IMPROVING HEALTH AND WELLBEING IN BARNSLEY

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BARNSLEY'S HEALTH AND WELLBEING STRATEGY 2013 – 2016

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FOREWORD

This is Barnsley's first Health and Wellbeing Strategy for the Borough and marks a significant shift in the way local health and social care services are designed and delivered.

The Health and Social Care Act 2012 brought about the abolition of Primary Care Trusts and Strategic Health Authorities throughout the Country, along with the introduction of Clinical Commissioning Groups, local Healthwatch as the consumer champion for health and social care services and the transfer of public health to local authorities.

The introduction of Health and Wellbeing Boards is seen as a key cornerstone of the legislation and a vehicle to make sure health and social care services are designed and delivered around local needs throughout the Country.

In Barnsley, we have been in shadow form throughout 2012 and are pleased to announce our first Health and Wellbeing Strategy. The strategy identifies a series of priorities, which we will work with local residents and communities to bring about positive action to improve overall health and wellbeing in the Borough.

It is clear that as a Borough we face some significant health and wellbeing challenges, but there are a significant number of positives and improvements being made, it's important that together, we collectively build on these and continue to improve individual, family and community health and wellbeing in what are challenging times.

If you would like further information about the Health and Wellbeing Board please access the below website:-

www.barnsley.gov.uk

We look forward to working with you to improve health and wellbeing for the people of Barnsley.

Yours sincerely,

Councillor Stephen Houghton
Chair of the Health and Wellbeing Board
Leader of Barnsley Council

GP Nic Balac
Vice Chair of the Health and Wellbeing Board
Chair of NHS Barnsley Clinical Commissioning Group

INTRODUCTION

What is the Health and Wellbeing Strategy?

The Health and Wellbeing Strategy (H&WBS) sets out the key priorities that the Barnsley Health and Wellbeing Board will seek to deliver, with the residents and communities of Barnsley, over the three year period to 2016 and the steps along that journey to improve the health and wellbeing of the Borough.

The strategy is a statement of the Board's vision, outcomes, priorities and principles for the period 2013-16. It draws heavily on the Joint Strategic Needs Assessment (JSNA) and other forms of local intelligence such as; the Joint Strategic Intelligence Assessment (JSIA) and Child Poverty Needs Assessment, to identify the health and wellbeing needs and assets of Barnsley residents, families and communities, from pre-birth to end of life, and how best to collectively address these, through the local commissioning of services.

What is the Health and Wellbeing Board?

The Barnsley Health and Wellbeing Board (H&WB) is a Committee of Barnsley Council, as set out in the Health and Social Care Act 2012. It brings together Elected Members and Officers of the Council, NHS colleagues, including members of NHS Barnsley Clinical Commissioning Group (CCG) and the NHS Commissioning Board, Local Healthwatch and Providers to improve the health and wellbeing of the residents and communities of Barnsley and narrow health inequalities within the Borough, and against the national average.

The Health and Social Care Act 2012, requires the Health and Wellbeing Board to:-

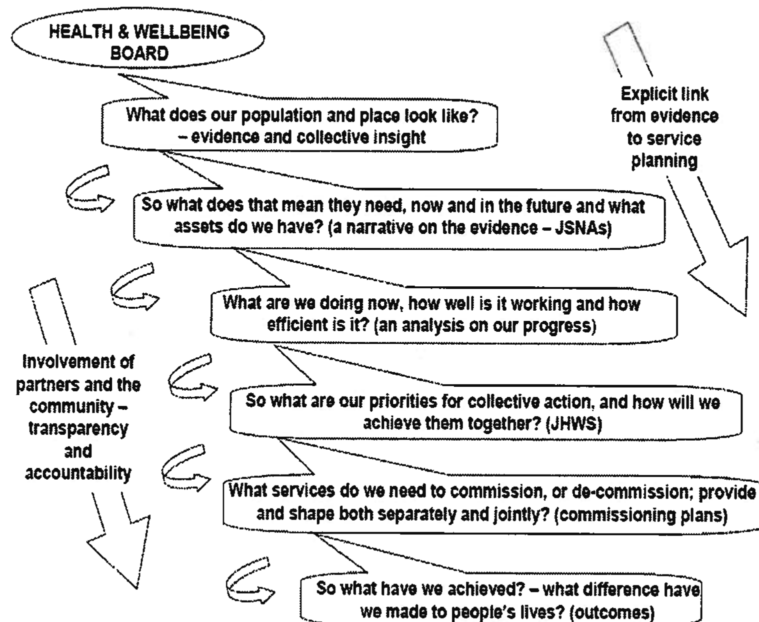
- **Oversee the production of the Joint Strategic Needs Assessment -** to provide a clear statement of the health and wellbeing needs and assets of Barnsley residents and communities,
- **Develop a Health and Wellbeing Strategy -** based on the needs identified in the JSNA and other forms of local intelligence, to provide a framework for how these needs are to be collectively addressed,
- **Ensure Commissioning Plans deliver against the Strategy -** develop health, social care and public health commissioning plans to deliver the priorities of the strategy, and
- **Promote and deliver integrated working -** across health, social care and public health and engender a culture of shared leadership, mutual accountability and responsibility.

What does the Health and Wellbeing Board do?

The purpose of the Board is to:-

- Establish a shared understanding of health and wellbeing needs and how these can be met with residents and communities,
- Secure better health and wellbeing outcomes for residents, quality of care and value for money,
- Support joint working and integration of services, taking a whole systems approach, which places the resident at the centre of the decision making process – including the further development of joint commissioning and the alignment of resources,
- Lead strategic planning and drive commissioning of NHS, public health, social care and related children's services around the needs of residents,
- Ensure the voice of local residents can influence and inform the strategic planning and commissioning of services,
- Lead and build partnerships for health and wellbeing across organisations and the wider community,
- Become a forum for discussion and accountability with regards to policies, services and activities that influence the health and wellbeing of residents and communities,
- Develop and drive major service re-design around health and wellbeing to deliver better local outcomes for local residents.

The following diagram depicts how the JSNA and H&WBS help to inform the commissioning priorities and plans within Barnsley:-



(JSNA and Joint Health and Wellbeing Strategy Guidance, DoH)

Who sits on the Health and Wellbeing Board?

The Board consists of a number of key officers and Elected Members from across the health and social care sector along with South Yorkshire Police.

