have been reported to the appropriate safeguarding partners during the period 1st April 2014 to 31st March 2015 . Section 5 of this report relates to safeguarding referrals that were concluded within the period 1st April 2014 to 31st March 2015 and may include referrals that were initiated in the previous year. Section 6 contains information related to Deprivation of Liberty (DoL) cases during the reporting period.

The data used to compile the charts and tables in sections 1 – 5 was extracted from the Barnsley MBC Adult Social Care information ERICA on the 20th January 2015 at 11:24. Any entry of data relating to reporting period covered by this report but entered after this point in time will not be included within this report but will be included in subsequent future reports. A consequence of late data entry to the ERICA system may mean that individual quarter data and cumulative totals may not balance back to earlier reports, similar variances can also be caused by correcting data entry errors in different quarterly periods.

Data relating to Deprivation of Liberty cases has been provided by the Barnsley MBC DoLs Team.

Previously when a safeguarding alert progressed to a safeguarding referral the count of alerts was reduced by one and the count of referrals increased by one so the total number of safeguarding incidents was represented by the [alerts] + [referrals]. Following advice from the Health and Social Care Information Centre (HSCIC) when alert progresses to referral the count of alerts should not be reduced so that it can be clearly seen how many incidents progress to referral.

Section 1: Alerts and Referrals



Section 2: Referral Demographics

The following section details alerts that have progressed to referral broken down into the following categories:-

- 2.1 Age:
  - o 18-64
  - o 65 and over

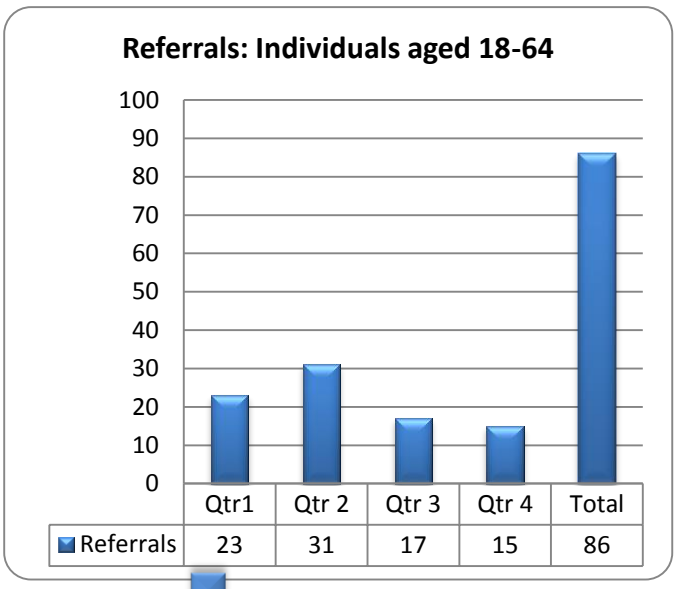
- 2.2 Gender:
  - o Male
  - o Female

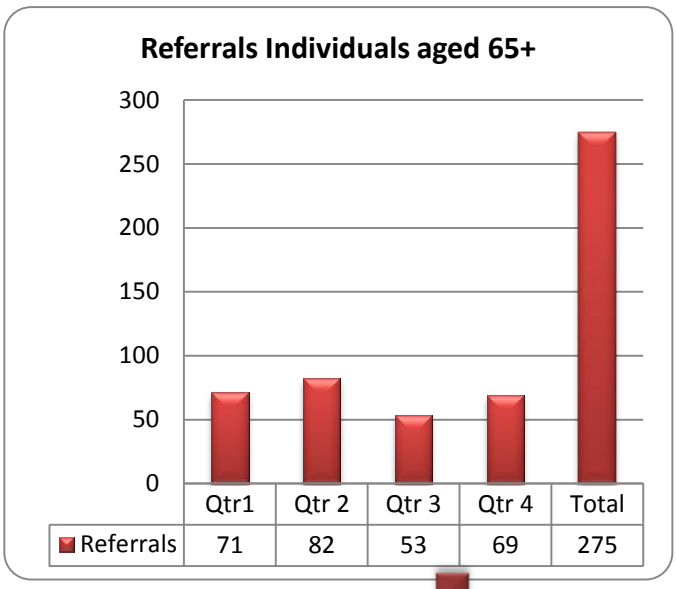
- 2.3 Client category:
  - o Physical Disability (included within this category are individuals that are physically frail or have a sensory impairment)
  - o Mental Health
  - o Learning Disability
  - o Substance Misuse
  - o Other Vulnerable People

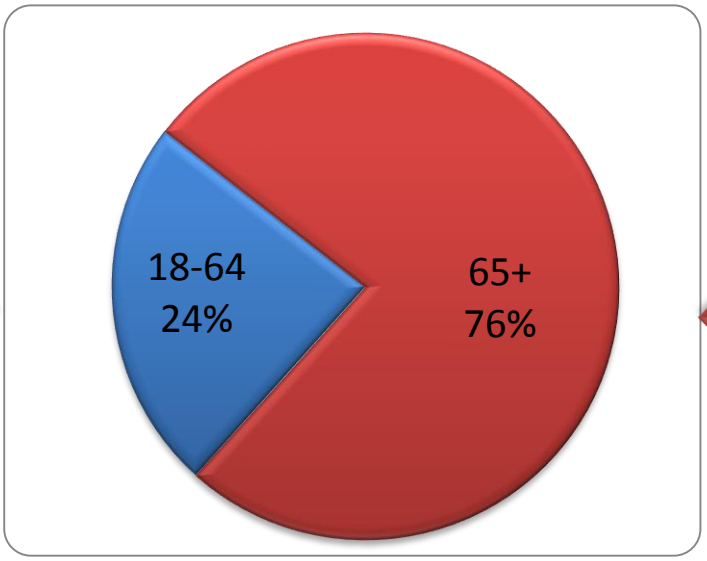
- 2.4 Ethnicity:
  - o White (includes White British, White Irish, Traveller of Irish Heritage, Gypsy/Roma, Any other white background).
  - o Mixed (includes White and Black Caribbean, White and Black African, White and Asian, Any other mixed background).
  - o Asian or Asian British (includes Indian, Pakistani, Bangladeshi, Any other Asian background).
  - o Black or British Black (includes Caribbean, African, Any other Black background).
  - o Other Ethnicity (includes Chinese, Any other ethnic group).

- 2.5 Geographic:
  - o Shows how the cumulative referrals for this stage of the reporting year are distributed across the 6 Area Council regions.

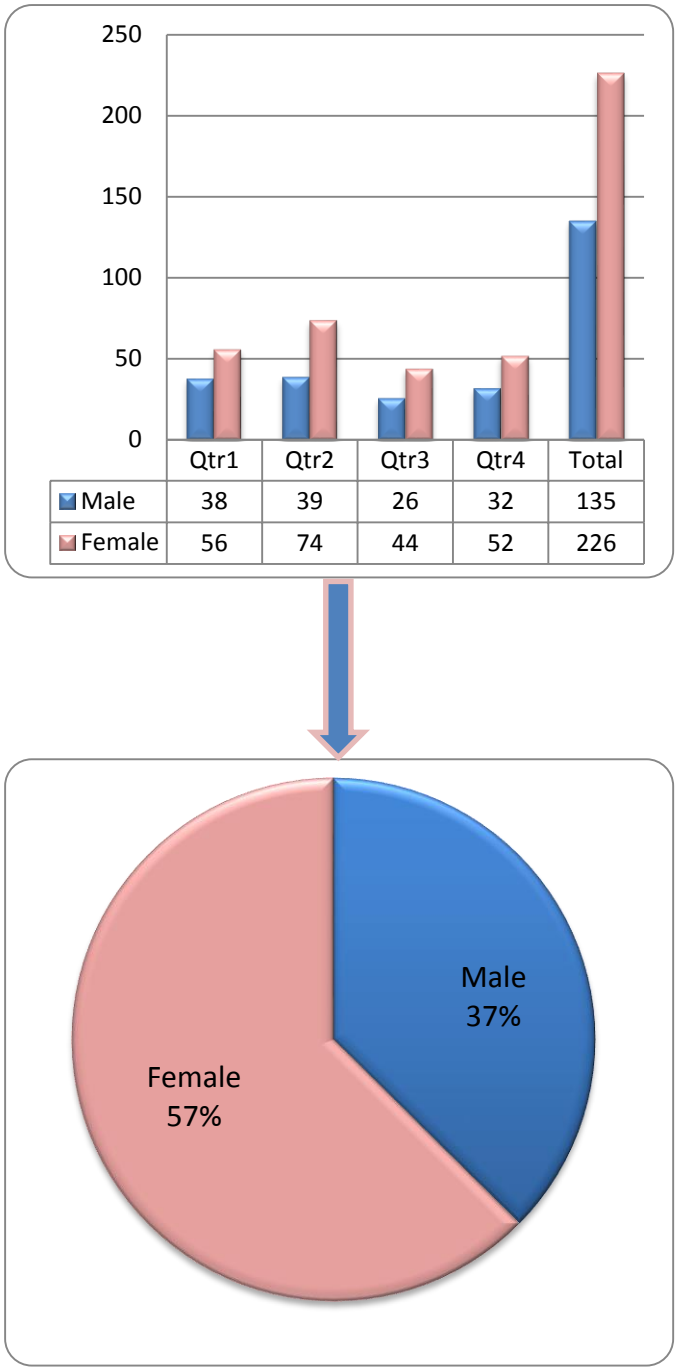
2.1 Age distribution of safeguarding referrals



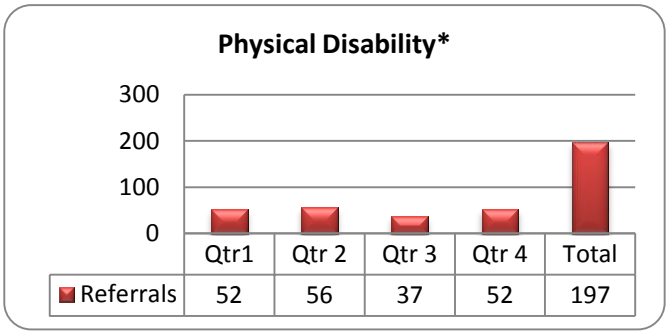


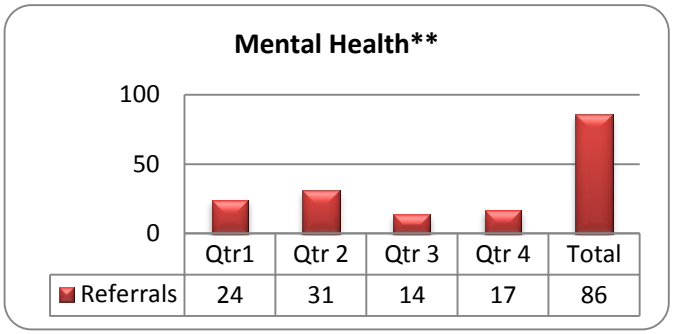


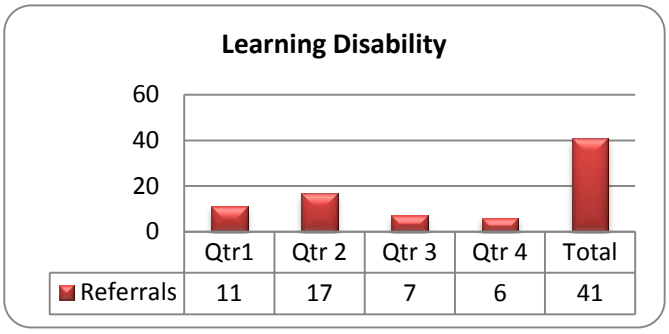
2.2 Gender distribution of safeguarding referrals

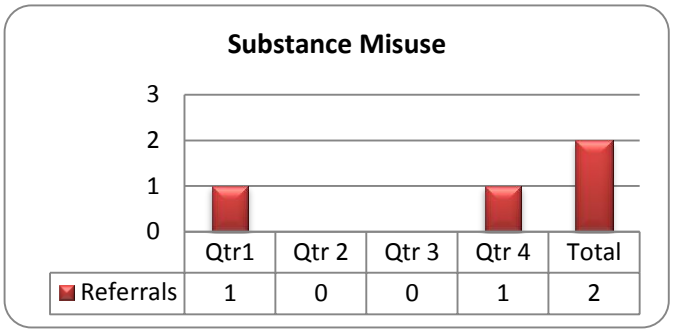


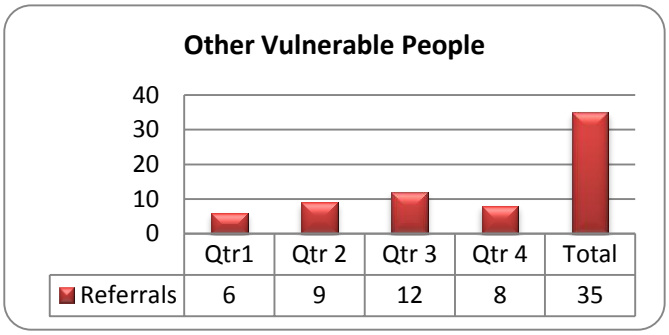
2.3 Client category distribution of safeguarding referrals

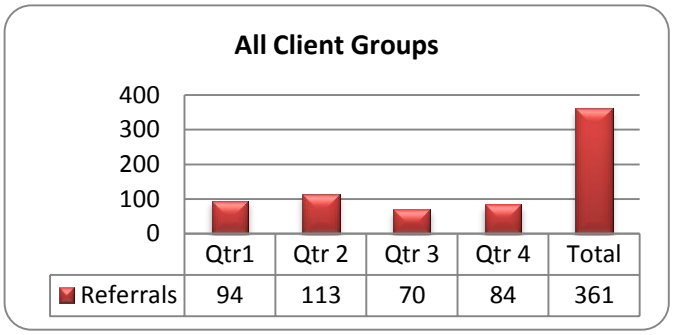


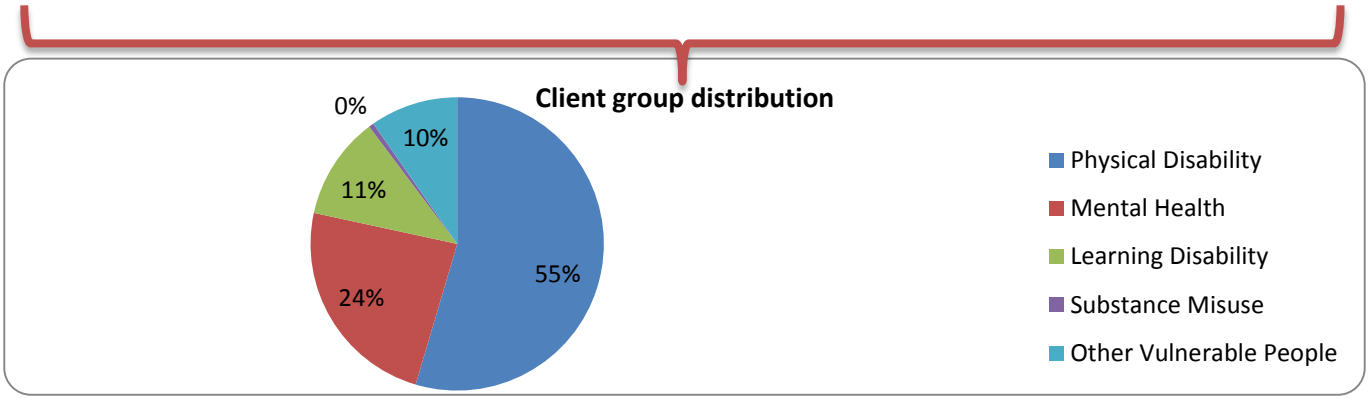






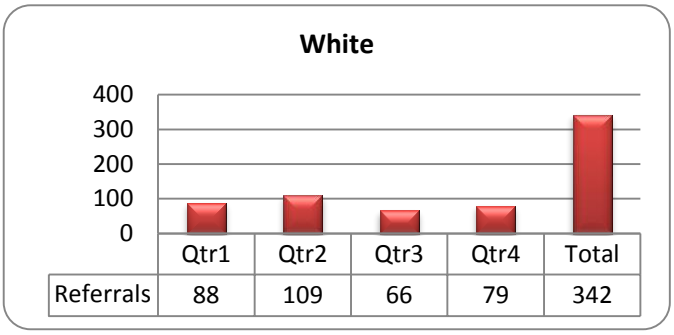


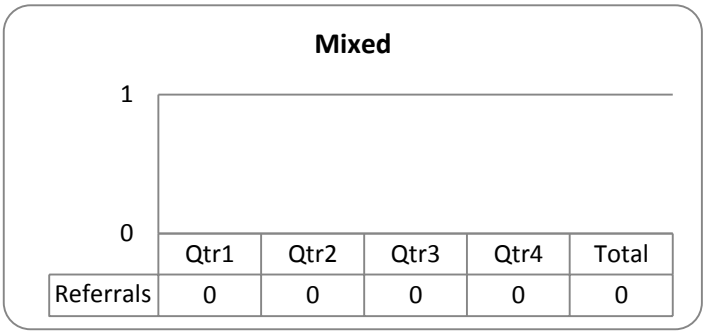


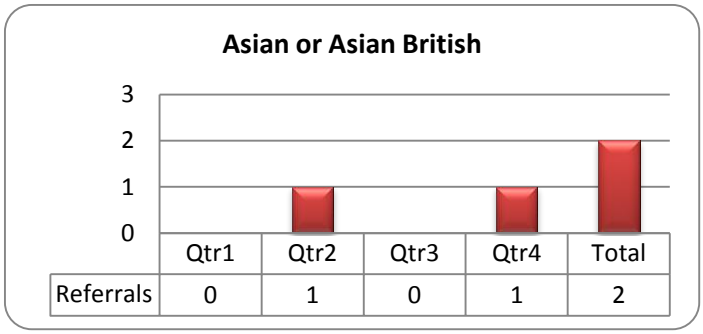


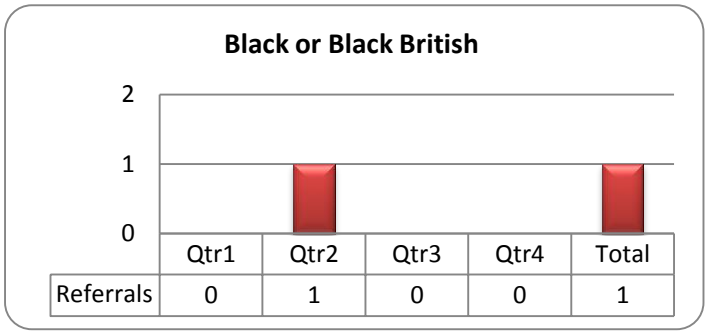
*Physical Disability includes sensory impairment and physically frail/temporarily ill clients
** Mental Health includes dementia.

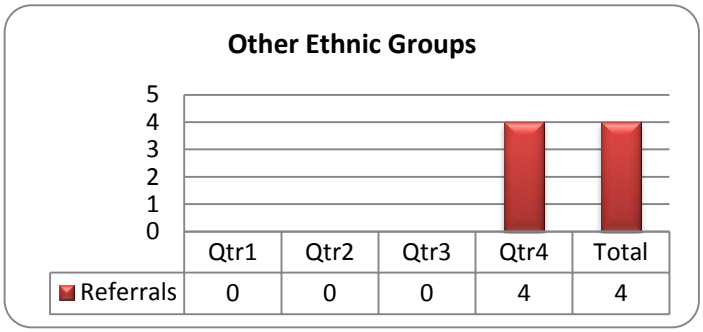
2.4 Ethnicity distribution of safeguarding referrals

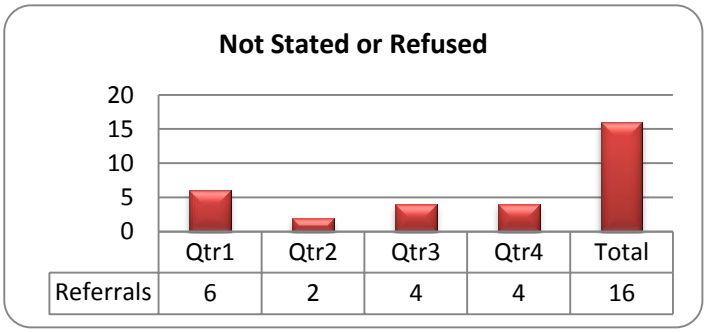






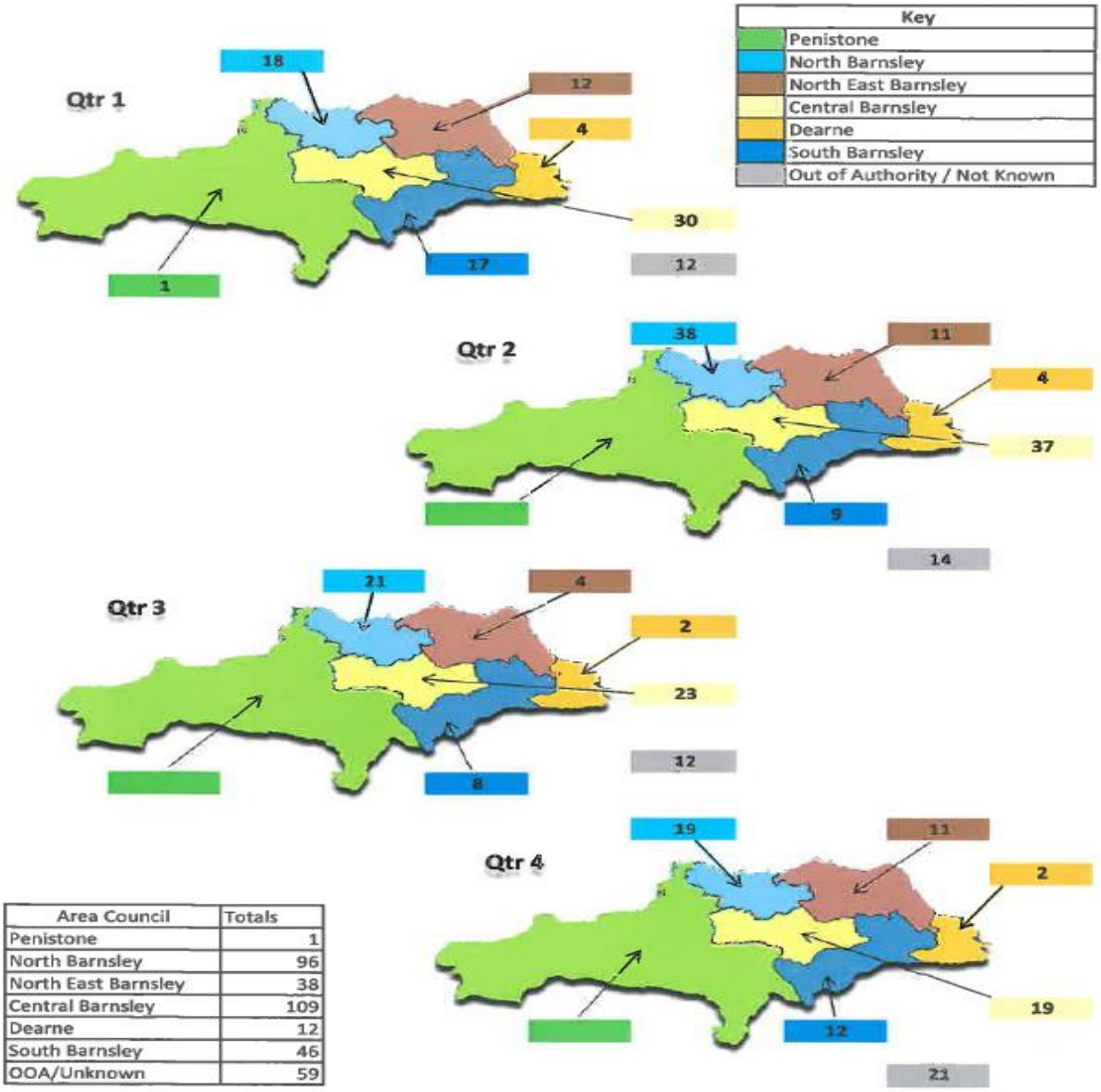






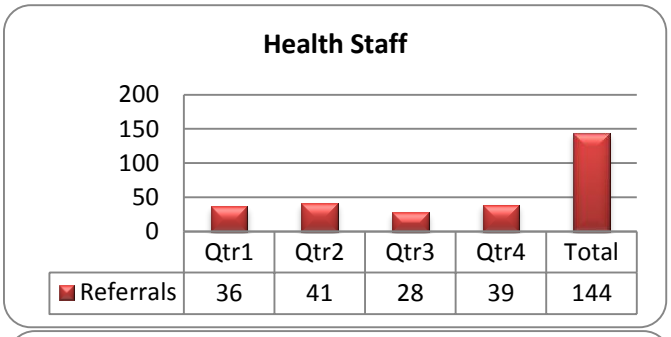
Ethnic Group	Qtr1	Qtr2	Qtr3	Qtr4	Total		Ethnic Distribution 2011 Census
White	93.6%	96.5%	94.3%	89.8%	93.7%		97.9%
Mixed	0.0%	0.0%	0.0%	0.0%	0.0%		0.7%
Asian or Asian British	0.0%	0.9%	0.0%	1.1%	0.5%		0.7%
Black or Black British	0.0%	0.9%	0.0%	0.0%	0.3%		0.5%
Other Ethnic Group	0.0%	0.0%	0.0%	4.5%	1.1%		0.2%
Not Stated	6.4%	1.8%	5.7%	4.5%	4.4%		
Total	100.0%	100.0%	100.0%	100.0 %	100.0%		100.0%

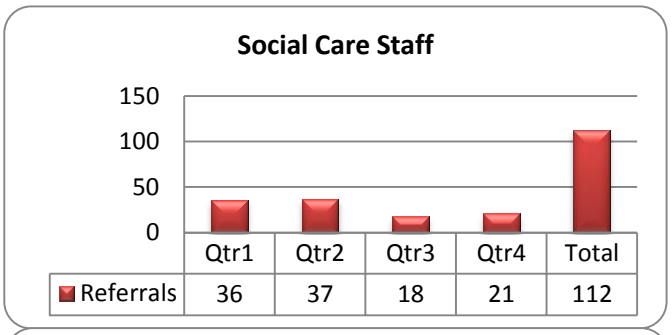
2.5 Geographic distribution of safeguarding referrals

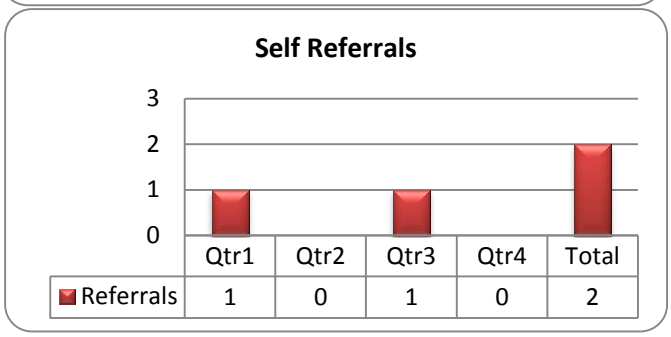


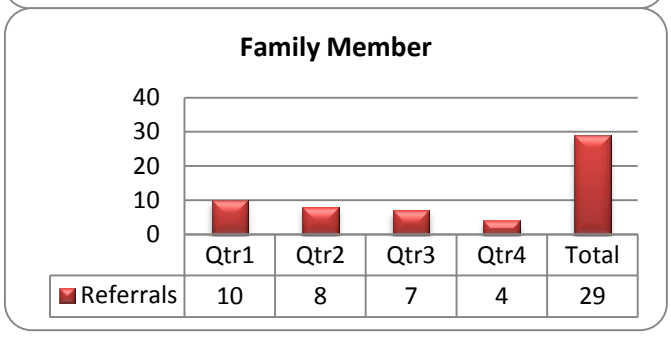
Area Council	Totals
Penistone	1
North Barnsley	96
North East Barnsley	38
Central Barnsley	109
Dearne	12
South Barnsley	46
OOA/Unknown	59

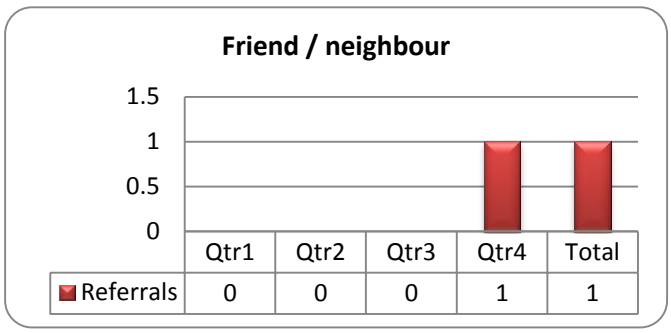
Section 3: Referral Source (who notified safeguarding manager of incident)

