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BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 9 August 2016
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 7th June, 2016 (HWB.09.08.2016/2) *(Pages 3 - 8)*

3 Minutes from the Children and Young People's Trust Executive Group held on 29th April, and 17th June, 2016 (HWB.09.08.2016/3) *(Pages 9 - 28)*

4 Minutes from the Barnsley Community Safety Partnership held on 11th May, 2016 (HWB.09.08.2016/4) *(To Follow)*

5 Minutes from the Stronger Communities Partnership held on 24th May, 2016 (HWB.09.08.2016/5) *(Pages 29 - 32)*

For Decision/Discussion

6 Better Housing, Better Health (HWB.09.08.2016/6) *(Pages 33 - 48)*

7 Adult Joint Commissioning Review and Work Plan (HWB.09.08.2016/7) *(To Follow)*

8 Annual Report of the Barnsley Safeguarding Adults and Children Boards (2015/16) (HWB.09.08.2016/8) *(Pages 49 - 166)*

9 Oral Health Improvement Action Plan (HWB.09.08.2016/9) *(Pages 167 - 180)*

10 Inspiring a Smoke Free Generation in Barnsley (HWB.09.08.2016/10) *(Pages 181 - 184)*

11 Health & Wellbeing Board Risk Register (HWB.09.08.2016/11) *(Pages 185 - 188)*

For Information

12 Local Digital Roadmap (HWB.09.08.2016/12) *(Pages 189 - 252)*

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 - 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
Richard Jenkins, Barnsley Hospital NHS Foundation Trust
Steven Michael OBE, South West Yorkshire Partnership NHS Foundation Trust

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

Monday, 1 August 2016

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 7 June 2016
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 Margaret Bruff, Cabinet Spokesperson - People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson - Communities
Nick Balac, NHS Barnsley Clinical Commissioning Group
Lesley Smith, NHS Barnsley Clinical Commissioning Group
Tim Innes, South Yorkshire Police
Tony Alcock HealthWatch Barnsley
Sean Rayner, South West Yorkshire Partnership NHS Foundation Trust
Steve Wragg. Barnsley Hospital NHS Foundation Trust

1 Declarations of Pecuniary and Non-Pecuniary Interests

Councillor Platts declared a non-pecuniary interest in minute numbers 6 and 11 in her capacity as a Member of Barnsley Hospital NHS Foundation Trust Governing Body, insofar as the discussion referred to the Trust.

2 Minutes of the Board Meeting held on 5th April, 2016 (HWB.07.06.2016/2)

The meeting considered the minutes of the previous meeting held on 5th April, 2016.

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

3 Minutes from the Children and Young People's Trust Executive Group held on 17th March, 2016 (HWB.07.06.2016/3)

The meeting considered the minutes from the Children and Young People's Trust Executive Group held on 17th March, 2016. Attention was drawn to minute number 7 and the fact that TEG had commissioned a multi-agency task and finish group to review the approach to tackling teenage pregnancy

RESOLVED that the minutes be received.

4 Minutes from the Provider Forum held on 9th March, 2016 (HWB.07.06.2016/4)

The meeting considered the minutes from the Provider Forum meeting held on 9th March, 2016.

RESOLVED that the minutes be received.

5 BCF Plan 2016/17 (HWB.07.06.2016/5)

The meeting received an update on the contents of the Better Care Fund (BCF) Plan for 2016/17, incorporating in the appendix a copy of the final draft plan submitted on

21st March 2016 under the assurance process. Partners were continuing to work on the approach to the BCF beyond 2016/17 and this would be the subject of a report to a future Board meeting.

RESOLVED:-

(i) that the report be received and the Better Care Fund Planning Submission Template and supporting narrative be endorsed;

(ii) that the Chair and Vice Chair of the Board be authorised to approve any amendments to the plan as a result of the assurance process;

(iii) that the further work required to develop the approach to the Better Care Fund beyond 2016/17 be noted.

6 Draft Refreshed Health and Wellbeing Strategy - initial consultation (HWB.07.06.2016/6)

The meeting received a presentation on the work to develop the Health and Wellbeing Strategy, having regard to the Board's initial guidance about the required outcome framework and the need to focus on systems leadership. The presentation made reference to the health and wellbeing system across Barnsley and the range of strategies that contributed to the overall strategy. The meeting noted the focus on not duplicating those strategies within the Health and Wellbeing Strategy itself, and seeking to focus on those areas where the Board could add value and progress only be achieved by working together.

The presentation set out the proposed Vision for the strategy: "People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live". The presentation also set out the Principles, Strategic Objectives and Outcomes considered central to delivering this Vision. This identified the importance of achieving a stronger economy and healthier workforce as a key Outcome, in addition to those previously seen as central to the Health and Wellbeing Strategy.

The meeting noted the proposed next steps, in particular continued engagement with stakeholders and a public consultation workshop scheduled for 21st June. Members commented on the importance of engaging the various Equality Forums in this consultation process. Partners also needed to undertake further work to identify and agree outcome indicators. It was intended to undertake consultation during July and August to allow the Board to consider the final draft in August / September. Once approved, further consideration of the associated Health and Wellbeing Board Work Programme will be required.

The Board discussed the importance of outcome indicators that confirmed rate and direction of travel but reflected the Board's system leadership role. It was equally important that those responsible for delivery against key outcomes could be held properly to account by the Board. Members commented on the need ensure that all relevant partners strategies were included in the list considered for the purposes of this work, and that these all meshed together in delivery of the outcomes. The relationship between work on the strategy and the developing Sustainability and Transformation Plan (STP) was acknowledged, particularly in providing the necessary Place-Based element of the STP.

RESOLVED:-

(i) that the approach to developing the Health and Wellbeing Strategy, and the proposed Vision, Principles, Strategic Objectives and Outcomes set out in the presentation, be approved for further work;

(ii) that the arrangements for consultation on the draft strategy be noted, and arrangements be made for engagement with the Equality Forums as part of this programme;

(iii) that the Board acknowledge the importance of focusing on those areas where the Board can add value, and in holding to account those partners responsible for delivering each outcome, and a suite of outcome indicators be developed that has regard to these requirements.

7 Annual Report of the Director of Public Health (HWB.07.06/2016/7)

The meeting received the Director of Public Health's Annual Report for 2015/16, focusing in particular on reducing premature deaths and preventable ill-health. The meeting noted that, whilst life-expectancy was increasing for both men and women, the length of healthy life remained poor by comparison. The meeting noted the importance of early intervention and the targeting of interventions, specifically towards younger people. The meeting noted the innovative approach taken in presenting the Annual Report as an interactive PDF that identified key activity across directorates and in communities, which had been commended outside the borough.

The meeting noted the need for the key messages about preventable disease and ill-health being repeated on a regular basis, particularly to young people. The success achieved in reducing smoking prevalence amongst younger people, for example, was noted, but some consideration of how these messages could be better incorporated into the school curriculum was needed.

RESOLVED that the Director of Public Health's Annual Report for 2015/16 be received and partners be requested to signpost the report to interested parties, as appropriate.

8 Mental Health Strategy, Action Plan and 'You Said, We Listened' Report (HWB.07.06.2016/8)

The meeting received a report on the All-Age Mental Health and Wellbeing Commissioning Strategy for 2015 to 2020 and noted the engagement with partners and service users in developing the strategy. The meeting welcomed in particular the focus on and approach to the mental health and wellbeing of children and young people. The strategy continued to be developed, with the intention to work up one section in detail with stakeholders as the model for developing the whole strategy.

Members commented on the importance of inter-agency working on this strategy, in particular to explore in the depth the range of interdependencies and undertake further action planning. The Board welcomed the approach to developing the strategy as a good example of listening, with a pause in the timeline to allow full feedback. The action planning needed to pick up the issue of outcome indicators that could show progress on delivering the strategy. Progress monitoring would be undertaken by the Adult Commissioning Unit and escalated to the Board as necessary.

RESOLVED that the All-Age Mental Health and Wellbeing Commissioning Strategy for 2015 to 2020 be endorsed.

9 Tobacco Action Plan/ Smoke Free Barnsley (HWB.07.06.2016/9)

The meeting received a report on the Smoke Free Barnsley Action Plan, outlining local ambitions to inspire a smoke free generation. Partners were asked to support the plan as organisations, with the aim of making smoking invisible across the community. Members commented on the importance of aligning this plan to the Sustainability and Transformation Plan and to clarify the timeline for achieving the various outcome measures.

The meeting noted ambitious targets for the region and nationally that would put pressure on partners to take concerted action and Members discussed the scope for reclaiming the outside of buildings and push smoking further away. Members commented on the need for partners to support the range of proposed interventions, and the meeting noted the importance of increasing the number of referrals into the Be Well Barnsley programme from Primary Care.

RESOLVED that the Smoke Free Barnsley action plan be approved and partners seek to adopt its objectives within their organisations.

10 BMBC Housing Strategy (HWB.07.06.2016/10)

The meeting received a presentation giving update on the Barnsley Housing Strategy and Delivery Plan and outlining the key objectives and ambitions with specific reference to achievements in 2015/16 and proposed future activity. The presentation highlighted the significant impact of housing on health and wellbeing and approaches to improve access to good quality rented housing and affordable properties to buy.

The meeting noted the impact of the Decent Homes programme in Council properties on the quality of tenants' lives. In terms of poor private landlords, there was a need for better coordinated activity to challenge them more effectively. In particular, full use needed to be made of the activity supported through the Area Councils to improve areas working with local communities and landlords. If a key objective of both the Sustainability and Transformation Plan and Better Care Fund was to help people live at home for longer, there was a need for properties that were capable of adaptation or met lifetime needs.

RESOLVED that the presentation on the Barnsley Housing Strategy and Delivery Plan be received and the proposed future activity to support health and wellbeing be noted.

11 Accountable Care Partnership (HWB.07.06.2016/11)

The meeting received a report giving update on progress in exploring the development of an Accountable Care Organisation (ACO) in Barnsley. The report summarised the ACO approach as a group of providers who agree to take accountability for all care and care outcomes for a given population for a defined period of time under a contractual arrangement with a commissioner. The arrangement envisaged a single accountable provider or structure, and had been

developed out of the current thinking for the Sustainability and Transformation Plan to have a local dimension.

Members commented on the current position of their organisations in relation to the approach. There was a need for all partners to be fully engaged in the work on the ACO and to remove any barriers to participation, whether perceived or real.

RESOLVED:-

(i) that the progress in developing an ACO in Barnsley be noted;

(ii) that more work be done to ensure that all partners affected by the proposals are fully engaged in this work;

(iii) that any proposals for an ACO in Barnsley be the subject of final approval by the Health and Wellbeing Board.

Chair

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Minutes of the Children and Young People's Trust Executive Group Meeting held on 29 April 2016

Present

Core Members

Rachel Dickinson (Chair)	BMBC, Executive Director: People
Brigid Reid	Barnsley CCG, Chief Nurse
Bob Dyson	Independent Chair of the Barnsley Safeguarding Children Board
Nigel Middlehurst	Voluntary Action Barnsley, External Services Manager
Dave Whitaker	Executive Headteacher, Representative of Secondary Headteachers
Cllr Tim Cheetham	Cabinet Member: People (Achieving Potential)
Cllr Margaret Bruff	Cabinet Member: People (Safeguarding)
Dr Claire Bannon	GP, Barnsley LMC
Sue Gibson	Head of Midwifery, BHNFT
Tim Innes	South Yorkshire Police Chief Superintendent (Barnsley Commander)
Jenny Miccoli	Barnsley College, Vice Principal Teaching, Learning and Student Support

Deputy Members

Emma White	BMBC Health and Wellbeing Principal (for Penny Greenwood)
Paul Hussey	BMBC, Service Director: Communities (for Wendy Lowder)
David Ramsay	SWYPFT (for Sean Rayner)
Katherine Clark	Headteacher, Hoyland Springwood School (for Gerry Foster-Wilson)

Advisers

Richard Lynch	BMBC, Head of Commissioning, Governance and Partnerships
Julie Green	BMBC, Strategic Lead, Procurement and Partnerships
Anna Turner	BMBC, School Models and Governor Development Manager

In attendance

Jonathan Wainwright	Barnsley Parent and Carer's Forum (for item 4)
Tracey Fahey	Barnsley Parent and Carer's Forum (for item 4)
Karen O'Brien	Lead Nurse
Carol Stringer (Minutes)	BMBC, Contracts and Relationships Officer

		Action
1.	**Apologies:** Mel John-Ross – BMBC Service Director of Children's Social Care and Safeguarding Gerry Foster-Wilson – Executive Headteacher, Representing the Barnsley Association of Headteachers of Primary, Special and Nursery Schools Sean Rayner – SWYPFT District Director Barnsley/ Wakefield Penny Greenwood – BMBC, Head of Public Health, Health Protection Wendy Lowder – BMBC, Service Director for Stronger, Safer and Healthier Communities Margaret Libreri – BMBC, Service Director for Education, Early Start and Prevention Denise Brown – Governance, Partnerships and Projects Officer After a round of introductions, Rachel welcomed Jonathan Wainwright and Tracey Fahey to the meeting as representatives of the Barnsley Parent and Carers Forum.	