The Health and Social Care Act 2012 sets out a mandatory membership, with the flexibility to add to this as the local area sees fit. The membership of the Board is set out below:-

- The Leader of the Council,
- The Cabinet Member for Adults and Communities,
- The Cabinet Member for Children, Young People and Families,
- The Chief Executive of Barnsley Council,
- The Council's Executive Director of Adults and Communities,
- The Council's Executive Director of Children, Young People and Families,
- Barnsley's Director of Public Health,
- The Chair of NHS Barnsley Clinical Commissioning Group,
- The Chief Operating Officer of NHS Barnsley Clinical Commissioning Group,
- The Chief Executive of Barnsley Hospital NHS Foundation Trust,
- The Chief Executive of South West Yorkshire Partnership Foundation Trust,
- Local Healthwatch representatives X2,
- The Medical Director of NHS South Yorkshire and Bassetlaw (NHS Commissioning Board),
- Barnsley's District Commander, South Yorkshire Police.

WHAT IS THE VISION FOR BARNSLEY?

The health and wellbeing vision for Barnsley is:-

"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."

The vision is based around the following core values:-

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

WHAT ARE THE OUTCOMES WE ARE LOOKING TO ACHIEVE?

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

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

It is also important to note the effect of wider socio-economic and environmental factors on the health and wellbeing of residents and communities in Barnsley. As such, the links and connections between the strategy and the Local Economic Strategy are important, as the prosperity of the Borough and its residents has a significant impact on overall health and wellbeing.

WHAT IS THE DEFINITION OF HEALTH AND WELLBEING?

The following definition has been developed for health and wellbeing in Barnsley:-

"Health and wellbeing is defined as the state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity, which may be achieved by connecting with people around you, being active, learning new skills, giving to others and taking notice of feelings and thoughts."

Think Local Act Personal: Making It Real – 'I Statements'

To support this vision and delivery of the outcomes, the Board has adopted the Think Local Act Personal: Making It Real – 'I statements'. These are what residents of Barnsley should expect to find as outcomes of a personalised, community based health and wellbeing system. The 'I statements' are set around the following 6 themes and are attached in more detail at appendix one:-

1. **Information and Advice:** having the information I need, when I need it;
2. **Active and Supportive Communities:** keeping friends, family and place;
3. **Flexible Integrated Care and Support:** my support, my own way;
4. **Workforce:** my support staff;
5. **Risk Enablement:** feeling safe and in control;
6. **Personal Budgets and Self Funding:** my money.

Core Principles

To bring this to life, the Board has established a series of core principles which will guide the individual and collective work of the Board, in a bid to create a health and wellbeing system fit for Barnsley residents and communities in the 21st Century. This means a system which:-

- **Is based on shared responsibility:**
  - ➢ Enables partnership working across the public, voluntary and private sector;
  - ➢ Maximises everyone's contribution to build communities and environments conducive to good health and wellbeing choices;
  - ➢ Encourages residents and communities to take responsibility and positive action to improve their health and wellbeing;
  - ➢ Recognises local assets and strengthens the ability of local communities to develop local solutions to local issues; and
  - ➢ Provides targeted support where necessary to increase community resilience and self-reliance, and targets resources to those in the most need.

- **Promotes independence to ensure health and social care services are targeted at those in greatest need:**
  - ➢ Encourages and enables healthy lifestyles;
  - ➢ Invests in prevention, early intervention and early help, therefore shifting resources to the prevention of ill health;
  - ➢ Promotes recovery, independence and self-care, drawing on available technologies;
  - ➢ Draws on evidence and evaluation of what works and innovates where appropriate; and
  - ➢ Adopts a person and family centred approach from pre-birth to end of life.

- **Offers health and social care services that are high quality and value for money:**
  - Integrates health, social care, family support across sectors and public health services to ensure the whole system works as effectively as possible;
  - Integrates services to create effective service and care pathways at all ages and stages beyond health and social care;
  - Offers community services, care and support as close to the home as possible to promote independence;
  - Offers choice and personalisation of services to embed choice, control and independence for the individual;
  - Improves the experience of patients and service users and delivers better local outcomes for local people; and
  - Reduces the need for acute hospital services and concentrates these to those at greatest need.

- **Protects the public:**
  - Ensures the public is protected against infectious diseases and other threats to their health and wellbeing; and
  - Safeguards children and vulnerable adults.

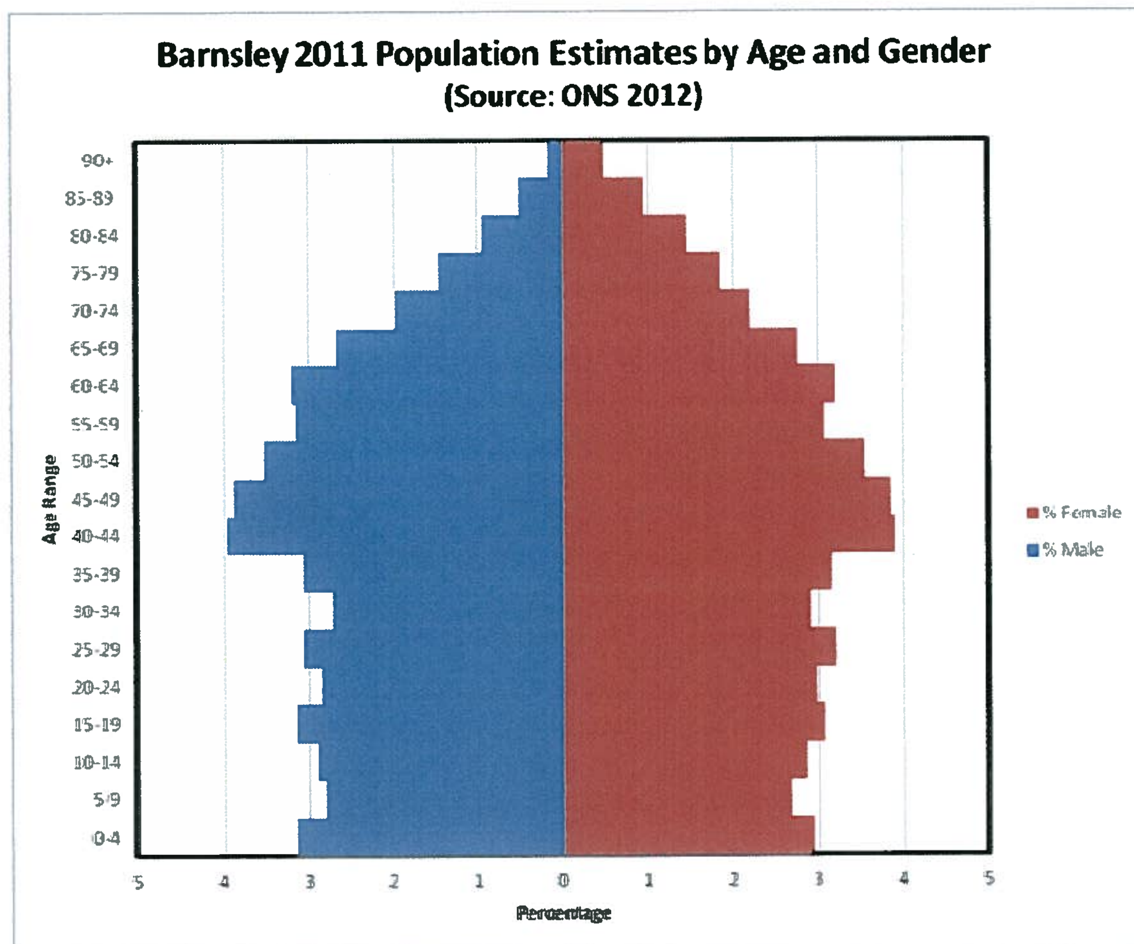
- **Is transparent and accountable:**
  - Gives the public, patients, services users and carers the opportunity to shape how services are designed and delivered to ensure the best possible outcomes for the individual;
  - Promotes the alignment and pooling of resources to deliver high quality services with limited resources, based on individual and community needs; and
  - Enables residents and communities to be confident in the Board and its decisions and able to hold service providers to account.