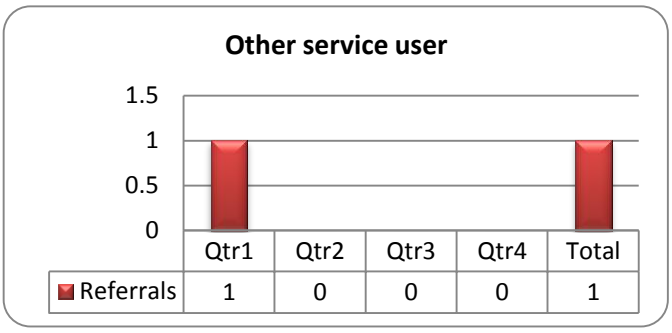


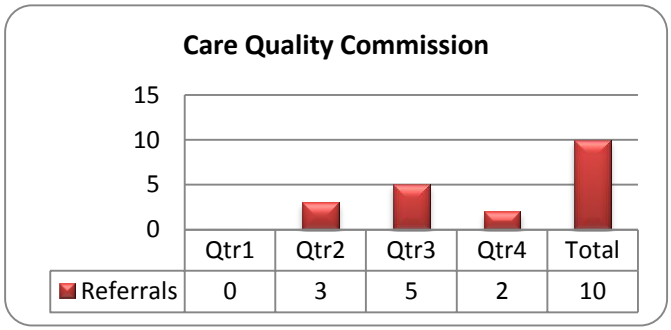


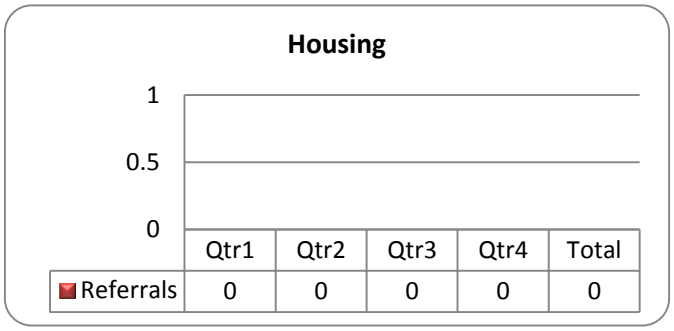


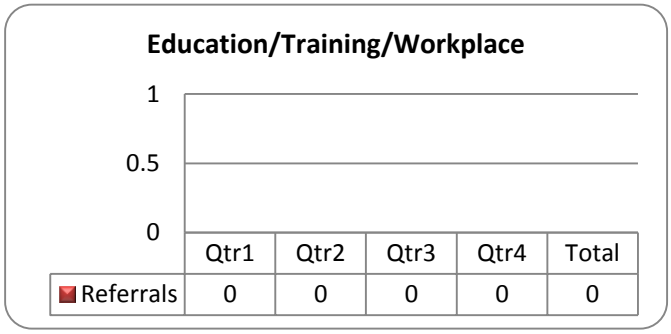


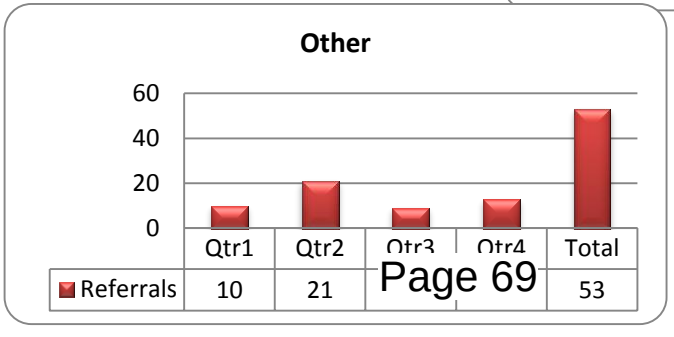








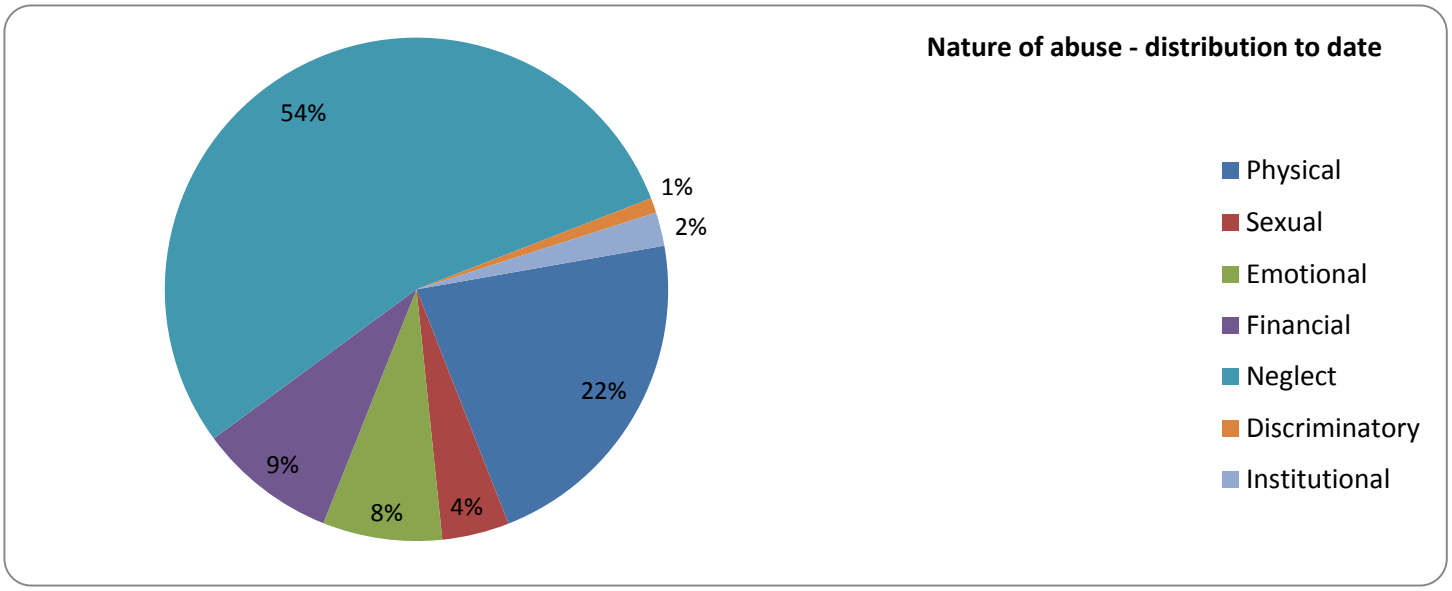




Section 4: Nature of abuse for safeguarding referrals

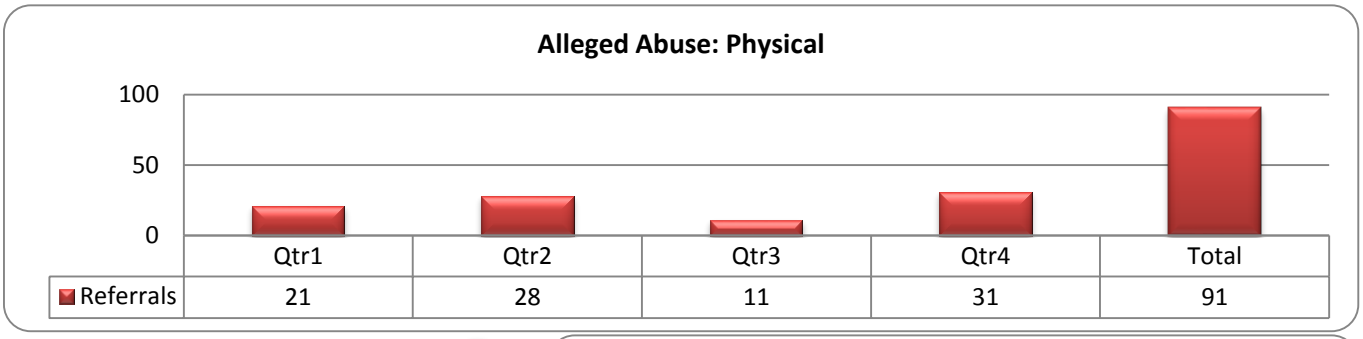
The data within this section relates to new safeguarding referrals received during the reporting period.

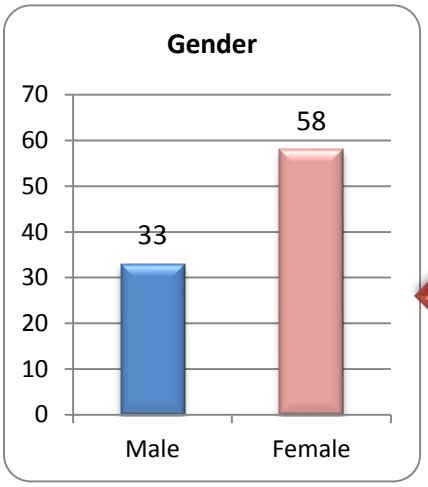
- Alleged abuse physical
- Alleged abuse sexual
- Alleged abuse emotional/psychological
- Alleged abuse financial
- Alleged abuse neglect
- Alleged abuse discriminatory
- Alleged abuse institutional

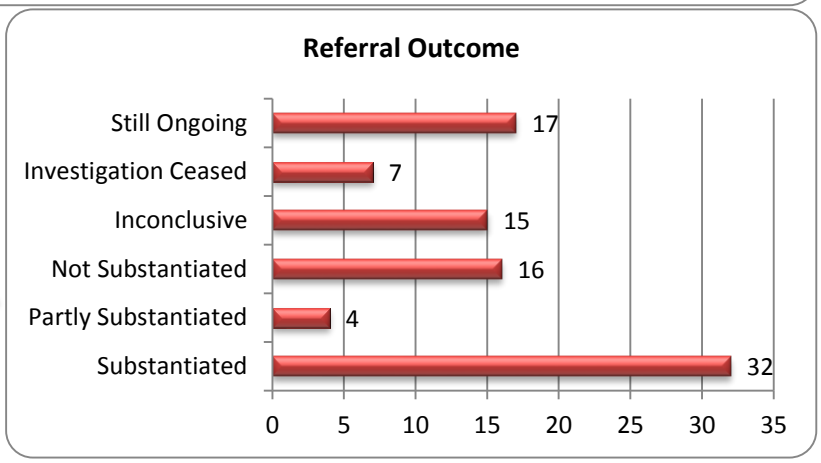


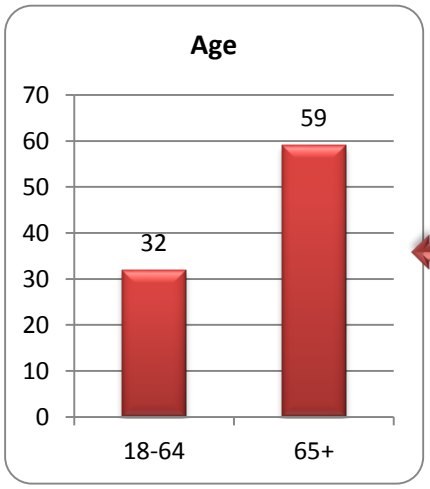
Each abuse category is then further cross referenced against

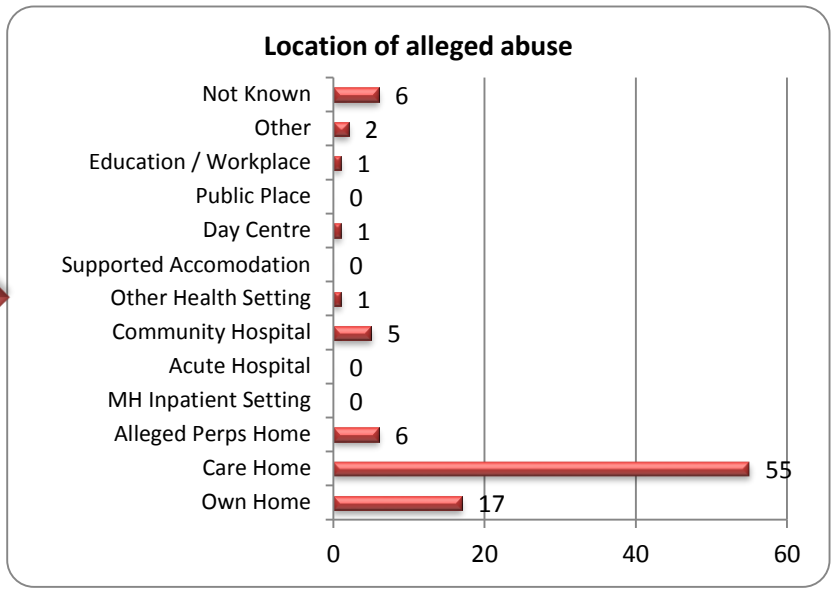
- Referral outcome
- Location of alleged abuse
- Relation of perpetrator to victim
- Gender
- Age

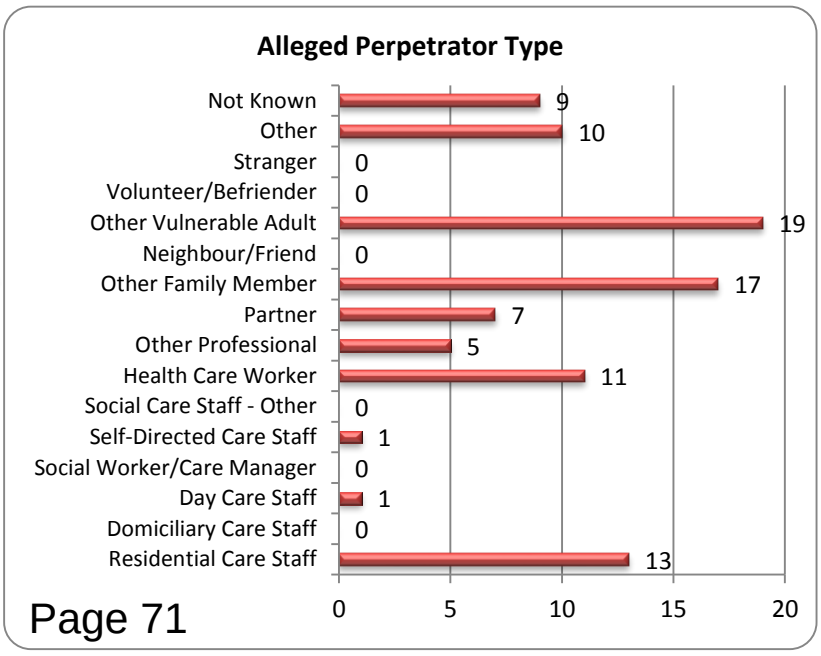

Alleged Abuse: Physical
100
50
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
21
28
11
31
91

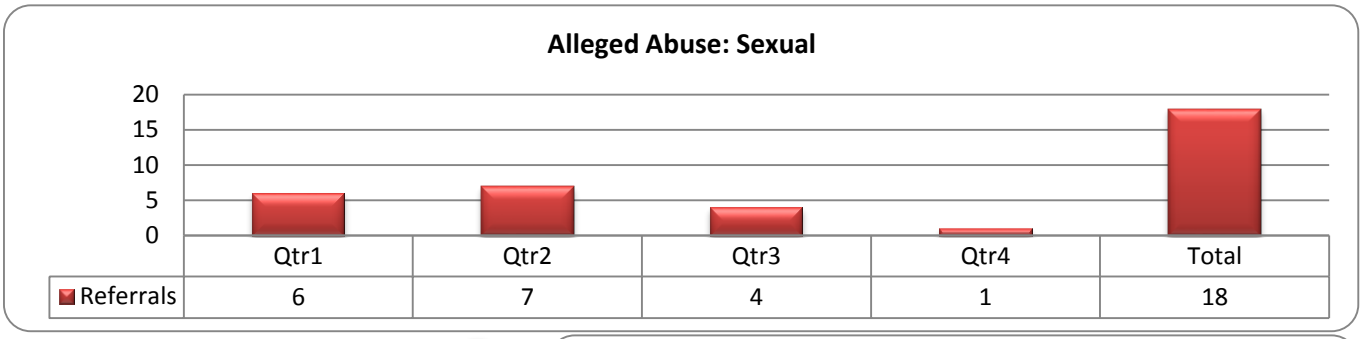

Gender
70
60
50
40
30
20
10
0
33
58
Male
Female

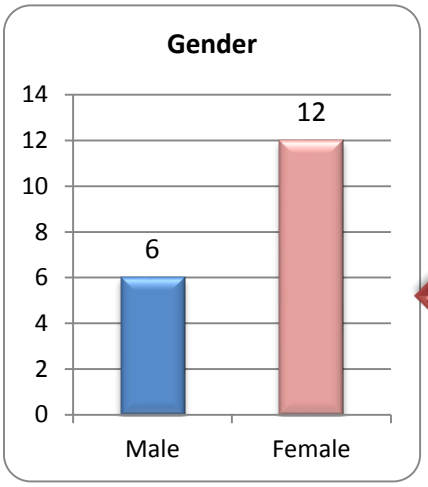

Referral Outcome
Still Ongoing
17
Investigation Ceased
7
Inconclusive
15
Not Substantiated
16
Partly Substantiated
4
Substantiated
32
0
5
10
15
20
25
30
35

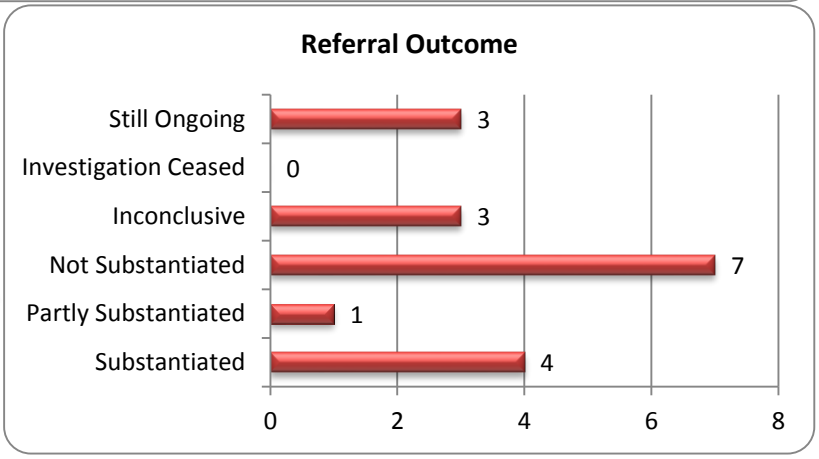

Age
70
60
50
40
30
20
10
0
32
59
18-64
65+

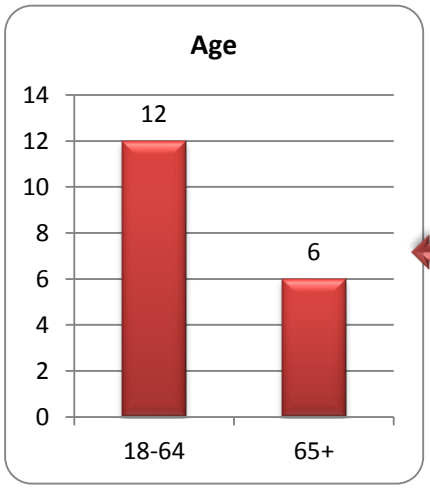

Location of alleged abuse
Not Known
6
Other
2
Education / Workplace
1
Public Place
0
Day Centre
1
Supported Accomodation
0
Other Health Setting
1
Community Hospital
5
Acute Hospital
0
MH Inpatient Setting
0
Alleged Perps Home
6
Care Home
55
Own Home
17
0
20
40
60

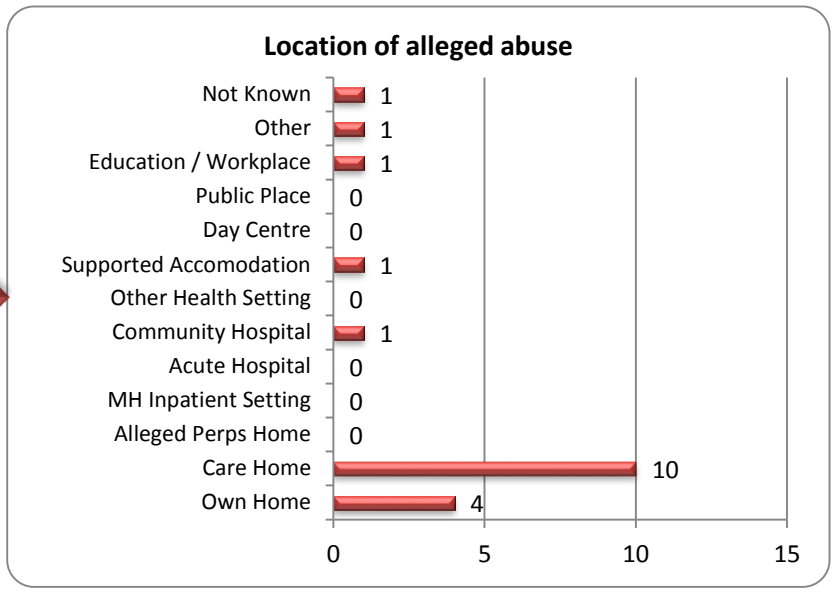

Alleged Perpetrator Type
Not Known
9
Other
10
Stranger
0
Volunteer/Befriender
0
Other Vulnerable Adult
19
Neighbour/Friend
0
Other Family Member
17
Partner
7
Other Professional
5
Health Care Worker
11
Social Care Staff - Other
0
Self-Directed Care Staff
1
Social Worker/Care Manager
0
Day Care Staff
1
Domiciliary Care Staff
0
Residential Care Staff
13
0
5
10
15
20

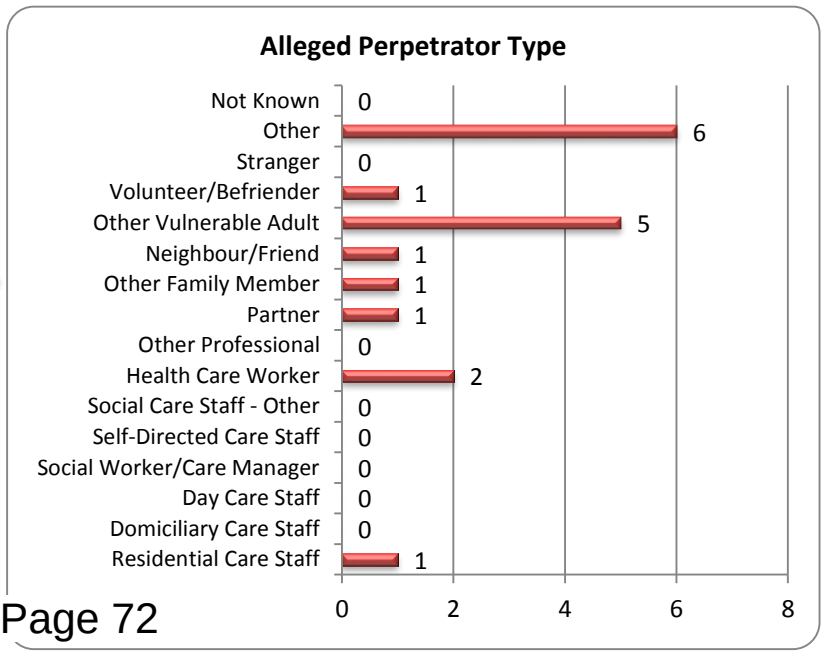

Alleged Abuse: Sexual
20
15
10
5
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
6
7
4
1
18

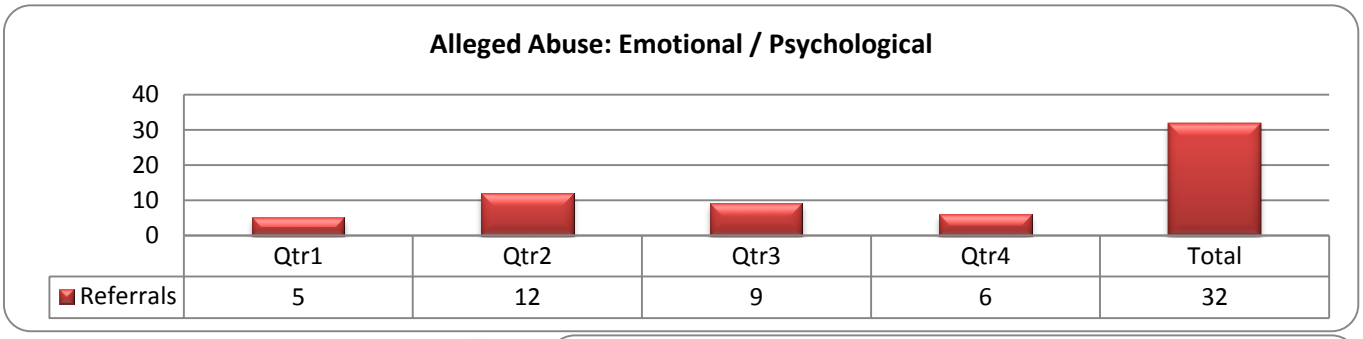

Gender
14
12
10
8
6
4
2
0
6
12
Male
Female

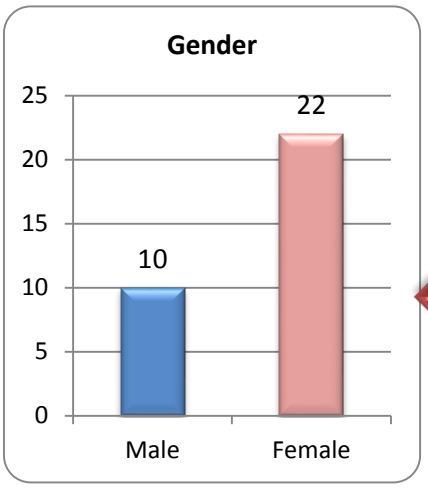

Referral Outcome
Still Ongoing
3
Investigation Ceased
0
Inconclusive
3
Not Substantiated
7
Partly Substantiated
1
Substantiated
4
0
2
4
6
8

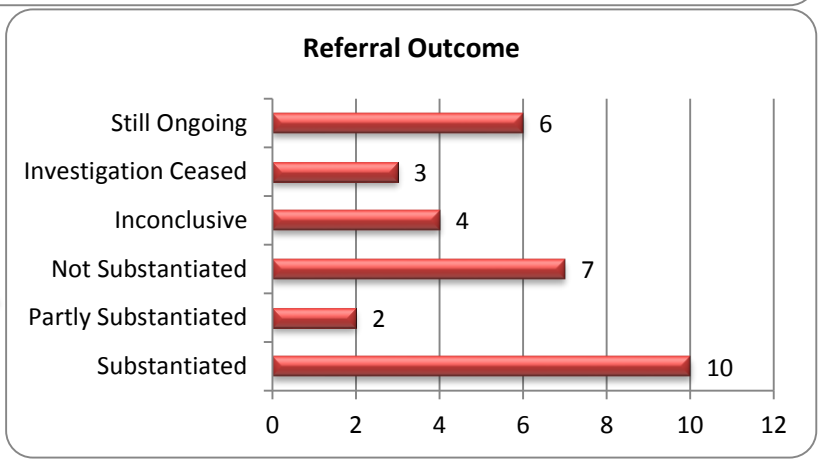

Age
14
12
10
8
6
4
2
0
12
6
18-64
65+

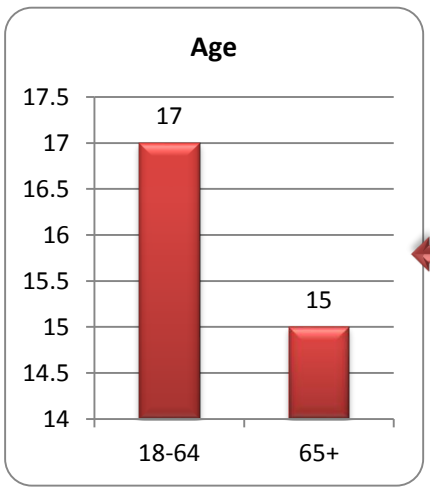

Location of alleged abuse
Not Known
1
Other
1
Education / Workplace
1
Public Place
0
Day Centre
0
Supported Accomodation
1
Other Health Setting
0
Community Hospital
1
Acute Hospital
0
MH Inpatient Setting
0
Alleged Perps Home
0
Care Home
10
Own Home
4
0
5
10
15

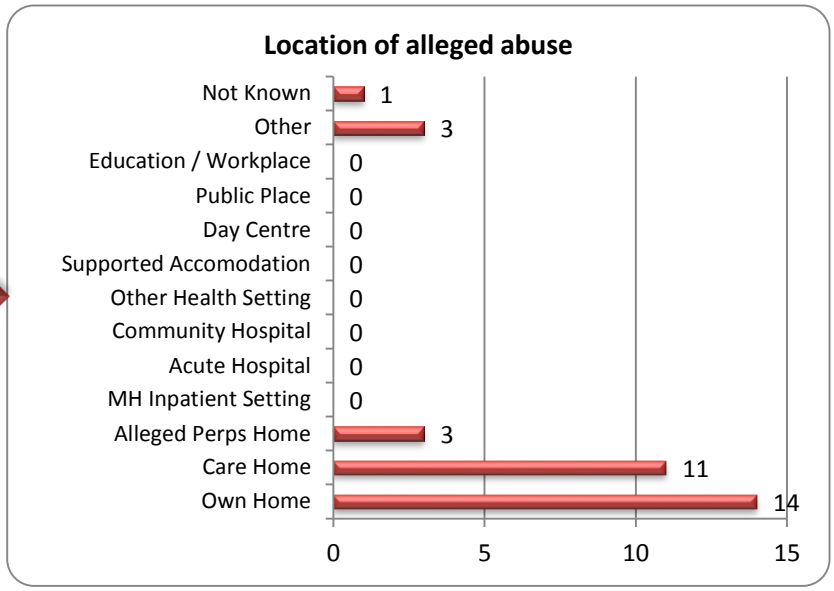

Alleged Perpetrator Type
Not Known
0
Other
6
Stranger
0
Volunteer/Befriender
1
Other Vulnerable Adult
5
Neighbour/Friend
1
Other Family Member
1
Partner
1
Other Professional
0
Health Care Worker
2
Social Care Staff - Other
0
Self-Directed Care Staff
0
Social Worker/Care Manager
0
Day Care Staff
0
Domiciliary Care Staff
0
Residential Care Staff
1
0
2
4
6
8

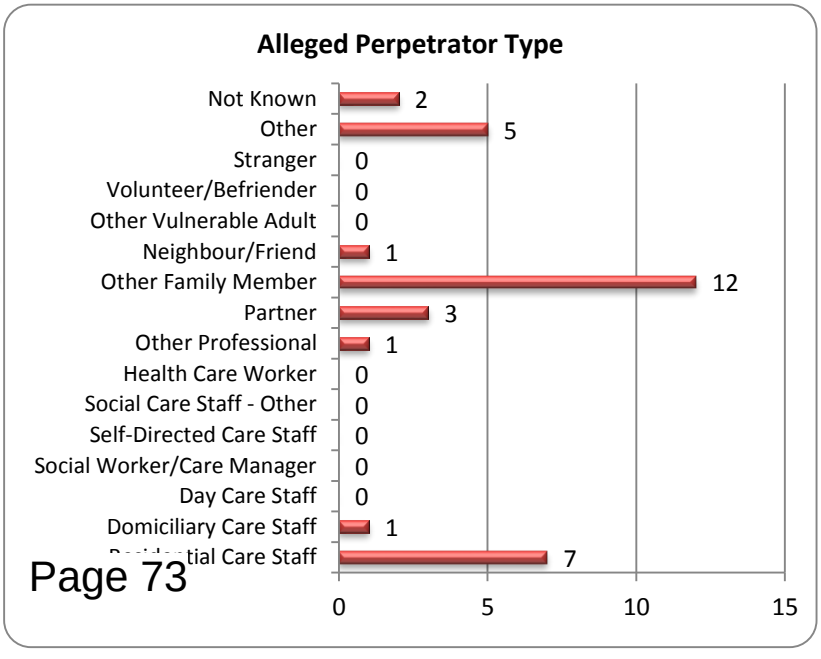

Alleged Abuse: Emotional / Psychological
40
30
20
10
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
5
12
9
6
32