		Action
2.	Identification of confidential reports and declarations of any conflict of interest Report for agenda item 12, Continuous Service Improvement Plan is to be treated as confidential and is not for further distribution. No conflicts of interest were declared.	
3.	Minutes of the Trust Executive Group meeting held on 17 March 2016 The minutes of the meeting were approved as an accurate record subject to an amendment noting the apologies of Bob Dyson. Thanks were expressed to Brigid Reid for chairing this meeting in Rachel's absence.	
3.1	Action log/ matters arising Actions arising from 17 March 2016: • Item 4 - Further detail on Child Health Programme Board workstreams to be provided to TEG members • Item 4.1 - It was agreed that Diane Lee, Jayne Hellowell and Sue Gibson meet to discuss work that had already been completed on the breastfeeding workstream. Sean Rayner to ask appropriate representative from SWYPFT to join the meeting. *Completed.* • Item 5 - Contact details for South Yorkshire Children's Sports Group to be sent to Public Health Specialist Practitioner. A meeting had been scheduled for next week. *Completed.* • Items 5.1 and 13 - TEG work plan to be reviewed to include Child Health Programme Board workstreams and gaps to be completed with TBC where timescales are unknown. *Completed.* • Item 6 - It was agreed that Richard Lynch discuss with Mel John Ross the tabling of data on school exclusions for consideration at the next Alliance Board. Inclusion via the relevant sub group. *Completed.* • Items 7 and 12 - Papers to be circulated on Empowering Young People and Access to Therapeutic Support. *Completed.* • Item 9 - Consider impetus on cultural change for Improving Staff Skills to Deliver Quality Services. Paul Hussey agreed to take this forward. • Item 14 - It was agreed to send Bob Dyson an electronic copy of the Family Nurse Partnership Exit Strategy. *Completed.* • Item 15 - It was agreed to invite a representative from the Parent Carer Forum to the next TEG meeting for the discussion on SEND reforms. *Completed.*	Diane Lee Paul Hussey
4.	Barnsley Parent and Carer's Forum (Jonathan Wainwright and Tracey Fahey) Jonathan Wainwright, Co-Chair of the Barnsley Parent and Carers Forum (BPCF) and his colleague Tracey Fahey attended the meeting to give a presentation on the work of BPCF. The following key points were noted: • There are 5 overarching planned actions to re-establish BPCF; develop strategic links with all SEND related services and to encourage open lines of dialogue at operational level. This to include developing a clear and coherent strategy on how they communicate and gather information from stakeholders and increase parent participation. • OFSTED consultation – designed for parents and carers to express their opinion about OFSTED and CQC's proposals for inspections and how	

		Action
	effectively local areas fulfil their responsibilities towards disabled children and young people and those who have special educational needs. To explore working in co-production of Barnsley SEND information, SENDIASS (formerly Parent Partnership Service) and BPCF hosted a borough-wide consultation event with parents, carers, children and young people. • A summary of findings from the above consultation included a solution focussed action plan which JW said was becoming outdated week by week as more people were being added to the "who can help" column. Comments from the consultation were noted, including: 'feelings of worry', 'general dissatisfaction', 'lack of trust' and 'frustration'. • BPCF's view on the findings are that all SEND providers need to be unwavering in their support to all parties to ensure that change can be affected before OFSTED arrive in the Borough, which could be sooner rather than later due to the high number of children with SEN classification and related issues. • A 'Hot Topics' consultation event had been held to gather feedback through meetings, social media and emailing parents/carers on their 500+ person database, and the following hot topics emerged: Speech and Language; Short Breaks and Social Care support; Education; Health and Care Plans and systems; School Transport; School Exclusion and School support and placements. Jonathan went on to explain that we need to deal with the "Here and Now" SEND related issues; imminent OFSTED and CQC joint inspection; the implementation of EHC plans; the parents and carers 'Hot topics' and managing the expectations of parents. Jonathan's desire is to place Barnsley on the map for SEND and to create a culture that would transcend any political change. Rachel asked whether there had been any impact/ change since the consultation in February, and Jonathan responded that although there seems to be the beginnings of change emerging, the journey from documentation to implementation is massive, and he could not yet be sure of the level of change at this stage. Rachel acknowledged that we are not sure where we should be, but we need to know that we have got engagement. It was acknowledged that hearing the child's voice is critical. Jonathan explained that there are three stages that parents go through when they have a child with a disability: *Passionate* – looking at everything to see what they can access for their child; *Angry* – not getting where they need to be; *Bitter* – got nothing, not coming back because issues are still the same. It is important to manage parents' expectations, particularly in relation to personalised budgets. The following comments were noted: • Everyone working at a strategic level needs to carry this learning back into their work areas as individuals and groups to ensure that this message is clear, and that positive solutions are implemented. • Confidence needs to be increased across the workforce in relation to the implementation of the work. • There is a need to articulate what the personalised budget <u>is not</u>, rather than what it is. All staff to be equipped with this information to increase confidence.	

		Action
	• It is important for the Parent and Carers Forum to keep in touch with the LA to ensure that progress is being made. • In relation to academisation, the Barnsley Alliance Board is in place and their work will be fundamental to bringing about improvements. • Jonathan and Tracey stressed the importance for parents to be listened to and understood. Jonathan and Tracey were thanked for their passionate presentation, for bringing these important messages from BPCF and for their valuable input. **The Trust Executive Group agreed to:** • Note the work of the Barnsley Parent and Carers Forum • Equip the workforce with the tools they need to increase confidence and effectiveness • Inform the Barnsley Alliance of the work of the Barnsley Parent and Carers Forum	Amanda Glew Margaret Libreri
5.	<u>Draft SEND Strategy</u> Rachel introduced this item as Margaret Libreri had given her apologies. The core purpose of the SEND strategy is 'to work together to improve children's outcomes'. A draft version of the strategy had been circulated for comment/ discussion. It was noted that Barnsley is publishing this SEND Strategy at a time of very significant change, with some of the biggest shifts in national policy for health, special educational needs and disability in over 30 years. The strategy is also intended, therefore, to ensure that Barnsley is well positioned to implement these changes for the benefit of children, young people and families. In this Strategy the local area recognises that SEND encompasses children and young people with a broad range of needs. For some, the focus of support will be wholly educational. For others, their families will need support from a number of statutory services and this may continue throughout their childhood and into adulthood. Comments were invited in relation to the strategy and the detailed high level action plan, and the following points were noted: • Jonathan stated that the Parents and Carers Forum had been invited to comment on the strategy, which he felt was very healthy and open for challenge. He felt that improvements to the documentation were getting there, but implementation would take longer. Rachel agreed that it is one thing to sign off this strategy and quite another thing to make a difference. • Kathryn commented that school sees a lot of parents in the 'angry' stage, and some in the 'bitter' stage. Everyone agrees with the general principles. There are passionate, talented people on the ground, but implementation is difficult. It was suggested that schools could get this right by hosting someone who could guide parents through the process. • Jonathan pointed out that children's issues start prior to a child accessing school. Every child needs to be looked at as an individual, and it is vital for schools to be able to work with children at a very early stage. • Jonathan feels that there is an unfair burden placed upon schools in relation to EHC plans, and that Health and Care are equally accountable. • Brigid commented that because of the physicality of the school, she could understand why they are the first port of call, but suggested that	

		Action
	if staff are unsure about a particular situation they need to find the relevant information and not pass the problem on like a 'hot potato'. Brigid suggested that we need to learn from the Right Care Barnsley work as this is a similar model. • Jonathan suggested that putting the Health and Care people into the buildings where SEND staff are based would make the biggest difference. Brigid agreed that some form of outreach going into schools may work, as school staff are very isolated and cannot come out of school, therefore others could go in to make the co-production work. • Dave agreed that most schools are quite happy to be the 'hub' and need other specialist support to do the best for the children. School staff know the children extremely well as they see them every day. • Jonathan and Tracey said that workers need to work with their 'story' – other professionals support is there, but the best case study is using their experience of being parents of children with a disability, and sometimes it is the little things that go wrong but make the biggest difference. Jonathan referenced the point about capturing the child's voice, which is very difficult if a child is non-verbal. • Bob queried whether the strategy was sufficient for the 'whole family'? • Rachel felt that the strategy needed to be 'sharper'. After the discussion, the following actions were agreed: • Colette Gollcher and Margaret Libreri to work with Jonathan and Tracey to emphasise the importance of including the child's voice, and to ensure that family support is strengthened. • Colette to meet with Brigid to include the Health agenda. • Everyone to reflect on what they have heard this morning and feedback to Rachel. Look at 'so what' – reflecting on a page → action, and whether we need to add/ amend after discussion. • Equip the workforce to capture the wishes and feelings of a non-verbal child. • Invite Jonathan and Tracey to attend a TEG meeting in a year's time to discuss progress.	Margret/ Colette Brigid/ Colette ALL Forward Plan
6.	<u>Early Help</u> – update on progress (Margaret Libreri) This item was deferred due to Margaret's absence.	Forward Plan
7.	<u>School Exclusions</u> update and discussion on issues raised (Dave Whitaker) (Verbal) Dave gave a verbal update following the last meeting when he had presented raw data on pupils excluded from schools. Dave explained his views on what the data was alluding to and key points were noted as follows: • Hypothesis around schools that exclude highly – whether this is because of changing behaviour or whether the children are no longer there; and if they are no longer there, where are they? • Overall Secondary School/Academy total days lost are slightly down on last year, even though 5 out of 9 schools have seen an increase. • 2 Secondary Academies have seen an increase in the number of incidents, but the numbers of exclusions are down. • Overall Primary School/ Academy total days lost have seen an increase with 22 schools/ academies excluding more, 20 schools /academies excluding less and 3 schools /academies remaining the same.	

		Action
	Following discussion it was agreed that Rachel would write to the Barnsley Alliance Board to ask them to commission a piece of work around exclusions to help the CYP Trust to understand the problem and co-ordinate how to move forward with this important system issue. Dave indicated that he would like to be involved in this piece of work. The work needs to include the outcomes for children who are permanently excluded. Dave stated that a number of pupils had moved 'in year' which is very unusual. It was noted that there had also been a huge spike in EHE and that a potential safeguarding issue is emerging. Bob stated that a joint letter had been sent to the DfE regarding the potential safeguarding issues of EHE but that the response had been disappointing. **The Trust Executive Group agreed** that Rachel would write to the Barnsley Alliance Board to ask them to commission a piece of work around exclusions for a future CYP Trust meeting.	Rachel/ forward plan
8.	<u>Summary from ECG work programme</u> (Richard Lynch) Richard went through the summary of the Executive Commissioning Group's work programme for 2015/16, commenting on the following key points of progress: • Bringing down the unit costs of LAC through the sufficiency strategy • Decommissioning of the Stronger Families Teams • 'Future in Mind' – will continue to report • In-house arrangements for 'return home' interviews are up and running and numerous referrals had been received • The development and procurement of short breaks, including a Short Breaks Commissioning Strategy reviewing existing short breaks provision, procurement of services and the development of a personalised approach to commissioning, including personal budgets and direct payments In relation to the work programme for 2016/17, Richard made particular reference to increasing personalisation and moving away from block contract provision, and the challenge ahead to taper transition to support families and meet their needs within a constantly challenging resource envelope. The following key areas of work during 2016/17 include: • Review Terms of Reference for the group, partnership arrangements and CCG contract negotiations. • Commissioning in relation to the SEND Strategy including the development of, and ability to deliver, personal budgets; implantation of the Short Breaks Commissioning Strategy; and the development of joint commissioning arrangements and governance. • The development of a sufficiency strategy for specialist education placements, and revision/ implementation of the LA Sufficiency Strategy for Children in Care. • The implementation of the agreed commissioning recommendations for the 0-19 contract. • Continued development of services which promote the emotional health and wellbeing of children and young people, and services which support vulnerable children. • A focus on performance and improvement of commissioned services. • The review and revision of the service specification for Children Therapies (SALT/ Occupational Therapy/ Physiotherapy). • The review and implantation of the ASD Assessment and Review Pathway. • Review and procurement of commissioned services as required.	