WHAT IS THE CURRENT HEALTH AND WELLBEING IN BARNSLEY?

Population Demographics

The Office for National Statistics estimates the current population of Barnsley at 231,900. From the 2011 Census data there were 100,700 household spaces occupied by 1 usual resident; this is an increase of 9.2% since 2001. The age distribution is similar to that seen nationally, except for a slightly lower proportion of young people aged 25 to 39 years, 19% of the population is aged under 16, with 17% aged 65 years or older. The median age of the population of Barnsley in mid-2011 was 41 years. In 2011, there were 2,991 live births in Barnsley and 2,274 deaths.

Figure One: Population Pyramid for Barnsley



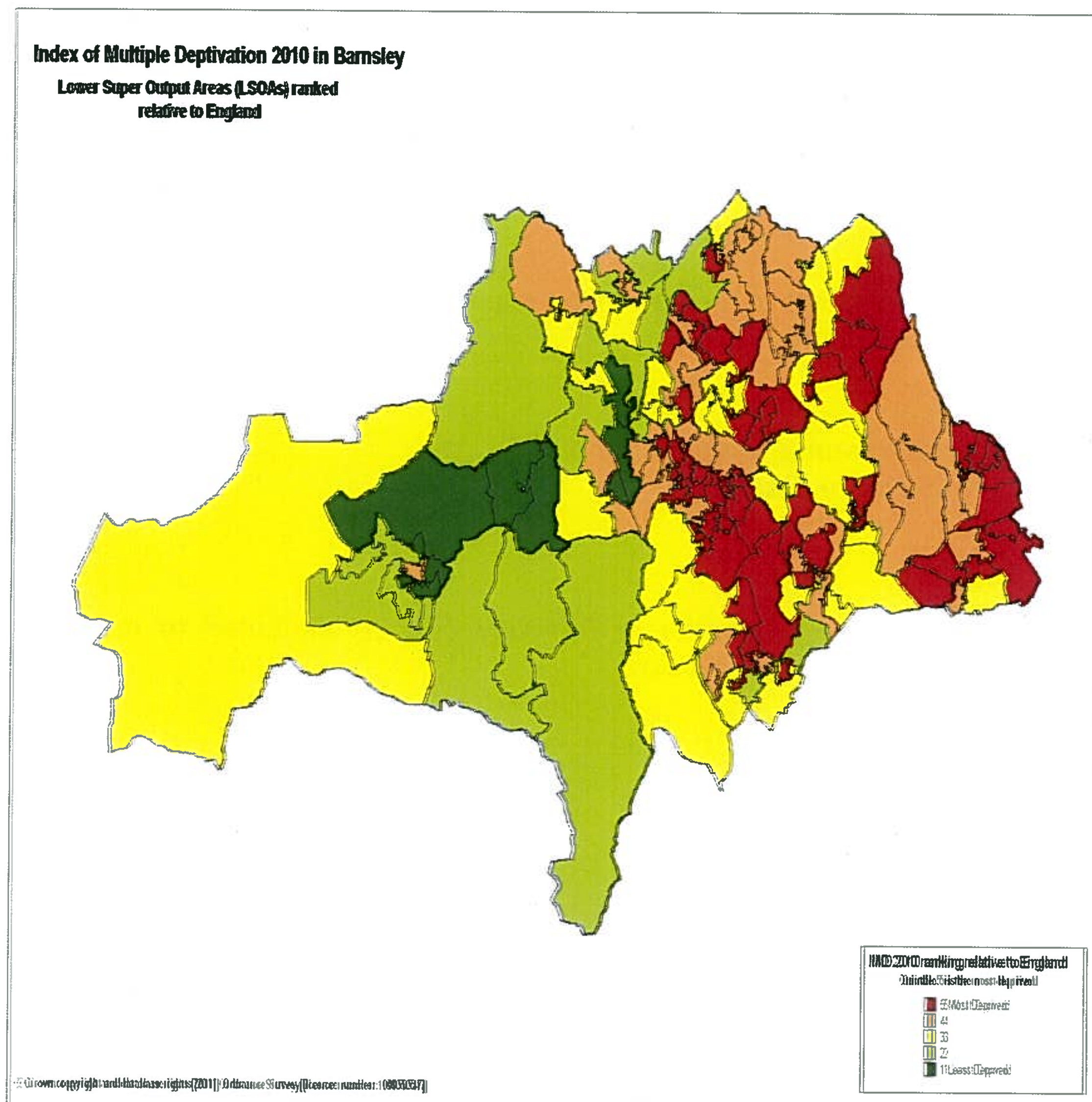
The total population of Barnsley is projected to rise by 7.2% by 2021 (2.9% from 2011 to 2015). The largest projected increase is likely to be those aged over 65, by 20.9% (9.7% from 2011 to 2015). The under 15 population is projected to rise by 12% (3.2% from 2011 to 2015), this is partly due to a small increase in births and only a 2.2% increase in those of working age.