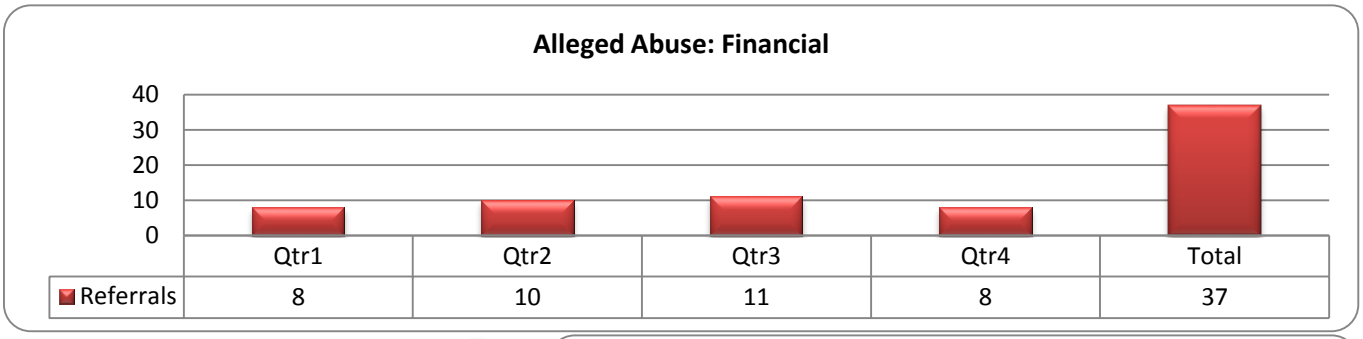

Gender
25
20
15
10
5
0
10
22
Male
Female

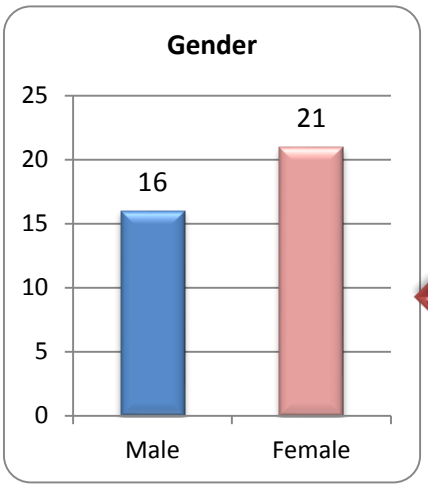

Referral Outcome
Still Ongoing
6
Investigation Ceased
3
Inconclusive
4
Not Substantiated
7
Partly Substantiated
2
Substantiated
10
0
2
4
6
8
10
12

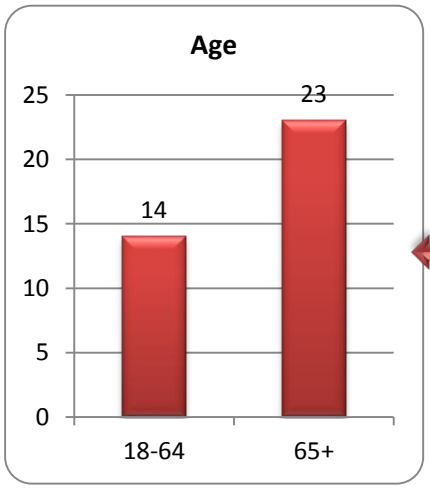

Age
17.5
17
16.5
16
15.5
15
14.5
14
17
15
18-64
65+

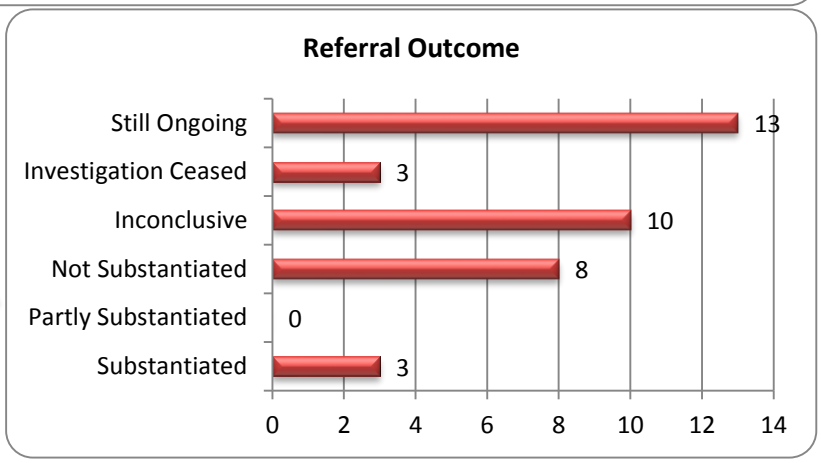

Location of alleged abuse
Not Known
1
Other
3
Education / Workplace
0
Public Place
0
Day Centre
0
Supported Accomodation
0
Other Health Setting
0
Community Hospital
0
Acute Hospital
0
MH Inpatient Setting
0
Alleged Perps Home
3
Care Home
11
Own Home
14
0
5
10
15

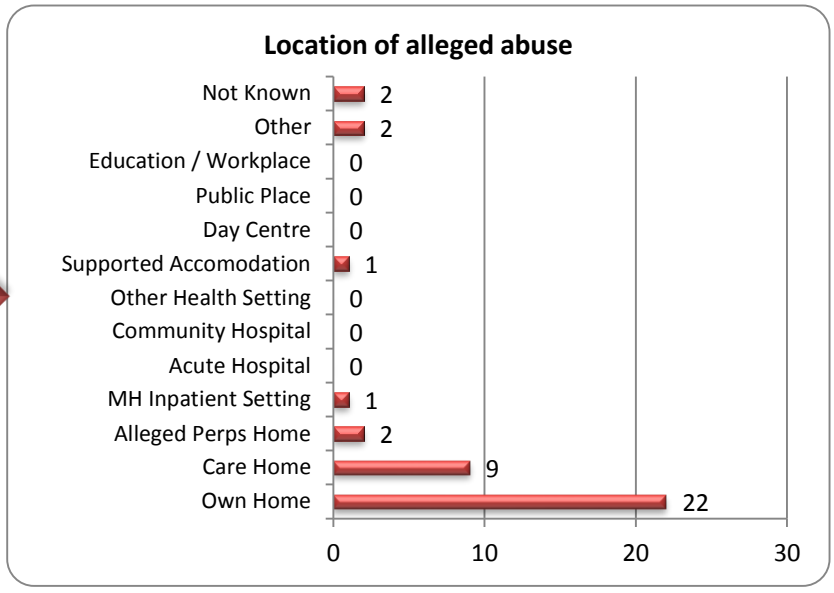

Alleged Perpetrator Type
Not Known
2
Other
5
Stranger
0
Volunteer/Befriender
0
Other Vulnerable Adult
0
Neighbour/Friend
1
Other Family Member
12
Partner
3
Other Professional
1
Health Care Worker
0
Social Care Staff - Other
0
Self-Directed Care Staff
0
Social Worker/Care Manager
0
Day Care Staff
0
Domiciliary Care Staff
1
7
0
5
10
15

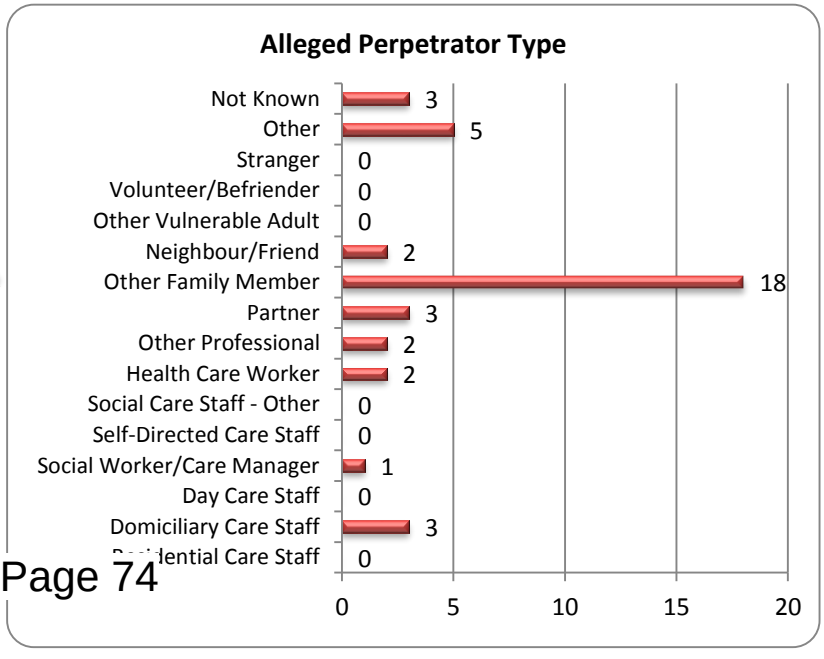

Alleged Abuse: Financial
40
30
20
10
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
8
10
11
8
37


Gender
25
20
15
10
5
0
16
21
Male
Female

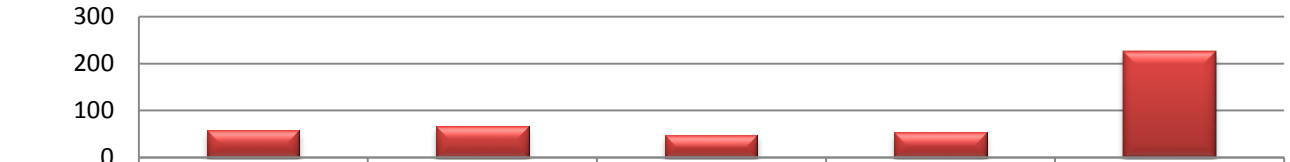

Age
25
20
15
10
5
0
14
23
18-64
65+


Referral Outcome
Still Ongoing
13
Investigation Ceased
3
Inconclusive
10
Not Substantiated
8
Partly Substantiated
0
Substantiated
3
0
2
4
6
8
10
12
14


Location of alleged abuse
Not Known
2
Other
2
Education / Workplace
0
Public Place
0
Day Centre
0
Supported Accomodation
1
Other Health Setting
0
Community Hospital
0
Acute Hospital
0
MH Inpatient Setting
1
Alleged Perps Home
2
Care Home
9
Own Home
22
0
10
20
30

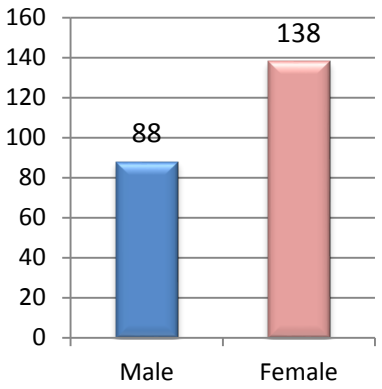

Alleged Perpetrator Type
Not Known
3
Other
5
Stranger
0
Volunteer/Befriender
0
Other Vulnerable Adult
0
Neighbour/Friend
2
Other Family Member
18
Partner
3
Other Professional
2
Health Care Worker
2
Social Care Staff - Other
0
Self-Directed Care Staff
0
Social Worker/Care Manager
1
Day Care Staff
0
Domiciliary Care Staff
3
0
0
5
10
15
20

Alleged Abuse: Neglect

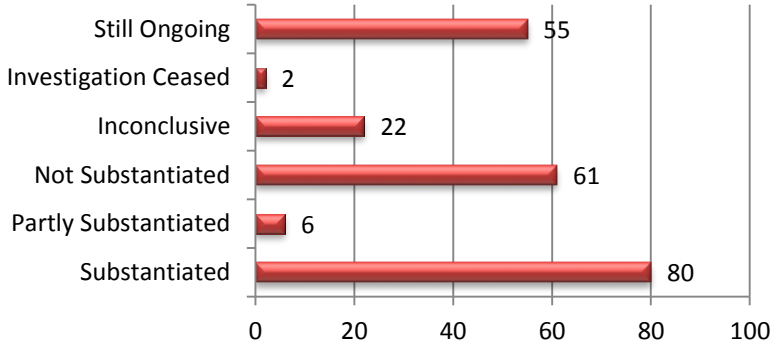


	Qtr1	Qtr2	Qtr3	Qtr4	Total
Referrals	58	67	48	53	226

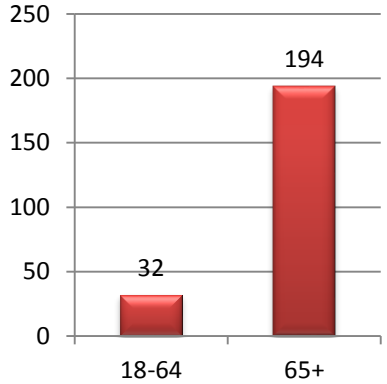
Gender



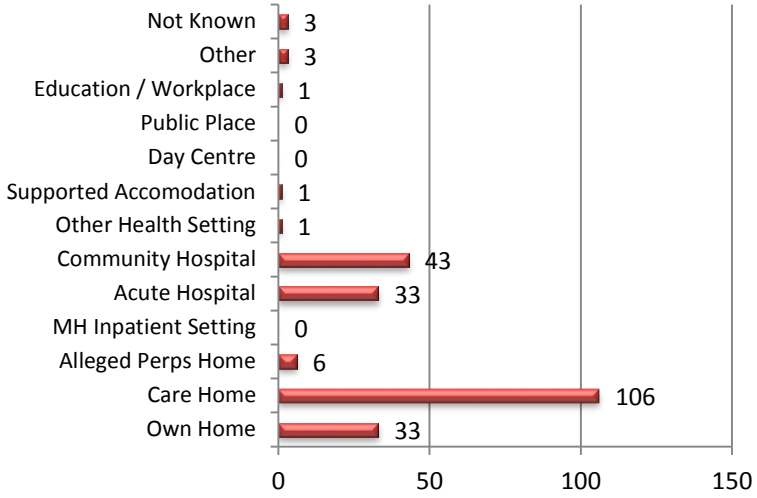
Referral Outcome



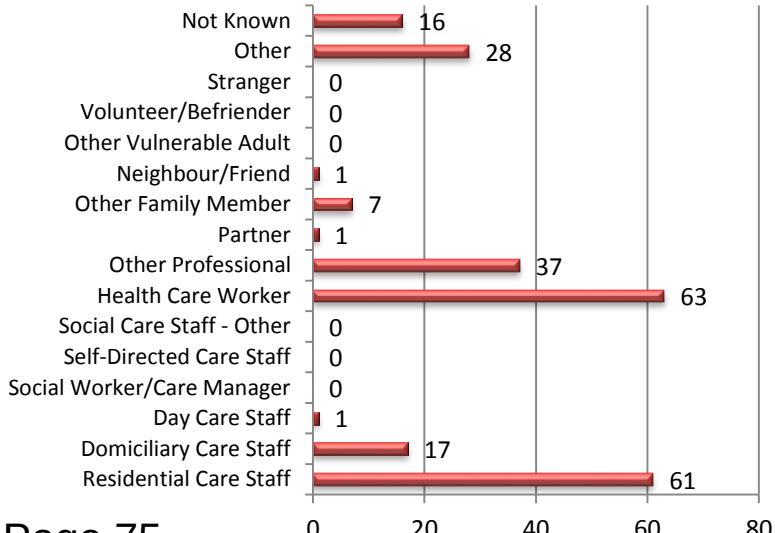
Age

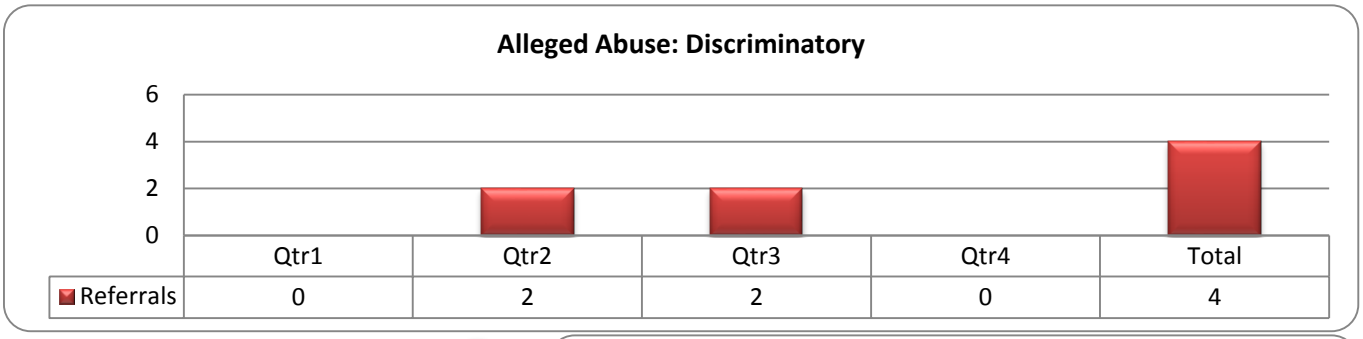


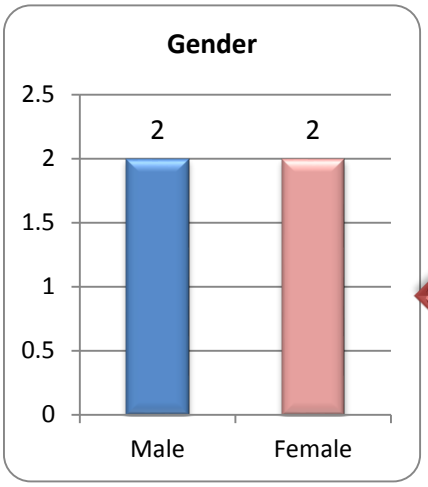
Location of alleged abuse

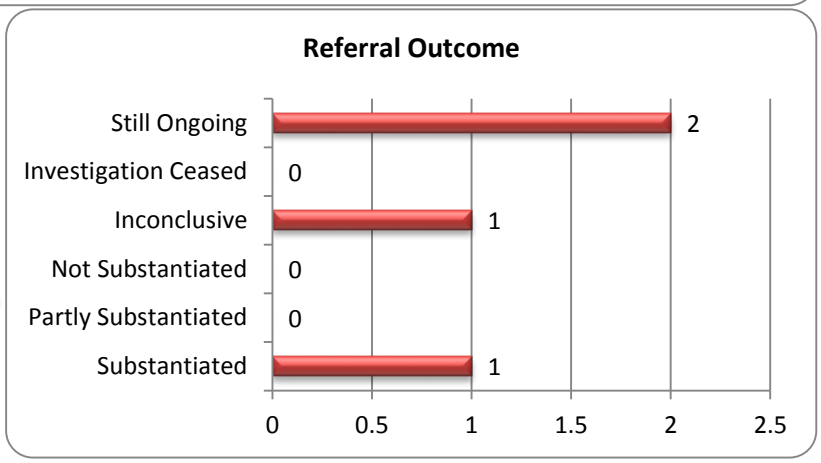


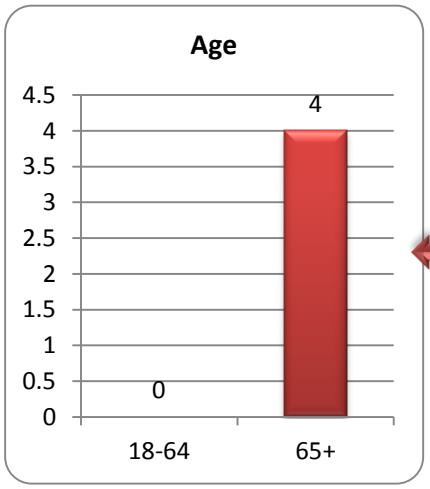
Alleged Perpetrator Type

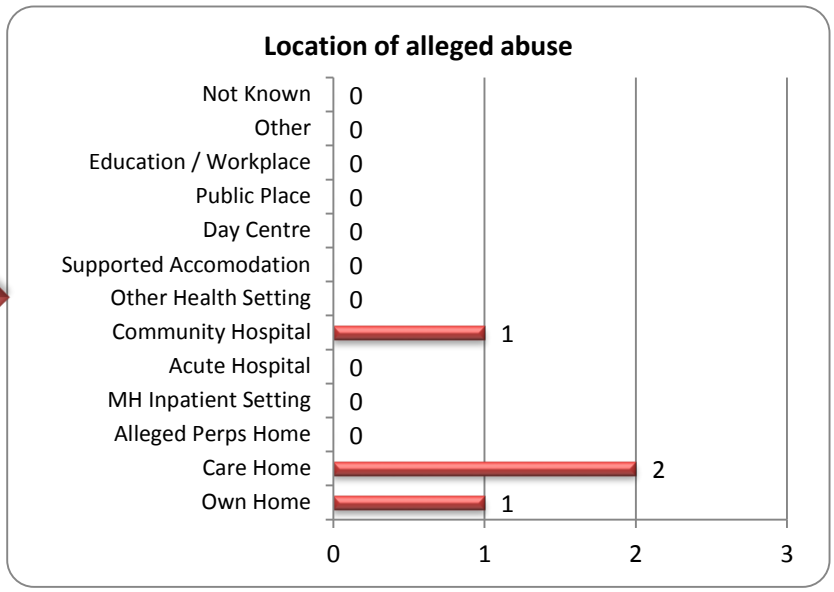


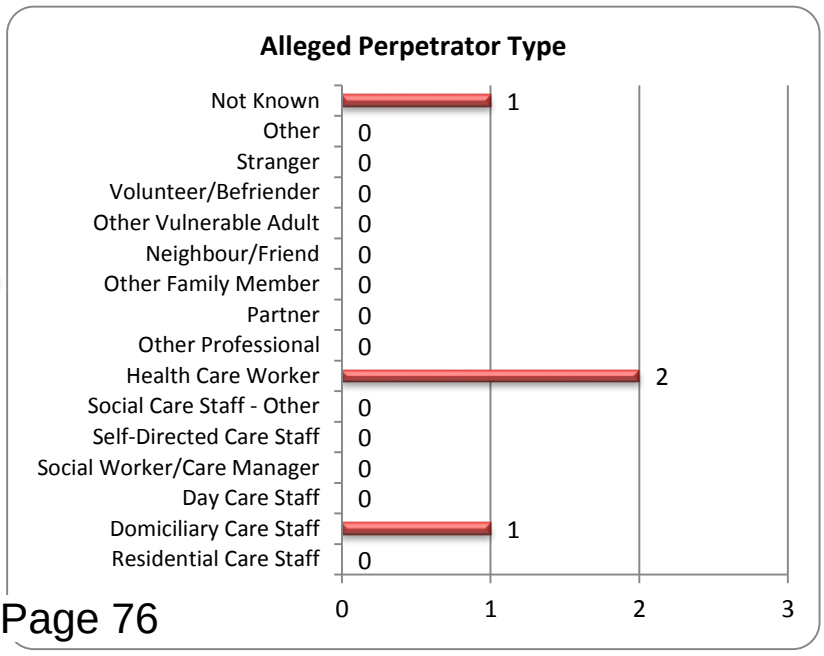

Alleged Abuse: Discriminatory
6
4
2
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
0
2
2
0
4

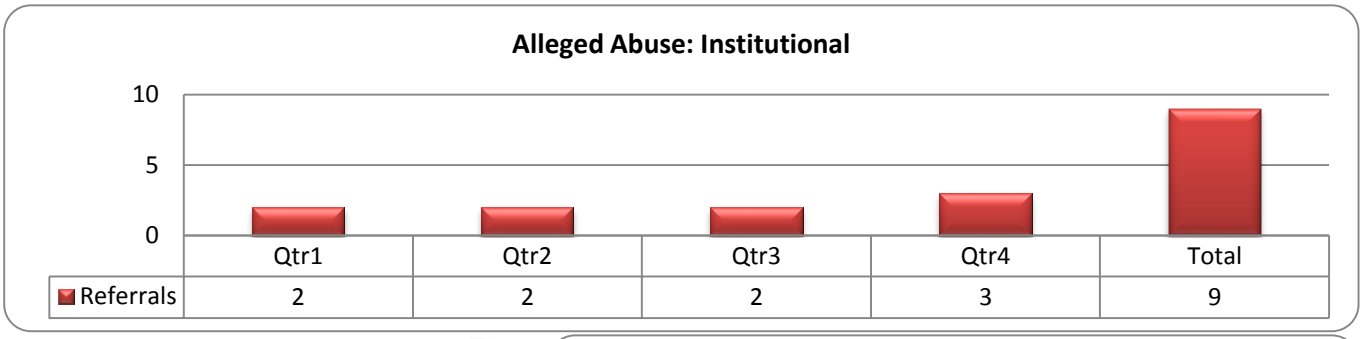

Gender
2.5
2
1.5
1
0.5
0
2
2
Male
Female

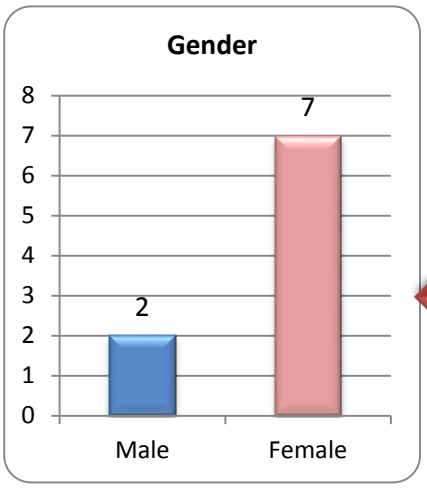

Referral Outcome
Still Ongoing
Investigation Ceased
Inconclusive
Not Substantiated
Partly Substantiated
Substantiated
2
0
1
0
0
1
0
0.5
1
1.5
2
2.5

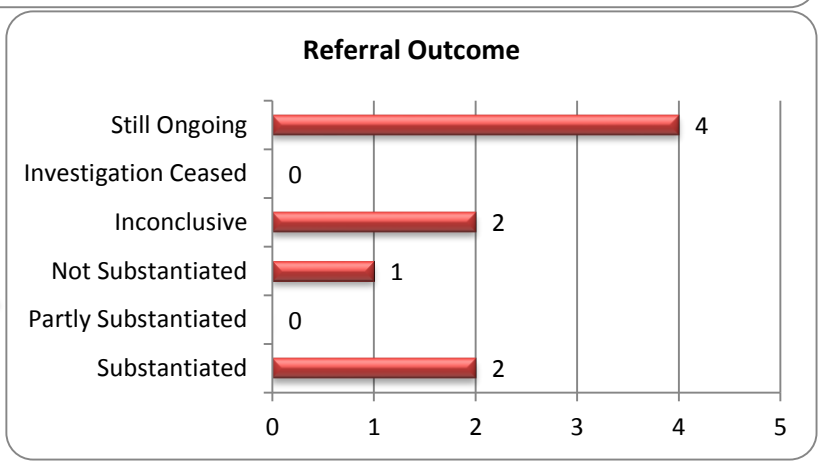

Age
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
0
4
18-64
65+

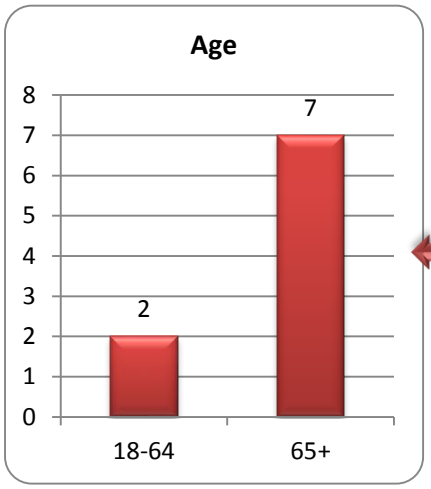

Location of alleged abuse
Not Known
Other
Education / Workplace
Public Place
Day Centre
Supported Accomodation
Other Health Setting
Community Hospital
Acute Hospital
MH Inpatient Setting
Alleged Perps Home
Care Home
Own Home
0
0
0
0
0
0
0
1
0
0
0
2
1
0
1
2
3

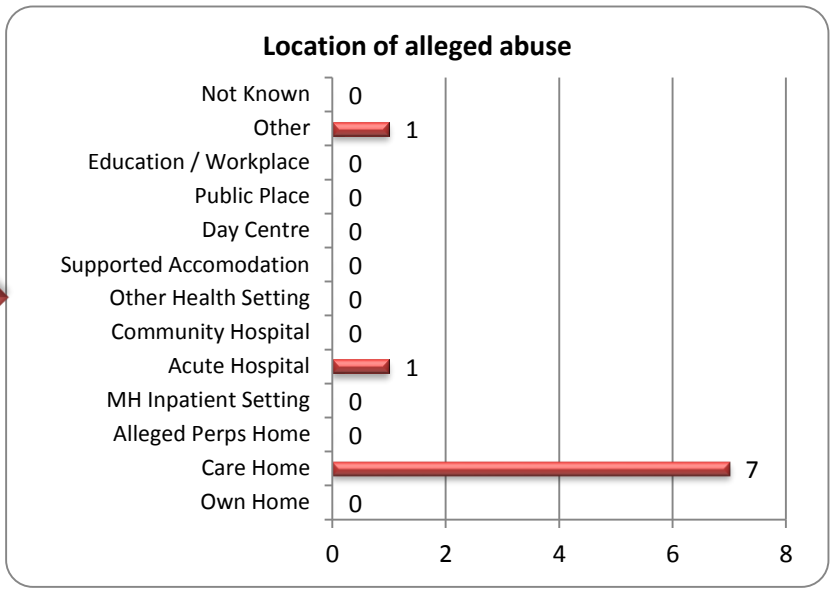

Alleged Perpetrator Type
Not Known
Other
Stranger
Volunteer/Befriender
Other Vulnerable Adult
Neighbour/Friend
Other Family Member
Partner
Other Professional
Health Care Worker
Social Care Staff - Other
Self-Directed Care Staff
Social Worker/Care Manager
Day Care Staff
Domiciliary Care Staff
Residential Care Staff
1
0
0
0
0
0
0
0
0
2
0
0
0
0
1
0
0
1
2
3

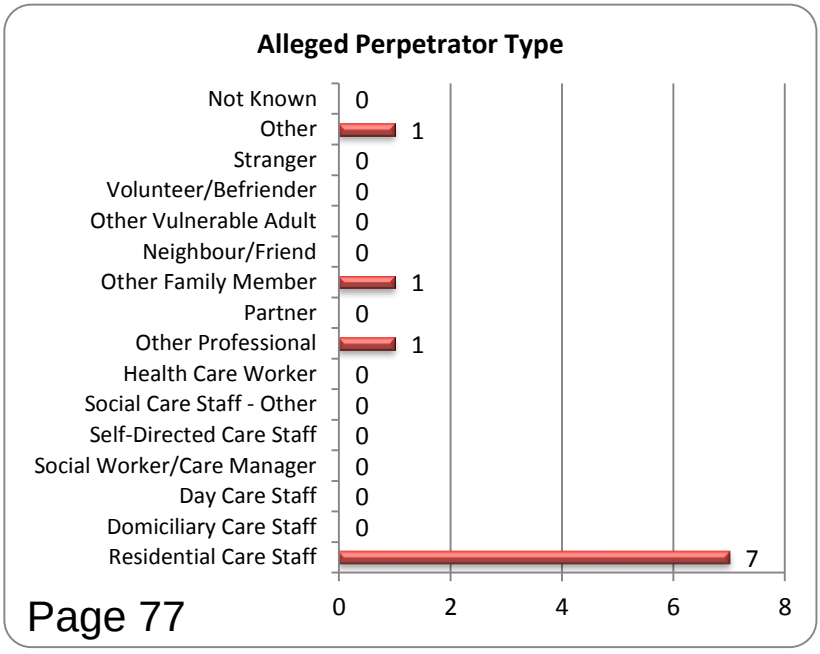

Alleged Abuse: Institutional
10
5
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
2
2
2
3
9


Gender
8
7
6
5
4
3
2
1
0
2
7
Male
Female


Referral Outcome
Still Ongoing
4
Investigation Ceased
0
Inconclusive
2
Not Substantiated
1
Partly Substantiated
0
Substantiated
2
0
1
2
3
4
5


Age
8
7
6
5
4
3
2
1
0
2
7
18-64
65+


Location of alleged abuse
Not Known
0
Other
1
Education / Workplace
0
Public Place
0
Day Centre
0
Supported Accomodation
0
Other Health Setting
0
Community Hospital
0
Acute Hospital
1
MH Inpatient Setting
0
Alleged Perps Home
0
Care Home
7
Own Home
0
0
2
4
6
8


Alleged Perpetrator Type
Not Known
0
Other
1
Stranger
0
Volunteer/Befriender
0
Other Vulnerable Adult
0
Neighbour/Friend
0
Other Family Member
1
Partner
0
Other Professional
1
Health Care Worker
0
Social Care Staff - Other
0
Self-Directed Care Staff
0
Social Worker/Care Manager
0
Day Care Staff
0
Domiciliary Care Staff
0
Residential Care Staff
7
0
2
4
6
8

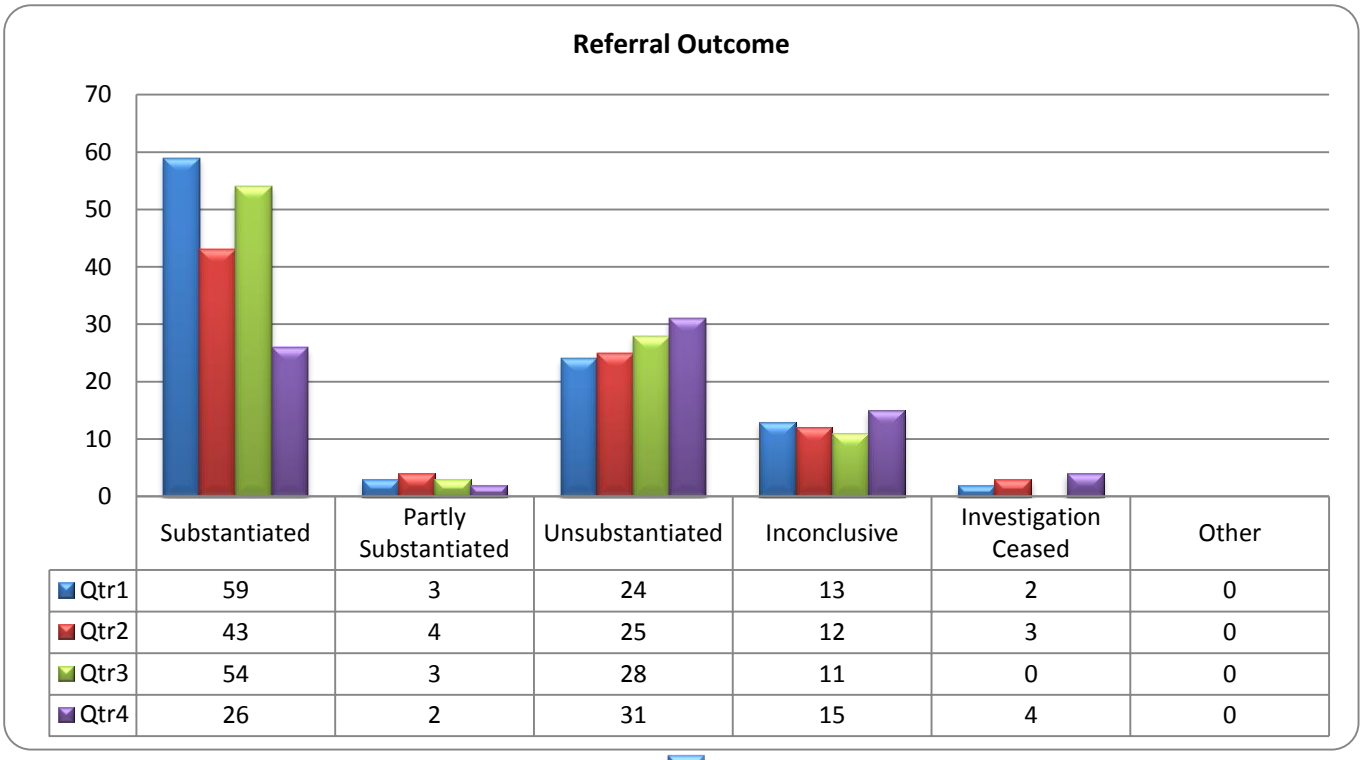
Section 5: Completed referral outcomes

The data within this section relates to safeguarding referrals that were completed within the scope of the reporting period and as such can include safeguarding referrals that were initiated in the previous year.