		Action
	• Consideration of the implications of the spending review. Rachel commented on the opportunity to communicate the work of the trust and commissioning work to the governing bodies. Brigid informed that the CCG prepares a quarterly update for Health. It was suggested that the extent of business would be helpful to combine with the work of the Trust. Paul queried whether it might be helpful to plot the commissioning offer against the continuum of need, and Richard pointed out that short breaks goes across all continuum, as does the Early Help Strategy, and he was therefore not sure how useful this would be. Brigid suggested that it may be possible to display it diagrammatically on a page. Tim informed that there is a significant issue around high risk delivery. There is a lot of good work taking place but it needs to be joined up. Rachel responded that this is a different and bigger issue and suggested that this be looked at during a workshop style discussion to consider how this is achieved and where it fits in terms of the Children and Young People's Plan. **The Trust Executive Group agreed to:** • Note the information provided concerning commissioning activity during 2015/16. • The key areas of focus on the work programme for 2016/17.	Richard/ Rachel
9.	<u>Encouraging Positive Relationships and strengthening Emotional Health – Future in Mind</u> (Brigid Reid) Brigid distributed the agenda and context document used at the Future in Mind Stakeholder workshop held on Thursday 28 April 2016 to aid discussion. Benefits of collaboration, co-production, joint working and the Care Bundle model were discussed. Key points were noted as follows: • Andrew Clark, Y&H Strategic Clinical Network (one of the leads at the workshop) reassured by saying this was a 5 year plan as it needs to be a resilient fix and not a quick fix. He also commented on the number of stakeholders in the room. David Black commented on the work in Barnsley as being 'exciting'. • The workshop adopted a 'speed dating' model delivery – 5 minutes for headliners and 5 minutes round table to discuss/ reinforce. • There was lots of commonality. Access service mapping is essential as there was a variable understanding of what the single access point is and if the public does not understand, neither do the workforce. • Call Centre would be manned by nurse practitioners and offers would be brokered through the system. • Now working on brokering hospital discharge – need to think how they can do this with professionals. • Brigid and Ben (Finlay) are to go to Right Care and lean on them to go for approval of concept. • Engaging children – build on what we have got and emphasise co-production. Consider how young people can be meaningfully engaged in the work. • Strengthen CAMHS support for LAC, tracking through the system. YOT strengthening input into the group of young people. • THRIVE approach – resilient programme, 6 strands and train the trainer model. Needs the full commitment from school, and a Project Manager will be coming into post. Work on whole school approach, building	

		Action
	resilience and recognising challenges and how to deal with them. It was noted that we need to keep this work, and need to make the link to not forget parents in all this. • Benefits – outcomes not just process (KPIs). Not all about money – need to use different language about sign-up. Comments and questions were invited and the following noted: • Need to learn from the challenges facing schools. • Alison Wilkes (Kings Oak Headteacher) is linking into the work of the 'Closing the Gap' group. • Emma stated that there had been a lot of discussion regarding school being a central environment, and queried how to ensure that there is a single point of access. • Need to closely monitor demand. • The 'eating disorder service' needs to be separately mandated. Chris Good had noted that talking about it is likely to reveal more demand. • Brigid asked colleagues who had attended the workshop to comment on the format. Jenny said it was active, organised and presentations were succinct. Jenny suggested that it would be good to involve young people next time and that Barnsley College was a good resource of young people to take part in surveys or updates etc. She felt that a 5 year plan was refreshing and would give time to monitor impact. • Staff wellbeing is important, as is the need to recognise that staff need support through increasing pressure and workload. • It was suggested that a bi-annual workshop be held. • Rachel queried how effective we are at communicating the headline messages. It was suggested that the Children and Young People's Trust Newsletter be used for this, as well as highlighting key areas of work on the website. Kathryn also mentioned a link in the Headteachers Bulletin. Brigid and Patrick are due to meet in Mid-May to take this forward. Rachel thanked Brigid for bringing this information to the attention of the Trust.	Brigid
10.	<u>Strategic Priority Themes performance highlights/risks to be escalated</u> (Theme Leads) No other performance issues or risks were highlighted.	
11.	<u>Barnsley Safeguarding Children Board</u> – highlights of meeting held on 11 March 2016 Bob advised that this feedback had been given at the last TEG meeting and there had been no further meetings since.	
12.	<u>Continuous Service Improvement Plan and DfE review in April</u> **CONFIDENTIAL** Julie Govan presented a verbal update of the Continuous Service Improvement Plan – April 2016. Julie noted that no items were rag rated 'red'. There were some rated 'amber', but this does not necessarily mean that they are off-track. Key points noted are as follows: • Rachel commented that there was still no shift in Early Help Assessments and acknowledged that the CAMHS elements need refreshing. • Julie updated the group on the progress made around the MASH implementation and advised that this project had slipped by 4-5 weeks.	

		Action
	Julie was due to meet with Natalie Shaw, head of PPU (as Mel is off) to establish what the slippage issues are. There appear to be issues with Virgin and connectivity (16 May). • Rachel and Tim to be kept updated to escalate any issues as necessary.	Julie Govan
13.	<u>TEG Work Programme Review</u> (Julie Green) Julie informed the group that the work programme had been amended following the comments made at the last meeting. Comments and questions were invited: • Rachel welcomed the new layout and commented that it was easier to read. • Emma undertook to fill in some of the gaps for Public Health. • Rachel mentioned some form of reflective workshop to ascertain whether our priorities are focussed accordingly and are able to be re-prioritised dependent on urgency/changes etc. Rachel said that we now have a level of maturity to set aside agenda items to discuss burning issues relevant at any given point. • Paul said he was happy to work with Margaret on Early Help and asked the group if an update on 'Think Family' would be useful. It was agreed to include a progress update on the work programme. Rachel expressed her best wishes to colleagues at SYPolice during a very difficult week. Tim thanked Rachel for her kind thoughts and said that colleagues on the ground thought that Barnsley was the best place to work.	Emma Rachel/ Julie Paul/ Margaret Forward Plan
14.	<u>Any other business</u> There were no other items of business to report.	
15.	<u>Proposed agenda items for the next meeting on 17 June 2016</u> It was agreed that the key priorities for the next meeting are: <u>For discussion</u> • Child Health Programme Board (Diane Lee) • Early Support Pathway for Children with additional needs (John Rooke/Anita McCrum) • Teenage Pregnancies/ Under-18 conceptions <u>Keeping Children and Young People Safe</u> (Bob Dyson/Mel John Ross) • Contacts into social care and the 'Front Door' • Children and Young People's Plan, strategic priority theme: sub-group report and performance highlights <u>Standard agenda items</u> • BSCB Minutes (Bob Dyson) • Continuous Service Improvement Framework (Rachel Dickinson/ Julie Govan) • Performance highlights and risks against CYP Plan priorities (strategic priority leads) • TEG work programme review <u>Updates on progress</u> • Breast Feeding	

Dates of future TEG meetings:

Date	Time	Venue
17 June (Friday)	13.30 – 16.30	Westgate Plaza Boardroom, Level 3, Room 3
*4 August (Thursday)	09.00 – 12.00	Westgate Plaza Boardroom, Level 3, Room 3
6 October (Thursday)	09.00 – 12.00	Westgate Plaza Boardroom, Level 3, Room 3
24 November (Thursday)	14.00 – 17.00	Westgate Plaza Boardroom, Level 3, Room 3

** school holidays*

Minutes of the Children and Young People's Trust Executive Group Meeting held on 17 June 2016

Present

Core Members

Rachel Dickinson (Chair)	BMBC, Executive Director: People
Bob Dyson	Independent Chair of the Barnsley Safeguarding Children Board
Margaret Libreri	BMBC, Service Director for Education, Early Start and Prevention
Mel John-Ross	BMBC, Service Director of Children's Social Care and Safeguarding
Gerry Foster-Wilson	Executive Headteacher, Representing the Barnsley Association of Headteachers of Primary, Special and Nursery Schools
Sean Rayner	SWYPFT District Director Barnsley/ Wakefield
Cllr Margaret Bruff	Cabinet Member: People (Safeguarding)
Sue Gibson	Barnsley Hospital NHS Foundation Trust, Head of Midwifery/ Nursing
Dr Clare Bannon	GP representing Barnsley Local Medical Committee
Julia Burrows	BMBC, Director of Public Health
Jenny Miccoli	Barnsley College, Vice Principal Teaching, Learning & Student Support
Jayne Hellowell	BMBC, Head of Locality Commissioning and Healthier Communities

Deputy Members

Ann O'Flynn	BMBC Service Director for Customer Services, Communities Directorate (for Wendy Lowder)
Martine Tune	Barnsley CCG, Deputy Chief Nurse (for Brigid Reid)
Patrick Otway	Barnsley CCG, Head of Commissioning (Mental Health, Children's and Specialised Services) (for Brigid Reid)
Christine Drabble	Voluntary Action Barnsley, CEO Corporate Services (for Nigel Middlehurst)

Advisers

Richard Lynch	BMBC, Head of Commissioning, Governance and Partnerships
Julie Green	BMBC, Strategic Lead, Procurement and Partnerships Manager
Anna Turner	BMBC, School Models and Governor Development Manager

In attendance

Rebecca Clark	BMBC Public Health Specialist Practitioner (for item 7.2 and 7.3)
Kay Bennett	BMBC Infant Feeding Strategy Coordinator (for item 7.1)
Caroline Berry	BMBC Research and Business Intelligence Advisor (for item 7.3)
Carol Stringer	BMBC, Contracts and Relationships Officer
Denise Brown	BMBC, Governance, Partnerships and Projects Officer

			Action
1.	**Apologies:**		
	Brigid Reid	Barnsley CCG, Chief Nurse	
	Wendy Lowder	BMBC, Service Director for Stronger, Safer and Healthier Communities	
	Amanda Glew	BMBC Organisation Development Manager	
	Tim Cheetham	Cabinet Member: People (Achieving Potential)	
	Nigel Middlehurst	Voluntary Action Barnsley, External Services Manager	

		Action
	Dave Whitaker — Executive Headteacher, Representative of Secondary Headteachers Angela Kelly — BMBC, Targeted Youth Support Operations Manager Diane Lee — BMBC, Head of Public Health Tim Innes — South Yorkshire Police Chief Superintendent (Barnsley Commander) Julie Govan — BMBC Children's Social Care and Safeguarding, Improvement Programme Manager	
2.	<u>Identification of confidential reports</u> It was noted that the reports for items 5; 6; 7.4; 9 & 10 were of a confidential nature. There were no conflicts of interest declared. Rachel shared her experience of a recent visit with a Social Worker and a Learning Disability Nurse who were doing some fantastic work with a family. It was clear that earlier intervention would have made a big difference to the young people and the family involved. Rachel stressed the importance of constantly reminding ourselves to the importance of working together to effectively support children as early in their lives as possible. Jenny suggested that a few moments are spent at the start of each meeting to share similar experiences from the front line.	
3.	<u>TEG Minutes of 29 April 2016</u> Carol was thanked for preparing the minutes of the last meeting. The minutes were approved as an accurate record of the meeting subject to including Margaret Libreri's name under 'apologies'.	Denise
3.1	<u>Action log</u> Rachel stated that Jonathan and Tracey had appreciated the welcome they had received at the last TEG meeting and felt that it had been worthwhile for them to attend. Rachel stated that she had invited Jonathan to have input into the Health and Wellbeing Board as well. The action log was updated as follows: <u>Actions outstanding from previous meetings</u>: 4.1 – The briefing by Ray Powell had been circulated. Action completed. 5.1 – Still births in Barnsley. Rachel had followed up the action for Communities Directorate and developing Family Centres to be made aware of the risk factors during pregnancy, including smoking. Wendy Lowder had confirmed that feedback had been received. Action completed. <u>Actions outstanding from 17 March 2016</u>: 4 – Detail on Child Health Programme Board work streams had been provided to TEG members. Action completed. 9 – Impetus on cultural change for improving staff skills to deliver quality services to be considered. Rachel requested an update from Paul Hussey and Ann undertook to follow up this action. <u>Actions from 29 April 2016</u>: 4.1 – Barnsley's Parent and Carer's Forum. Confidence and effectiveness of the workforce need to be increased, particularly in relation to personalised	Ann

		Action
	budgets. Amanda to take forward the issues in terms of the Workforce Development Strategy. 4.2 – The Barnsley Alliance Board would be meeting at the end of June when Margaret would inform them of the work of the Barnsley Parent and Carers Forum. Action outstanding. 5.1 – SEND Strategy. Action outstanding for Colette and Margaret to work with Jonathan and Tracey to emphasise the importance of including the child's voice and to ensure that family support is strengthened. 5.2 – Action outstanding for Colette to meet with Brigid. It is understood that work is taking place with Karen O'Brien. 5.3 – No further comments or amendments had been received. 5.4 – Equipping the workforce to capture the wishes and feelings of a non-verbal child is being included in the Workforce Development Strategy. 5.5 – The TEG work programme had been updated to include an invitation to the Parent and Carers Forum to attend a meeting in a year's time to discuss progress. 6 – Early Help update on progress is on the TEG agenda for 4 August 2016. 7 - Rachel to write to the Barnsley Alliance Board to ask them to commission a piece of work around school exclusions for a future CYP Trust meeting. 8 – Richard proposed that an annual report of activity be developed for the Trust, including the work of the Executive Commissioning Group. The report would be structured in line with the Children and Young People's Plan. A report would be brought to a future meeting following approval of the format of the performance report. Rachel commented that this would be a useful driver and a form of accounting of the difference that has been made as a partnership. It was agreed that the proposed report would be prepared for the next meeting. 9 – Future in Mind. A successful stakeholder event had been held. Gerry and Jenny confirmed that they had found it to be very positive. Two more events are being arranged, the next one being in September. Patrick stated that stakeholders had agreed to fund existing priorities for 2016. A lot of work is taking place to train teaching staff, and training for children themselves is also being considered. Patrick to escalate any barriers to the Trust. 10 – Continuous Service Improvement Plan and the implementation of MASH is on track. 13.1 – The TEG work programme review was completed. 13.2 – Rachel requested that the action to consider holding a reflective workshop be carried over. Need to consider the right time to hold a workshop to determine whether or not priorities are focussed accordingly and to re-prioritise depending upon urgent changes. 13.3 – An update on 'Think Family' is on the work programme for 6 October 2016 for Paul Hussey and Margaret Libreri.	Amanda Margaret Colette/ Margaret Colette Rachel Richard Rachel/ Richard Paul/ Margaret
4.	<u>Performance: escalated items:</u> No performance issues were escalated.	
5. 5.1	<u>Child Health Programme Board Work streams</u> <u>Breastfeeding</u> (Kay Bennett) The report provided an update on the present position of breastfeeding, giving both the national and local picture for 2015-16, demonstrating future challenges. The following points were highlighted: • The Breastfeeding and Infant Feeding Steering Group used to report into the Child Health Programme Board which no longer meets. • The group needs a broader range of representatives at decision making	