Deprivation

Barnsley is ranked as the 47th most deprived borough of the 326 English boroughs, with 32% of the population living in the 20% most deprived areas in the country. The deprivation is concentrated in the east of the borough expressed in figure 2 below. 23.8% of children in Barnsley currently live in poverty. Educational attainment is relatively low, with only 44.9%% of young people in Barnsley schools achieving five A*-C passes in 2011/12, lower than the regional average of 56.8% and the England average of 58.6% (provisional data).

Unsurprisingly, therefore, there are substantial and persistent inequalities in the health needs and outcomes of the residents and communities of Barnsley both within the borough and compared to the rest of the country as a whole. For example, the percentage of Barnsley residents with a long-term illness or disability is 24.6%, higher than the national average of 17.3%.

Figure Two: Index of Multiple Deprivation 2010 in Barnsley



Health Needs

The Board and its partners have discussed the existing 2011 JSNA and have agreed that this is a sufficiently accurate assessment of need, to be able to inform the development of the first H&WBS. It is however anticipated that over 2013, the JSNA will be reworked, taking on board the emerging findings of the 2011 Census and other quantitative and qualitative data and intelligence, and giving the opportunity to undertake an in depth consultation on needs and assets within the Borough.

Notwithstanding future developments, the 2011 JSNA does provide a comprehensive description of the health and wellbeing needs in Barnsley, combined with the analysis of the 2011 Director of Public Health's Annual Report and other forms of local intelligence. Bringing all this together, the health and wellbeing needs of Barnsley residents and communities are summarised as follows:-

Life Expectancy

Life expectancy at birth in Barnsley is increasing from 76.4 years in 2007-09 to 76.8 years in 2008-10 for men and from 80.1 years in 2007-09 to 80.4 years for women. This is 1.75 years less for men and 2.17 years less for women compared to the England average. Unfortunately, the rate of improvement isn't as fast as the national average, with the gap in life expectancy widening both within the Borough and between Barnsley and the national average, particularly for men.

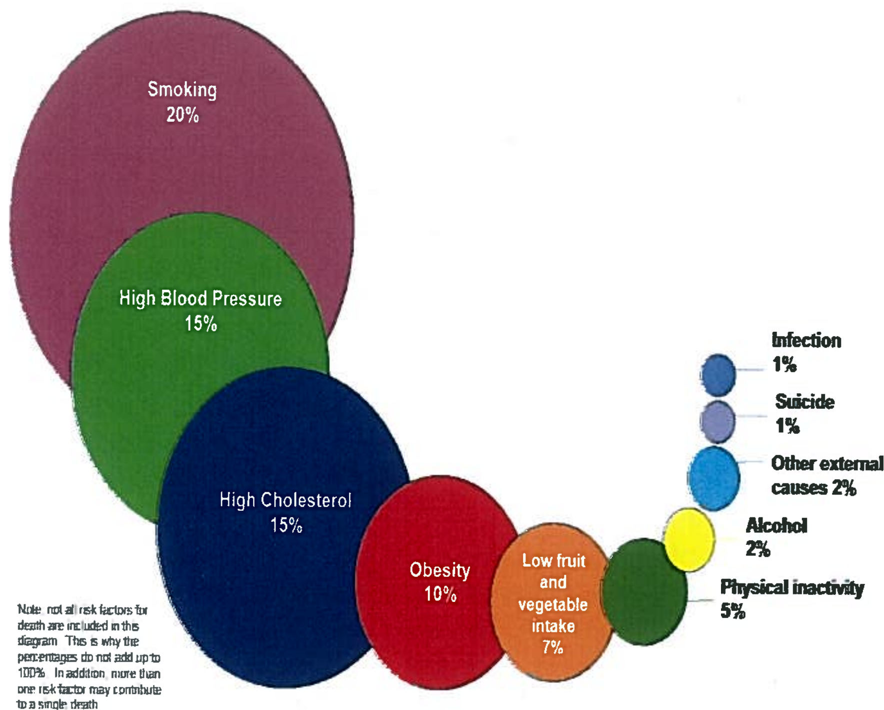
The main contributors to the gap in life expectancy between Barnsley and the rest of the country are:-

- **Cancer;**
- **Cardiovascular disease; and**
- **Respiratory disease.**

Risk Factors

A large proportion of deaths in Barnsley can be attributed to modifiable lifestyle factors, as detailed below:-

Figure Three: Risk factors contributing to deaths in Barnsley 2008- 10



(ONS, 2012; The World Health Report 2002 [WHO: Geneva, 2003]; Statistics in Smoking, The Information Centre, 2006)

The substantial contribution of smoking to deaths in Barnsley reflects the high prevalence of smoking within the borough. After smoking, high blood pressure and high cholesterol together contributed to 30% of deaths in Barnsley over the 2008-10 period.

The prevalence of risk factors in Barnsley is derived from modelled estimates and should be interpreted with some caution. However, estimates suggest that locally:-

- 25.6% of adults smoke cigarettes;
- 15.9% of adults have high blood pressure;
- 6.6% have diabetes;
- 28.4% of adults are obese;
- 79.7% do not eat healthily, as measured by eating five portions of fruit and vegetables a day;
- 12.0% of adults comply with recommended physical activity levels; and
- 22.1% drink excessive amounts of alcohol.

Children, Young People and Maternity

The infant mortality rate in Barnsley is lower than the England average, and there are no significant differences in low birth weight and very low birth weight. Deaths in infancy are concentrated in areas of higher deprivation locally. A significant proportion of women are recorded as smoking at the time of delivery (23.3%).

Breastfeeding rates at 6-8 weeks are 26% which is lower than the national average however, rates continue to improve locally. Childhood immunisation rates are better than national figures (92.7% of children received their MMR), but children's oral health remains, on average poor, with limited use of preventive dentistry among many groups.

Childhood obesity remains a problem in Barnsley; especially amongst Year 6 children (age 10/11). Obesity is a significant risk factor for poor health in later life.

The under 18 conception rate in 2010 was 55.2 per 1000 girls aged 15-17, representing an unwelcome increase; the rate is now the highest in South Yorkshire. Statistics for 2010 reveal that the under-18 conception rate for England has seen a downward trend since 1998. However, although Barnsley's annual rate has also fallen since 1998, it remains higher than the regional and England averages. The most recent figures for 2008-2010 (three year rolling average) show that the rates in Barnsley have increased slightly; now at 53.2 per 1,000 15-17 year old girls. The annual rates roughly equate to approximately 220 conceptions to women under the age of 18 in Barnsley every year.