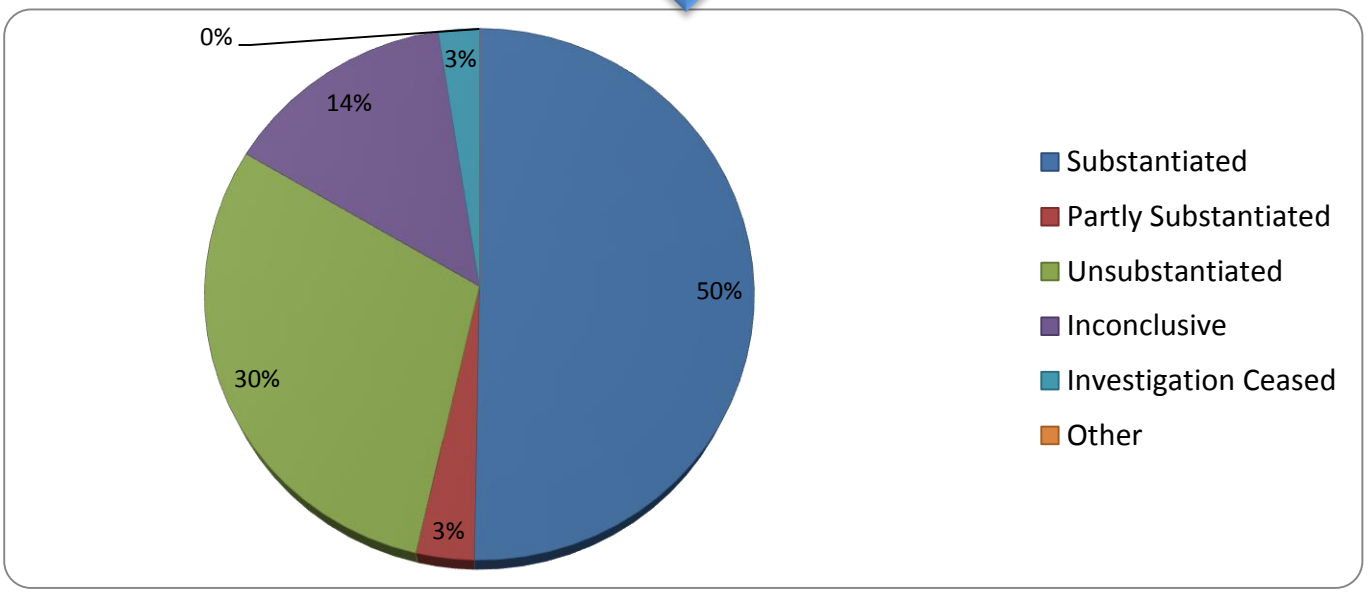
Referral outcomes have been broken down by case conclusion:

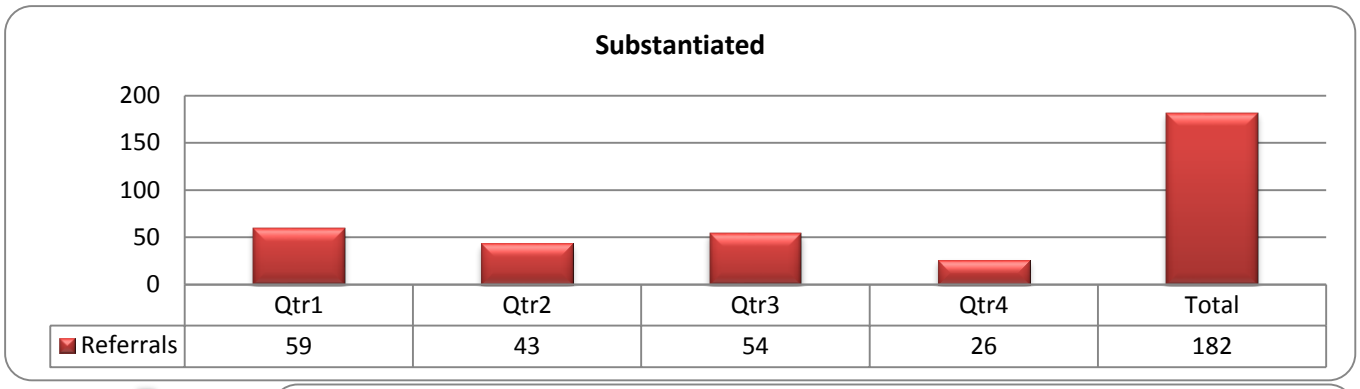
- Substantiated
- Partly Substantiated
- Not Substantiated
- Inconclusive
- Investigation ceased at individuals request

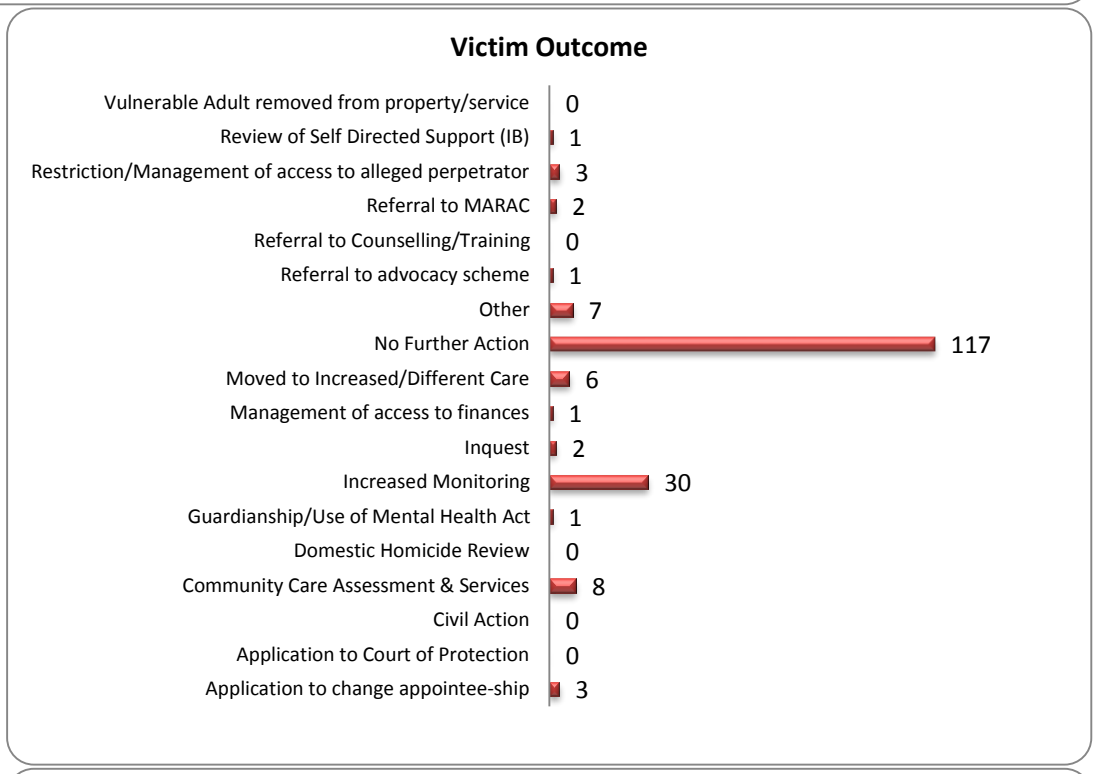
Each case conclusion is sub categorised by outcome for the victim and by outcome for the perpetrator.

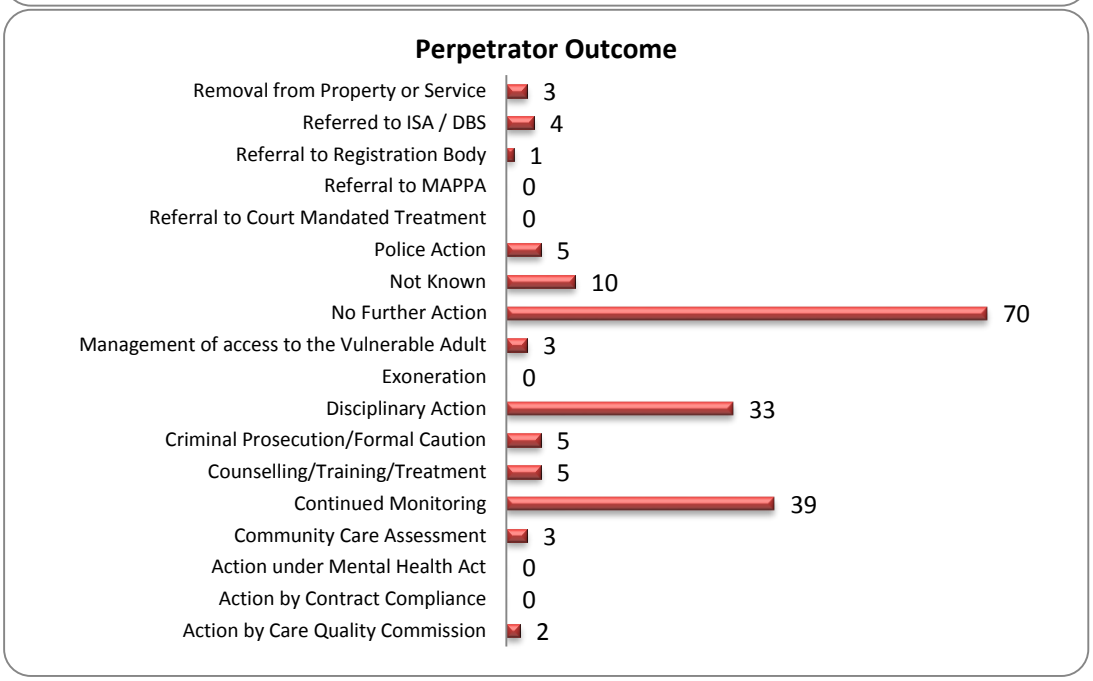


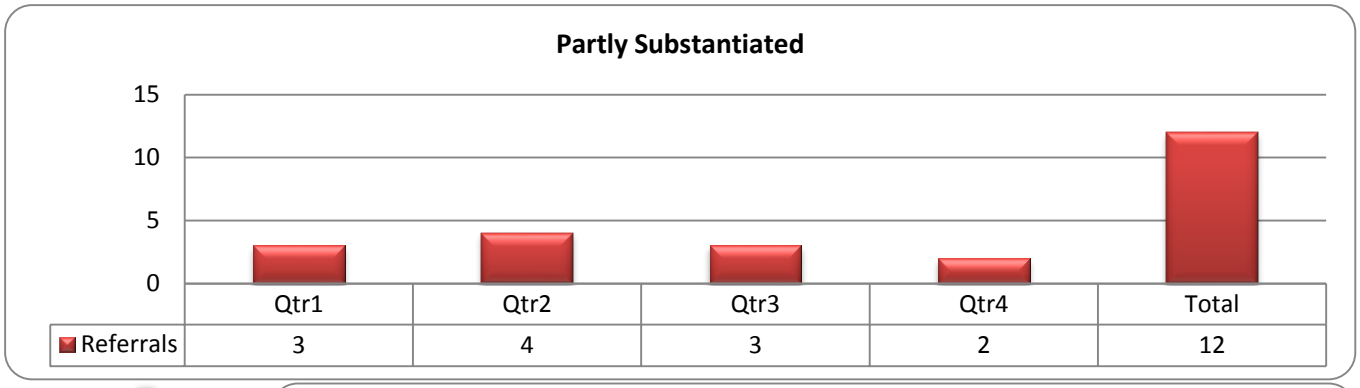
	Substantiated	Partly Substantiated	Unsubstantiated	Inconclusive	Investigation Ceased	Other
Qtr1	59	3	24	13	2	0
Qtr2	43	4	25	12	3	0
Qtr3	54	3	28	11	0	0
Qtr4	26	2	31	15	4	0

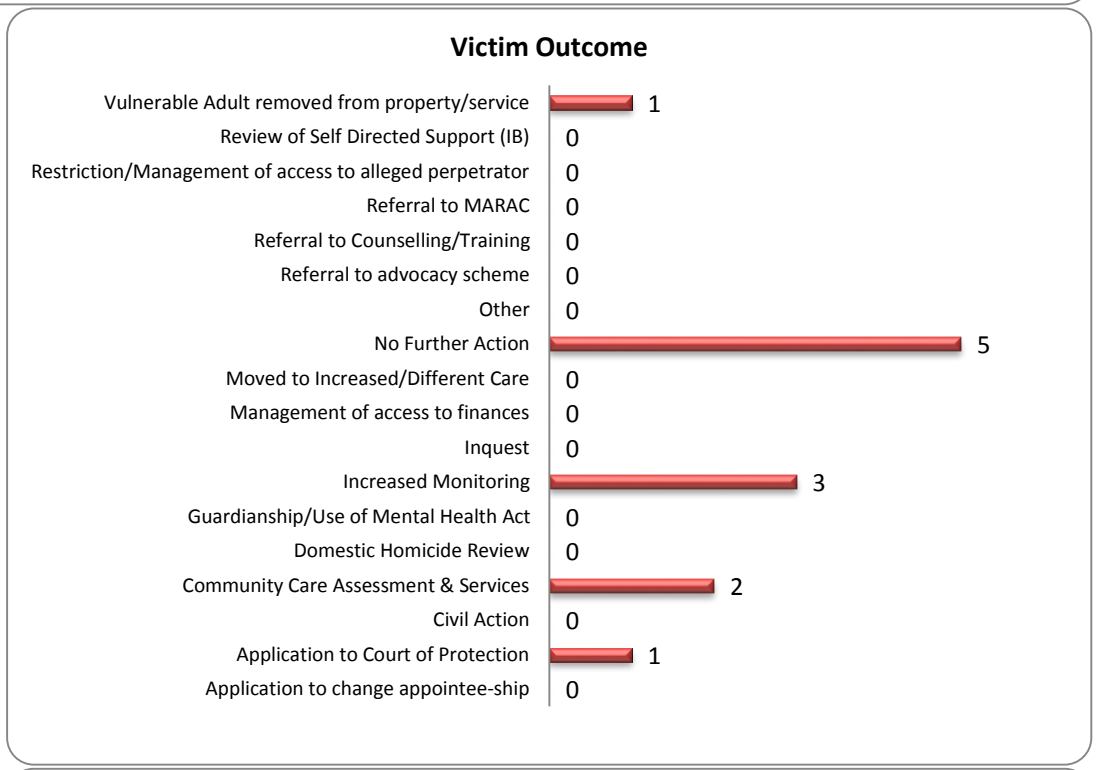


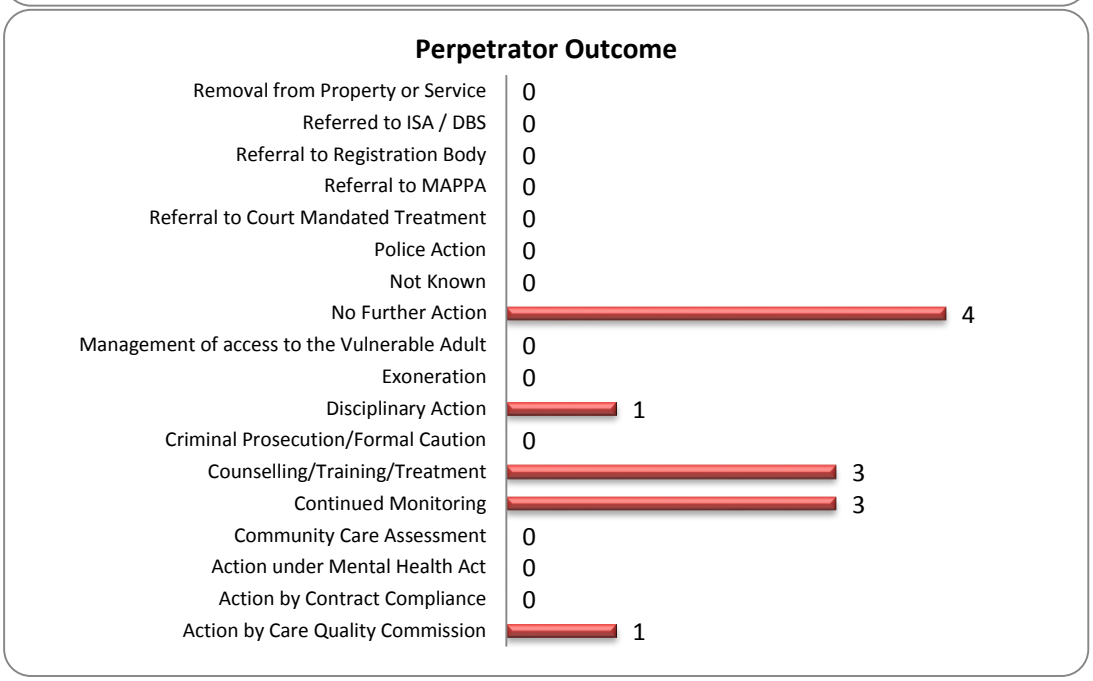

Substantiated
200
150
100
50
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
59
43
54
26
182

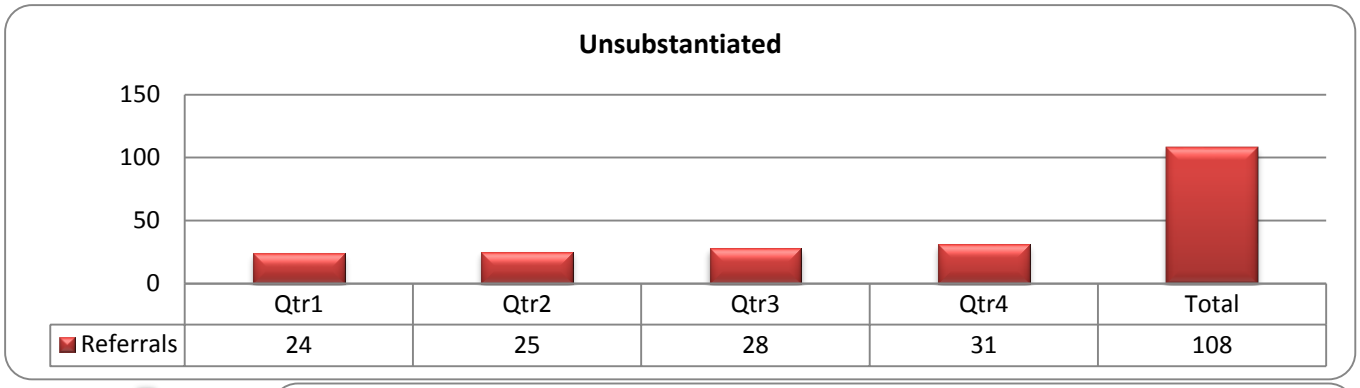

Victim Outcome
Vulnerable Adult removed from property/service 0
Review of Self Directed Support (IB) 1
Restriction/Management of access to alleged perpetrator 3
Referral to MARAC 2
Referral to Counselling/Training 0
Referral to advocacy scheme 1
Other 7
No Further Action 117
Moved to Increased/Different Care 6
Management of access to finances 1
Inquest 2
Increased Monitoring 30
Guardianship/Use of Mental Health Act 1
Domestic Homicide Review 0
Community Care Assessment & Services 8
Civil Action 0
Application to Court of Protection 0
Application to change appointee-ship 3

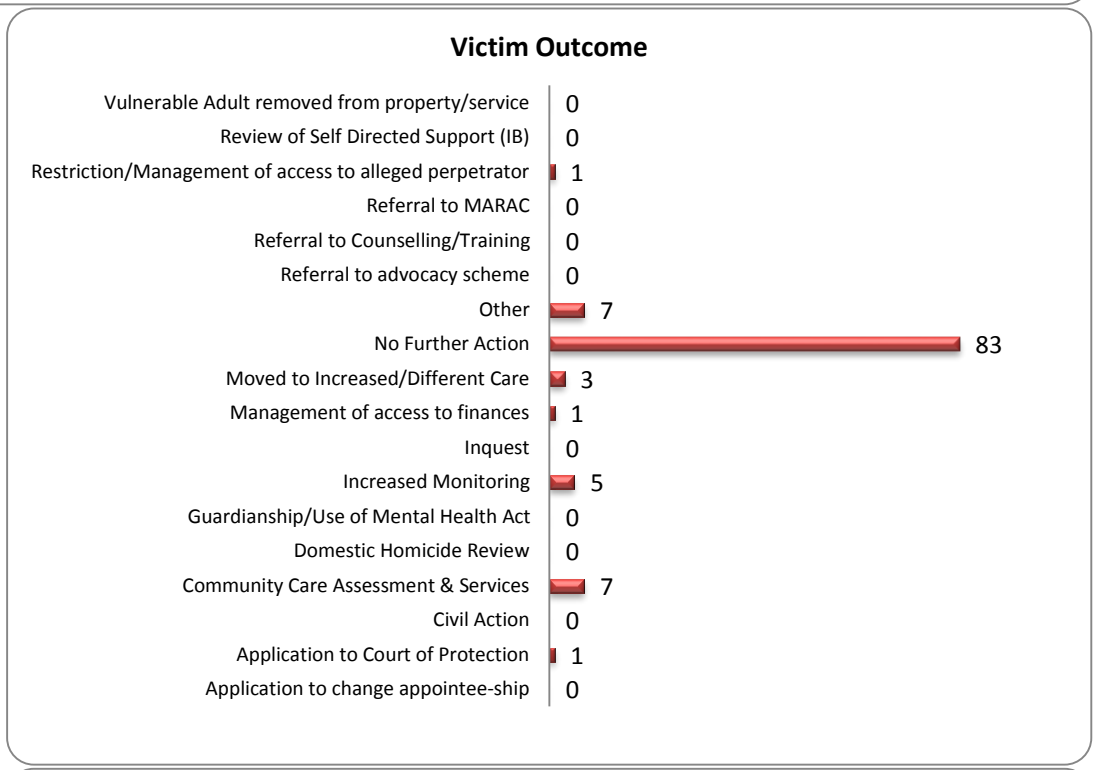

Perpetrator Outcome
Removal from Property or Service 3
Referred to ISA / DBS 4
Referral to Registration Body 1
Referral to MAPPA 0
Referral to Court Mandated Treatment 0
Police Action 5
Not Known 10
No Further Action 70
Management of access to the Vulnerable Adult 3
Exoneration 0
Disciplinary Action 33
Criminal Prosecution/Formal Caution 5
Counselling/Training/Treatment 5
Continued Monitoring 39
Community Care Assessment 3
Action under Mental Health Act 0
Action by Contract Compliance 0
Action by Care Quality Commission 2

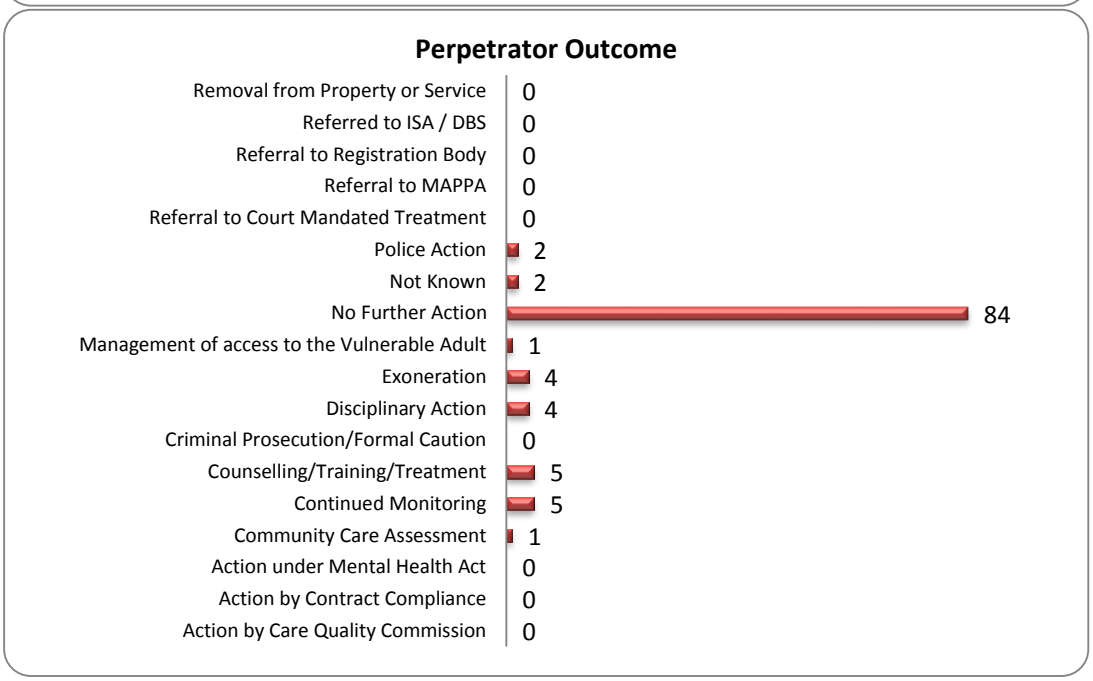

Partly Substantiated
15
10
5
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
3
4
3
2
12

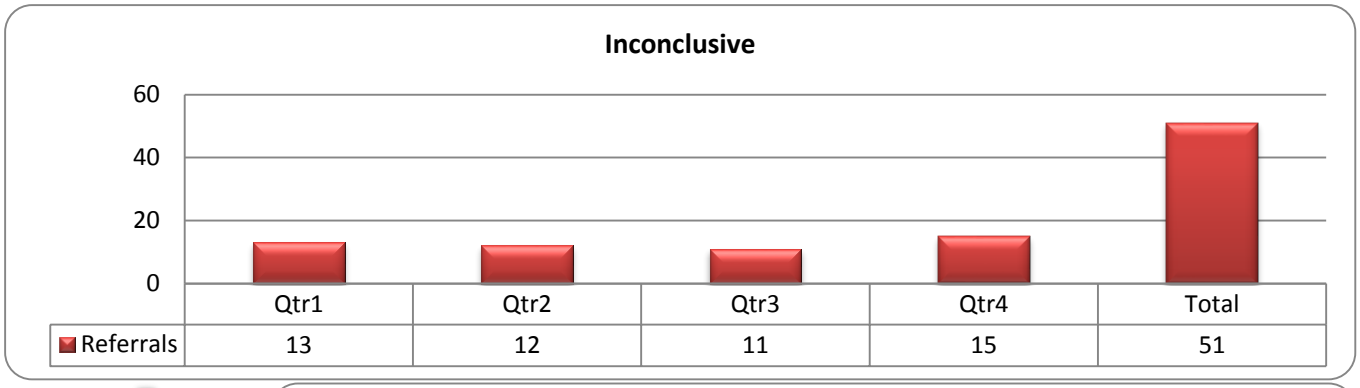

Victim Outcome
Vulnerable Adult removed from property/service 1
Review of Self Directed Support (IB) 0
Restriction/Management of access to alleged perpetrator 0
Referral to MARAC 0
Referral to Counselling/Training 0
Referral to advocacy scheme 0
Other 0
No Further Action 5
Moved to Increased/Different Care 0
Management of access to finances 0
Inquest 0
Increased Monitoring 3
Guardianship/Use of Mental Health Act 0
Domestic Homicide Review 0
Community Care Assessment & Services 2
Civil Action 0
Application to Court of Protection 1
Application to change appointee-ship 0