		Action
	level to strengthen its effectiveness. • Breastfeeding and infant feeding needs to be incorporated into other strategies, including healthy weight and healthy lifestyle choices such as stop smoking. • The 'Baby friendly' initiative is due to be accredited in three years. Accreditation needs to be continually maintained and audits are relentless. The Hospital and Children's Community Services are fully accredited, and it is hoped that the Neonatal Centre will become accredited in its own right. It is quite an expensive programme but is worth the cost benefits of future savings. It is important to have good champions to support breastfeeding and to advocate for it. • There is a concern that the data received is not accurate. The data shows that there are about 30 mums breastfeeding at 6-8 weeks, but Kay acknowledges that there may be a lot of women still breastfeeding that are not known to the service. • Data is collected by Health Visitors and submitted to Public Health England. Sue stated that problems had been experienced with a new data system and that this was currently being resolved. • Breastfeeding initiation rates have been going up over the last few years, but young women are not continuing to breastfeed. 64% of mothers start breast feeding and 28% are still breast feeding by the time the child is 6-8 weeks. It is important to focus efforts to encourage young women to continue to breastfeed at that stage. • The Lactation Consultant has left, and specialist breastfeeding support needs to be developed. • The plea is for partners to ensure that their respective organisations and services are welcoming to women who wish to breast feed, and for schools and further education institutions to support young women who choose to return to education. Guidance also needs to be developed for young women who are breastfeeding. • It was acknowledged that a cultural change is needed, which takes a long time to achieve. • Julia stated that a research project was undertaken in Sheffield giving shopping vouchers to young women who were breastfeeding. Not everyone may agree with this approach, but it does seem to be effective and may start to change the culture. • Factors that influence breastfeeding include: experiencing pain when breastfeeding; night feeds; worklessness; feeding in public places and poor body image; peer pressure; pressure from boys to not breast feed; young women wanting to get their figures back. • 'Having a baby' programme provides one to one support which is very effective. It was acknowledged that peer support is most effective. • The excellent work of Kay and the breastfeeding team was acknowledged. • Anna suggested sharing positive case studies to encourage young women to continue to breast feed. • Ann O'Flynn suggested that breast feeding be promoted through the Registrar's Service when the birth is registered. Kay requested that parents also be signposted to the Service's Facebook page. • Susan is happy to support the Neonatal Unit becoming 'baby friendly' accredited. • Jenny suggested educating young men. Kay stated that the service would welcome working with Barnsley College. The Trust Executive Group agreed to the recommendations in the report.	

		Action
	Kay undertook to contact colleagues to invite them onto the Breastfeeding and Infant Feeding Steering Group, and it was agreed that any difficulties in recruiting the right people, or resolving the issues around data, would be flagged up to the TEG.	Kay
5.2	<u>Teenage conception</u> (Rebecca Clark) Rebecca presented slides prepared by Megan Ward who had been unable to attend. The following comments were noted: • The latest data available for under-16 abortion rates is from 2014. It would be helpful to have more up-to-date data, and to look at local data sources. Sue asked Rebecca to let her know what data was needed. • It would be interesting to know the number of planned pregnancies. It is important to raise the aspirations of young people and to break generational cycles and cultural 'norms'. • It was noted (slide 11) that RSE is achieving access in all but one school in Barnsley, and it would be useful to know what impact this has. • Since the demise of the Youth Service it would be helpful to know what education is offered by voluntary sector organisations. • Rachel suggested that a steering group be formed to track the impact and challenges from different parts of the system to make sure the issue of teenage conception prevention is being considered by partner agencies. It was agreed that Public Health would coordinate the group to consider how this work could be integrated. • There had been good feedback as a result of Spectrum working in Horizon School. • It was agreed that an update would be submitted to a future meeting. • Richard pointed out that consideration be given to monitoring the Children and Young People Health and Wellbeing Strategy.	Rebecca Public Health Work Programme
5.3	<u>Young People Health and Wellbeing data presentation</u> (Caroline Berry) After the presentation, the following comments were noted: • It would be helpful to know whether excessive use of alcohol is changing. • The WAY Survey shows that more girls are involved in risk taking behaviour, which in turn may be resulting in increased teenage conceptions. • Some of the issues are enduring and have been spoken about for years. Need to continue the work through Public Health and through schools to enforce the messages about stop smoking, having a good diet and responsible drinking habits. The number of young people smoking has gone down, but the issues of alcohol abuse and obesity still need to be prioritised. • Need to consider how well the frontline workforce understand the health risks to key lifestyle outcomes, and how effectively young people most at risk are able to be identified. • It was noted that the 'Be Well Barnsley' website is still under construction. • It was agreed that Rachel and Julia would consider how TEG partners could support the work of the Child Health Programme Board to add value to this work. *(Kay, Rebecca and Caroline left the meeting and Mel John-Ross arrived at this point.)*	Rachel/ Julia

		Action
5.4	<u>0-19 Healthy Child Programme progress update</u> (Julia Burrows) The paper provided an update on the transition of the 0-19 Healthy Child Programme for School Nursing and Health Visiting Services, which will be delivered by the Council from 1 October 2016. A Transition Board has been established along with Transition Steering Groups and a number of sub-groups to drive this work. Clare stated that GPs had expressed concern regarding the impact on their workloads, having to complete lengthy referral forms for the School Nursing Service. SWYPFT to follow this up. It was noted that Julia is scheduled to attend the Local Medical Committee meeting in July. A multi-agency event, focusing on maximising the frontline workforce, is being planned for October with stakeholders.	SWYPFT
6.	<u>Contacts into social care and the front door</u> (Mel John-Ross) Mel provided an update following the report that was presented to TEG in February, highlighting the following points: • On average, 1100 contacts had been received into social care each month. The high conversion rate to assessment resulted in a lot of families having to undergo intrusive assessments, many which resulted in no further action. The number of contacts into social care has also affected assessment timeliness, and it was acknowledged that resources would have been more effectively targeted on those children needing to be safeguarded. • During February, TEG and BSCB endorsed a proposed change to the way contacts are recorded and screened, and an 'operational guide for screening staff' has been implemented. • Children Social Care staff are not recording contacts that don't meet the threshold for statutory services, and the number of contacts into social care have reduced. • Children Social Care and early intervention need to work together and have the right conversations about families to ensure that resources are most effectively targeted. The following comments were noted: • There is a risk that a safeguarding concern may be missed if all contacts are not being recorded, and it is therefore essential that the right referrals are being processed. Mel confirmed that this is a valid concern that had been raised previously, and there has been agreement to invite agencies to the CSC Screening Meeting to discuss these concerns. • It is important to ensure that all partners have systems in place to support staff with safeguarding concerns that don't meet the threshold of social care. Organisations need to ensure that referrals into social care are appropriate and that staff use the escalation process if they don't get the right response. Further, that ownership is taken of the safeguarding concern and followed through for the sake of the child. • A significant number of referrals come from schools and it is important that designated safeguarding leads are well supported. • Mel to check with Nigel Leeder that quarterly meetings have been set up with the Schools Safeguarding Leads and that dates are circulated.	Mel

		Action
	The Trust Executive Group agreed to note the report and members were encouraged to keep the conversations going in their respective organisations.	
7.	<u>Keeping children and young people safe</u> (Bob Dyson and Mel John-Ross) The report provided an overview of current performance data in relation to this TEG priority, and the following points were highlighted: • The BSCB is concerned about the low number of early help assessments being completed. Despite there being fewer assessments, the timeliness of assessments continues to be a concern, taking 45 days and more to complete. Work is taking place to address this. • It is pleasing to note that there were no S47 assessments awaiting allocation. Also that the backlog of S17s had been cleared. • Child Sexual Exploitation remains a priority for the BSCB. A dedicated sub-group monitors the recently refreshed strategy and action plan. Three cases of CSE were recorded by the Police. It appears that Barnsley does not have the gang related incidents found in other places. • There are a lot of young people who go missing at times and some of those are repeat offenders, particularly looked after children. • The Board is doing further work to understand an increase in violent crime where the victim is under 18 years of age. • The Board provides high quality training courses, and is trying to determine what impact that has on outcomes. • A campaign to raise awareness of various safeguarding issues will be taking place the week of 4 July. • It was noted that there had been an article in the Barnsley Chronicle to raise awareness of FGM. • Barnsley has more children on child protection plans than statistical neighbours, and there needs to be a discussion regarding the added value and protection that a CPP has as opposed to a Child in Need form. Bob added that improvements in Early Help Assessments should reduce the need for CPPs. The Trust Executive Group agreed to note the report and the issues raised.	
8.	<u>Sustainability and Transformation Plan (STP)</u> (Julia Burrows) The paper provided an update on the development of the Sustainability and Transformation Plan. The following points were highlighted: • Every health and care system in England will be producing a STP showing how local services will evolve and become sustainable over the next five years, with a view to providing better patient care and improve NHS efficiency. The process has been very NHS focused. • A lot of discussion has taken place about re-designing the secondary care system. • Lesley Smith is the CCG leader for South Yorkshire and Bassetlaw 'footprint'. • There are some challenging discussions to be had regarding local services and how this fits in with the bigger tertiary centre in Sheffield. • Alongside the STP is the development of the Barnsley Integrated Place Based Plan. These will be important to accessing transformational	

		Action
	funding to make a real difference to health inequalities and outcomes in Barnsley. • Timescales are challenging with a submission date of 30 June. Discussions have been held to consider the advantages to the system; the priorities for Barnsley; and what could be done differently. Priorities include: life expectancy; smoking; changing relationship with communities and individuals; mental health; changing the way we work together. Need to consider a small number of things that will make a difference. Christine stated that Voluntary Action is working in partnership with counterparts in Sheffield, Rotherham and Bassetlaw, and regular meetings are being held regarding this work. It is important that TEG members are kept informed of progress.	
9.	<u>BSCB meeting 13 May 2016</u> (Bob Dyson) The minutes of the Barnsley Safeguarding Children Board meeting held on 13 May had been circulated for information. Bob stated that after the BSCB meeting he had met with a group of about 15 young people who had come across as very articulate, and overall it had been a very positive session. Issues raised included: • Mental health and frustrations over waiting times. • Young people don't feel that they are being listened to. • Places that don't feel safe include the Barnsley Bus Station, and they are aware of low level drugs and drinking in the Town Centre which makes them feel uncomfortable. South Yorkshire Police have responded by allocating a Town Centre team to address some of the issues raised. • Other issues of concern included sexualisation of young women and reports of on-line bullying. Bob had written to each young person to thank them for their involvement and had reported back to them what had been done as a result.	
10.	<u>Continuous Service Improvement Plan</u> (Mel John-Ross) During the update it was noted that: • No actions are flagged as red - everything is on target and is work in progress. New actions added since the last TEG are shaded grey. • Priorities remain: early help; front door; emotional and therapeutic support for young people. • Another priority is the need to improve our offer to care leavers and this will be the main agenda item at the next BSCB meeting. Rachel suggested that as there will be a discussion on early help at the next TEG meeting it would be helpful to include information from the improvement plan. Rachel suggested that the Officer Group carries out an assessment of where we think we are in terms of the framework, following the inspection 2 years ago. This could form the basis for discussion at the next TEG/ BSCB meeting.	Margaret/ Mel

		Action
11.	Children's workforce development The report prepared by Amanda Glew to provide TEG with an update in respect of improving staff skills and early help training was noted, and members agreed that they were happy to give their endorsement. Members were asked to provide any further feedback directly to Amanda Glew at AmandaGlew@barnsley.gov.uk	Members
12.	TEG work programme review The TEG work programme had been extended to July 2017 and was presented for comment. Members were asked to keep it under review and to be aware of the discussions that are scheduled for future meetings. Margaret stated that Nina Sleight would attend the next TEG meeting in her absence. The Children and Young People's Plan had been finalised and members were reminded to take it though their respective organisation's governance structures.	
13.	Date of next meeting The next TEG meeting will be held on 4 August 2016, from 13.30 – 16.30 in Westgate Plaza, Level 3, Room 3.	