Improvement in the arrangements for meeting the health needs of children in care is a key action for health and social care services resulting from the Ofsted inspection of Safeguarding and Looked After Children in July 2012. Analysis shows that the percentage of health assessments for children in care has seen a significant decline over the last few years, as has dental care and immunisation take up.

Although the following are predominately focused on the adult population, it is important that children and young people are supported to develop and embed a culture of positive lifestyle choices within families, communities and educational settings. This will have a positive effect on their health and wellbeing throughout childhood and into adulthood – as the next generation.

Cancer

Cancer is the leading cause of premature death in Barnsley, and the second leading cause of death overall. Although premature mortality from cancer is falling, the rate of this fall is not as fast as that seen across the rest of the country and therefore the gap in cancer mortality between Barnsley and England is widening. For the period 2008-10, the cancer premature mortality rate was 140.5 per 100,000 population compared to 143.21 per 100,000

population in 2007-09. The number of premature cancer deaths for this period was 1118.

The largest single cause of cancer deaths in Barnsley is lung cancer, followed by prostate, breast and bowel cancer. Five year survival rates for prostate, bowel and breast cancer are significantly lower in Barnsley compared to the rest of the country. Over half of all cancers could be prevented by lifestyle changes, predominantly stopping smoking.

Cardiovascular Disease (CVD)

Cardiovascular disease is the leading cause of death in Barnsley, and the second leading cause of death in those aged under 75 years. For the period 2008-10, the CVD premature mortality rate was 84.7 per 100,000 population compared to 86.66 per 100,000 population in 2007-09. The majority of these deaths were from coronary heart disease and stroke. Whilst improvements are being made locally, Barnsley has a significantly higher premature CVD mortality rate compared to the national average.

Modelled estimates suggest there may still be high numbers of residents with undiagnosed hypertension and diabetes locally. Recent analysis has shown that an estimated 211 deaths per year could be averted locally by fully implementing a list of evidence based interventions in primary care.

Respiratory Disease

Respiratory disease is the third most common cause of death in Barnsley, accounting for 1155 deaths per year (2008-10). The largest number of deaths from respiratory disease is from pneumonia, with Barnsley having the highest mortality rate for women and the second highest for men from pneumonia in the Yorkshire and Humber region. Pneumonia also accounts for a large proportion of hospital admissions.

There are also a large number of deaths from Chronic Obstructive Pulminary Disease (COPD), with a mortality rate of 34 per 100,000 between 2008-10, COPD is responsible for a substantial burden of disease locally. The predominant risk factor for COPD is smoking.

Mental Health and Wellbeing

It is estimated that 29,234 adults aged 16-74 years in Barnsley have a neurotic disorder. 30,673 adults had a diagnosis of depression in Barnsley (15.8%); this is higher than the average for England (11.7%). Furthermore, 1,688 individuals had a diagnosis of schizophrenia, bipolar disorder and other psychoses in Barnsley (0.7%) compared to 0.8% nationally. Mental wellbeing places a significant role in how individuals live their lives and cope with daily activities, contribute to society and are able to deal with changing circumstances personally, within families and communities.

Long Term Disease and Disability

There are an estimated 23,611 people over the age of 65 years with a limiting long term illness, this is projected to rise year on year up to 2015 when the estimate will be at 25,237, this alongside the general elderly population growth rate at 3% year on year will have a significant burden on both health and social care services.

There are an estimated 4,285 adults with learning disabilities in Barnsley; this figure is set to gradually increase over the next 3 years. By 2015 the figure is estimated to be 4,382. Of these 908 have moderate learning disabilities and 203 have severe learning disabilities.

Ageing Population

There are approximately 231,900 people living in Barnsley. This is projected to increase to 238,500 by 2015 and to 248,600 by 2021. These interim projections from Office for National Statistics (ONS) show that the largest projected increase is likely to be in those aged over 65 (increasing by 20.9% in 2021). 20% of the total population will be aged over 65 in 2021.

The demographic trend of an ageing population means that demands on health and social care services will continue to grow. It is important that residents are supported to maintain healthy and independent living for as long as possible, supported by a commitment to end of life care and the effects of dementia, to not only improve the quality of life in elder years but also to reduce the burden on health and social care services.

Alcohol Misuse

The impact of alcohol misuse nationally is widespread, encompassing alcohol related illness and injuries such as correlation to high blood pressure, stroke, cancers and depression, as well as significant social impacts including crime and anti-social behaviour, domestic violence, teenage pregnancy, loss of workplace productivity and homelessness. As alcohol has become increasingly affordable, consumption has increased by 121% between 1950 and 2000 (Prime Minister's Strategy Unit 2004). One in four adults now drinks above the recommended limits and there has been a corresponding rise in alcohol related disease and mortality; the cost to the NHS alone is an estimated £2.7 billion a year.

Barnsley's rate of binge drinking is significantly higher than the England average. The rates of alcohol related hospital admissions are rising (a year on year increase since 2007/08) with men having significantly higher alcohol specific hospital admissions than the England average (546.5 per 100,000 for Barnsley compared to 450.9 nationally in 2010/11).

In terms of young people, 29.9% of males and 30.1% of females in Year 10 reported drinking alcohol often or daily; this shows a slight decrease from the

2008 data when 32.6% of males and 39.0% of females reported they were drinking alcohol often or daily. Furthermore, during the period 2008/09-2010/11 Barnsley had a significantly higher rate of under 18s alcohol specific hospital admissions when compared to the England average (87.8 per 100,000 for Barnsley compared to 55.8 per 100,000 nationally).

Housing and Accommodation

Maslow's hierarchy of need identified that one of the most fundamental physiological needs is for shelter. The provision of a well maintained, heated, ventilated and insulated property impacts directly on an individual's physical and mental wellbeing, their ability to thrive and their ability to maintain an independent life. It is therefore important that the JSNA takes account of the Strategic Housing Market Assessment and the resulting housing and accommodation needs of Barnsley residents. This needs to cover both the social housing sector and the private rented sector to improve overall health and wellbeing within the Borough.