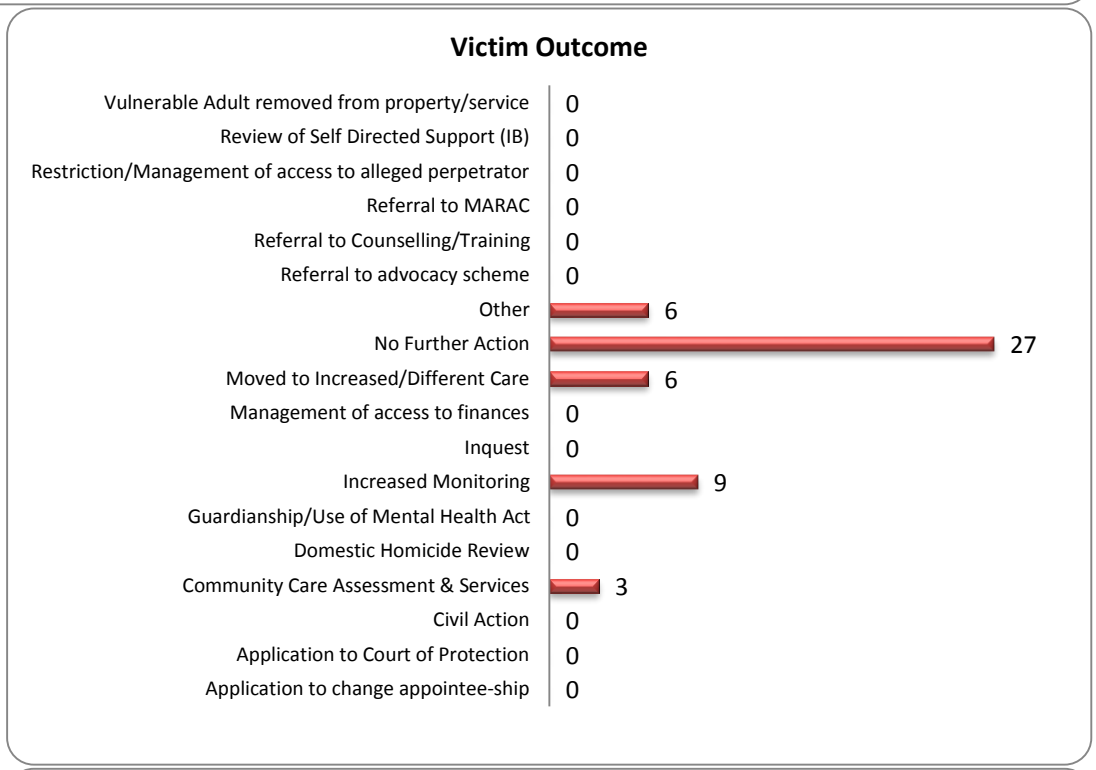

Perpetrator Outcome
Removal from Property or Service 0
Referred to ISA / DBS 0
Referral to Registration Body 0
Referral to MAPPA 0
Referral to Court Mandated Treatment 0
Police Action 0
Not Known 0
No Further Action 4
Management of access to the Vulnerable Adult 0
Exoneration 0
Disciplinary Action 1
Criminal Prosecution/Formal Caution 0
Counselling/Training/Treatment 3
Continued Monitoring 3
Community Care Assessment 0
Action under Mental Health Act 0
Action by Contract Compliance 0
Action by Care Quality Commission 1

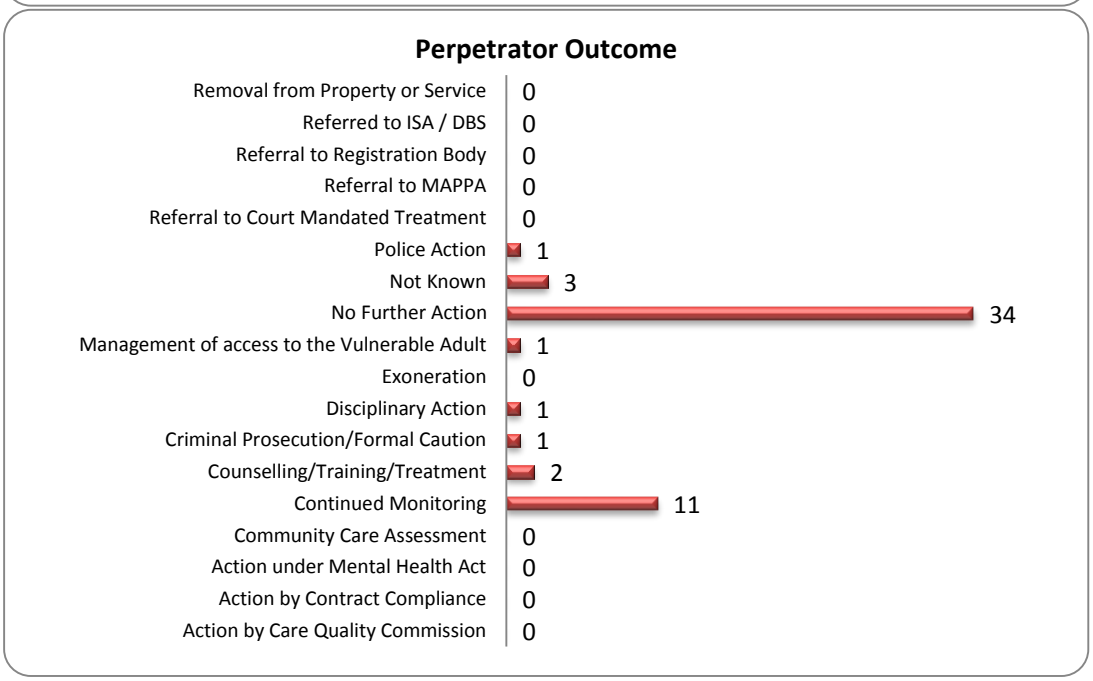

Unsubstantiated
150
100
50
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
24
25
28
31
108

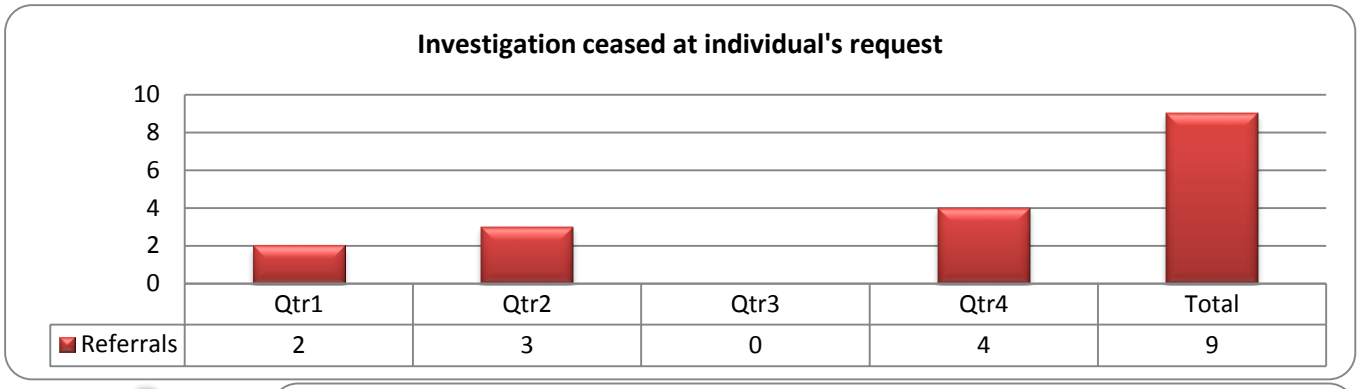

Victim Outcome
Vulnerable Adult removed from property/service 0
Review of Self Directed Support (IB) 0
Restriction/Management of access to alleged perpetrator 1
Referral to MARAC 0
Referral to Counselling/Training 0
Referral to advocacy scheme 0
Other 7
No Further Action 83
Moved to Increased/Different Care 3
Management of access to finances 1
Inquest 0
Increased Monitoring 5
Guardianship/Use of Mental Health Act 0
Domestic Homicide Review 0
Community Care Assessment & Services 7
Civil Action 0
Application to Court of Protection 1
Application to change appointee-ship 0

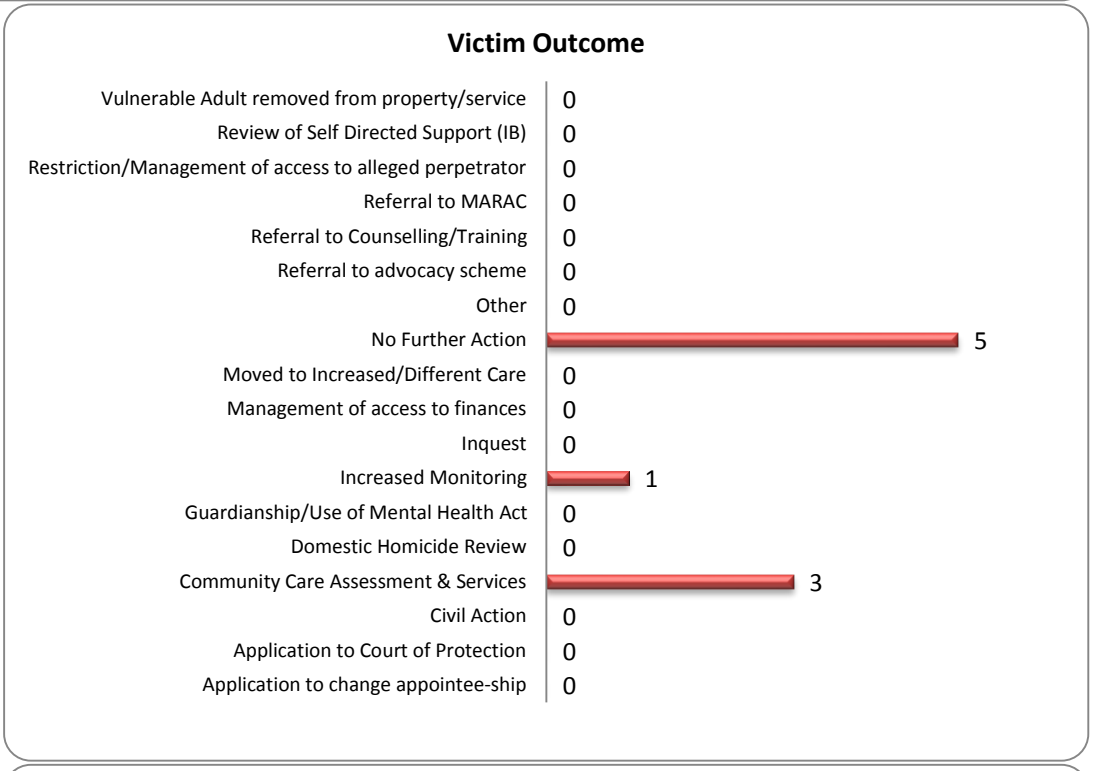

Perpetrator Outcome
Removal from Property or Service 0
Referred to ISA / DBS 0
Referral to Registration Body 0
Referral to MAPPA 0
Referral to Court Mandated Treatment 0
Police Action 2
Not Known 2
No Further Action 84
Management of access to the Vulnerable Adult 1
Exoneration 4
Disciplinary Action 4
Criminal Prosecution/Formal Caution 0
Counselling/Training/Treatment 5
Continued Monitoring 5
Community Care Assessment 1
Action under Mental Health Act 0
Action by Contract Compliance 0
Action by Care Quality Commission 0

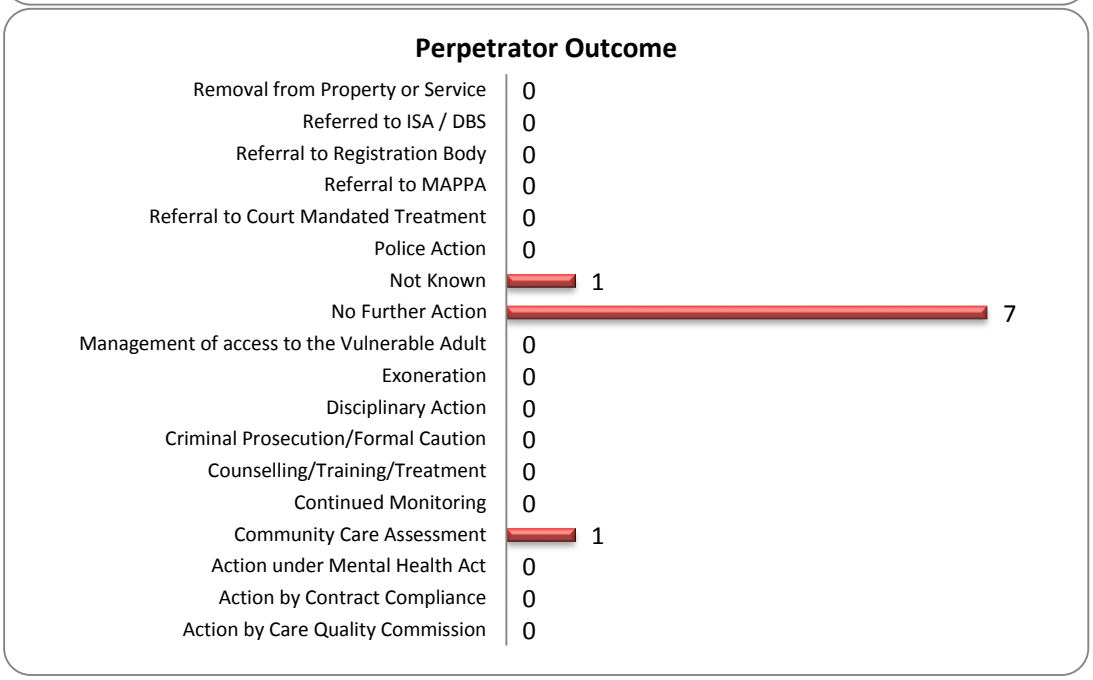

Inconclusive
60
40
20
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
13
12
11
15
51


Victim Outcome
Vulnerable Adult removed from property/service 0
Review of Self Directed Support (IB) 0
Restriction/Management of access to alleged perpetrator 0
Referral to MARAC 0
Referral to Counselling/Training 0
Referral to advocacy scheme 0
Other 6
No Further Action 27
Moved to Increased/Different Care 6
Management of access to finances 0
Inquest 0
Increased Monitoring 9
Guardianship/Use of Mental Health Act 0
Domestic Homicide Review 0
Community Care Assessment & Services 3
Civil Action 0
Application to Court of Protection 0
Application to change appointee-ship 0


Perpetrator Outcome
Removal from Property or Service 0
Referred to ISA / DBS 0
Referral to Registration Body 0
Referral to MAPPA 0
Referral to Court Mandated Treatment 0
Police Action 1
Not Known 3
No Further Action 34
Management of access to the Vulnerable Adult 1
Exoneration 0
Disciplinary Action 1
Criminal Prosecution/Formal Caution 1
Counselling/Training/Treatment 2
Continued Monitoring 11
Community Care Assessment 0
Action under Mental Health Act 0
Action by Contract Compliance 0
Action by Care Quality Commission 0


Investigation ceased at individual's request
10
8
6
4
2
0
Qtr1
Qtr2
Qtr3
Qtr4
Total
Referrals
2
3
0
4
9


Victim Outcome
Vulnerable Adult removed from property/service 0
Review of Self Directed Support (IB) 0
Restriction/Management of access to alleged perpetrator 0
Referral to MARAC 0
Referral to Counselling/Training 0
Referral to advocacy scheme 0
Other 0
No Further Action 5
Moved to Increased/Different Care 0
Management of access to finances 0
Inquest 0
Increased Monitoring 1
Guardianship/Use of Mental Health Act 0
Domestic Homicide Review 0
Community Care Assessment & Services 3
Civil Action 0
Application to Court of Protection 0
Application to change appointee-ship 0


Perpetrator Outcome
Removal from Property or Service 0
Referred to ISA / DBS 0
Referral to Registration Body 0
Referral to MAPPA 0
Referral to Court Mandated Treatment 0
Police Action 0
Not Known 1
No Further Action 7
Management of access to the Vulnerable Adult 0
Exoneration 0
Disciplinary Action 0
Criminal Prosecution/Formal Caution 0
Counselling/Training/Treatment 0
Continued Monitoring 0
Community Care Assessment 1
Action under Mental Health Act 0
Action by Contract Compliance 0
Action by Care Quality Commission 0

Section 6: Deprivation of Liberty statistics

	In Qtr Figures			Cumulative Figures		
	Total Applications	**Granted**	**Not Granted**	**Applications**	**Granted**	**Not Granted**
Qtr1	149	116	10	149	116	10
Qtr2	172	131	20	321	247	30
Qtr3	208	56	8	529	303	38
Qtr4						

The official statistics from the Health and Social Care Information Centre (HSCIC) paint a clear picture of the very significant increase in Deprivation of Liberty Safeguard (DoLS) applications since the 19 March 2014 Supreme Court judgment. There have been over 55,000 applications in the six months following the judgment and if this trend continues it points to a more than 8 fold-plus increase on 2013-14 figures (13,000 applications).

In addition to seeing a significant increase in the number of applications, the Supreme Court judgement handed down an "acid test"; where an individual lacks capacity and there is no valid consent, there will be no deprivation of liberty unless the test is met:

- Are they “free to leave”? Just because they are physically unable to leave of their own accord does not mean they are not free to leave for the purpose of the test – they may for example be able to leave with family assistance.

- Are they under “continuous control and supervision”? If the individual is in a private room and checked only every few hours then they may not necessarily be under continuous control and supervision.

This has simplified the assessment process and has seen the number of applications granted for the first six months of the year rise to 77% compared with 43% for applications received in 2013-14

NOTE : Total number of DoLS applications does not equate to the total number of DoLS applications granted and not granted, as some applications were not yet signed off by the Supervisory Body at the time of data submission or were withdrawn

5. Safeguarding Adults and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Training Sub-group Report.

SAFEGUARDING ADULTS AND MCA/DoLS TRAINING ATTENDANCE ANALYSIS						
(April 14 - March 15)						
Safeguarding Adults	**Courses delivered by ACWDU(***)**				**Courses delivered by Partner Organisations**	
Course	**BMBC**	**Indep Sec (*)**	**Health Orgs**	**Other (**)**	**BHNFT**	**SWYPFT**
Safeguarding Adults Awareness	15	462	2	1	701	434
E-Learning (Completions)	46	70			662	661
Safeguarding Minute Taking	10		9			
Safeguarding Champions		18				
Safeguarding Investigators	4		4			
Working Together to Safeguard Adults	4		1	14		
MAPPA Awareness		9				
Migration and Disabled/Vulnerable People	20					
CHANNEL Awareness (E-Learning)	9					
TOTALS	108	559	16		1363	1095
GRAND TOTAL	**3156**					
NOTE: E-learning package currently being revamped for both MCA/DoLS and Safeguarding Adults.						
**** Higher Education Institutes', Police, Probation * includes Personal Assistant's.**						
****ACWDU= Adults and Communities Workforce Development Unit.**						

(April 14 - March 15)						
MENTAL CAPACITY ACT/DoLS	**Courses Delivered by ACWDU**				**Courses Delivered by Partner Organisations**	
Course	**BMBC**	**Indep Sec(*)**	**Health Orgs**	**Other****	**BHNFT**	**SWYPFT**
MCA/DoLS Advanced Decisions Awareness	32	197	160	0	516	45
E-Learning (Completions)	0	0	0	0	60	31
Keeping the Record Straight	7	60	3	0	0	0
Bespoke MCA Sessions	119	52	0	0	0	0
New DoLS Case Law	10	71	2	1	0	0
TOTALS	168	380	165	1	576	76
GRAND TOTAL	**1366**					

NOTE: E-learning package currently being revamped for both MCA/DoLS and Safeguarding Adults

**** Higher Education Institutes', Police, Probation * includes Personal Assistant's.**

6 Safeguarding Adults Board Targets for 2015-2016

- The Safeguarding Adults Board (SAB) to maintain a clear vision of the outcomes it wants to achieve during 2015 – 2016 through its Safeguarding Adults Strategic Plan.

- To continue effective joint working between the Safeguarding Adults Board (SAB), the Safeguarding Children Board (SCB) and local strategic partners.

- To ensure partner agencies understand their leadership roles, responsibilities and their contributions towards the Safeguarding Adults Board's Strategic plan.

- To ensure full implementation of the requirements of the Care Act 2014 in relation to Making Safeguarding Personal (MSP).

- To ensure full implementation of the requirements of the Care Act 2014 in relation to the production of an Annual Report and a Strategic Plan for each financial year.

- Ensuring the Communication Strategy and the Safeguarding Adults Board Action plan are reviewed and updated in light of the Care Act 2014.

- Ensuring Safeguarding Adults Procedures for South Yorkshire are being implemented across all partner agencies in order to ensure the safety and protection of vulnerable adults.

- To maintain liaison with regional partners to maintain networks in order to share and disseminate good practice across South Yorkshire.

- To ensure that systems are in place, including a clear strategy that incorporates service user and carer involvement in the safeguarding of vulnerable adults.

- To highlight areas of concern through sub group analysis and produce learning outcomes for additional training sessions as required.

- Continue to participate fully in the PREVENT agenda for those who are vulnerable to messages of violent extremism. The Counter-Terrorism and Security Act 2015 requires that all front-line workers are trained to recognise when a person might be susceptible to the messages of violent extremism and radicalisation.

- Encourage multi-agency participation in Domestic Homicide Reviews (DHRs) and Serious Case Reviews (SCRs), now known as Safeguarding Adults Reviews (SARs) and to provide appropriate levels of training to the multi-agency workforce that become involved with DHRs and SARs.

- To ensure the Safeguarding Adults Board uses the experiences of those using safeguarding services to drive improvements in services and to provide for quality

assurance through the use of regular audits of safeguarding activity and the quality of the work undertaken.

- To ensure the Safeguarding Adults Board drives quality assurance forward through its Performance Management and Quality Assurance Sub-group and ensure there is appropriate evidence that this leads to service improvement.

- Ensure the Safeguarding Adults Board has effective arrangements to identify and secure financial resources to deliver its vision and strategy.

- The Safeguarding Adults Board continues to ensure that a training strategy is in place to include all levels of safeguarding training from basic awareness to the chairing of complex safeguarding adults cases.

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7 Current Membership of the Safeguarding Adults Board

NHS Barnsley and the Safeguarding Adults Board continue to report to the Health and Wellbeing Partnership.

Membership of the Safeguarding Adults Board 2014-2015

Cabinet Spokesperson for Adults & Communities - CHAIR	BMBC
Deputy Cabinet Spokesperson for Adults & Communities – DEPUTY CHAIR	BMBC
Executive Director of Adults & Communities	BMBC
Assistant Executive Director of Vulnerable Adults & Chair of Operational Management Group	BMBC
Assistant Executive Director, Disability & Provider Services & Chair of Training Sub Group	BMBC
Assistant Director of Nursing, Clinical Governance and Safety (Portfolio Lead Safeguarding Adults and Children), SWYPFT & Chair of Performance Management and Quality Assurance Sub Group	SWYPFT
Specialist Nurse, Safeguarding & Chair of the Practice Learning Sub Group	Barnsley CCG
Safeguarding Adults Service Manager	BMBC
Chief Nurse	Barnsley CCG
Deputy Chief Nurse	BHNHSFT
Acting Director, Public Health	BMBC
Head of Safeguarding and Welfare, Children Young People and Families	BMBC
Assistant Director, Community Safety Partnership	BMBC
Business Planning and Performance Manager, Adults and Communities	BMBC
District Crime Manager, Barnsley	SY Police
Safeguarding Officer	SY Fire & Rescue
Service User / Carer Representative	

Director of Housing Management	Berneslai Homes
Affordable Housing Enabling Officer, Strategy, Growth and Regeneration	BMBC
Assistant Executive Director, Joint Commissioning Unit	BMBC
Vice Principal Students	Barnsley College
Vice Principal (Residential and Administrative Services)	Northern College

Safeguarding Adults Board Annual Report 2014-2015

Author:
Yvonne Butler, Safeguarding Adults Service Manager

With contributions from Safeguarding Adults Board partners.

Appendix A

Meetings and Frequency

The Safeguarding Adults Board meets on a three-monthly basis. Extraordinary SAB meetings are convened as required.

Appendix B

Safeguarding Adults Board Sub Groups

- Operational Management Group
  – Convened bi-monthly

- Safeguarding and MCA/DoLS Training Sub Group
  – Convened bi-monthly

- Performance Management and Quality Assurance Sub Group
  – Convened bi-monthly

- Communication/Engagement Sub Group
  – Convened bi-monthly

- Specific Time-Limited Sub Group
  – Convened as required.

The roles and functions of the Safeguarding Adults Operational Management group and Sub Groups are to inform the strategic direction and implement the SAB Action plan set out by the Barnsley Safeguarding Adults Board.

Extra-ordinary meetings of the Operational Management Group and Sub Groups can be convened as required.

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REPORT TO THE HEALTH AND WELLBEING BOARD

8 December 2015

PUBLIC HEALTH STRATEGY 2016-18

Report Sponsor: Julia Burrows
Report Author: Rebecca Clarke
Received by SSDG: 16 November 2015
Date of Report: 23 November 2015

1. Purpose of Report

1.1 To present the Public Health Strategy 2016-2018 to the Health and Wellbeing Board.

2. Recommendations

2.1 Health and Wellbeing Board members are asked:-

- Note the content of the Public Health Strategy.
- Consider how the strategy's outcomes and priorities and can be aligned to the work of their organisations.

3. Introduction/ Background

3.1 A Healthier Happier Barnsley is our three-year Public Health Strategy for the borough. The strategy demonstrates the commitment of the council to work with partners to improve the health of all people living in Barnsley. It outlines our Public Health vision 'children have the best start in live and everyone enjoys a happy healthy life wherever they live and whoever they are' and includes four long term public health outcomes as well as three short term public health priorities.

3.2 We know that what happens to children before they are born and their experiences as they grow and develop can affect their health and opportunities later in life. We also know that children and young people who grow up in a safe environment and have a positive relationship with their families and communities are more likely to do better as they go through life. Therefore, the council is committed to work with partners to tackle the problem of poor health and health inequalities by focusing our efforts on children, young people and their families across the borough.

3.3 The strategy contributes to achieving the Barnsley Council vision, a brighter future and a better Barnsley and the three Barnsley Council priorities, thriving and vibrant economy, people achieving their potential and strong and resilient communities through our four long term public health outcomes:

- Our residents will start life healthy and stay healthy
- Our residents will live longer healthier lives
- We narrow the gap in life expectancy and health between the most and least healthy
- We protect our communities from harm, major incidents and other preventable health threats

3.4 To demonstrate we are making a difference in the short term we recognise that we must focus our resources in order to achieve the biggest impact on public health and wellbeing. We have therefore focused on three evidence based priority areas:

- improving the oral health of children
- creating a smokefree generation
- increasing levels of physical activity.

4. Conclusion/ Next Steps

4.1 A separate action plan will be developed for each of the three priority areas to identify in greater detail what we will do and how we will do it to. This will also provide evidence to demonstrate how the distributed model of public health is working in Barnsley.

4.2 The strategy will be used as a resource to embed public health outcomes and priorities into day to day working as a public health council. The strategy will be shared with all partners involved in building a sustainable public health system in Barnsley. It will also be made available to residents on the Barnsley Council website.

5. Financial Implications

5.1 There are no financial considerations at this time.

6. Consultation with stakeholders

6.1 The strategy has been drafted in consultation with colleagues from the People, Place, Communities Directorates, Barnsley CCG, Healthwatch and presented to the Barnsley Public Health Forum.

6.2 The report has been discussed by Senior Management Team and the Senior Strategic Development Group.

7. Appendices

7.1 Appendix 1 – A Healthier Happier Barnsley: Our Public Health Strategy 2016-2018.

Officer: Rebecca Clarke **Contact:** 01226 776445 **Date:** 23 November 2015

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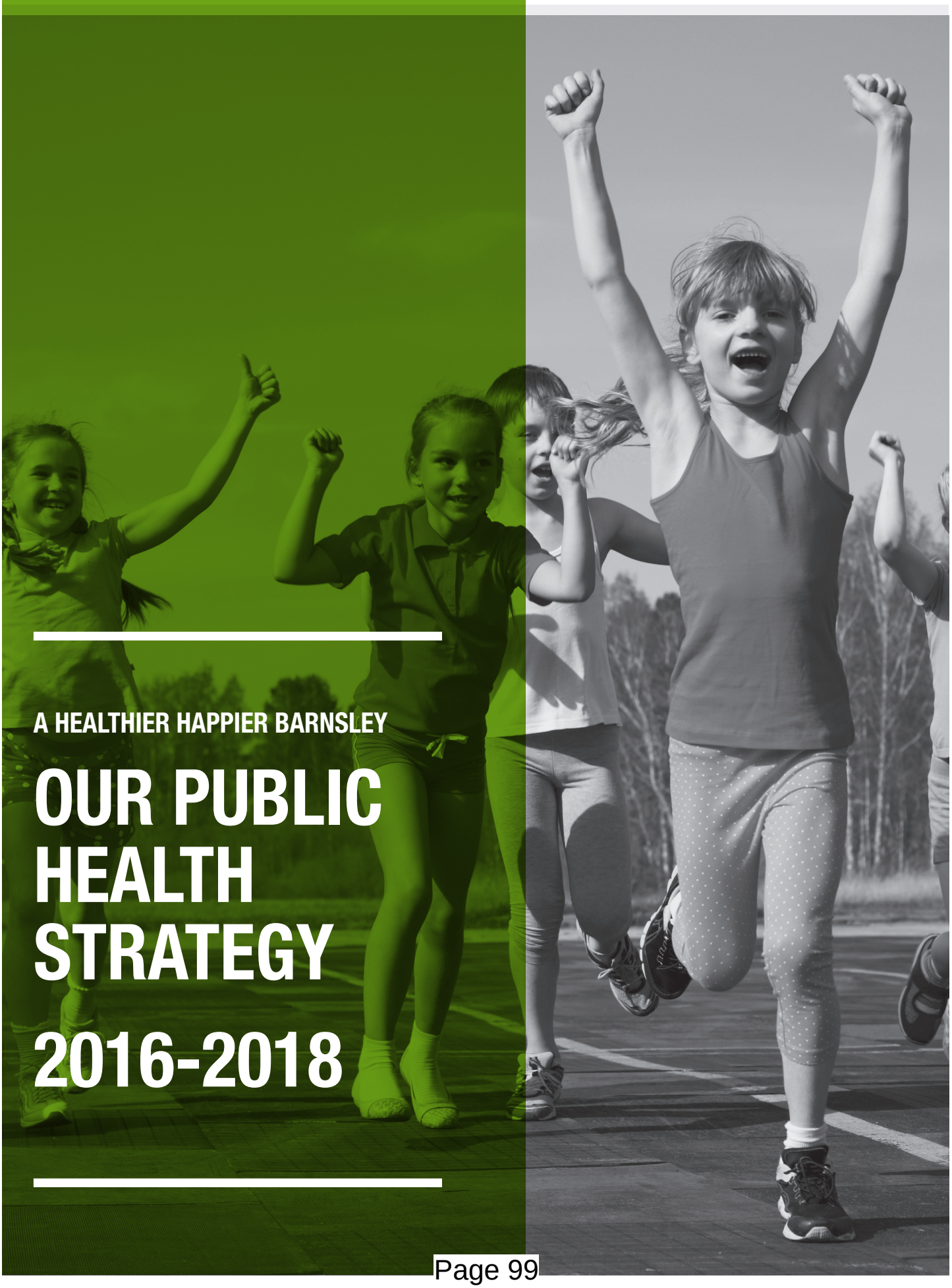
BARNSLEY
Metropolitan Borough Council



A HEALTHIER HAPPIER BARNSLEY

OUR PUBLIC HEALTH STRATEGY 2016-2018

Contents

Foreword

We want to ensure that all Barnsley children are given the best start in life and all our residents enjoy a happy healthy life. We recognise the considerable effect that health and wellbeing has on the happiness and life chances of our residents.