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BARNSLEY METROPOLITAN BOROUGH COUNCIL
COMMUNITIES DIRECTORATE

STRONGER COMMUNIES PARTNERSHIP
on Tuesday, 24TH May, 2016
at Shaw Lane Sport Club

MINUTES

1. Welcome and Introductions.

Attendees:

Cllr C Lamb	BMBC (Chair)
Cllr J Platts	BMBC
Keith Dodd	BMBC
Paul Hussey	BBMC
Susan Hyatt	BMBC
Tony Dailide	BMBC
Wendy Lowder	BMBC
Jade Rose	BCCG
Dave Fullen	Berneslai Home
Carrie Abbott	Public Health
Diane Lee	Public Health
Christine Drabble	VAB
Gill Parker	SYHA
Gill Stansfield	SWIFT (Repr. For Sean Raynor)
Adrian England	Health Watch
Margaret Barker	Health Watch
Marie Hoyle	Kakoty Practise
Paul Bibby	Barnsley GP Federation

Crescentia Catling Minute Taker

Apologies:

Chris Millington
Lisa Wilkins
Margaret Libreri
Phillip Spurr
Sean Raynor

2. MINUTES OF THE LAST MEETING, 16th February 2016

Joe Micheli is liaising with Kirsty Wagnell from CCG to progress the Voluntary Sector Review Report.

Children and Young People's Plan was circulated with the meeting papers.

3. TERM OF REFERENCE

Vision: Keith Dodd thanked the Group for the comments on the draft Vision.
The wording in the updated Term of Reference presented at the meeting was agreed.

Declaration of Interest: The draft statement regarding Declarations of Interest was also agreed.

Membership: Representation on the partnership was discussed.

ACTION: **Keith Dodd** to update and circulate the membership list for the Partnership and Delivery Groups

4. DELIVERY GROUP PROGRESS

Keith Dodd presented an update on progress of the four Delivery Groups. All four Delivery Groups now have a Chair and Deputy Chair, Term of Reference, multi-agency representation, regular meeting schedules and action plans.

Early Help (Children):

- Successfully reorganised Children Centres into Family Centres and created revised pathways for 0-19 (25 where child has a disability) and a single gateway into Early Help.
- Booklet for all Agencies/Professionals on how Early Help is designed to work – distribution and presentations taking place including schools and primary care.
- Improved systems for case tracking.

ACTION: **Keith Dodd** to circulate booklet with the minutes.

Early Help (Adults):

- Planned and delivered partnership workshops on key themes – social prescribing and falls prevention.
- Providing leadership for the UIA work – potential for a workshop at next SCP.
- Work to gain better insight into demand on statutory adult services and what preventive work is most effective – resource bids.
- Working with SYF&R – Safe and Well Checks – targeted on vulnerable people to reduce fire risks but also much more – health and wellbeing, risk of falls, heating/fuel poverty, mental health, welfare benefits.

Anti-Poverty:

- Integration of LWA, Housing Options Team and Welfare Advice – staff now located together at Civic.
- Anti-Poverty considerations built into Cabinet reporting on policy issues.
- Fuel poverty – supporting vulnerable people to install/upgrade central heating
- Energise Barnsley.
- My Living store – Wombwell.
- Second Community shop in Athersley – delays due to legal issues around the asset transfer but these are now close to resolution.

- Strengthening links with the Credit Union – publicising services.

Resilient and Healthy Communities:

- Supporting the implementation of VCSE Review.
- Better understanding of health challenges – life expectancy increasing but healthy life expectancy increasing more slowly.
- Developing a commissioning framework which requires providers to encouraged, supported and empowered people to take responsibility and control of their lives.

Document Sharing: The Group discussed access to common documents. The current shared drive is only available to those with access to the BMBC network.

ACTION: **Keith Dodd** to explore options for document sharing across all agencies.

5. DEVELOPMENT OF ALL AGE EARLY HELP PLAN

Diane Lee and Susan Hyatt presented a paper on the development of an all-age early help strategy. A number of comments and contributions were made to the draft.

ACTION: **Susan Hyatt** to produce a more complete version to be presented at the next meeting. **ALL:** comments and further contributions to be sent to Susan Hyatt.

6. HOUSING AND HEALTH

Dave Fullen presented a paper on how Berneslai Homes are contributing to the Early Help agenda. It was suggested that the 'Something Does not Look Right' initiative could be brought under the umbrella of the Early Help (Adults) Delivery Group.

ACTION: **Diane Lee** to discuss with Dave Fullen.

7. DATE & TIME OF NEXT MEETING

Tuesday, 16th August 2016 at 1.30 PM.

The Group agreed to run a workshop on Universal Information Advice at this meeting.

ACTION: **Diane Lee** and **Keith Dodd** to liaise with Ann O'Flynn.

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REPORT TO THE HEALTH AND WELLBEING BOARD

Better Homes, Better Health

Report Sponsors: Julia Burrows & Helen Jaggar
Report Author: Phil Ainsworth - Senior Health Improvement Officer - BMBC
Received by SSDG: 20h June 2016
Date of Report: 20th June 2016

1. Purpose of Report

This paper recommends the strengthening of the partnership between health and housing and summarises the potential opportunities to develop strategic partnerships with all local housing providers to support an integrated health and well-being improvement offer together. Through this partnership it will allow a targeted approach to help tackle fuel poverty, falls prevention, excess winter deaths, social isolation and homelessness.

There is a wealth of evidence that supports the links between good housing and good health. Poor housing that is cold, damp and hazardous contribute to slips, trips and falls resulting in injuries, worsened chronic conditions and mental health. Support with housing can improve the health of individuals and help reduce overall demand for health and social care services. Good standard housing also provides the basis for individuals to build a more independent life, in many cases returning to work or education. Barnsley MBC and its social housing providers have considerable experience in designing and delivering services that enable positive health outcomes however the private rented sector does not always practice the same ethical approach on this. Working in partnership, health providers, housing associations, Berneslai Homes and private landlords can make those transitions easier and provide advice and support as well as provide better pathways and outcomes for service users.

2. Recommendations

Health and Wellbeing Board members are asked to:-

2.1 Support the development of a stronger health and housing partnership to better address shared health and housing outcomes.

2.2 To position and embed housing tenure and housing need into existing pathways and support service provision to enable people to access practical preventative support measures tailored to their needs. The proposed new social prescribing liaison service could be an intermediary through which health and social care professionals provide support & signposting for relevant housing advice and support.

2.3 Encourage, subject to budget availability, Health & Wellbeing Board partners to better align resources with the Council to take forward front line practical support measures and consider joint investment proposals to strengthen bids to finance interventions to address health and housing issues.

2.4 Encourage partner organisations to share data and intelligence to strengthen funding bids and better target front-line service delivery.

2.5 Support the inclusion of relevant health & social care representatives on the housing and health task group which monitors the impact of these recommendations.

2.6 Support the development of a local Memorandum of Understanding setting out those areas in which partners will cooperate and work together to better tackle health and housing issues.

A commitment to work to the key principles for this agenda:

1. **Recognising and acting upon the shared agenda between housing and health.**

2. **Offering a safe environment for all with a key focus on vulnerable people in Barnsley.**

3. **Working towards affordable warmth for all to reduce fuel poverty.**

4. **Preventing ill health exacerbated by poor housing conditions.**

5. **Preventing excess winter deaths in the home.**

6. **Supporting vulnerable residents to maintain their homes to reduce isolation and loneliness and prevent homelessness**

7. **Managing the health response to rough sleepers and transient populations**

The implementation and maintenance of these recommendations will be progressed by the health and housing task group. This group consist of;

- **Helen Jagger – CEO, Berneslai Homes (Chair)**
- **Richard Kershaw – Group Leader (Housing and Energy), BMBC**
- **Julie Tolhurst – Public Health Principal, BMBC**
- **Phil Parkes - Area Lead, Care Health and Wellbeing, SYHA**
- **Phil Ainsworth – Senior Health Improvement Officer, BMBC**
- **Jade Rose – Head of Commissioning for Partnership and Integration, Barnsley Clinical Commissioning Group**
- **Jayne Hellowell- Head of Locality Commissioning & Healthy Communities, Communities, BMBC**

3. Introduction/Background

Our home is our health setting for most, if not all, of our life. Lives start in the home and often end there too. Poor housing, however, is estimated to cost the NHS at least £2 billion every year. We want people in Barnsley to have healthier, happier and longer lives. What we also know is those living in more deprived communities tend to contain the most vulnerable people which also have direct effects on health. Housing conditions are often conceptualised as an issue for the elderly and sick, but these types of living conditions also affect families and young children. Once a child starts to become ill from a cold home, poor attendance and attainment in schools can occur, consequently effecting personal developments academically and socially which has a detrimental effect on opportunities later in life.

Marmot (2011) reviewed the existing evidence of the direct and indirect health impacts suffered by those living in fuel poverty and cold housing. The evidence reviewed in this paper shows the dramatic impact that cold housing has on the population in terms of cardio-vascular and respiratory morbidity and on the elderly in terms of winter mortality. It also highlights the stark effect that fuel poverty has on mental health across many different groups, while also having an impact on children and young people's well-being and opportunities.

What We Know Locally

3.1 Excess Winter Deaths (EWDs)

Excess winter deaths are a statistical measure, expressed as the number of extra people who have died, or as an index comparing winter deaths to the number that occur at other times of the year.

EWDs in Barnsley:

- 2011/12 **100**
- 2012/13 **163**
- 2013/14 **140**

 **134 average deaths per year**

The Office of National Statistics, which publishes the figures, acknowledges that the numbers involved are relatively small statistically and are subject to random fluctuation; therefore there is no consistent pattern across local authorities. These EWDs are a result of illness, disease and long term health conditions that can be exacerbated by poor housing conditions.

3.2 Falls Prevention

- The number of over 65s being admitted to hospital with an injury due to a fall is increasing in Barnsley. This is in contrast with the national picture, where the

number of admissions due to injuries from falls in the 65+ age range has remained stable over the last 5 years.

- In 2014/15 there were 1,195 emergency admissions to hospital in the 65s and over from injuries due to falls. This was significantly more than expected when compared to the national rate, by the high age sex standardised rate of emergency hospital admissions from injuries due to falls in people aged 65 and over per 100,000 in 2014/2015

An understanding of the seasonal variations and the location of where trips and falls occur, could allow resources to be targeted appropriately and reduce admissions to hospital and health and social care services. For example, trips and falls can occur within the home, around the curtilage of a person's home and within public spaces. The Council's management agent Berneslai Homes provides equipment and modifications to council houses to minimise trips and falls within the home and during the winter months pay for gritting around high density elderly population areas such as sheltered housing schemes to mitigate trips and falls.

3.3 Fuel Poverty

- **9.2%** of households in Barnsley are in fuel poverty – (Public Health England, 2015). Low Income High Cost indicator (LIHC).
- **9,421** households in Barnsley are living in fuel poverty being exposed to health risks through the lack of affordable warmth. (PHE 2016)
- **Over 17%** of households in the private rented sector are in 'fuel poverty'.

3.4 Housing Standards in Barnsley

Private Rented Sector

Almost 31,000 private sector dwellings are classified as non-decent

	Owner Occupied	Private Rented	All Private Sector
Number of non-decent homes	25,950	4,850	30,800
Percentage of total stock that is non-decent	36.3%	45.7%	37.5%

**Private Sector House Condition Survey 2010*

A home is considered to be non-decent if it fails to meet all of the following criteria:

- Meet minimum standards for housing under the Housing Health and Safety Rating System (HHSRS)
- Be in a reasonable state of repair

- Have reasonably modern facilities and services
- Have efficient heating and effective insulation

A significant proportion of the housing stock in Barnsley is nearly 100 years old and it is in the oldest properties that the very worst housing conditions are found. The majority of this aged stock is in the private sector, with a particular concentration towards the bottom end of the private rented sector, occupied by vulnerable households.

Owner occupied Sector

In the owner occupied sector there is also a significant proportion of housing in poor condition, often occupied by asset rich, cash poor elderly residents.

Social housing/Stock decency

Ongoing capital investment programmes have ensured that vast majority of social housing providers meet the Decent Homes standard. For example, in 2010 council housing in Barnsley achieved full decency for all its stock and has a rolling investment programme to ensure decency is maintained.

3.5 My Best life - Social Prescribing

Social Prescribing involves linking people to activities in the community that they might benefit from, connecting them to non-medical sources of support. Many small scale studies of social prescribing schemes describe the benefits of a range of interventions for people experiencing a range of common mental health problems, long term physical health problems and social isolation. Advocates suggest that at its best, social prescribing can:

- Support people to overcome chronic illness and unhealthy lifestyles.
- Enable people to learn new skills.
- Support people to become less dependent on financial assistance and help to seek work.
- Provide the tools to create an enterprising community.
- Deliver better social and clinical outcomes for people with long term conditions as well as their carer's.
- Allow more cost efficient and effective use of NHS and social care resources.
- Provide a wider, more diverse and responsive local provider base. Connect people to their community to build resilience.