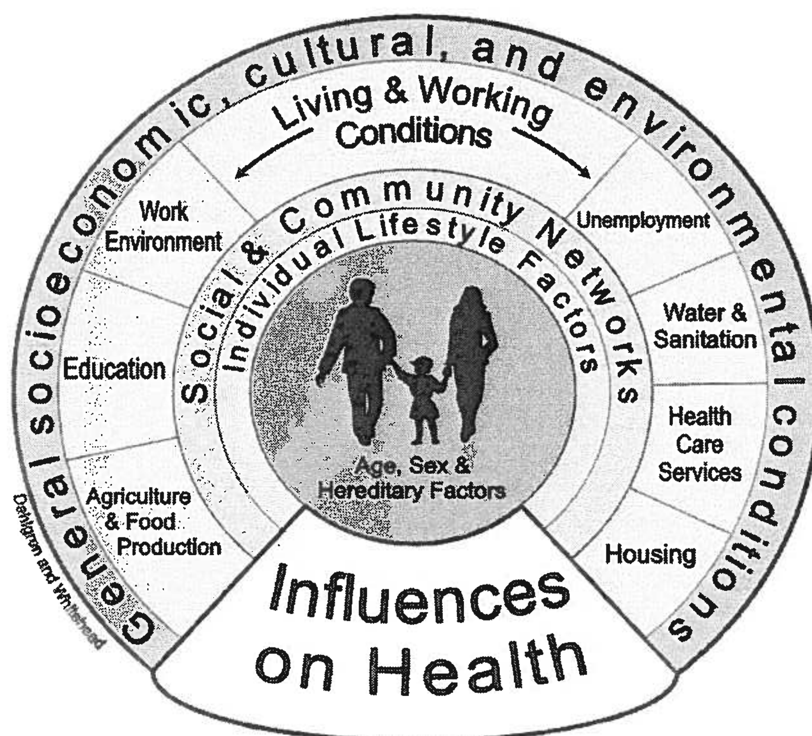
ACTIONS TO REDUCE HEALTH INEQUALITIES

Barnsley's JSNA 2011, states that whilst health and social care services make a contribution to health, wider determinants associated with environmental factors make a significant impact on the health and wellbeing of residents and communities. Factors such as early childhood experiences, education, family poverty, employment, housing, the environment and levels of income all have an impact on health, mental health and personal wellbeing and resilience.

Additionally, there are health issues that may be more problematic for particular equality groups; for example low take-up of breast and cervical screening services by lesbians, higher incidences of mental health issues amongst the lesbian, gay, bisexual and transgender community and service access issues for the deaf community.

The JSNA and wider forms of intelligence strongly suggest that many of these factors are adversely affecting the health and wellbeing of residents and communities within Barnsley. The industrial legacy of the Borough, coupled with intergenerational worklessness, high levels of unemployment and poor levels of educational attainment have prevented the health of Barnsley residents reaching the levels enjoyed by other parts of the Country, and are causing significant health inequalities within the Borough itself. The figure below describes these wider determinants of health.

Figure Four: Factors which influence health outcomes and inequalities



(Dahlgren and Whitehead, 1991)

Life expectancy is increasing in Barnsley but at a slower rate than the rest of the country, so the gap between Barnsley and England continues to widen. This illustrates the level of health inequalities in the Borough. Some Health inequalities are as a result of biological factors, others occur as a consequence of certain lifestyle choices, and others are due to external social and environmental factors, as described in the classic Dahlgren and Whitehead 'rainbow' model which shows the main determinants of health.

The interaction between all these factors is extremely complex. However, social and economic deprivation is one of the most powerful determinants of health inequalities. This is especially relevant in Barnsley, which remains relatively deprived compared to other parts of the country.

It is now clear that disadvantage can start before birth and accumulate throughout life. Action to reduce inequalities and promote good health and wellbeing therefore needs to start before birth and be followed through to end of life. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.

There is much to be done to improve the lives and health of people of all ages. Services that promote the health, wellbeing and independence of older people, and in so doing, prevent or delay the need for more intensive or institutional care, make a significant contribution to ameliorating health inequalities.

WHAT ARE THE PRIORITIES FOR 2013-16?

To give the Board focus and to ensure it adds value, the following 4 areas have been identified for the three year period 2013-16:-

- Investing in health and wellbeing through a life-course approach and empowering people of all ages;
- Tackling the major health challenges;
- Strengthening people-centred health and wellbeing systems; and
- Creating resilient communities and supportive environments.

Investing in health and wellbeing through a life-course approach and empowering people of all ages

Supporting good health and wellbeing throughout the life-course leads to increased healthy life expectancy and better quality of life in later years. This not only improves the quality of life of the individual, but also generates important economic, societal and individual benefits. The changing demographics facing Barnsley means that an effective life-course strategy which promotes health and wellbeing and prevents ill-health and dependence upon state support will produce a healthier society, with residents and communities experiencing better wellbeing from pre-birth to elder years, thereby facilitating an active contribution to civil society.

Tackling the major health challenges

Tackling major health challenges requires a combination of public health action and broader health and wellbeing intervention. The effectiveness of these is underpinned by actions on equity, social determinants of health and wellbeing, empowerment and supportive environments. An whole systems approach from pre-birth to end of life, designed at preventing illness and long term state dependency, through prevention and early intervention, means that limited resources can be directed to those most in need, promoting a culture of self help and self care, where residents and communities are empowered to take control of their individual health and wellbeing.

Strengthening people-centred health and wellbeing systems

Achieving high quality care and improved health and wellbeing outcomes requires health and social care systems that are financially viable, fit for purpose and people-centred. Barnsley has to adapt to changing demography and patterns of health and social care need, including; mental health challenges, chronic diseases and conditions related to an ageing society. This requires a reorientation of current systems to give priority to prevention and re-ablement, which fosters continual quality improvement and integrated service delivery, whilst ensuring continuity of care, support to self help and greater independence to be delivered at home, or as close to home as possible. This approach is known locally as Inverting the Triangle.

Creating resilient communities and supportive environments

Building resilience is a key factor in protecting and promoting health and wellbeing at both a resident and community level. It is recognised that people's health and wellbeing is closely linked to the conditions in which they are born, grow up, work and grow older. Empowered residents and communities which are resilient, respond proactively to new or adverse situations, prepare for economic, social and environmental change and deal better with crisis and hardship.

SO WHAT'S THE FOCUS FOR 2013-14?