We know that what happens to children before they are born and their experiences as they grow and develop can affect their health and opportunities later in life. We also know that children and young people who grow up in a safe environment and have a positive relationship with their families and communities are more likely to do better as they go through life. Therefore, the council is committed to work with partners to tackle the problem of poor health and health inequalities by focusing our efforts on children, young people and their families across the borough through actions aimed at giving every child in Barnsley the best start in life. We recognise that we must focus our resources in order to achieve the biggest impact on public health and wellbeing. We have therefore focused on three areas, improving the oral health of children, creating a smokefree generation and increasing levels of physical activity.

We have put in place a distributed model that places public health resource and expertise throughout Barnsley Council. This means we can address the borough's public health challenges as a public health council. We recognise that we need to work collectively to build a sustainable public health system in Barnsley, where agencies with statutory responsibilities work collaboratively with all agencies that make a contribution to public health. This means the council; the NHS, police, fire, probation service, schools, employers, businesses, voluntary and community agencies and others across the borough, all have a role to play. No single agency has the answer, and we must all work together, playing our parts and playing to each others' strengths.

Our ambitions need to be realistic given the challenge of cuts to local government funding, which includes the public health grant as part of central government austerity measures. By working differently to achieve this strategy we want to bring benefits now and in the future to our children and all local people, in terms of their quality of life and better health.

Cllr Jim Andrews
Deputy Leader of the Council, Cabinet Spokesperson for Public Health

1. Our vision

All Barnsley children are given the best start in life and everyone can enjoy a happy healthy life regardless of who they are and wherever they live.

This strategy reflects on the public health work already underway in Barnsley with thousands of residents already making use of and benefiting from public health services each year (see Figure 1).

Figure 1 Snapshot of Barnsley public health service usage in the last year

2,652 children in Reception and **2,316** children in Year 6 reached by the National Childhood Measurement Programme	**1,301** residents helped to quit through stop smoking services	Over **14,500** Barnsley pre-school children have received oral health promotion advice	Over **300** children and young people have taken part in free weekly physical activity events
1,590 people who achieve the lifestyle behaviour change goal identified in their Personal Health Plan	**Public Health Services**		**13,900** residents were in contact with Sexual and Reproductive Health services
976 new cases of sexually transmitted infections[1] have been diagnosed and treated	**2,743** (95%) of Barnsley children received two doses of MMR by their 5th birthday	**8,517** NHS Health Checks delivered to eligible residents aged 40-74	**1,810** new mothers have been supported to initiate breast feeding

This strategy also describes our future priorities and focus. Avoidable ill-health and the risk factors for this, if left un-tackled, will hinder our efforts to achieve our vision and grow the economic prosperity of the borough. Therefore our focus needs to be on:

- Doing more to ensure our children have the best start in life to grow up healthy, ready for school and later in life the workplace.
- Doing more to focus on building healthier communities and the contribution that everyone can make to improving health and reducing health inequalities including:

[1] excluding chlamydia under 25 year olds

Elected Members through Area Councils and Ward Alliances, NHS bodies, schools, employers, businesses, community and voluntary groups.

2. Why a strategy for Public Health?

Good health is what we all aspire to for ourselves, our families, carers, friends and communities. There are many determinants of health including genetic factors, the impact of where we live, our social, environmental and economic circumstances and the quality of health care, especially primary care. Recent policy has acknowledged that local government is well placed, in its strategic place-making role to lead on these elements with partners.

The Marmot Review[2] into health inequalities in England was published in 2010. This important report proposes an evidence based strategy to address the social determinants of health. The circumstances in which people are born, grow, live, work and age can contribute to health inequalities. Central to the Marmot Review is a life course perspective and giving every child the best start in life. Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child and on into adulthood. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. In addition the report of the Inquiry, Due North, was published in September 2014. The Inquiry panel, supported by a wide range of experts, made recommendations aimed at tackling the root causes of health inequalities and focused on the contributions that national and local government, the NHS and other agencies can make to reduce inequalities experienced by individuals and communities in the north of England. The recommendations follow four broad themes:

- economic development and living conditions
- early childhood as a critical period
- devolving power to make a difference at the right level
- the role of the health sector

For these reasons, every child having the best start in life is our highest priority in Barnsley along with recognising that there is a clear need to address the health and happiness of all our residents across the life course.

[2] Marmot Review http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

3. How this strategy contributes to Barnsley Council's Corporate Plan

Barnsley Council's Corporate Plan 2015-18[3] sets out what we want to achieve over the next three years for our local residents.

The council has changed significantly over the last three years as we have implemented our Future Council Strategy. This has challenged us to change our culture and deliver services in more innovative ways, whilst delivering planned savings and efficiencies.

We have a new vision: 'working together for a brighter future, a better Barnsley', not only for the council, but also for the borough which has been agreed with our partners within 'One Barnsley'. The Plan sets out priorities and outcomes which enable us to be clear about how we are going to work and what impact we need to make (see figure 2).

Figure 2. Corporate Plan Priorities and Outcomes

Corporate Plan Priorities	Corporate Plan Outcomes
Thriving and vibrant economy	1. Create more and better jobs and good business growth 2. Increase skills to get more people working 3. Develop a vibrant town centre 4. Strengthen our visitor economy 5. Create more and better housing
People achieving their potential	6. Every child attends a good school 7. Early, targeted support for those that need it 8. Children and adults are safe from harm 9. People are healthier, happier, independent and active
Strong and resilient communities	10. People volunteering and contributing towards stronger communities 11. Protecting the borough for future generations 12. Customers can contact us easily and use more services online

[3] Corporate Plan 2015-18 https://www2.barnsley.gov.uk/media/3704553/corporate_plan_2015-18.pdf

While our Public Health Strategy specifically contributes to delivering Outcome 9 'People are healthier, happier, independent and active', it will also work across all of the three priority areas and a number of the twelve outcomes. Health improvement and inequality continues to be a challenge for the borough and this is influenced by a number of factors such as the quality of healthcare, lifestyle and wider factors such as employment, education, housing and poverty. We have also ensured it aligns well with other council plans, strategies and partnerships, such as the multi-agency Stronger Communities Partnership, which brings together system-wide leadership to the community and early help offer. The approach we are taking supports the agreed single vision for health and care in Barnsley set out in the Health and Wellbeing Strategy 2014-2019:

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

It also reflects the emerging over arching theme of keeping people healthy drawn from the development work undertaken by the Health and Wellbeing Board in September 2015.

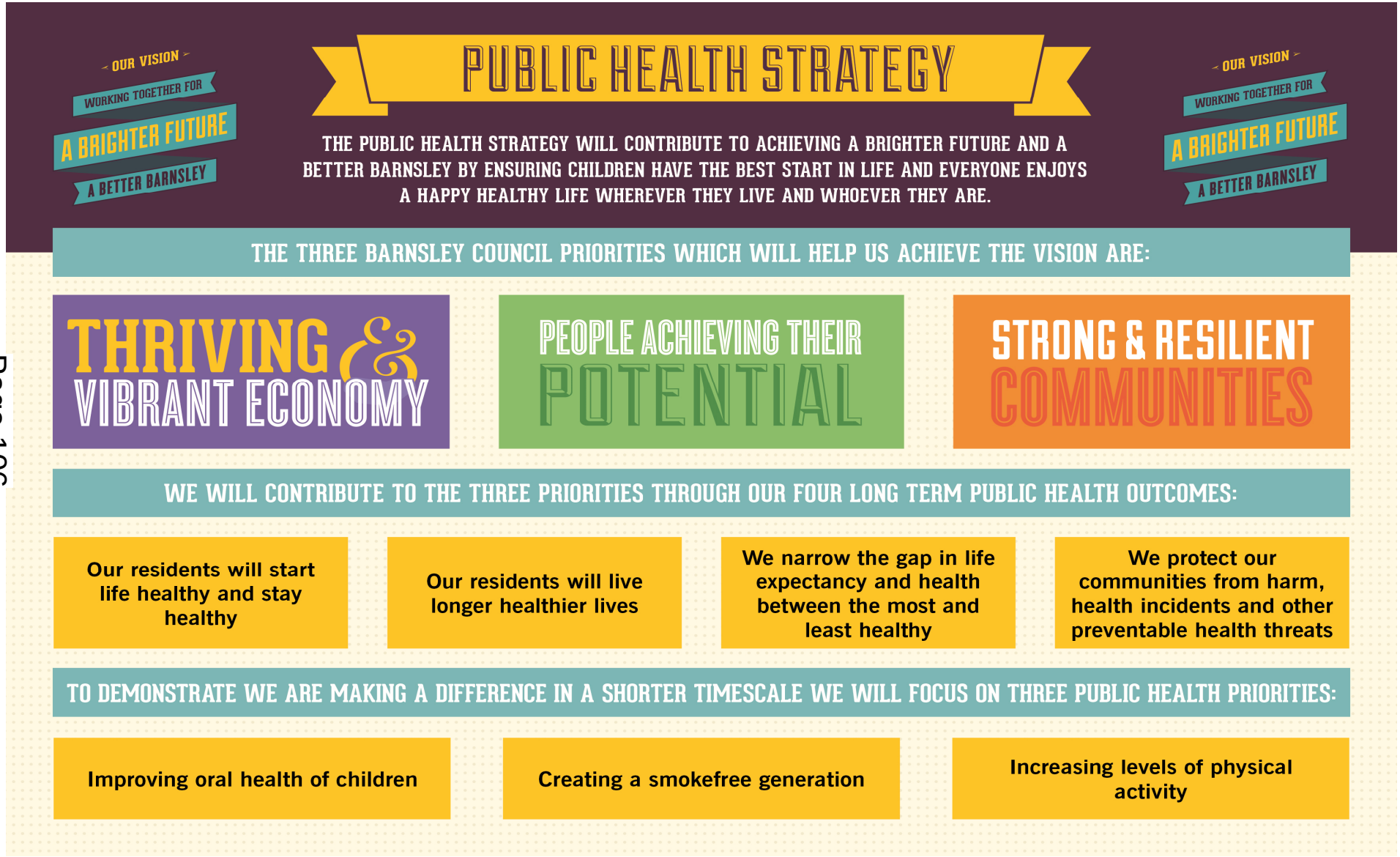
This strategy supports the vision, priorities and strategic direction of Barnsley Clinical Commissioning Groups Strategic Commissioning Plan 2014-2019 (refresh). Which recognises that we will achieve little working in isolation and need to work with our partners to make sure we deliver our shared priorities and improve health outcomes across Barnsley.

There is a clear focus across the borough on enabling people to take responsibility for their own health and wellbeing by providing the environments, infrastructure, skills and opportunities. We need to work jointly with local people, communities, partners, providers and other stakeholders to ensure that health and care services are delivered in an efficient and effective way, focused upon the needs of patients and designed to improve the health of Barnsley residents.

4. Our Public Health Strategy at a glance

An overview of the our Public Health Strategy is shown in summary in Figure 3 which sets out our vision to give every child the best start in life and improve health outcomes for all our residents and how this contributes to the Council vision and priorities.

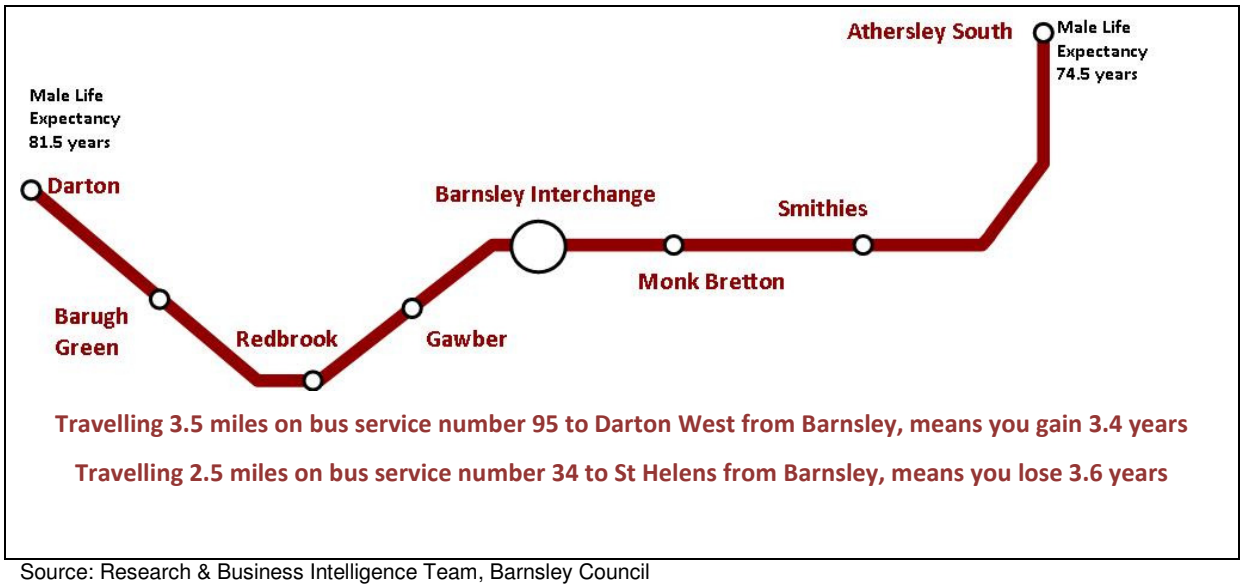
Figure 3: Our Public Health Strategy at a glance



5. Health needs in Barnsley

Although the health of residents in Barnsley is improving, too many people are dying prematurely from diseases that are largely avoidable. There are considerable differences in life expectancy and healthy life expectancy when compared with England, other local authority areas and within the borough. As illustrated in Figure 4 below.

Figure 4: Differences in Male Life Expectancy within Barnsley (2009-2013): The bus journey of inequality



Source: Research & Business Intelligence Team, Barnsley Council

There are a number of reasons why there is this considerable difference locally:

- Too many people in our borough live their lives in avoidable disability caused by disease as a result of modifiable lifestyle issues including: smoking, obesity, poor diet, low levels of physical activity and excess alcohol consumption.
- Too many people in our borough die early from avoidable diseases such as cancer, heart disease and stroke.
- Smoking remains our biggest cause of avoidable death.
- Being overweight or obese is reducing the life expectancy of too many of our young people and adults.
- The number of people experiencing preventable mental ill-health conditions is high.

6. Public Health Council

We know that times of austerity will have a detrimental impact on health and need for services so it is vital to maintain preventive initiatives at a time when our resources are constrained. We will aim to identify the public health interventions that will both improve health and assist those most affected by economic recession and stimulate economic recovery. There is good evidence to support an expanded role for health improvement and disease prevention to increase value for money and, for some approaches, to go further and actually create a return on investments for health and other sectors, as well as potentially promoting an increase in wider economic productivity.

Therefore the resources of the council, not solely the public health grant, should be fully utilised to maximise health and wellbeing through all the work it does with Barnsley residents. Obviously, health services make a crucial contribution to population health, and we will continue to work closely with NHS commissioners (the Barnsley Clinical Commissioning Group, NHS England and Public Health England) and health service providers to maximise the impact of clinical health services on Barnsley's health. The NHS Five Year Forward Plan makes it clear that public health prevention and promotion is a key priority for the NHS. NHS England also has an important public health role in commissioning vaccination and immunisation, and screening programmes. We will continue to monitor these, and seek assurance that these programmes are delivered safely and effectively.

As part of the Barnsley "distributed" public health model each council directorate has taken responsibility for ensuring the borough makes progress against specific indicators in the Public Health Outcomes Framework (PHOF). The PHOF requires local areas to focus on increasing life expectancy and reducing health inequalities. This can be achieved by addressing a range of indicators across four key domains:

i) Improving the wider determinants of health – improvements against wider factors that affect health and wellbeing and health inequalities
ii) Health improvement - people are helped to live healthy lifestyles, make healthy choices and reduce inequalities
iii) Health protection – the population's health is protected from health incidents and other threats, whilst reducing health inequalities

iv) Healthcare public health and preventing premature mortality – reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities.

7. What we will achieve and how we will work together

For Public Health to succeed and deliver real outcomes for residents, progress has to be made in three key areas:

Creating and re-shaping local services – shaping services which is determined by local priorities and where the financial risk associated with large inherited NHS contracts is reduced through: re-procurement, new models of commissioning, a shift of spend away from expensive hospital-based settings to community care and primary care (e.g. GPs and pharmacies); and by focusing more spend on prevention.

Creating a public health council – ensuring that the council influence on the wider determinants of health (such as housing, education, employment and planning) is brought to bear to improve health and wellbeing for our residents. This also includes all council staff and elected members perceiving health and wellbeing to be part of their responsibility, so that any council contact with the general public is seen as an opportunity to promote health and wellbeing ('making every contact count').

Valuing our partners - ensuring that the council works productively with key partners such as the Barnsley Clinical Commissioning Group (CCG), NHS England, Public Health England, police, schools, and the voluntary sector to address population-level challenges that no single agency can address on its own, e.g. effective multi-agency and partnership approaches to preventing and managing childhood obesity and increase physical activity.

8. Public Health outcomes

As outlined in Figure 3, we have developed four long term Public Health outcomes to deliver this strategy and provide the borough with public health programmes that are focussed on priorities, provide value for money and take account of the anticipated pressure on future budgets. They are important not just to the agencies in Barnsley with statutory public health roles, but to everyone. Figure 5 below outlines for each outcome, what it means, why we have chosen it, our successes so far, our challenges and what we need to do to achieve it.

The responsibility of delivering these outcomes lies with not only the public health distributed model but with collectively work across the public health system in Barnsley. Agencies with statutory responsibilities work in partnership with all agencies, voluntary sector and local people to make a contribution to public health. The successes of this partnership working are outlined in Figure 5 below.

A separate action plan will be developed to identify in greater detail what we will do and how we will do it to. This will also provide evidence to demonstrate how the distributed model of public health is working in Barnsley.

Figure 5. Achieving our public health priorities for our residents

Outcome 1	**Our residents will start life healthy and stay healthy**
What does this mean?	All Barnsley children are given the best start in life. We will ensure to do what we can to improve health and wellbeing before conception across the life course.
Why have we chosen this?	There is overwhelming evidence that a healthy start for children and young people is a key public health priority. Giving every child the best start in life is crucial for sustaining health throughout life into older age.
Successes – a snapshot of what we have already achieved	• Infant feeding service supports over 1,800 mothers and their babies per year. The service promotes mother to mother infant feeding support, promoting, protecting and normalising breast feeding. • Breastfeeding Welcome Scheme for all premises accessed by the public which also includes staff returning to work and breastfeeding. • 'Brushing twice a day is the super hero way' message and superhero images to encourage brushing twice a day, visiting the dentist and awareness raising of the application of fluoride varnish. • Cook and eat sessions across Area Councils for children, young people and families. • Active travel plans are inclusive of the needs of children, young people and families. • Trading standards and regulatory services working with fast food facilities. • 'Fit Families' successfully piloted. All participating families increased their

	physical activity and they were set goals to continue. • Promotion of local physical activity initiatives such as Bike it, Bikeability and Junior Park Run. • Smokefree homes promotion in partnership with South Yorkshire Fire and Rescue has been established. • Work with trading standards and regulatory services to address under age tobacco sales and illicit/counterfeit tobacco. • Social norms work to reduce incidence of uptake of smoking in children and young people. • Spectrum Community Health is delivering Barnsley's new Integrated Sexual Health Services. This includes the delivery of a Relationship and Sex Education (RSE) programme that schools are entitled to, free of charge.
Challenges	The following areas remain a local concern and challenge and lie at the root of avoidable ill health and inequality:- • Under 18s conceptions • Obesity in children • Poor oral health • Smoking prevalence • Physical inactivity • Maternal obesity • A&E attendances
What do we need to do?	i) Commission all mandated public health services in a way which underpins a life course approach to early help, prevention and health improvement. ii) Ensure the 0-19s integrated public health service for children and young people will make a major contribution to the development of self-esteem, positive relationships and healthy behaviour and lifestyle choices. iii) Ensure a healthy start, early intervention and prevention for every child through effective coverage of pre-conception, prenatal and perinatal care, health visiting, immunisation and public health services. iv) Create a targeted approach to improving the oral health of children. v) Reduce childhood obesity starting with a focus on the areas of highest prevalence. vi) Increase physical activity levels, engagement with sport and physical activity. vii) Create a smokefree generation, with particular focus on reducing smoking in

	pregnancy. viii) Ensure sexual health services, including contraceptive services, are accessible, personalised and effective. ix) Ensure under 18 conceptions continue to reduce. x) Develop a resilience model to support vulnerable families to reduce risky behaviours. xi) Work with the 0-5s service to ensure children are ready for school and opportunities are identified to tackle the causes of child poverty. xii) To work in partnership to ensure every effort is made to prevent unintentional and deliberate injuries to children and young people.

Outcome 2	**Our residents will live longer healthier lives**
What does this mean?	Increase life expectancy and healthy life expectancy in Barnsley and reduce health inequalities within our population. Reduce the prevalence of the five most common risk factors for early death: smoking, obesity, inactivity, poor diet and excess alcohol consumption.
Why have we chosen this?	There is overwhelming evidence that too many Barnsley residents spend a significant part of their lives in avoidable ill health and disease related disability.
Successes – a snapshot of what we have already achieved	• We have seen reductions in all-age and all-cause mortality; reduction in early death rates from heart disease, stroke and cancer. • The distributed model of public health is an important step in supporting work throughout the council to improve public health outcomes by addressing the wider determinants of health, and through working with all partners, including the NHS, on reducing health inequalities and healthcare quality. • The public health offer to Barnsley Clinical Commissioning Group (CCG) - as well us using public health skills and resources to improve health for local residents, the core offer to the CCG has provided an opportunity to work together with the CCG to improve outcomes. We have been able to challenge and influence each other to really begin to make a difference to the healthy life expectancy of our local population and influence primary care services. • The council has launched an innovative integrated health and wellbeing

	service - Be Well Barnsley. This service provides a suite of accessible lifestyle interventions to support Barnsley people to make sustainable health and lifestyle changes.
Challenges	• Premature death and life expectancy although generally improving remains significantly worse for some areas. • Preventable disease, especially diabetes, stroke, cancer and heart disease remain high. • The teenage conceptions still remain a concern when compared to national, regional rates in some electoral wards across the borough. • Significantly high numbers of people remain smokers and young people continue to take up smoking. • Obesity in adults and children remains a challenge and lies at the root of many other avoidable ill-health. • Increasing the proportion of the Barnsley population moving from a sedentary lifestyle to a moderately active one. • Hospital stays for alcohol related harm are significantly higher than the England average. • Building emotional resilience and reducing preventable mental health.
What do we need to do?	i) Develop a health improvement programme which identifies action across the life course with a focus on early help and prevention and reduces the development of long term conditions. ii) Create a smokefree generation and continue to reduce smoking prevalence. iii) Reduce obesity starting with a focus on the areas of highest prevalence. iv) Increase and sustain the increase in physical activity uptake. v) Reduce harmful alcohol consumption. vi) Work with partners to ensure that maximum improvement in health is achieved by all services from NHS commissioners and providers to council, voluntary and community sector services. vii) Implement regulatory, policy and population measures to improve health, including spatial planning, licensing and responsibility deals. viii) Develop public mental health approaches to building resilience and reducing preventable mental ill-health. ix) To develop a public health response to dementia both in terms of interventions which may reduce prevalence of dementia and in ensuring those who develop dementia are supported to live well with it.

	x) Work with employers to improve the health of adults of working age, and reap the economic benefits of this. xi) To develop a pathway into employment targeting vulnerable groups. xii) Develop public health approaches for adults with particular and complex needs such as adults with learning disabilities, physical disabilities and chronic mental health problems. xiii) Ensure NHS health checks are part of a universal offer for adults, with appropriate targeting for populations who experience poor health outcomes. xiv) Ensure drug and alcohol services are accessible and high performing and help people to reduce harm and recover appropriately. xv) Develop a preventative falls pathway which will reduce demand on health and social care services.

Outcome 3	**We will narrow the gap in life expectancy and health between the most and least healthy**
What does this mean?	Reducing inequalities in health outcomes and life expectancy.
Why have we chosen this?	The health of people in Barnsley is generally worse than the England average. Deprivation is higher than average and about 23.8% (10,300) children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 7.9 years lower for men and 5.9 years lower for women in the most deprived areas of Barnsley than in the least deprived areas of the borough. Out of 32 national key health indicators, published in the Public Health England 2015 Barnsley Health Profile, the borough is significantly worse than the national average in 18 indicators.
Successes – a snapshot of what we have already achieved	• Intelligence and data are available in the updated Health Inequality profiles for Barnsley, Area Councils and electoral wards. • Work is underway on a housing and health partnership to better address the needs of households at risk of cold-related illnesses and excess winter deaths. • Successful bid by the Barnsley Healthcare Federation to the Prime Minister's Challenge Fund to deliver the 'I HEART Barnsley' initiative (Improving Health, Equality, Access, Responsiveness and Treatment Barnsley) will

	provide extended access to primary care. • A successful community shop is well established in Goldthorpe to give our communities access to low cost food and support services tackling a range of issues associated with poverty.
Challenges	• Austerity will have consequences for health inequalities, with the greatest impact on with those in the poorest communities. • The impact of poverty on health remains a significant factor in avoidable ill-health, disability and death. • Tackling the wider determinants of health by working with our partners. • Addressing the needs of households at risk of cold-related illness and excess winter deaths. • Ensuring robust data is available to identify inequalities and inequity, including knowledge gathering and equity auditing.
What do we need to do?	i. Implementing evidence based actions that have an effect on reducing inequalities within a short timescale. • early detection of Cardiovascular disease • early detection of respiratory diseases. • good uptake of cancer screening programmes. • services address physical and mental health needs of clients. • scale up brief intervention and preventative interventions of all front line health and social care staff. • strengthen regulation, enforcement and changes to the environment e.g. tobacco control as smoking is a major contributor to health inequalities. • review community engagement approaches in prevention and early intervention programmes. ii. Commission and deliver services across the health care system which consider inequalities and equity and target appropriate areas of worst health whilst delivering a universal offer to everyone using the principles of proportionate universalism. iii. To support the implementation of the Anti Poverty Action Plan across partners and stakeholders. iv. Improve equity of access and outcomes to services in the most vulnerable and most disadvantaged populations and those with worst outcomes.

	v. Support local health and housing partnerships to better address the needs of households at risk of cold-related illnesses and excess winter deaths. vi. Improve the Joint Strategic Needs Assessment process to identify inequalities and inequity, including knowledge gathering and equity auditing. vii. Identify particular communities and populations which do less well than the majority of our residents, and identify what specific actions we need to take to improve their health outcomes.

Outcome 4	**Protect our communities from harm**
What does this mean?	Deliver robust and effective health protection arrangements.
Why have we chosen this?	Health protection responsibilities sit across a range of agencies and they are crucial to achieving good health for the population. We have a statutory responsibility to deliver and assure a robust health protection system.
Successes – a snapshot of what we have already achieved	• Uptake of childhood immunisation achieving World Health Organisation targets to prevent the spread of vaccine preventable diseases. • The Child Death Overview Panel process has been reviewed and revised in line with statutory published guidelines Working together to safeguard children (HM Government, 2015) • Robust interagency plans are in place to prepare for a wide range of emergencies and health incidents such as pandemic influenza. • Barnsley has continued to reduce the incidence of infections attributed to health care year-on-year. • Health Protection Board established as a sub-committee of the Barnsley Health and Wellbeing Board, providing assurance that local health protection arrangements are effective. • Infection Prevention and Control (IP&C) Commissioning Advisory Service jointly commissioned by Barnsley CCG and Barnsley Council.
Challenges	• Assurance from NHS England Local Area Team to maintain immunisation coverage. • Healthcare acquired infections. • Communicable diseases e.g. TB. • Influenza vaccination in the over 65s.

	• Horizon scanning and emerging risks.
What do we need to do?	i. Ensure an overarching health protection assurance framework is in place which is agreed with local stakeholders with annual review and identification of risks. ii. Receive assurance from NHS England that relevant vaccination and screening programmes are being provided to residents, risks identified, control measures are in place and there is regular performance monitoring. Provide local advice to residents to promote vaccination and screening programmes. iii. Ensure that there are appropriate and effective arrangements in place in the community for infection prevention and control. Make certain that infection prevention and control specifications are embedded in all contracts of all relevant local authority commissioned services. iv. Ensure all contracted services adhere to local safe guarding procedure. v. Ensure all commissioned providers are compliant with CQC standards and relevant legislation in relation to infection prevention and control and they meet set national government targets. vi. Demonstrate evidence of effective partnership working between Public Health and Environmental Health, Trading Standards and Regulatory Services on joint agendas. vii. Commission sexual health and contraception services for Barnsley residents. viii. Protect the health of Barnsley residents from hazards and threats ranging from minor outbreaks and health protection incidents to full scale public health emergencies e.g. pandemic flu, infectious disease outbreaks etc.

9. Public Health priority areas

Public health outcomes are long term, hard to achieve and it is often difficult to see that progress has been made. To do this we will focus initially on three priorities that we can make a difference on by galvanising action which we believe will impact on our priorities and contribute to delivering our Corporate Plan.

We recognise that we must focus our resources in order to achieve the biggest impact on public health and wellbeing. We have therefore focused on three priority areas with specific targets.