Through this work we want identify residents housing tenure at the start of any referral. We also need to observe how a person's tenure is affecting their health and also distinguish which referrals maybe generated by property related issues but also which referrals may be due to social isolation. Case studies would be the preferred method of evaluation to capture this. Below is an example of how housing related support could contribute to improved health outcomes. Mapping of these services is currently underway. The service is currently out for tender and aims to be functional from April 1st 2017. In Barnsley, a three tier model of social prescribing services is

being commissioned, level one and two are signposting/self-referral and direct referral from a health/social care professional to community activity or voluntary/statutory sector provider. The proposal is that a health and housing referral route is developed and embedded as part of this model.

Example Pathways

- **Fuel Poverty** – Debt management services, Citizens Advice Bureau (CAB), Community shop, National Energy Advice (NEA) workshops, Credit Union, Green Doctors, DIAL services.
- **Falls**- Falls pathways through SWYPT & BHFT, Healthy Bones Classes, SYFRS safe and well checks, Stay Put.
- **Housing standards** - Better Homes Barnsley, BMBC Enforcement service, Stay Put.

4. National Policy

While the main focus has been on integration of health and social care, there are also new directives for the NHS relating to housing. The Care Act 2014 states that "**the provision of housing accommodation is a health-related provision**" in relation to the duty on the NHS, clinical commissioning groups and local authorities to promote integration of care and support, health and health-related provision.

4.1 NICE Guidance

'***Excess winter deaths and morbidity and the health risks associated with cold homes'*** published in March 2015 provides a call for action and includes recommendations for a health and housing referral service – to identify people at risk of ill health from living in a cold home and provide tailored solutions accessed through a single point of contact. It places a requirement for the NHS to work with others beyond its boundaries to address the problem of deaths caused by cold homes, and recommends integrated teams. The social prescribing model will start to address these recommendations. Other content is around provision and discharging vulnerable people from health or social care settings to a warm home to relieve service pressures and better place patients, joint working through the SSDG around system change are able to facilitate these discussions.

4.2 Memorandum of Understanding (MoU)

This national document sets out a commitment from 20 key organisations to understand the benefits of a practical partnership between housing and health. Public Health England, Local Government Association, Department of Health and NHS England are just a few of those signed up. Under the Care Act there is a requirement for closer cooperation of services that support the health and wellbeing of those who may be in need of care and support. An emphasis is placed on greater integration between health and social services to deliver more person-centred outcomes. The MoU details areas of improvement and the action plan that will ensure organizations work together to:

- Establish and support national and local dialogue.
- Information exchange and decision-making across government, health, social care and housing sectors.
- Coordinate health, social care, and housing policy.
- Enable improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services
- Promote the housing sector contribution to: addressing the wider determinants of health; health equity; improvements to patient experience and develop the workforce across sectors so that they are confident and skilled in understanding the relationship between where people live and their health and wellbeing and are able to identify suitable solutions to improve outcomes.

4.3 The NHS Five Year Forward View

This document recommends 'New Models of Care' to create a health service that has **prevention** at its core and is sustainable in the long term. This new long-term vision, coupled with the unprecedented pressure on NHS, is causing CCGs and others to look more widely for solutions. Local authorities have statutory responsibilities for housing, including providing advice and assistance and securing accommodation for the homeless, the maintenance of council stock to decency standard and monitoring and enforcement of housing health and safety standards within the private rented sector and ensuring the availability of affordable housing to all those who need it.

The 2016/17 to 2021/22 planning guidance for the NHS requires local health care systems to work together to produce a Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision.

Barnsley CCG is finalising its Sustainability and Transformation Plan, to address health and wellbeing, quality and outcomes and finance and efficiency gaps. The SSDG have identified the priorities for a local STP for Barnsley which includes urgent care and complex patients, adult's social care and early help and prevention. This presents an opportunity to ensure joined up working and to consider the housing impact and solutions required when considering these priorities.

5. Conclusions/ next steps

For Health & Wellbeing Board to:

- Note the potential health, social care and financial gains for developing the health and housing offer

- Discuss recommendations and make any further suggestions as to how the housing and health offer could be enhanced

- Support the inclusion of this agenda in the developing Sustainability and Transformation Plan

- Subject to H&WBB approval, support the implementation of the recommendations

6. Financial Implications.

- Research by the Chartered Institute of Housing found that **every £1 spent adapting a home this could save the NHS £69.37 over 10 years and that every £1 spent improving a cold home, could save the NHS £34.19 over 10 years** (Housing Learning & Improving network 2011). **See Appendix 1**
- Falls and fractures in the over 65's, account for 4 million hospital bed days each year in England, costing the NHS around **£2 billion per annum** (Royal College of Physicians 2011).
- Treating children and young people injured by accidents in the home costs A&E departments across the UK around **£146 million per year** (NICE 2010).
- If just **10%** of injuries were prevented, this would save Councils around **£80,000 a year** (NICE 2010).
- **Excess cold costs Barnsley costs £1.7million per year, damp and mold £2.5 million per year and falls, trips and slips costs around £4.8 million per year.** BRE (2013). **See Appendix 2**

Pooling resources across all sectors would allow for better investment with better returns on health outcomes. Not only does this have a better impact on services financially but also influences social capital. The Better Care Fund and the inclusion of the aids and adaptations grant is an example of this and there is an opportunity to discuss how this budget is used, should it be extended to include assistive telehealth as an "aids and adaptations" option. **See appendix 3**

7. Consultation with stakeholders

Barnsley Council has been in consultation with a variety of stakeholders in relation to this agenda. The housing and health task group is currently made up of several housing providers, social care, public health, BMBC's Housing and energy lead and chaired by CEO of Berneslai homes. We have had national influence from the leading charity in this area, National Energy Action (NEA) who strongly advised this

paper to the health and well-being board and fully support our collaborative work. **See Appendix 4**

This work has also gained political interest locally in which Barnsley Council has been working with councillors and MP Dan Jarvis to look at how policy in this area can be challenged to improve the health of our residents. This work also feeds into other key work priorities and partnerships such as;

- The Strategic Housing Partnership Board, where the link with the private rented landlord associations can be utilised
- Stronger Communities Partnership (Early Help & Prevention)
- Health & Wellbeing Provider Forum
- Anti-Poverty Delivery Group

Barnsley Council is also working with South Yorkshire Fire and Rescue to implement safe and well checks across the borough. These checks influence health and the service acts as an additional referral arm to local services. This will allow access into properties by a trusted service of the community as well as identifying vulnerable people who are not known to existing services. Berneslai Homes and SYFRS have a long standing partnership and this service is already in place within the Council's housing stock for all new tenancies and where vulnerability concerns are identified with existing tenants.

Governance

Accountability of the agreed recommendations and actions will be driven by the Early Help Adults subgroup of the Stronger Communities Partnership. Transparency of the actions will be available to ensure partners understand all decision making processes abiding to legislative requirements.

8. Appendices

8.1 Appendix 1 - Return on investment for housing and health

Return on investment

Housing interventions to keep people warm, safe and free from cold and damp are an efficient use of resources. Every £1 spent on improving homes saves the NHS £70 over 10 years.

The King's Fund

Local Government Association

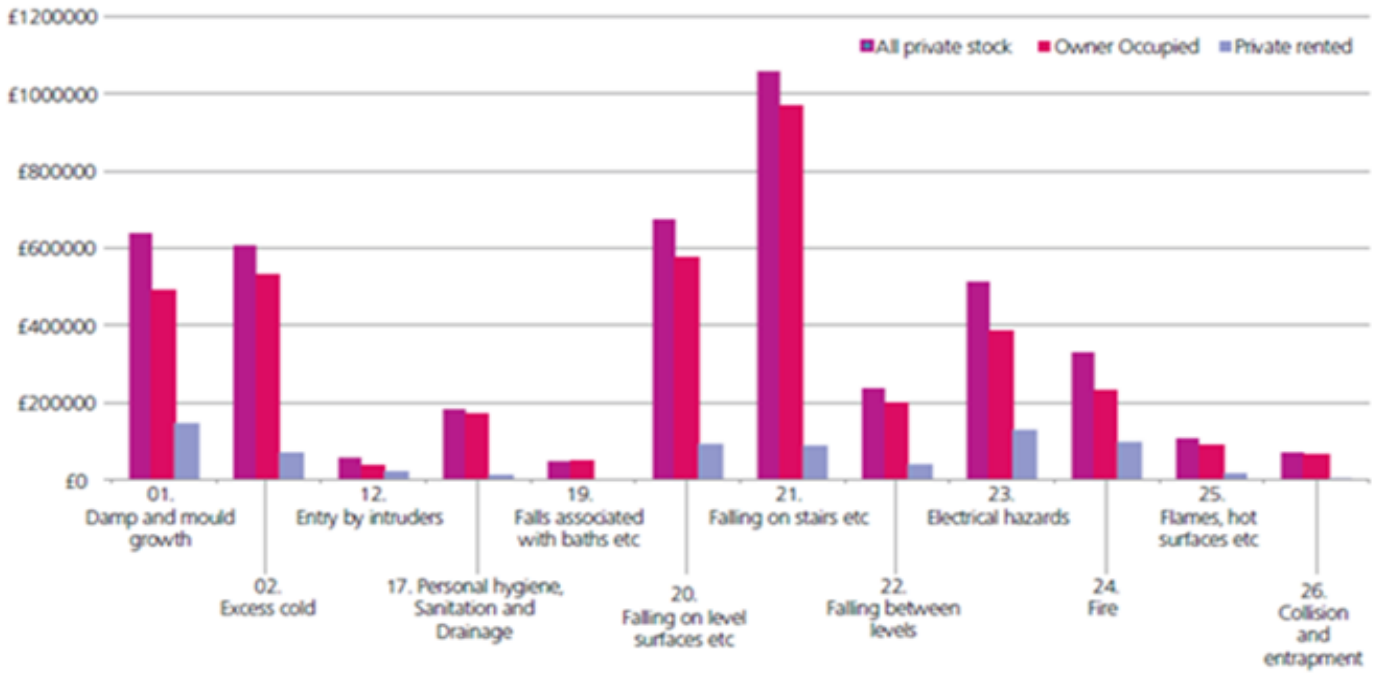
8.2 Appendix 2 - Cost savings for Barnsley from BRE report

Table 3. The annual costs to society of Category 1 housing hazards in Barnsley by tenure

Cost to society before work	All private stock	Owner Occupied	Private rented
01. Damp and mould growth	£1,604,200	£1,234,450	£369,725
02. Excess cold	£1,687,100	£1,482,800	£204,300
12. Entry by intruders	£161,525	£94,925	£66,600
17. Personal hygiene, Sanitation and Drainage	£458,525	£420,425	£38,075
19. Falls associated with baths etc	£121,400	£121,400	£0
20. Falling on level surfaces etc	£1,869,950	£1,603,425	£266,500
21. Falling on stairs etc	£2,840,350	£2,602,675	£237,650
22. Falling between levels	£596,200	£500,375	£95,825
23. Electrical hazards	£1,292,025	£963,225	£328,800
24. Fire	£839,025	£586,350	£252,650
25. Flames, hot surfaces etc	£281,350	£231,250	£50,075
26. Collision and entrapment	£189,800	£182,125	£7,675
Total	£11,941,450	£10,023,425	£1,917,875

Saving to society	All private stock	Owner Occupied	Private rented
01. Damp and mould growth	£1,599,050	£1,230,500	£368,525
02. Excess cold	£1,518,400	£1,334,525	£183,875
12. Entry by intruders	£145,425	£85,450	£59,950
17. Personal hygiene, Sanitation and Drainage	£458,050	£419,975	£38,050
19. Falls associated with baths etc	£120,725	£120,725	£0
20. Falling on level surfaces etc	£1,682,950	£1,443,100	£239,850
21. Falling on stairs etc	£2,643,800	£2,422,575	£221,225
22. Falling between levels	£592,900	£497,600	£95,300
23. Electrical hazards	£1,287,575	£959,900	£327,650
24. Fire	£830,625	£580,475	£250,125
25. Flames, hot surfaces etc	£272,675	£224,125	£48,550
26. Collision and entrapment	£174,875	£167,800	£7,075
Total	£11,327,050	£9,486,750	£1,840,175

Figure 4. Potential annual savings to the NHS



8.3 Appendix 3- How housing can deliver on health outcomes

8.4 Appendix 4 – Letter of support from National Energy Action

Action for Warm Homes

National Office
Level 6 (Elswick)
West One
Forth Banks
Newcastle upon Tyne
NE1 3PA
Tel: 0191 261 5677
Fax: 0191 261 6496
e-mail: info@nea.org.uk
http://www.nea.org.uk

Cllr Houghton
Barnsley Health and Wellbeing Board
Civic Hall
Eldon Street
BARNSLEY
S70 2JL

18th March 2016

Dear Cllr Houghton,

National Energy Action (NEA), the national fuel poverty charity, is concerned that the UK is approaching a cold homes crisis. NEA is committed to influencing and increasing strategic action against fuel poverty, progressing solutions to improve access to energy efficiency products and providing advice on fuel poverty alleviation services to benefit the health of vulnerable households.