To help deliver the change required over the next few years, the Board has decided to focus on 5 specific areas for the next financial year, based firmly on the local evidence of the health and wellbeing needs in Barnsley, these are:-

- **Cancer;**
- **Cardiovascular Disease;**
- **Alcohol Misuse;**
- **An ageing population and the need to support independent living;**
- **Children's Health**; with a particular focus on:-

- Ensuring the needs of children and young people on the autistic spectrum disorder are recognised, assessed, diagnosed and supported effectively through streamlined pathways;
- Targeting the health and wellbeing of young people (aged 13 to 19) sexual health and relationships, addressing risky behaviours (misuse of alcohol and other substances);
- Ensuring that the health needs of children in care are met effectively;
- Early Intervention Strategy incorporating pre-birth assessments, Family Nurse Partnership, Health Visiting, Children and Young People's Improving Access to Psychological Therapies, education, health and care plans for disabled children.

Whilst these priorities have been identified as areas of focus, where the Board feels it can add real value over the coming year to deliver improved outcomes for the residents and communities of Barnsley, this does not replace the existing and/or programmed activity taking place within Barnsley across the wider determinants of health and wellbeing.

HOW WILL PROGRESS BE MEASURED?

To ensure the Board can assess the progress being made against the delivery of the outcomes and priorities for Barnsley residents and communities, a series of performance indicators have been identified. These will have targets assigned to them and will be monitored on a regular based to ensure the Board is fully aware of progress being made and any issues which may require further attention. The performance indicators are largely taken from the NHS (NHSOF), Public Health (PHOF), Adult Social Care (ASCOF) and CCG Outcome Frameworks and are detailed below:-

Overall Life Expectancy (Correlation to Cancer and Cardiovascular Disease)

- Life expectancy at 75 – males and females (NHSOF/ PHOF).
- Differences in life expectancy and healthy life expectancy between communities – males and females (PHOF);
- Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (NHSOF);
- Smoking prevalence – over 18 adult (PHOF).

Priority - Cancer

- Under 75 mortality rate from cancer (NHSOF/ PHOF);
- Cancer survival rates (NHSOF);
- Cancer diagnosis at stage 1 and 2 (PHOF);
- Cancer screening coverage (PHOF).

Priority - Cardiovascular Disease

- Under 75 Mortality rate from cardiovascular disease – including heart disease and stroke (PHOF/ NHSOF);
- People who have had a stroke who are admitted to an acute stroke unit within four hours of arrival to hospital (CCG Outcome Indicator);
- People who have had a stroke who receive thrombolysis following an acute stroke (CCG Outcome Indicator);
- People who have had a stroke who are discharged from hospital with a joint health and social care plan (CCG Outcome Indicator);
- People who have had a stroke who receive a follow up assessment between 4 – 8 months after initial admission (CCG Outcome Indicator).

Priority - Alcohol Misuse

- Alcohol-related admissions to hospital (PHOF);
- Under 75 mortality rate from liver disease (PHOF/ NHSOF).

Priority - An ageing population and the need to support independent living

- Proportion of people using social care who receive self-directed support, and those receiving direct payments (ASCOF);
- The proportion of people who use services who have control over their daily life (ASCOF);
- Permanent admissions to residential and nursing care homes per 1,000 population (ASCOF);
- Proportion of people feeling supported to manage their condition (NHSOF);
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions – adults (NHSOF);
- Emergency admissions for acute conditions that should not usually require hospital admission (NHSOF);
- Emergency readmissions within 30 days of discharge from hospital (NHSOF);
- Proportion of older people (65 and over) who were still at home 91 days after discharge into rehabilitation (NHSOF/ASCOF);
- The proportion of people who use services who feel safe (ASCOF).

Priority – Children's Health

- Infant mortality (PHOF);
- Low birth rate of term babies (PHOF);
- Breastfeeding (PHOF);
- Smoking status at the time of delivery (PHOF);
- Under 18 conception (PHOF);
- Excess weight in 4-5 and 10-11 year olds (PHOF);
- Hospital admissions caused by unintentional and deliberate injuries in under 18s (PHOF);
- Incidence of harm to children due to 'failure to monitor' (NHSOF);
- Tooth decay in children aged five (PHOF);
- Children in poverty (PHOF);
- Access to non-cancer screening programmes (PHOF);
- Vaccination coverage (PHOF);
- Smoking prevalence – 15 year olds (PHOF);
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHSOF);
- Emergency admissions for children with lower respiratory tract infections (NHSOF);
- Children becoming subject of a child protection plan for the 2nd or subsequent time in a year.

WHAT NEXT?

High Level Strategic Planning

To ensure collective ownership and mutual accountability of the strategy, an executive group has been established to promote and develop whole systems re-design. This group will look at the totality of spend and assess how health and wellbeing outcomes can be better addressed within the limited resources available. This will in turn, inform the commissioning intentions and plans for Barnsley.

Commissioning Plans

In order to deliver the vision, outcomes and priorities contained within the strategy, the Board will ensure that the commissioning plans for health and social care; including the CCG, public health and social care, across the entire life course, deliver services which contribute directly to the strategy for 2013-16, and specifically the priorities for 2013-14. Partners and services will be held to account for their individual contributions and the Board, collectively, for its added value.

Performance Management

To ensure progress can be measured, the Board will develop a performance management framework including priority action plans, building on the national outcome frameworks to ensure it can demonstrate improvements in outcomes and quality of life for the residents and communities of Barnsley. Partner agencies will be held to account for the delivery of their actions as part of the regular business of the Board.

Further JSNA's, the Index of Multiple Deprivation and local profiles will also demonstrate whether the delivery of the strategy has had an impact on the deprivation within Barnsley and whether or not health inequalities have reduced, within the Borough and against national averages.

Reviewing the Strategy

The strategy covers a three year period to 2016; it will be formally reviewed annually to ensure the priorities remain consistent with local need and any changes nationally in policy direction. The first review will be particularly significant following the first full year of operation.

Over the course of the three years, the picture of local needs and assets within Barnsley will continue to be further enhanced, via the JSNA, Local HealthWatch and the commissioning of services, giving a much clearer picture of the characteristics of Barnsley residents and communities and their health and wellbeing.

Appendix One: Think Local Act Personal: Making It Real – 'I Statements'

1. Information and advice: having the information I need, when I need it

- I have the information and support I need in order to remain as independent as possible,
- I have access to easy-to-understand information about care and support which is consistent, accurate, accessible and up to date,
- I can speak to people who know something about care and support and can make things happen,
- I have help to make informed choices if I need and want it,
- I know where to get information about what is going on in my community.

2. Active and supportive communities: keeping friends, family and place

- I have access to a range of support that helps me to live the life I want and remain a contributing member of the my community,
- I have a network of people who support me – carers, family, friends, community and if needed paid support staff,
- I have opportunities to train, study, work or engage in activities that match my interests, skills and abilities,
- I feel welcomed and included in my local community,
- I feel valued for the contribution that I can make to my community.