Figure 6. Public Health priorities

Public Health Priority	Headline target	To be achieved by
Improving the oral health of children	Increase the percentage of Barnsley children getting fluoride, using a targeted approach.	2017
Creating a smokefree generation	Reduce smoking prevalence in Barnsley	2017
Increasing levels of physical activity.	Reduce the percentage of Barnsley residents who are physical inactive	2017

Each of the priority areas has a detailed action plan being developed, with specific targets and metrics. Figure 7 outlines why we have chosen these priority areas, what we need to do and how we will do it.

Figure 7: Public Health priorities and headline actions (more detail will be available in associated action plans and performance measures)

Public Health Priority	**Improving oral health in children**	**Smokefree Generation**	**Increasing levels of physical activity**
Why have we chosen the priority?	• Tooth decay is the main oral health problem affecting children with significant impacts on their daily lives including pain, sleepless nights and time missed from school. • There are wide inequalities in the distribution of tooth decay. In Barnsley the average number of decayed teeth in some wards is five times higher than in other less deprived wards of the borough. • Over 600 Barnsley children are admitted to hospital every year for the removal of decayed teeth, 1.1% of all children in Barnsley. • The main risk factors for tooth decay are diets high in sugars and lack of exposure to fluoride therefore tooth decay is largely preventable.	• Smoking prevalence in Barnsley is reducing but we still have one of the highest smoking rates in the country. • The latest data illustrates that 22.3% of the adult population In Barnsley are smokers - significantly higher than the England average of 18.0%. • There is a wide variation between wards where the proportion of adult smokers ranges from 12% to 29%. The prevalence amongst routine and manual workers within Barnsley is much higher than the overall prevalence at 29.2% compared to 22.3% (2014). • The smoking prevalence at age 15 of 10.7% is significantly worse than the England average of 8.2% (2014/15). • Although recently smoking in pregnancy has recently reduced to 20.4%, this is significantly higher than the England	• Leading a physically active lifestyle has been proven to improve both the length and quality of life for individuals and reduces the burden of disease and disability. Being active can boost workplace productivity; reduce sickness absence, crime and anti-social behaviour. • Physical inactivity is the fourth largest cause of disease and disability in the UK • Children and young people who are physically active are more likely to continue the habit into adult life and can bring benefits for academic attainment and

		average of 11.4%. • Smoking attributable mortality and admissions are significantly higher in Barnsley when compared with the regional average. • It is estimated that £62 million per year is spent on tobacco by the smokers of Barnsley. This is on average around £1323 per Barnsley smoker per year. • Smoking costs to Barnsley are around £67 million per year, this includes factors such as lost productivity, the cost of social care and smoking-related house fires.	attention. • Barnsley falls below the national and regional average for physical activity participation with the latest figures from the Active People Survey indicating that in 2014 45.8% of adults achieve the recommended levels of 150 minutes of moderate intensity physical activity a week. 37.8% of Barnsley adults are classified as inactive. Both figures are significantly worse than the Yorkshire and the Humber and England averages.
What do we need to do?	We know that fluoride remains the most effective means of preventing tooth decay. To achieve improvements in tooth decay levels in children we need to provide more intensive exposure to fluoride as children grow up, both at	We will focus on doing all we can to encourage children and young people to choose not to smoke We will aim to reduce adult smoking prevalence by 1% in Barnsley. This would mean 5,982 fewer Barnsley residents are	We know that in Barnsley there are a large number of people who would benefit from being more physically active and there are many opportunities in daily life to be active.

	home, at school and in the dental practice.	smokers, putting £7.8 million back in the pockets of Barnsley's families. It will have an impact of the health of the population by reducing the risk for lung cancer and many other types of cancer, heart disease, respiratory symptoms, such as coughing, wheezing, and shortness of breath. We will monitor the smoking prevalence rates in key groups such as routine and manual workers, pregnant women and young people (age 15 years). We need to continue to promote the shift in social attitudes so that choosing not to smoke is the normal thing no matter who you are or where you live. We need to continue to reduce the attractiveness of tobacco, particularly to young people	We will prioritise working with children & young people who are inactive, to become more active as part of their daily lives. We need to enable our residents to be more active, whether through organised activities, through making active travel an easier choice, or by ensuring our natural and built environment supports rather than creates barriers to active choices.

How we will do it	• Working with NHS England we will increase the use of fluoride varnish by dental practices in Barnsley by targeted work. • Dental practices in Barnsley to be encouraged to undertake training in Making Every Contact Count. • Tooth brushing packs to be distributed to the most vulnerable families in the borough via food banks. • Tooth brushing clubs will be established in early years, nurseries and reception year settings across Barnsley. • A programme of training for early years, nurseries and reception staff to support delivery of daily tooth brushing will be introduced. • 0-19s healthy child public health service provision will include oral health promotion to be delivered at key contact points.	• Through our Integrated Wellness Service – Be Well Barnsley, we will ensure that good quality evidence-based Stop Smoking Services are accessible to all smokers and targeted to areas of high deprivation and increased smoking prevalence. • The Breathe 2025 campaign will be rolled out across Barnsley, working towards seeing the next generation of children being smokefree growing up in a town free from tobacco. This new approach is based on changing social norms so that smoking is unusual. • Smoking will be embedded in all areas of work and included in key policies and action plans such as the Anti Poverty Plan for Barnsley. • Smokefree Play Parks will be implemented in targeted areas with the highest smoking prevalence. • We will ensure that BMBC and partners support create a healthier local	Through the implementation of the Barnsley Sport & Active Lifestyle Strategy, we will ensure the delivery of a systematic, evidence informed programme of action to improve physical activity levels. • We will increase the physical activity opportunities for children and young people, women and girls and those from lower socioeconomic groups through the delivery of a range of initiatives e.g. Coaching into Sport and Health Walk programmes. • Work will take place to ensure that systematic approaches for increasing physical activity amongst children & young people are built into school based programmes.

	• Work will take place to integrate oral health promotion as part of every contact counts in social care. • The Oral Health Improvement Advisory Group will take action to develop policies on restricting advertising of high sugar products and healthy food and drink in early years, schools and workplace settings.	environment by: -Ensuring building, grounds and work vehicles are completely smokefree. -Encouraging and supporting staff to quit smoking -Supporting and promoting the Breathe 2025 campaign. • We will make it harder for children and young people to access and use tobacco by: -Ensuring retailers aren't selling to under 18's by carrying out underage test sales. -Providing training/information to retailers to ensure they are aware of the legislations. • We will make tobacco less affordable and appealing, especially for children and young people by: -Ensuring an effective illicit tobacco identification and management programme. -Raising awareness of illicit tobacco and how to report it.	• We will support an increase of those physically active by 2% over the life of the Be Well Barnsley contract [3 years]. • More disabled people will be supported to access sport and physical activity opportunities through local community provision (Creating Connections led by South Yorkshire Sport) • We will develop the active travel agenda by working with schools and employers to implement active travel plans and cycle/walking routes • Bikeability training (Level 1 & 2) will be delivered in primary schools for year 5 /6 pupils, with support for schools to install adequate cycle

		-Enforcing standardised plain packaging (from May 2016). -Enforcing point of sale restrictions. • We will educate young people to make healthy choices around smoking and tobacco by: -Ensuring that good quality evidence-based Stop Smoking Services are accessible to all smokers. -Enabling schools and school nurses to provide education and support/ referral for stopping smoking. • We will reduce exposure to smoking and second hand smoke by: -Enforcing no smoking in cars with under 18s legislation. -Training people who work in a front line capacity or in some other way to enable them to signpost members of the general public into Stop Smoking Services. -Ensuring events aimed at families, children and young people across the borough are smokefree.	storage shelters. • Workplace health advice will be provided to businesses, including commitment to the Workplace Charter which covers a standard for improving physical activity amongst employees.

10. What does success look like?

This strategy will develop a mainstream public health function across the council that will work to tackle some of the key challenges laid out in the Joint Strategic Needs Assessment and the joint Health and Wellbeing Strategy. It will contribute to delivering Outcome 9 of the Council's Corporate Plan: 'People are healthier, happier, independent and active' resulting in local communities feeling more empowered to tackle health and wellbeing issues which affect our borough. We will know that we have succeeded in addressing these issues if we can demonstrate that in Barnsley:

- Life expectancy and healthy life expectancy for residents has improved.
- More residents are physically active;
- Fewer residents smoke, particularly amongst pregnant women;
- Fewer residents misuse alcohol and there is a reduction in levels of alcohol related harm;
- More residents successfully complete treatment for substance misuse;
- Fewer residents are requiring treatment for sexually transmitted infections;
- Fewer teenage women become pregnant;
- Fewer babies are born with a low birth weight;
- Fewer children are affected by poor oral health;
- Fewer children are overweight or obese;
- Fewer residents are infected with tuberculosis;
- More residents are accessing preventative wellbeing services
- There is a reduction in excess winter deaths and those experiencing fuel poverty
- More residents with a long-term health condition are employed
- Few residents are killed or seriously injuries on our roads.

Work will be undertaken to develop proxy measures to assess our progress towards achieving these outcomes.

Appendix 1 Requirements of the Public Health Grant

1. Background

In April 2013, a number of local public health functions were transferred from the NHS to the council as a result of the Health and Social Care Act 2012. The council's public health work is currently funded through a ring-fenced grant from the Department of Health. The mandatory functions which this grant must support include:

Sexual health services
NHS Health Checks programme
Local authority role in health protection
Public health advice to NHS commissioners (the 'core offer')
National Child Measurement Programme
Oral health of their population
Responsibility for public health services for prisoners
Public Health Services for 0-5 year olds (from October 2015)

In addition, the ring fenced public health grant may be used for the following activities ('non-prescribed functions'), based on local need:

- Obesity
- Physical activity
- Drug misuse - adults
- Alcohol misuse - adults
- Substance misuse (drugs and alcohol) - youth services
- Stop smoking services and interventions
- Wider tobacco control
- Children 5-19 public health programs
- Miscellaneous, which includes:
    - Wider determinants
    - Non-mandatory elements of the NHS Health Checks programme
    - Nutrition initiatives
    - Health at work
    - Programmes to prevent accidents
    - Public mental health
    - General prevention activities

- Community safety, violence prevention & social exclusion
- Dental public health and fluoridation
- Local authority role in surveillance and control of infectious disease
- Information & Intelligence
- Any public health spend on environmental hazards protection
- Local initiatives to reduce excess deaths from seasonal mortality
- Population level interventions to reduce and prevent birth defects (supporting role)

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Combined Patient Flow Review Projects

September 2015

Results and Action Recommendations

Barnsley NHS Foundation Trust and
NHS Barnsley CCG

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Project Objectives

All patients in acute care beds were reviewed against Medworxx Utilisation Management Clinical admission/continued stay/discharge criteria.

Focus: Could an *alternative level of care (ALC)* setting have met the patients' needs?

Focus: Which ALC care setting might have prevented the admission or reduced the patient's length of stay? Are such ALC beds or home care capabilities in existence, available?

Focus: Assess the efficacy and efficiency of current admission avoidance, in-patient care coordination and discharge planning programmes

Focus: What strategic change is required to develop a smooth patient journey and "vertically integrated" care network?"

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Summary Findings

- Small number of ‘Avoidable Admissions’ patients at BHNFT
- No ‘Avoidable Admissions’ in Community Hospitals or Intermediate Care Beds
- 30% patients at BHNFT - ‘Ready for Discharge’
- No ‘Ready for Discharge’ patients at Kendray Hospital but some at Mount Vernon and in IC Beds

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Recommended Actions

Barnsley NHS Foundation Trust, Barnsley CCG and Community Services

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Critical Element - NOW

I. Take these **IMMEDIATE ACTIONS** whilst following through on 3 Critical Elements

a) Strengthen and improve the Step-up Care schemes

b) Fully develop and implement the Virtual Ward programme

c) Broaden the access criteria to Intermediate Care Rehabilitation Beds to accept patients with underlying medical conditions

d) Increase the number of Sub-acute Care beds at Mt Vernon and Kendray CH to at least 10 beds

e) Shorten the length of stay and home visits @ each LOC

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Critical Element Number One

1. Initiate an Organisational Development (OD) Programme to engage systemic, community-wide culture change to support
   a) Reduced length of stay in acute and community hospitals
   b) Reduced home visits of nursing and therapy
   c) Accountability for over-use or under-use of health care resources

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Critical Element Number Two

2. Implement the UM Infrastructure
   a) Community-wide UM Steering Group
   b) Agree clinical, evidence based admission and discharge CUR criteria for each level of care, criteria that are adhered to *(NHS England CUR CQUIN Standard ...a standard that supports the use of Medworxx UMS)*
   c) Review every patient, every day (Case Manager review and at Bullet Rounds)
   d) Establish EDD programme for every patient in acute and step-down care including home visits, an EDD based on the clinical condition of each patient factored by tariff

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Critical Element Number Two

2. Implement the UM Infrastructure
   d. Example: EDD based on the clinical condition a patient with COPD w/o intubation, with co-morbid condition(s) using Medworxx UMS criteria
      1. Clinical Condition for Discharge:
         a) Values normal or can be managed in community;
      2. PBR Tariff: £2,718 = pays for 5 days of acute care
      3. EDD: Target: Day 3 or 4
      4. Plan for Discharge documented within 24 hours of admission: 78 year old patient w/Type 2 Diabetes and Heart Failure. Plan for discharge home with Hospital at Home support. Refer to H@H Team now for assessment and discharge planning

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Critical Element Number Two (cont.)

2. Implement UM Infrastructure (cont.)

d) 'Pull' system for step-down care access

e) Refer LTC management candidates at every access point (clinic, A&E, wards, etc.) to the LTC Management Team

f) Transfer hospice and respite care candidates before or early in the acute or community hospital stay to the most appropriate care setting

g) Determine the appropriate staffing level and shift cover for the Case Managers and members of the Admission Avoidance Teams (RRT, H@H, Frailty Team, etc.)

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Critical Element Number Three

3. Take Action(s) based on UM Data and UM Review Findings

a) Quantify the needed amount of step-down beds and community services using Medworxx UMS and other data sources

b) Monitor UM Performance by Speciality/Service Line; Clinical Directorate; Ward, etc. holding each party accountable for over-utilisation or under-utilisation

c) Overcome patient flow barriers

d) Community-wide UM Steering Group will report monthly on UM actions to their respective Boards

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Levels of Care: The Vision

Level of Care	Care Capabilities	Staff	Diagnostics	LOS Range Target LOS
1.Acute care	•Clinical observation /intervention •Medication management •Oxygen, IVs, monitors • ICU/CCU/HDU •Theatre	•Consultants, SHOs, etc 24/7 •Nurses providing skilled care every 4 hours •Therapists and other AHP	•Yes, on-site •24/7 access	•Range: 1-7 days or visits •Target: 5 days or visits
2.Complex Continuing Care *(aka Virtual Ward)* Can be provided in 24 hr facility or by Hospital @ Home	•Clinical observation •Medication management •Oxygen, IVs	•GP or Consultant, daily rounds •Nurses provide skilled care every 6 hours •Patient too ill for PT/OT	•Yes, either on-site or accessible on demand 24/7	•Range: 5-15 days or visits •Target: 10 days or visits
3. Rehabilitative Care (high intensity) Can be provided in 24 hr facility or Hospital @ Home service	•Clinical observation •Medication monitoring •Pt motivated to participate in aggressive therapy	•GP or Consultant, rounds every 48 hours •Nurse provide skilled care every 8 hr •P/O/S TH up to 3hr per day/6d/wk	•Not available on site •Pt or specimen transported to site for diagnostics	•Range: 5-30 days or visits •Target: 15 days or visits
4.Therapist led rehabilitation care (slow stream) Can be provided in bedded facility or through home based	•Patient must be motivated and able to participate in slow stream therapy programme	•Physical/occupational/ speech therapy 1 hr per day, up to 4 days per week •Low nurse cover	•Not available on site •Pt or specimen transported to site for diagnostics	•Range: 4-45 days or visits •Target: 20 days or visits

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REPORT TO THE HEALTH AND WELLBEING BOARD

8 December 2015

Better Care Fund – Quarter 2 Reporting

Report Sponsor:	Lesley Smith/Rachel Dickinson
Report Author:	Jamie Wike
Received by SSDG:	
Date of Report:	26 November 2015

1. Purpose of Report

1.1 To provide the Board with an update on progress against the Key Performance Indicators (KPIs) contained within the Better Care Fund, being reported to NHS England on 27 November 2015

1.2 To provide an overview of the financial position in relation to the Better Care Fund (BCF)

2. Recommendations

2.1Health and Wellbeing Board members are asked to:-

- Note the contents of the report.

3. Introduction/ Background

3.1 The Better Care Fund (BCF) was established from 1 April 2015, in line with NHS England and Local Government Association directions.

3.2 The aim of the BCF is to support transformation and integration of Health and Social Care in line with the Health and Wellbeing Strategy for Barnsley.

3.3 The total value of the fund in 2015/16 is £20,374k. £2,016k of this is provided from grants made directly to the Local Authority for Disabilities Facilities and Social Care Adaptations. The remaining £18,358k is provided from the CCG baseline allocation.

3.4 In 2015/16, the Barnsley Health and Wellbeing Board (H&WB) developed and submitted a plan for usage of BCF resources, which set out KPIs and planned schemes and initiatives aimed at delivering against these.

3.5 The only KPI which has a financial impact is that related to reducing emergency admissions. The plan submitted by Barnsley H&WB included a trajectory to reduce emergency activity by 2.9% over the periods Quarter 4 2014/15

(reporting period 1) to Quarter 3 2015/16 (reporting period 4). Failure to achieve this reduction results in a Payment for Performance element to be withheld from the fund and retained by the CCG in order to off-set increasing emergency overtrades. The value withheld for periods 1, 2 and 3 totals £1,194k. A further £782k is attributed to performance in periods 4. Therefore, the total value of the payment for performance fund is £1,976k.

3.6 In line with the agreed Section 75 agreement with the Local Authority, the financial impact of failure to achieve the payment for performance element is to be shared equally between the CCG and the Local Authority. The financial implications for both parties are set out in section 3 below.

4. Payment for Performance (P4P) related to Emergency (Non-Elective) Admissions

4.1 The current performance levels against the target reductions within the BCF plan are set out below:

- Period 1 (Quarter 4 2014/15) – 1.5% increase (114 against target reduction of 128)
- Period 2 (Quarter 1 2015/16) – 5% increase (387 against target reduction of 58)
- Period 3 (Quarter 2 2015/16) – 8.8% increase (661 against a target reduction of 353)

4.2 In order to meet the target set for this KPI for 2015/16, reductions required would be:

Target reduction periods 1-4	892
Actual over-performance against baseline (Q1-3)	1,162
Total reduction required in period 4	**2,054**

4.3 In financial terms, the value withheld for periods 1, 2 and 3 totals £1,194k. In line with the Section 75 agreement, the CCG has paid BMBC £597k less and will manage the risk related to the £597k applicable to the CCG internally.

4.4 Reducing the number of emergency admissions is a key objective for the wider health and care economy and therefore there is a continued focus on ensuring a sustained effort to reduce the number of admissions into hospital and also to improve the flow of patients through the hospital and support timely discharge by commissioning appropriate out of hospital services.

4.5 There have been a number of in year developments that have taken place to ensure continued efforts to reduce the number of emergency admissions and ensure the health and care system is resilient over the remainder of the year, particularly winter. Recent developments include:

- Proposals to introduce a triage to off-site primary care/GP appointments to reduce the number of people being seen in A&E.

- Reviewing the intermediate care access criteria and bed base to ensure there is adequate capacity to support admission avoidance and support effective discharge
- Extended opening of the respiratory hub within BHNFT to provide increased access for patients and reduce the need for admissions.

4. Other Key Performance Indicators

5.1 Reduction in the number of permanent residential and nursing home admissions (65yrs & over). Latest performance is below the BCF plan with lower numbers of permanent admissions – **achieving**

5.2 Increase the number of people who are still at home 91 days after discharge from hospital who access reablement services. Latest performance indicates that more people remain at home 91 days after discharge than the BCF plan – **achieving**

5.3 Maintaining the number of delayed transfers of care. Performance in Barnsley is good with low numbers of delayed discharges and therefore the plan was to maintain the levels seen in 2013/14. The latest performance shows that the average number of delayed discharges per month is lower than the BCF plan – **achieving**

5.4 Reduce the proportion of people reporting a poor experience of General Practice – The 2014/15 results show an improvement from 7.3 to 6.4 (average number of negative responses per 100 patients) between 13/14 and 14/15. The BCF target was based upon the 2012/13 baseline of 5.3 and the aim was to reduce the numbers reporting a poor experience of GP services. The 2013/14 results show that performance deteriorated with the number increasing above the baseline to 7.3 creating a bigger challenge in respect of achieving the BCF target. There has however been significant investment in primary care and this has been supplemented by the Prime Ministers challenge fund to improve access to primary care which reflect the improvement between 2013/14 and 2014/15, the first year of the BCF - **not achieving** but improving based upon the latest reported position to March 2015.

5.5 Increasing the proportion of people who feel they are supported to manage their long term condition. Performance has improved between the baseline position of 67.7% however performance remains below target. Activity in 2015/16, particularly in primary care to support people with long term conditions is anticipated to lead to improved performance against this measure and delivery of the agreed target of 69.95 by the end of the 2015/16 financial year, based on the survey reporting period to March 2016 – **not achieving** but improving and expected to achieve by period 4.

6. Financial Implications

6.1 Based upon current performance, there is a significant risk that the reduction in emergency admissions will not be achieved in this financial year. If this risk does crystallise, BCF resources will be reduced by £1,976k and in line with the Section 75 agreement, this risk would be shared 50/50 between the CCG and BMBC.

5.2 If, however, performance improves and the annual target is met, the full value of the performance-related element of £1,976k will be payable to the BCF.

Officer: Jamie Wike **Contact:** 01226 433702 **Date:** 26/11/15

Barnsley HWB Board Development Session 23rd September

Facilitated by Robin Douglas

The session was called to strengthen the focus of the Board, build clarity about key priorities and agree effective the working arrangements.

Introductions

The introduction from Chair stressed the need for the Board to have a clear purpose, add real value and work to explicit priorities.

The members added the following expectations:

- There was strong agreement that the Board needs a stronger sense of purpose
- Put some 'meat on the bone' of the high level commitments and direction, and clearer timelines to follow
- Clarify the Board's role in respect of the HWB Strategy and the recent review
- Build a clearer common purpose based on outcomes for local people
- Develop some underlying principles that guide the work of the Board
- Strengthen behaviour in the Board to reflect more honesty

Robin referred to the note that had been circulated on challenges faced by boards nationally, he then reflected on the following themes as a guide to the conversation:

- To achieve the scale of change we need in local services, effective organisational leadership will only take us so far: the requirement is for much more far reaching and cross-organisational working that can only be achieved through *system leadership*. The Board offers an important focus for this approach.

- At the heart of such leadership is the need for coherent, *common purpose*. Without such shared or common cause, a Board too easily becomes just another council committee.

- In terms of working in complexity, Robin emphasised the work of Richard Beckhard in 'Solving Problems and Managing Dilemmas'. The work of the Board is more likely to be successful if it focuses more on working with dilemmas(or wicked problems), rather than just trying to solve problems – that are often the responsibility of member organisations/partnership rather than the Board.

- The work of the Board is then likely to move from solution focused/scrutiny activity to a more *facilitating, influencing role* that recognises the need to support and encourage the work of existing organisations and integrated services. There may be areas where the Board may add value through additional commissioned or direct activity, but the test should always be 'Is this something the Board and only the Board should do?'

Discussion

The members raised the following themes in discussion

- The need to remember the 'Barnsley Six' key values

- The Vision for Health and Care work led by the CCG was recognised as an important contribution to building a common 'story'

- Setting realistic aspirations given the continuing austerity programme and the future pressures on services

- The need to re-examine the 'core offer' given the cuts and restrictions on services. Recognising local assets as well as the need for services and direct support.

- Keep the HWB Strategy alive and at the centre of the Board's work, it should be a living idea not just a paper based plan.

- Stephen suggested' 3 things that matter' as the heart of the Board's work:
    - 'Local People living healthily and independently as long as they can'
    - 'When people need help we will provide it as well as we can'
    - 'We should support people supporting themselves'

- Some principles to guide the work of the Board were suggested:

    - Partners should recognise the impact of their organisational decisions on one another, and aim to understand the pressures upon members from other sources
    - Be sufficiently challenging with one another to enable issues to be dealt with and not 'fester'
    - Ensure that there is a common story or narrative to which all members subscribe and can use as the basis of discussions on priorities etc
    - Recognising that there are likely be constant changes in national and local policies, and local health needs. The overall strategic approach by the Board has to be sufficiently flexible to accommodate such changes, without being diverted from its core purpose.

- The business of the Board should include:

    - Challenging member organisations to live up to 'the stories they tell'
    - Understanding what 'good' is
    - Supporting and challenging members in their approach to delivery/creating benefit
    - Identifying gaps in the strategy and (rarely) sponsoring/commissioning additional activity
    - Understanding the effects of changes in policy, practice and community and the effects on members commissioning or services.

- The success of the Board would be judged by:

    - The extent to which it facilitated local organisations to work in more integrated ways
    - The movement towards achievement of the HWB Strategy, complete with real evidence of progress
    - Real engagement of local people in the nature and progress of the Strategy
    - Board members understanding what is working less well or not being achieved
    - To be using agreed and collective intelligence – paying attention to key indicators rather the regularly 'deep diving' into details
    - Understanding members organisational pressures and priorities and the effects of these on collaborative/integrated working

- It was noted that an important member organisation – the BHNFT was not represented in the discussion. It was agreed to approach them to encourage their further involvement.

- The work of SSDG in supporting the Board was recognised and it was acknowledged that this had improved significantly in recent times. The balance of effort between this

group and the Board will need to be kept under review as not every member of the Board is represented in SSDG discussions.

- The group agreed to develop the discussion further, both in terms of focus for the agenda and in more open, working arrangements. It was suggested that there is a need for regular developmental space for the Board, separate from the public meetings, and a further future review should be planned to assess progress.

- At the completion of the session, the Chair produced a brief summary of his sense of the discussion. See below:

Points from Health and Wellbeing Presentation (Stephen Houghton):-

- Design on H&WBB Strategy based upon the 3 principles.
- Identify what good looks like for the 2 principles.
- Measure current position against them.
- Identify actions to close the gap.
- Identify performance measures against those actions.
- Write the 'Story' of the H&WBB from these actions.
- Get a communications plan to tell partners.
- Identify principles / behaviours to underpin the strategy.
- Design H&WBB agendas to test if it looks better.