There is now a longstanding recognised connection between living in a cold home and the impact to a person's health and wellbeing. In the 5 years leading up to 2012/13 (the last year where local data is available), there were 600 excess winter deaths in Barnsley, people who may not have died if they were living in a safe and warm home. Additionally, for every death it is assumed that there are around 8 hospital admissions that go uncaptured by the excess winter death figures.

Whilst over 80% of the excess winter deaths last year were those aged over 75, it must not be forgotten the devastating impact that living in a cold home can have on a child's health and their potential for the future. Children living in a cold home are twice as likely to develop asthma and up to three times more likely to experience coughing or wheezing – a child is admitted to hospital every 18 minutes due to asthma. Cold homes are intrinsically linked to poor housing, in Barnsley almost 31,000 private sector dwellings are classified as non-decent and over 17% of households in the private rented sector are in 'fuel poverty'.[1]

NEA has worked in Barnsley and with Barnsley Metropolitan Borough Council for a number of years. Barnsley MBC has consistently supported NEA's Warm Homes Campaign to raise awareness of people living in fuel poverty. During 2015, Barnsley MBC took part in NEA's Improving Energy Efficiency in Communities project with 57 professionals trained in Energy Awareness and 2 energy awareness sessions held to the job club and the local food bank.

[1] https://www2.barnsley.gov.uk/media/3140485/final_barnsley_jsna_2013_summary_ss_14-10-13.pdf

NEA fully supports the work of Barnsley MBC in tackling fuel poverty, excess winter deaths and the impacts of living in a cold home and echo the recommendations made in the paper. As the national energy policy is typically unstable, it highlights the need for a strong, local single point of contact to help Barnsley residents navigate the complex landscape of assistance. Additionally we would advocate greater collaboration between existing agencies to provide a better service to the community; only by working together can the full needs of the individual be met. The assistance and resource for a closer strategic and operational relationship between the housing and health disciplines is required to recognise the benefits of joint preventative action to improve poor health outcomes caused / exacerbated by poor housing conditions.

We look forward to working with you to tackle fuel poverty and cold homes in Barnsley.

Yours sincerely

Maria Wardrobe
Director of External Affairs

8.5 Appendix 5- Case study

In March 2016 BMBC received a call from a resident seeking help for improvement works for their home. The residents were disabled women with numerous conditions including, asthma, fibromyalgia and a recent diagnosis of chronic bronchitis. Other residents included a disabled daughter who suffers from asthma and is recently due to undergo surgery with asthma Her elderly father lives at the property next door and is no longer to help financially to tackle issues with his daughter's property.

Issues within the property such as black mould existed in every room in the house. The property is a 200 year old stone built property which she owns. The residents stated that the walls felt wet all of the time and there was a possible leak in the roof.

The lady attends her doctor every week due to ongoing illnesses which undoubtedly are worsened by the state of house, especially considering the nature of the respiratory and musculoskeletal conditions.

Their financial situation means they simply cannot afford to pay for the works needed on the property. Nor are they eligible for works to be taken out via current schemes because of the tenure.

We have given the residents contact details to social services, welfare assistance, Stayput, DIAL and the Disabled facilities grants and any other service we felt maybe able to assist.

BMBC often get calls from people in these kinds of circumstances, home owners with long term health conditions, and there is nothing available to offer them. These are the vulnerable people living in poor housing conditions who are falling through the gaps of current provision. This case study highlights the effects housing can have on health locally. With the right support mechanisms and funding streams to be able to improve homes in the private sector we can unquestionably reduce admissions to services and improve resident's quality of life and enable them to manage their long term conditions within their own home as well as help offset further illnesses.

9. Background Papers

- British Research Institute (2013). Health Impact Assessment of Private Sector Housing in Barnsley - An evaluation of the impact of poor private sector housing on health in Barnsley. 1. UK: BRE.

- Department of Health, (2014). A Memorandum of Understanding (MoU) to support joint action on improving health through the home. 1. UK: Housing Learning and Improvement Network.

- Marmot Review Team (2011). The Health Impacts of Cold Homes and Fuel Poverty. London: Friends of the Earth and the Marmot Review Team. Available at: www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty

- National Institute for Health and Clinical Excellence, (2015) Preventing excess winter deaths and illness associated with cold homes [Homepage of NICE], [Online]. Available: https://www.nice.org.uk/guidance/qs117

- National Institute for Health and Clinical Excellence (2010). Preventing Unintentional Injuries among under-15s in the Home: Costing report. NICE public health guidance 30. London: NICE. Available at: http://guidance.nice.org.uk/PH30/CostingReport/pdf/English

- NHS Alliance (2016), Social Prescribing [Homepage of Primary Care Foundation], [Online]. Available: http://www.nhsalliance.org/making-time-in-general-practice/part-2-social-prescribing-health-and-housing/

- Public Health England (2016), Public Health Outcomes Framework - Over Arching Indicators [Homepage of Public Health England], [Online]. Available: http://www.phoutcomes.info/public-health-outcomes framework#page/0/gid/1000049/pat/6/par/E12000003/ati/102/are/E08000016

Officer: Phil Ainsworth

Contact: philainsworth@barnsley.gov.uk 01226 787950

Date: 20/06/2016

REPORT TO THE HEALTH AND WELLBEING BOARD

9th August 2016

ANNUAL REPORTS OF THE BARNSLEY SAFEGUARDING ADULTS BOARD AND SAFEGUARDING CHILDREN BOARD (2015/16)

Report Sponsor:	Rachel Dickinson (Executive Director: People, Barnsley MBC)
Report Author:	Richard Lynch (Head of Commissioning, Governance and Partnerships, Barnsley MBC)
Received by SSDG:	Not applicable
Date of Report:	25th July 2016

1.0 Purpose of Report

1.1 To present for the Board's information and consideration, the latest Annual Reports of the Barnsley Safeguarding Adults Board and Safeguarding Children Board.

2.0 Recommendations

2.1Health and Wellbeing Board members are asked to:-

- Note the progress and achievements made by each Board, during 2015/16, as outlined in their respective Annual Reports, together with the key actions to be pursued during 2016/17.

- Identify any issues which could be incorporated as an objective within the Borough's forthcoming, revised Health and Wellbeing Strategy.

3.0 Introduction/ Background

3.1 In accordance with statutory guidance both Local Safeguarding Adults Boards (LSABs) and Local Safeguarding Children Boards (LSCBs) are required to publish and present an annual report which outlines their achievements and progress, together with their plans and priorities going forward.

3.2 Barnsley's Safeguarding 'Framework' *(please see Appendix 1)* acknowledges the importance of effective Member led challenge and accountability in promoting the wellbeing of both adults and children and, in particular, ensure that they are safeguarded from harm or exploitation.

3.3 As a result, both Annual Reports are presented not only to the respective Board but also for the attention and consideration of the Council's Cabinet and the Health and Wellbeing Board.

3.4 Summary Of The Annual Report Of The Barnsley LSAB (2015/16)

3.5 The LSAB's latest Annual Report is attached as Appendix 2. It includes reference to the purpose of the LSAB, together with its governance and funding arrangements.

3.6 The Report also outlines progress made against key actions, during 2015/16, including the following:

- Challenging and holding partner organisations to account for their performance in safeguarding vulnerable adults.
- Engaging vulnerable adults, in ensuring their safety and wellbeing.
- Development of the local Vulnerable Adult Risk Management Model.
- Multi agency training and the development of a coherent Barnsley Safeguarding Adults Training Plan.

3.7 A number of case studies embellish the Annual Report as part of depicting how continuing improvements in the quality of safeguarding have benefited vulnerable adults.

3.8 The LSAB's Business Plan, indicating its objectives during 2016/17, is summarised in Page 38 of the Annual Report.

3.9 Summary Of The Annual Report Of The Barnsley LSCB (2015/16)

3.10 The LSCB's latest annual report is attached as Appendix 3. Similarly, the Report provides an assessment of the quality and effectiveness of local services for the safeguarding and effectiveness of children and young people in the Borough and the promotion of their welfare.

3.11 In particular, the Health and Wellbeing Board is recommended to note the following information in the Annual Report:

- The challenge provided by the Board in holding to account the performance and effectiveness of partner organisations in protecting and safeguarding children.
- Progress towards achieving key priorities during 2015/16, including the development of the Children's Integrated Assessment and Investigation Service (incorporating the Multi Agency Safeguarding Hub) in Barnsley.
- The role of the LSCB towards implementing the recommendations contained in the Ofsted review of its effectiveness, undertaken in 2014.
- Using learning derived from serious case reviews to inform continual improvements in the protection of vulnerable children.
- The added value provided through the Board's multi agency training and development programme for practitioners.

- The LSCB's key priorities and planned developments during 2016/17 as outlined in Pages 53-54.

4.0 Conclusion/ Next Steps

4.1 The Health and Wellbeing Board is recommended to consider the progress and achievements of both the Barnsley LSAB and LSCB in promoting the wellbeing and ensuring the safeguarding of vulnerable adults and children, during 2015/16, together with the key actions to be pursued by each Board, in 2016/17. The Board is, also, requested to identify any key actions within either Report which should be incorporated as an objective within the 'Refresh' of the Borough's Health and Wellbeing Strategy.

4.2 The respective managers of the LSAB and LSCB will be attending today's meeting of the Health and Wellbeing Board to help clarify any issues relating to either Annual Report.

5.0 Financial Implications

5.1 There are no financial implications for the Health and Wellbeing Board, emerging through consideration of both these Annual Reports.

6.0 Consultation with stakeholders

6.1 In formulating both Annual Reports, consultations have taken place with partner organisations on each Board as part of ensuring a place based, systems led approach to promoting the wellbeing and protection of vulnerable adults and children.

6.2 One outcome of these consultations has been the forthcoming development of an interactive PDF version of the LSAB's Annual Report with a design that will appeal to a wider audience.

7.0 Appendices

7.1 Appendix 1 – Barnsley Framework for Safeguarding Children and Adults (Report of the Executive Director (People) to Cabinet, 4th November 2015)

Appendix 2 - Annual Report of the Barnsley Local Safeguarding Adults Board (2015/16)

Appendix 3 - Annual Report of the Barnsley Local Safeguarding Children Board (2015/16)

8.0 Background Papers

8.1 Background papers, including legislation and statutory guidance, used in the compilation of this report are available to view by contacting the People Directorate, Barnsley Metropolitan Borough Council, PO Box 634, Barnsley, South Yorkshire S70 9GG

Officer: Richard Lynch **Contact: Tel. No. 01226 773672 or e-mail richardlynch@barnsley.gcsx.gov.uk**

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 the Cabinet

(21st October 2015)

Barnsley Framework for Safeguarding Children and Adults

1.0 Purpose of Report

1.1 The purpose of this report is to inform and brief members on Safeguarding Children and Adults arrangements in Barnsley following the implementation of the Care Act (2014) (*henceforth to be known as The Care Act or The Act in the remainder of this report)*.

2.0 Recommendations

2.1 That the current arrangements for safeguarding children in the Borough are noted.

2.2 That the current arrangements for safeguarding vulnerable adults in the Borough, including the progress made in implementing the relevant provisions of The Care Act (2014) are noted.

2.3 That the approach to non - statutory Safeguarding enquiries, as outlined in Page 7, Paragraphs 12.5 – 12.8 of the report, be endorsed.

2.4 That an All Members Information Briefing on the evolving safeguarding landscape be scheduled during 2015-16

3.0 Governance and Scrutiny Arrangements - Safeguarding Children and Adults

3.1 Barnsley Safeguarding Children Board (BSCB)

3.2 The BSCB comprises of representatives from a range of statutory partners, whose role is to promote the safeguarding and wellbeing of local children, young people and families in Barnsley.

3.3 The independently chaired BSCB provides a forum to hold partners to account and test effectiveness of multi-agency working to safeguard children, including early help. The BSCB will 'hold the ring' on challenging performance providing a forum for partners to challenge across the piece.

3.4 The BSCB's prime responsibilities are:

a) To co-ordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area, and
b) To ensure the effectiveness of what is done by each person or body for that purpose.

3.5 The work of the BSCB is driven by the annual business plan and supported by an effective sub-group structure. In testing effectiveness, the BSCB will draw on both performance data and quality assurance activity that examines in detail the quality and effectiveness of front line practice.