3. Flexible integrated care and support: my support, my own way

- I am in control of planning my care and support,
- I have care and support that is directed by me and responsive to my needs,
- My support is co-ordinated, co-operative and works well together and I know who to contact to get things changed,
- I have a clear line of communication, action and follow up.

4. Workforce: my support staff

- I have good information and advice on the range of options for choosing my support staff,
- I have considerate support delivered by competent people,
- I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers,
- I am supported by people who help me to make links in my local community.

5. **Risk enablement: feeling safe and in control**

- I can plan ahead and keep control in a crisis,
- I feel safe, I can live the life I want and I am supported to manage any risks,
- I feel that my community is a safe place to live and local people look out for me and each other,
- I have systems in place so that I can get help at an early stage to avoid a crisis.

6. **Personal budgets and self funding: my money**

- I can decide the kind of support I need and when, where and how to receive it,
- I know the amount of money available to me for care and support needs, and I can determine how this is used (whether its my own money, direct payment, or a council managed personal budget),
- I can get access to the money quickly without having to go through over-complicated procedures,
- I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this.

Children, Young People and their Families

As well as the 'I' statements above which include children, young people and their families, there are specific considerations to take into account:-

- Children and young people will have a fair start to life and every opportunity to succeed,
- Parents and carers will get the support they need to enable their children to flourish and achieve all of the 'I' statements in their own right,
- Children and young people will get the right age-appropriate help and support in all settings, including health services, social care services, school, and in training and employment,
- Children and young people will be supported by a system which has high expectations of individual abilities in all aspects of their lives,
- Parents and carers will have a strong influence on the support their children need, and children will be helped to prepare for adulthood and take more control as they grow older,
- Services will work together to meet the needs of children, young people and their families.

Appendix Two: Strategy Mapping

There are a number of supporting strategies which will help to deliver the health and wellbeing vision, outcomes and priorities for Barnsley residents and communities, these are:-

- One Barnsley Community Strategy 2012/15,
- BMBC Corporate Plan 2012/15,
- Children, Young People and Families Prospectus 2012/13,
- Older People and Vulnerable Adults Strategy 2012/15,
- Draft Children and Young People Autism Strategy 2013/14,
- One Path One Door - Strategy for Disability and Complex Needs,
- Forthcoming Young People's Health and Wellbeing Strategy 2013/14,
- Health Visiting Implementation Plan,
- Barnsley's Child and Family Poverty Strategy,
- Growing Barnsley's Economy (2012-2033) - An Economic Strategy For The Borough,
- Barnsley Alcohol Harm Reduction Strategy 2010/13,
- Barnsley DAAT Annual Treatment Plan 2012/13,
- Barnsley Safer Communities Partnership Strategy,
- Barnsley Carers' Strategy 2010/13,
- NHS Barnsley CCG Commissioning Plan: Working Together – a commissioning plan for 2013/14 and beyond that puts the people of Barnsley first,
- Mental Health Strategy,
- Housing, Independence and Prevention Strategy 2012/17,
- BMBC Equality Scheme 2012 to 2015 'Equality: Now More Than Ever'.

HEALTH AND WELLBEING STRATEGY 2013-16 CONSULTATION RESPONSE

Respondent	Comments
1. Barnsley Save Our NHS Campaign	• Re-affirm the commitment of collective action to support people when they are ill and promote good health, • Address the life expectancy gap within the Borough, • Investment in health and social care services and jobs, • Greater public involvement in health and social care.
2. Alzheimer's Society Barnsley	• Citation of dementia within the ageing population priority, • Think Local Act Personal: Making it Real 'I statement' need to resonate more with people with dementia.
3. Performance and Partnerships Division, BMBC	• Potential for obesity to be included as a priority, • Children's priorities for 2013/14 are very specific in focus against the other broader priorities, • Make the connections with the local economic strategy around prosperity and wider health and wellbeing, • Governance links with the Local Strategic Partnership review.
4. Michael Dugher MP	• Extend the vision to include a specific statement about 'access' i.e. residents are able to access facilities and services, • Ensure there is enough information, advice and guidance practically, to enable residents to make informed choices, • How does the strategic intention translate into tangible delivery – action planning, • Potential for obesity and increased exercise to be included as a priority, • Potential focus on teenage pregnancy, • Reference to dental health within the strategy.
5. Barnsley Hospice	• The recognition of the involvement of the private sector – links between this strategy and the economic prosperity of the Borough, • The importance of promoting a 'good death' – end of life care, linked to a target to reduce deaths in hospital.

Respondent	Comments
6. South Yorkshire Safer Roads Partnership	• Recognition of the promotion of safer roads and the reduction of road traffic collisions and casualties, • The promotion of exercise (walking and cycling) and its positive effect on health and wellbeing, • Importance of air quality and reducing carbon emissions.
7. Berneslai Homes	• The need for appropriate shelter (housing) and its contribution to a person's health and wellbeing, • Housing/accommodation for an ageing and growing population, • The need to engage housing providers in the development of the Health and Wellbeing Board.
8. NHS Barnsley CCG	• Communication and branding for the Board and the strategy, • Population level pledges that the Board signs up to deliver, • Three year strategy, important to draw out what success looks like over the three years and enable robust performance management, • The use of common language, in particular 'residents' and the potential to replace with 'people', • The need to link in the importance of and relationship with the economic strategy.
9. SY Police	• The need to draw out the inexplicable link between community safety and health and wellbeing within communities.
10. Expert Partnerships	• The inclusion of mental health as a priority, • The importance of carers within the Borough, • The need to address those experiencing the greatest health inequalities within society, • The need for an easy read version.
11. Dennis Patton	• The positive role of the natural environment on health and wellbeing, • Potential for green infrastructure to be included as a priority, • The need for positive lifestyle behaviours and the importance of the wider health determinants.
12. Kayla Kavanagh	• The need to make mental health more predominant within the strategy, • The need for service user and carer involvement in the Health and Wellbeing Board.
13. Phil Hollingsworth	• The need to make appropriate links to the emerging area arrangements within the Council.

Respondent	Comments
14. Ian Haigh	• The need to close the gap against the national average on some of the key health inequalities, • The need to continue existing projects which are having a positive impact on health and wellbeing even in a climate of reducing resources, • Potential for obesity to be included as a priority, • Promotion of healthy lifestyles for children, young people and their families.