Note prepared by Robin Douglas

September 26th 2015

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Sheffield City Region

STRATEGIC ECONOMIC PLAN AND DEVOLUTION UPDATE: BARNSLEY

November 2015

OVERVIEW

1. The Sheffield City Region's devolution journey

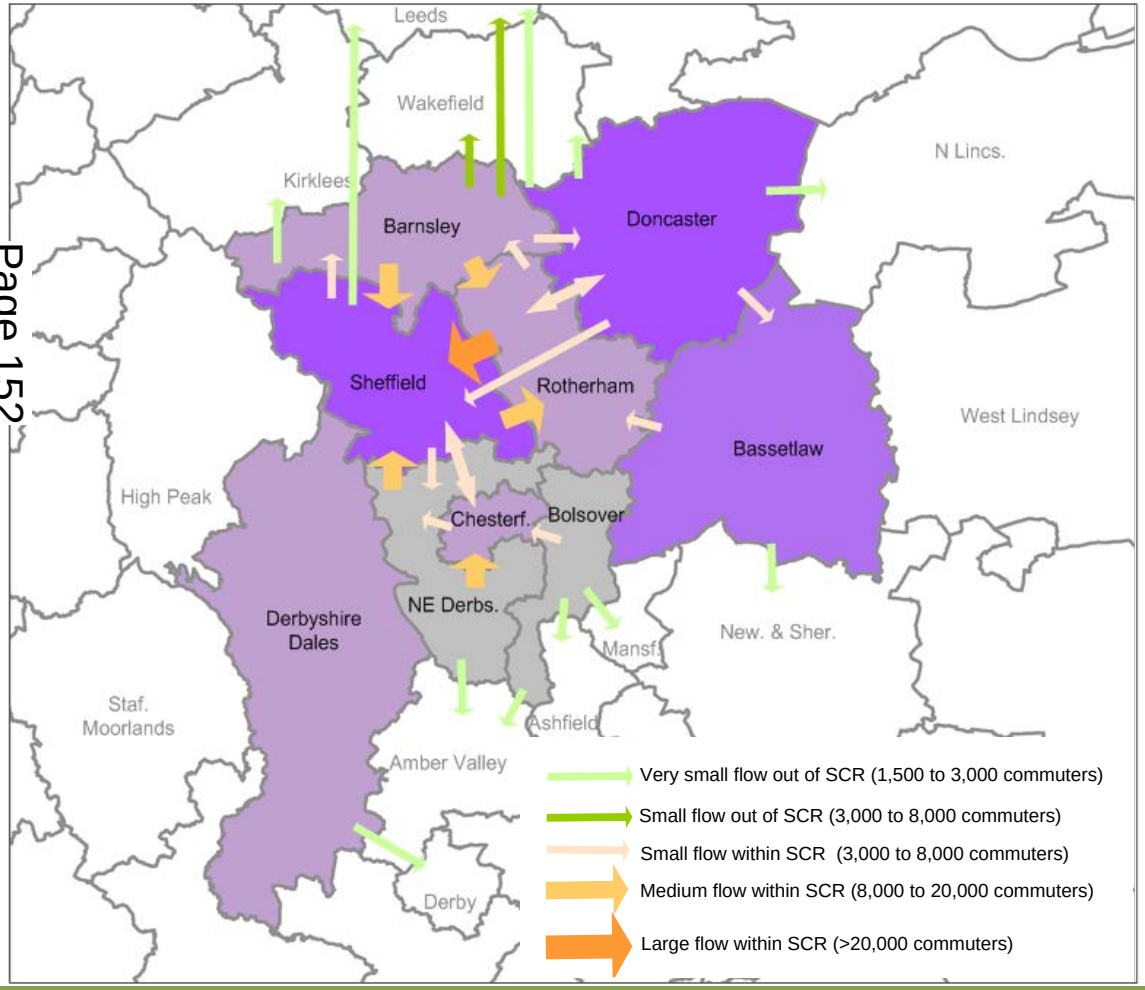
2. The Sheffield City Region's proposed devolution deal

3. The Mayoral Combined Authority

Sheffield City Region

1. THE SHEFFIELD CITY REGION'S DEVOLUTION JOURNEY

THE SHEFFIELD CITY REGION REFLECTS OUR FUNCTIONAL ECONOMIC GEOGRAPHY



- The Sheffield City Region came together to reflect the functional economic area and relationships of where people live and work.
- Every day 42,000 SCR residents cross the Yorkshire / East Midlands boundary to access employment in the City Region

SHEFFIELD CITY REGION – THE JOURNEY

From 1986
SYPTE, SY joint services
SOUTH YORKSHIRE JOINT SECRETARIAT

2008
SCR Forum

2009
SCR Executive formed

2010
Sheffield City Region INWARD INVESTMENT
Sheffield City Region Local Enterprise Partnership

2011

2012
Sheffield City Region Deal
SCR RGF Programme

2013

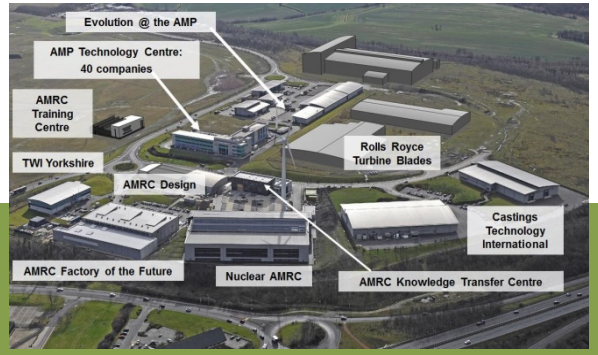

2014
Growth Deal
Sheffield City Region COMBINED AUTHORITY

2015
Devolution Deal
Growth Deal 2
Devolution Deal 2

Since 2012 the City Region has been delivering Government investment, generating significant benefits

In Barnsley benefits include:

- Unlocking Business Investment Programme:
  - >£4m invested in 14 companies, unlocking £18m of private investment,
  - Creating more than 300 jobs and safeguarding a further 40 to date.
- A £25m Skills Made Easy programme:
  - Engaged with 230 employers and 110 training plans agreed in the year to date.
  - Generated 60 apprenticeships and upskilled 80 employees in the year to date
- Enterprise Zone
  - 1,100 jobs created across the SCR on the Enterprise Zone
  - £14.9m of private sector in Barnsley alone
- Delivering infrastructure schemes through SCRIF including:
  - Junction 36, Junction 37 Claycliffe link and superfast broadband.
- JESSICA / GPF:
  - £5.6m invested at Rockingham, with a further £2.7m in the pipeline for Rockingham 2



IT HAS ALSO DEVELOPED ITS 10 YEAR PLAN FOR GROWTH – BASED ON MORE PRIVATE SECTOR JOBS

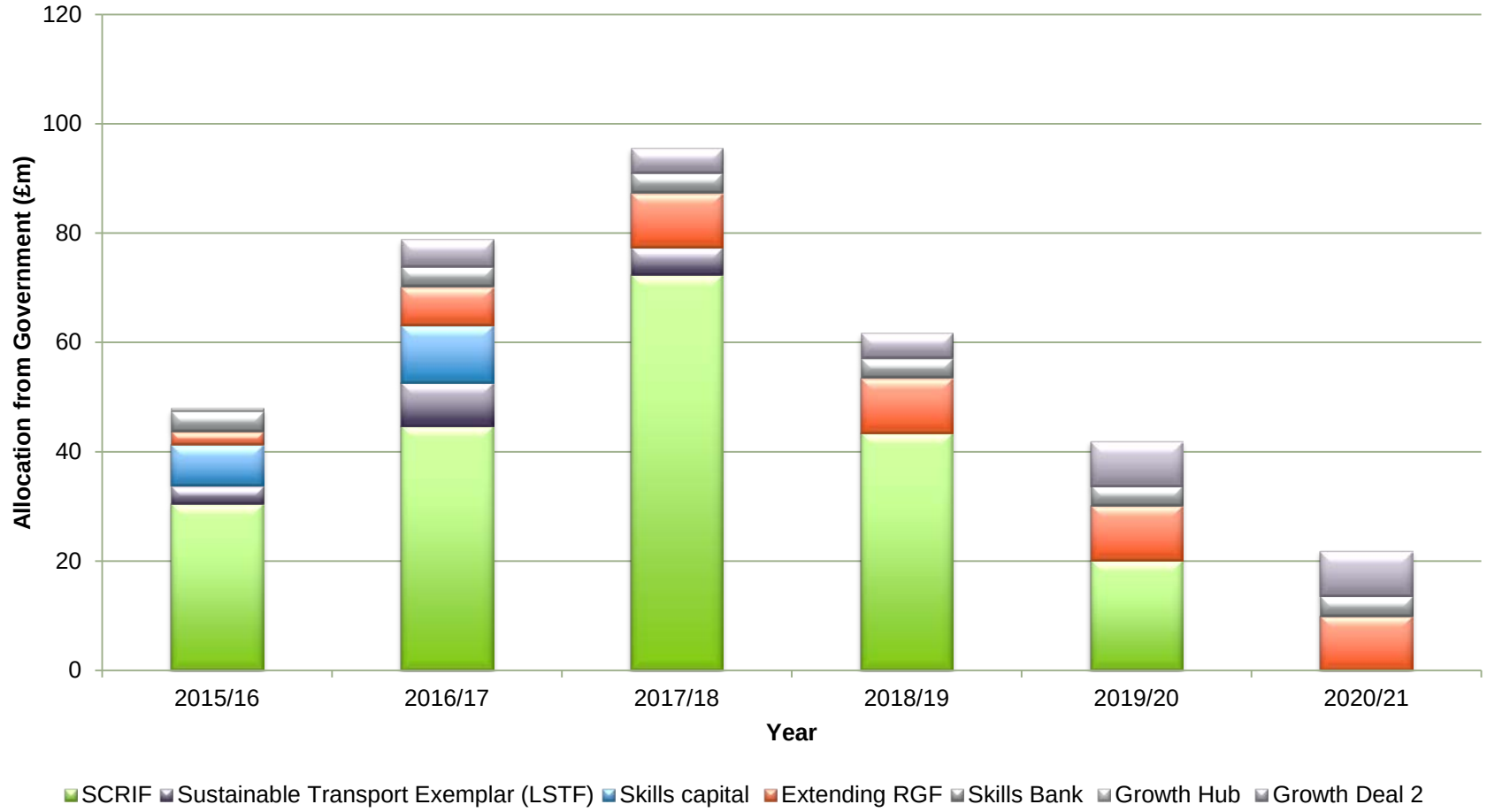
Vision

A stronger and bigger private sector that can compete in national and global markets

Focus areas

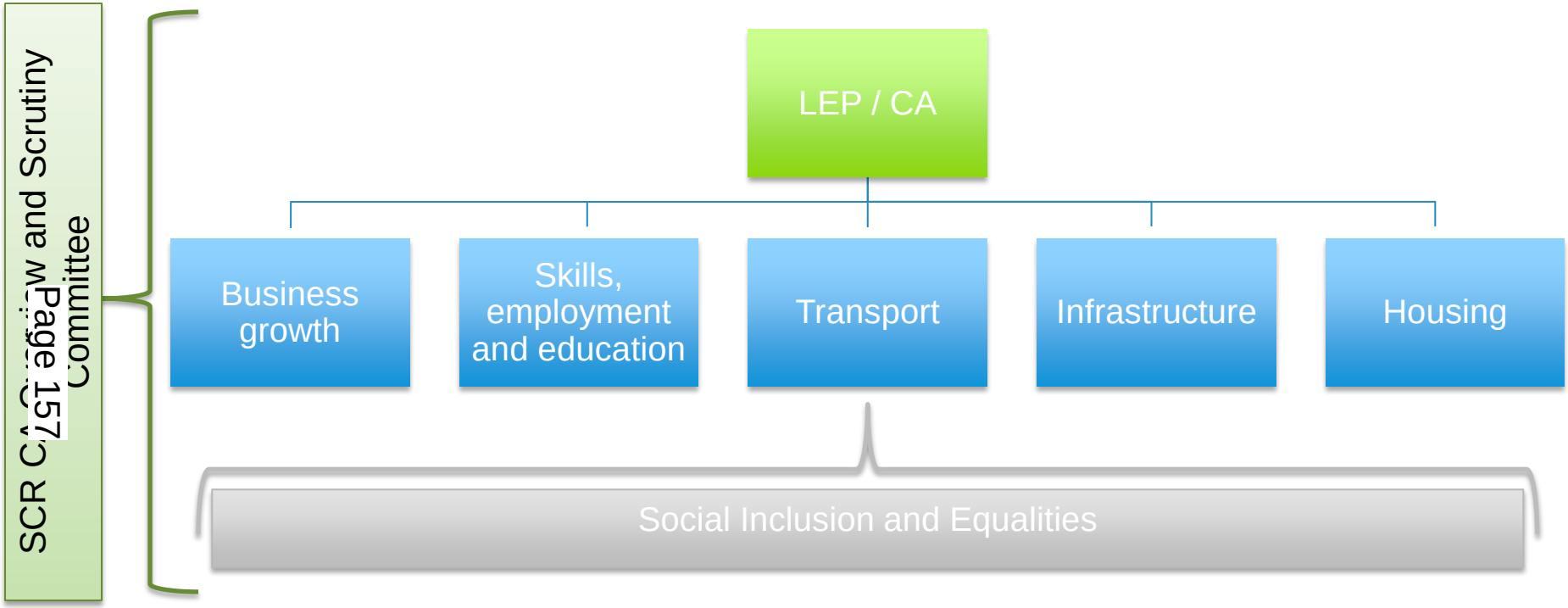
- Skills
- Infrastructure
- Business Growth

THE STRENGTH OF THIS PLAN HAS SECURED THE CITY REGION A £350M, AND THE 5TH LARGEST, GROWTH DEAL



Sheffield City Region

THE CITY REGION HAS STRENGTHENED ITS GOVERNANCE STRUCTURE TO DELIVER THESE DEALS



In addition there will be some sub boards e.g. Access to Finance to be agreed by the Executive Board once established

ULTIMATELY THE SCR IS FOCUSED ON ACCELERATING THE DELIVERY OF OUR STRATEGIC ECONOMIC PLAN

More jobs

70,000

70,000 jobs to narrow the gap with other parts of the country

More highly skilled occupations

Approximately 30,000 highly skilled occupations to create a more prosperous economy

More businesses

An additional 6,000 businesses are required to reduce the enterprise deficit

Higher productivity

An increase in GVA in excess of £3billion to narrow the productivity gap

Sheffield City Region

2. THE SHEFFIELD CITY REGION'S PROPOSED DEVOLUTION DEAL

KEY ISSUES TO NOTE

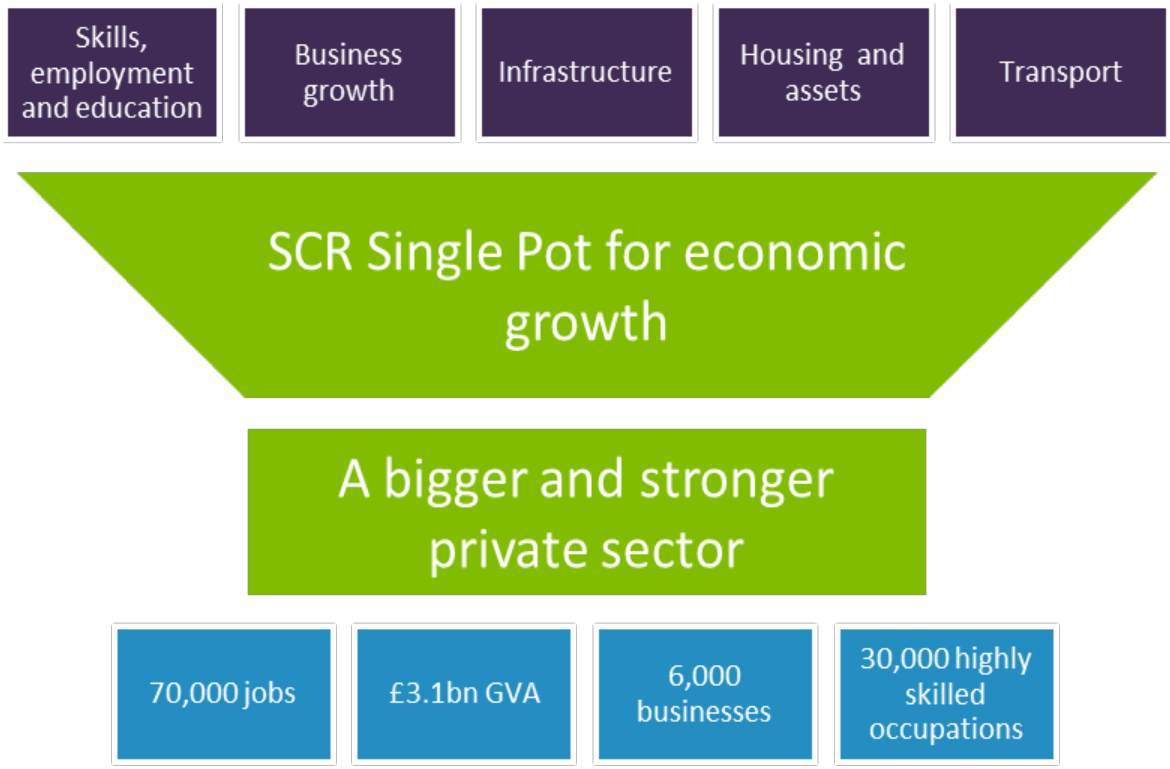
- This is an **economic deal** – the Combined Authority have been clear that powers over the Police and Health services do not form part of the Mayoral governance remit.
- The Government and the SCR Combined Authority are clear that this agreement is part of a longer process and should not be considered the end-point of devolution
- Leaders from each council have been clear that the directly-elected Mayor and Combined Authority will receive powers from Whitehall rather than aggregate powers from local areas.
- There is much to be negotiated over the coming months – significant issue is the current Spending Review process.

THE SINGLE POT – A *CRITICAL* PART OF THE DEAL

- The single pot includes the £30m x 30 years allocation (60:40 capital / revenue split)
- This is in addition to a range of national funding streams wrapped up into one pot.

Through further detailed discussions SCR is effectively seeking:

- A single line in the Spending Review.
- Provision of a multi-year allocation for national funds.
- Performance measured against jointly developed outcome measures.

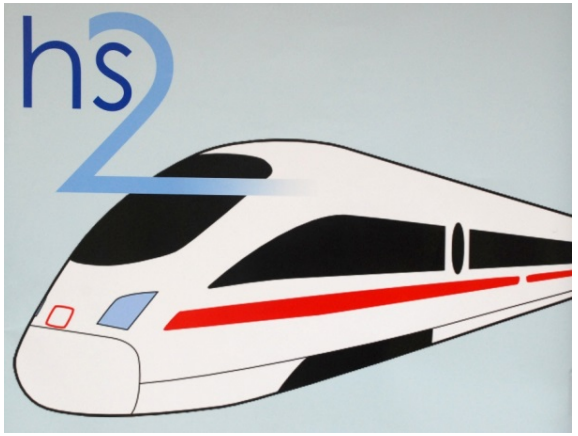


This embodies devolution rather than decentralisation

1. An integrated 21st Century Transport Network with greater intra and inter city region connectivity

The SCR secured:

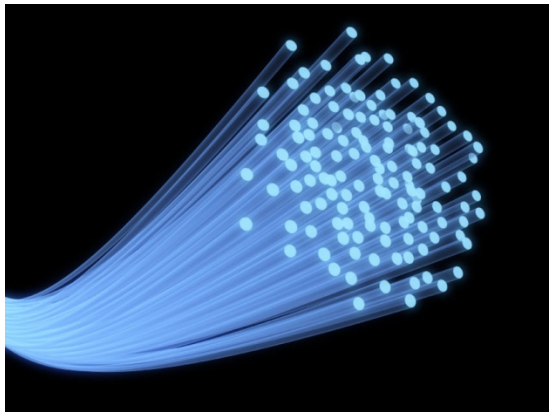
- A consolidated, devolved transport budget, with a multi year settlement to be agreed at SR.
- Control of the powers and resources for the bus network in South Yorkshire, including the potential to franchise services
- Smart ‘oyster style’ ticketing
- Re-stated commitment from Government to deliver Transport for the North and HS2 and HS3 in SCR
- Commitment to explore options to give more planning powers over the delivery of transport schemes
- The identification of a Key Route Network of local authority roads that will be collaboratively managed and maintained



2. A world leading area for innovation, advanced manufacturing and business growth

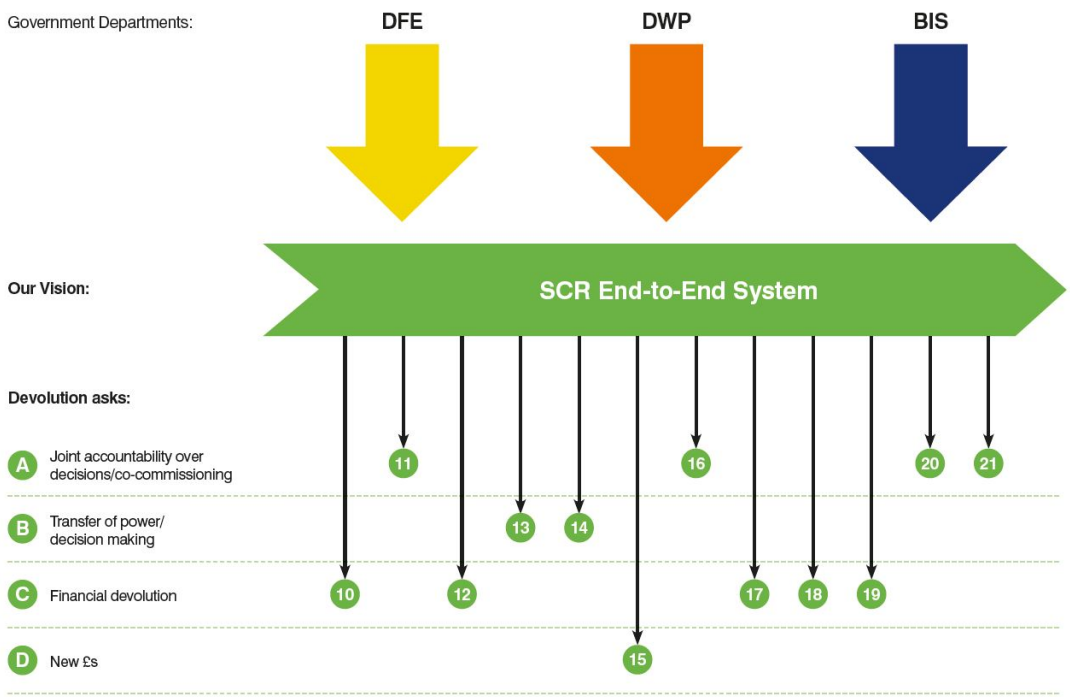
The SCR secured

- A re-stated commitment to a single, tailored business support model for SCR
- An improved approach and greater accountability to SCR of national inward investment and trade support
- Government support to develop our bid for a Science and Innovation Audits and
- Dedicated workshops with the Smart Specialisation Advisory Hub
- The ability to bring forward proposals for the Advanced Manufacturing Innovation District (as part of the Single Pot)
- The ability to work with Government to achieve our ambitions for a National Institute for Infrastructure in Doncaster.



3. MORE PEOPLE LEARNING, EARNING, IN APPRENTICESHIPS AND HIGHER SKILLED EMPLOYMENT IN THE SHEFFIELD CITY REGION

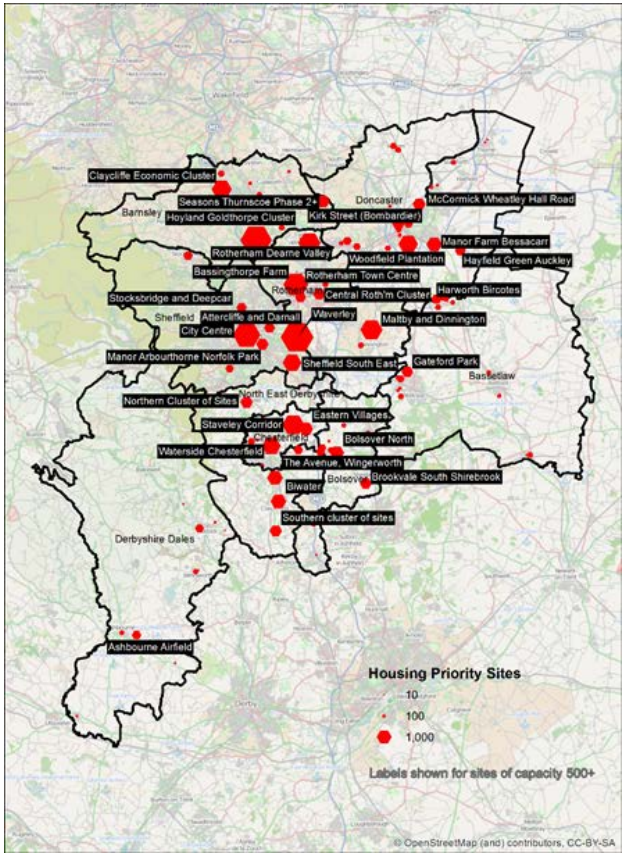
- Full devolution of the Adult Skills Budget for college and training providers.
- SCR to produce a local skills strategy, following the Area Based Review
- The co-design and co-commissioning of new employment programmes.
- A commitment to develop a business case for an innovative pilot to support the hardest to help.



4. Better use of publicly owned assets and increased planning capacity and powers to double our housing delivery and increase commercial development

The SCR secured:

- The ability to make the best use of all public land and assets through an expanded role for our existing Joint Assets Board
- Planning powers including the ability to create a spatial framework, Development Corporations and Supplementary Planning Documents, and be consulted on / have call-in powers for applications of strategic importance.
- Commitment that Enterprise Zone expansion proposals will be considered as part of the current bid process.
- A commitment to continue to discuss the creation of a flexible Housing Investment Fund

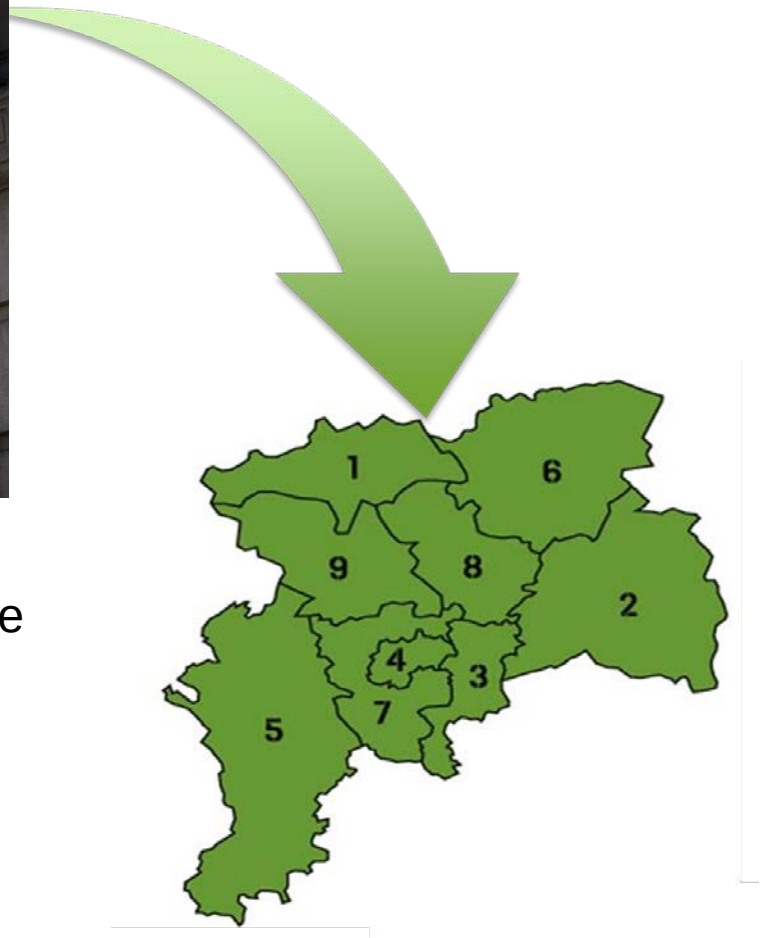


5. A stable, long term financial settlement that puts the SCR in control of its own destiny

The SCR secured :

- £900m of Government funding for the SCR over 30 years, as part of our single pot
- A commitment to agree national funds that will be devolved to the SCR as part of the Single Pot by the SR.
- The ability to pilot the retention of 100% Business Rate growth and ongoing discussions on full localisation by 2017.
- Intermediate Body Status for SCR's ESIF allocation

6. GREATER ACCOUNTABILITY OF NATIONAL PROGRAMMES TO THE SHEFFIELD CITY REGION



- The Cities and Local Government Devolution Bill, if passed, would give the SCR Scrutiny Committee the ability to scrutinise Government departments
- Much greater role with UKTI, DWP, Business Growth Service

SUMMARY HEADLINES

- Control of a **new, flexible single pot of funding** for economic growth, which incorporates an **additional £30 million annual allocation** over the next 30 years
- Control over **European Structural Investment Funds** (ESIF) via Intermediate Body status
- A greater **share of the benefits of economic growth** through a pilot of retention of business rate growth.
- Full devolution of **the Adult Skills Budget for college and training providers**
- The **co-design and co-commissioning of new employment programmes**.
- **Devolved transport powers and funding** – including the powers to refranchise the bus network
- An improved approach and greater accountability to Sheffield City Region of national **inward investment and trade support**
- Recognition of city region assets, including the Advanced Manufacturing Innovation District and the National College for High Speed Rail / National Institute for Infrastructure

Sheffield City Region

3. THE MAYORAL COMBINED AUTHORITY

THE GEOGRAPHY OF THE DEAL – AND THE MAYORAL COMBINED AUTHORITY

- The totality of the deal spans the Sheffield City Region – including new powers to a South Yorkshire Mayor as well as new powers, and control over funding to the wider Sheffield City Region through the SCR Combined Authority.
- The Mayor will only be elected by the four South Yorkshire members of the CA and will only be able to exercise devolved powers over that footprint.
- The Combined Authority, Chaired by the Mayor (which has also secured new powers directly) will continue to operate and exercise its functions across all of the nine.
- The deal is clear that in any circumstance where they would be able to become a constituent member of the CA any of the five districts would be welcomed – but current legislation does not allow this.
- The Mayor and the CA will be scrutinised and held to account by the SCR Overview and Scrutiny Committee

A MAYORAL MODEL THAT IS 'BOUND' INTO THE COMBINED AUTHORITY

- The Mayor will chair the SCR Combined Authority – and will lead an SCR Cabinet
- The members of the SCR Combined Authority will serve as the Mayor's Cabinet and will act as a supporting and advisory function to the Mayor and Combined Authority
- Even where powers reside with the Mayor the SCR Cabinet will be able to exercise a veto over Mayoral strategies and funding plans if two-thirds of the members agree to do so – and on planning arrangements unanimous approval from CA members will need to be secured.
- On proposals for decision by the CA the Mayor will have one vote – as will other voting members on the CA
- The Mayor will also be a member of the LEP

POWERS DEVOLVED TO THE MAYOR

The heads of terms agreement is very clear on the where devolved powers and funding will sit in terms of the Mayor / Combined Authority

The Mayor, acting as Chair to the Sheffield City Region Combined Authority will exercise the following powers and functions devolved from central Government:

- Responsibility for a consolidated, devolved transport budget, with a multi-year settlement to be agreed at the Spending Review.
- Responsibility for franchised bus services, which will support the Combined Authority's delivery of smart and integrated ticketing across the Combined Authority's constituent councils.
- Responsibility for an identified Key Route Network of local authority roads that will be collaboratively managed and maintained at the city region level by the Combined Authority on behalf of the Mayor.
- Powers over strategic planning, including the responsibility to create a spatial framework for the city region and to chair the Sheffield City Region Joint Assets Board.

POWERS DEVOLVED TO THE COMBINED AUTHORITY

The SCR Combined Authority will continue to exercise its current set of powers and influence as well as newly devolved powers and resources.

These include:

- Control over the new additional £30m a year funding allocation over 30 years
- Responsibility for the devolved 19+ adult skills funding and chairing the Area Based Review
- Joint responsibility with Government on the co-design and co-commissioning of employment programmes
- Joint working with UKTI to boost trade and investment.

Thank you for listening and any questions

THE FULL TEXT OF THE DEAL CAN BE FOUND HERE:

- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465340/Sheffield_devolution_deal_02102015.pdf

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Barnsley and Devolution

Barnsley and devolution

Transport and infrastructure

Further devolvement of transport and infrastructure funding. Funds are already devolved with opportunities for Barnsley:

- Hickleton Marr bypass – joint scheme with Doncaster
- Northern Orbital
- Town centre – further investment eg public realm, private sector investment
- Barnsley Rail vision – align HS2 with local aspirations

- Transpennine connectivity feasibility work – M1/A1 links and rail
- HS2 given priority and still government focus on Meadowhall
- Public transport improvements eg smart ticketing, bus franchises
- Devolved highways funding at Combined Authority level and collaboration work on key route networks

Barnsley and devolution

Housing and planning

- Improved opportunities to develop joined up programme of assets disposals with government
  - Jnct 36 business park, network rail assets, NHS estate land
- Barnsley represented on SCR Joint Assets Board –
  - Right of first refusal for all central government land and assets
- Changing role of Homes and Communities Agency – opportunity to establish a housing investment fund
  - Housing growth areas and affordable sites
  - Critical to tackling unviable sites for development
  - Increased role for private sector eg Barnsley developer forum
  - Further work needed with government on Investment Fund

Barnsley and devolution

Housing and Strategic Planning

The Sheffield City Region Combined Authority Mayor will exercise strategic planning powers to support and accelerate these ambitions. Subject to the agreement of each authority this will include the power to:

- Create a spatial framework which will act as the framework for managing planning across the Sheffield City Region
- Create supplementary planning documents (e.g. S. Yorks Residential Design Guide).
- Help alignment of local development plans with the aspirations of the Strategic Economic Plan for the region
- Demonstrate duty to cooperate across the region
- Be consulted on and/or call-in planning applications of strategic importance to the City Region

Barnsley and devolution

Business growth/trade/investment

- Business support programmes – local and national – developed through the new growth hub for SCR which builds upon success of Enterprising Barnsley
- Significance of growing a healthy tax base in Barnsley
- Access to higher level support for Barnsley businesses eg export, access to finance
- No specific changes in terms of Enterprise Zones – opportunity to strengthen financial incentives and raise profile of our EZs
- Ultra fast broadband – will benefit business parks and EZ sites – first in the country eg Capitol Park, 99% coverage
- Inward investment – Barnsley to get increased investment opportunities, better account management with UK trade and industry, builds on Barnsley property investment fund, international connections

Barnsley and devolution

Skills and employment

- Area Based reviews of post 16 education and training led in region
  - Barnsley College – opportunity for expansion building upon changes across other parts of the region and track record in Barnsley
  - Link College with other public owned estate in town centre
- Employment support programmes to be developed more locally in Barnsley – close working with Job Centre, third sector and role for communities
  - Increased focus on traineeships and apprenticeships
  - Joining up careers advice and needs of Barnsley businesses
  - Fits well with 'more and better jobs' strategy being developed
- Adult skills budget closer working between council and providers