3.6 The Board is strongly committed to further strengthening its relationship with other strategic partners, including the Barnsley Children and Young People's Trust Executive Group and the Barnsley Health and Wellbeing Board established in April 2013, together with the local strategic partnership, 'One Barnsley', whose membership is drawn from public, private, community and voluntary organisations. To affirm all these relationships, the Board has approved a protocol covering governance arrangements and the degree to which they enable partners to assess whether they are fulfilling their statutory responsibilities to help, protect and care for children and young people.

3.7 The BSCB will refer to the Children and Young People's Trust matters that have commissioning implications. The chair of the BSCB will escalate matters to the governance structures of partners and / or the Health and Well-Being Board where it is considered that agencies are failing to discharge responsibilities under 'Working Together' (2013).

3.8 The BSCB's role in safeguarding children from harm and exploitation was reviewed by Ofsted last year. The inspection report concluded that arrangements for keeping children and young people safe from harm were effective but 'Require Improvement' in order to be judged 'Good'.

3.9 Reporting to the BSCB are eight multi-agency sub groups who drive forward improvement in safeguarding policy, practice and procedure. These are:

Child Sexual Exploitation (CSE) Strategic Group
Policy, Procedure and Practice Developments
Workforce Management and Development
Serious Case Review
Children with Disabilities and Complex Health Needs
Performance, Audit and Quality Assurance
Child Death Overview Panel

4.0 <u>Barnsley Health and Well Being Board</u>

4.1 The Health and Well-Being Board is a formally constituted committee of the Council and chaired by the Leader of the Council. As Chair of the Board, the Leader meets with the independent chair of the BSCB annually and the annual report is presented to the Health and Well-Being Board for consideration. The Lead Member for children's services is also a Member of the Health and Well-Being Board and along with their Cabinet Support Member sits on the BSCB as an observer, in accordance with the statutory regulations '*Working Together To Safeguard Children' (updated in March 2015)*

The Annual Report of the Barnsley Safeguarding Adults Board has been presented at the Health and Well Being Board by the Chair.

5.0 <u>Barnsley Children and Young People's Trust Executive Group</u>

5.1 The Children's Trust, chaired by the Executive Director (People) in the statutory role of Director of Children's Services, secures the co-operation of partners to strategically

plan and align service commissioning and delivery to improve children's' outcomes and efficiency of service delivery. The Trust has a Children and Young People's Plan in place that sets out the ambition, vision and priorities of the Trust The Children and Young People's Plan which is, currently, being reviewed, is supported by a commissioning strategy which places improving outcomes for children and young people and the 'voice of the child' at the heart of commissioning intentions.

6.0 Continuous Improvement of Children's Services

6.1 Through the removal of the Improvement Notice and the dis-establishment of the Improvement Board which had been implemented following the outcomes of the Ofsted inspection in 2012, BSCB now has the lead responsibility for the Continuous Children's Service Improvement Plan. The plan provides the means by which progress and impact on services and outcomes for children and young people will be measured. The plan is mapped against the Ofsted requirements (following the child's journey) and will enable both the BSCB and the Children and Young People's Trust to determine whether sufficient progress is being made, i.e. the right amount of progress, in the right direction, at the right pace. The plan is a 'live' working tool and areas for improvement arising from the Ofsted Inspection 2014 are actively being addressed within it.

6.2 The Continuous Service Improvement Officer Group is a multi-agency Officer Group, chaired by the Executive Director (People) and supported by the Service Director (Children's Social Care and Safeguarding) who work to deliver the Continuous Service Improvement Plan. The Plan is routinely presented to the BSCB in order that progress can be reviewed and actions taken to tackle insufficient progress or poor performance where necessary. Issues which have commissioning implications are reported to the Children and Young People's Trust for consideration

6.3 The Safeguarding and Quality Assurance Unit

6.4 Additional investment has been awarded by the Council to the Safeguarding and Quality Assurance Unit in Business Unit 2, to support the Children's Social Care Service (CSC) continued service improvement journey. The Unit provides independent reviewing functions for looked after children's care planning arrangements and for children who require a formal, multi- agency child protection plan.

6.5 Council investment will support additional quality assurance through regular auditing of CSC case files and monthly quality assurance visits to the front line by the Executive Director, Service Director and Lead Member for Children's Services (*Cabinet Spokesperson – People (Safeguarding))*

6.6 The Unit will support practice development within CSC, supporting the service in moving from compliance to producing consistently high standards of quality in assessment, practice, intervention and planning for children, young people and their families that is evidence based and outcome focused,

6.7 The Unit will also provide support to the Barnsley Safeguarding Adults Board (BSAB) supporting effective governance and partnership arrangements.

6.8 Both the BSCB and BSAB now commission the same Independent Chair, supporting consistency of standards across both Boards and the application of transferrable knowledge and development.

6.9 There is to be one designated local authority designated officer (LADO) responsible for the management and oversight of cases where allegations of abuse of abuse or mistreatment are made against professionals and/or carers who work with both children and vulnerable adults. This role will incorporate the responsibilities of the Designated Adult Safeguarding Manager (DASM).

7.0 Member Led Challenge – Safeguarding Children and Adults

7.1 Member led challenge is critical to ensuring that vulnerable children and adults are appropriately safeguarded. In Barnsley, there are seven separate elements to Member led challenge:

- Council
- Cabinet
- Health and Wellbeing Board
- Overview & Scrutiny Committee (including 'Task and Finish' Groups)
- Safeguarding Scrutiny Committee
- Corporate Parenting Panel
- Peer Review

7.2 To enable the continued improvement and positive impact of the Council's Scrutiny function, a proposal was recently presented to Cabinet to change the Children's Services Scrutiny Committee to a Safeguarding Scrutiny Committee, to include the scrutiny of adults safeguarding.

7.3 This reflects the recent changes made in The Care Act which include the statutory requirement for an Adult Safeguarding Board as well as a Children's Safeguarding Board, together with other developments such as the Council's new 'People' Directorate structure as well as Dame Louise Casey's Report on Rotherham Council which highlights that safeguarding is the responsibility of all services.

7.4 The Safeguarding Scrutiny Committee will continue to meet in both private and public session to scrutinise and challenge performance. It has the right to refer matters, 'call in' recommendations and propose alternative recommendations to the Council's Cabinet and request a review of any area of activity if it has particular concerns. The Children's Services Scrutiny Committee has undertaken scrutiny of the performance of children and young people's services and the work of the BSCB to date. The annual self-assessment of children and young people's services (generated through a robust process which incorporates regional peer challenge) is presented to Scrutiny on an annual basis.

7.5 The Corporate Parenting Panel is charged with acting as a 'pushy parent' on behalf of the Council's looked after children and works to challenge and improve the effectiveness of services to children in care, adoption and care leavers. This Panel also performs a useful role in scrutinising, challenging and holding to account, service performance in relation to children in care and care leavers. The Panel in particular will significantly increase its level of engagement with vulnerable children and young people through a variety of forums, including the Barnsley 'Care4Us' Council.

7.6 On 11th March 2015, Cabinet considered a report setting out a programme of activity aimed at assuring that all Council Services, with a stake in protecting children from harm and exploitation, are compliant with this responsibility, statutory regulations and best practice.

7.7 The Programme, which is subject to regular review by SMT, has included progress in the following activity:

7.8 Regulatory Services – Licensing

- The Head of Regulatory Services is a permanent member of the BCSB's Child Sexual Exploitation Sub Group
- As part of the above, all taxi drivers (new and existing) are to undertake mandatory safeguarding awareness training, with priority being given to drivers engaged in Home to School transport
- Awareness training is also taking place for businesses, including hotels and bed and breakfast establishments, Registered SIA Door Staff, Taxi Marshals, late night refreshment venues and other licensed premises
- A specific section on safeguarding and preventing CSE has been included in Elected Member training concerning their licensing responsibilities and on how they can report or escalate issues of concern.
- An internal audit review of Licensing has commenced which will include how far the Service has learned from and applied the findings and recommendations of the Casey Report. Discussions are taking place between the four local authority licensing services to identify areas of best practice; consistency in licensing policies and conditions, data sharing, training and awareness.

7.9 Planning Regulatory Board

- In deciding whether to award planning consent for the development of businesses, particularly near to schools, Members of the Committee are required to be mindful of any safeguarding considerations within supplementary planning guidance.

7.10 Challenge and Accountability

- Through the LGA, Members of the Safeguarding Scrutiny Committee and the former Children's Services Scrutiny Committee, have received training on effective 'critical friend' techniques in relation to tackling CSE
- Please also see Paragraphs 7.2 – 7.5
- Ensuring vulnerable children and adults are safe from harm and exploitation is an explicit objective within the Council's Equality Scheme (2015-18) and progress towards improving awareness and acting upon reported incidents will form part of the Council's corporate performance reporting framework

7.11 Empowering and Training 'Front Line' Employees

- As part of enhancing the 'eyes' and 'ears' of services, the Borough's CSE Strategy and BSCB multi agency training programme will ensure that front line staff, including teaching and non teaching staff in schools, foster carers, youth support workers and NHS practitioners become more aware of and know what to do if they suspect the grooming of children and young people is taking place.

8.0 Service Challenges – Safeguarding Children

8.1 Following the 2012 Ofsted inspection which resulted in a Notice of Improvement for Barnsley Children's Social Care Services and, as part of the Continuous Children's Services Improvement Plan, the 'Threshold of Need' document was revised and lowered, with the intention of ensuring that Children's Social Care responded to

children who were in need and/or in need of protection as set out under the Children Act 1989. The revision of the Thresholds has led to more children having their needs appropriately assessed and responded to by Children's Social Care.

8.2 At the same time, national and local high profile inquiries into child abuse has led to an increase in social work activity by Children's Social Care Services. Consequently more children are being referred to Children's Social Care Services for a statutory service.

8.3 Whilst progress has been made across partner agencies, our Early Help 'Offer' has not had any significant impact to date on reducing the number of 'Contacts' into Children's Social Care Services, rather contacts have remained at the same level.

8.4 The increase in demand, which is consistent with a local and national picture, has put significant pressure on statutory social work services. This has impacted negatively upon the Service's capacity to allocate and complete children's assessments in a timely manner, as set out under the statutory guidance, 'Working Together to Safeguard Children' (updated in March 2015).

8.5 Equally, the increased volume of activity has resulted in social worker caseloads increasing. This has the potential of reducing both the quality of dedicated social work intervention for the Borough's most vulnerable children and, adversely affecting social work morale, recruitment and retention.

8.6 A review and analysis of data suggests that too much is being done at all stages of the contact, referral and assessment process, requiring a re-balancing in the system as well as re-alignment of resources.

9.0 <u>Inter-Agency Arrangements for Safeguarding Children</u>

9.1 The BSCB's Website provides guidance to all member agencies, including the local authority and the public on what to do and who to contact if anyone is concerned about a child's safety. The website provides clear definitions of harm. It provides guidance for parents and carers, on how to make a complaint and provides advice on safeguarding issues that can affect all children and families, for example, bullying, safe sleeping and accident and prevention.

9.2 Robust, jointly agreed policies and procedures are accessible on the Website for all agencies to access, on agency roles and responsibilities in working together to identify and respond to safeguarding children. These policies and procedures provide detailed guidance to all practitioners and are underpinned by relevant legislation and statutory guidance, including '*Working Together to Safeguard Children'*.

9.3 Multi-agency training is an effective way of bringing together professionals from different agencies to gain a better understanding of their roles and responsibilities for safeguarding and protecting children and young people. The BSCB offers an extensive range of free training courses to individuals and agencies who have a responsibility for safeguarding children. Courses are facilitated by the Board's multi-agency training officer with input from a number of external facilitators, who are commissioned to provide training on behalf of the Board. BSCB provides both face to face training and e-learning opportunities.

9.4 Plans are on track for the development and implementation of a Multi Agency Safeguarding Hub (MASH) which will integrate the Police, Children's Social Care and the local NHS. This will improve inter-agency information sharing and screening of

child protection referrals. An integrated team has already been established to tackle child sexual exploitation.

10.0 BSCB Communication Strategy

10.1 Communication and awareness raising is a core function of a Safeguarding Children Board. An effective communication strategy aims to deliver messages to the Board's target audiences to help achieve its objectives in an organised and targeted way. The BSCB Communications Strategy outlines the way in which the Board will share information with children, young people, families, and partner agencies, the media and the wider public, encourage two-way communication and explain how everyone can contribute to keeping children and young people safe in Barnsley

11.0 The Care Act and Safeguarding Adults

11.1 The Care Act replaces 'No Secrets' Guidance and sets responsibility for adult safeguarding in primary legislation, endorsing the principle of wellbeing and giving safeguarding adults duties a statutory basis.

11.2 New responsibilities for Safeguarding Adults Boards now exist, including safeguarding duties having legal effect on partners with clear statutory responsibility to ensure enquiries into abuse and neglect are made or caused to be made. Safeguarding Adults Boards are placed on a statutory footing, with a legal requirement for Safeguarding Adult Reviews to take place and a duty to cooperate is placed on and between the Board Members and relevant partners

11.3 The Statutory Guidance supports Section 14 of The Care Act, where safeguarding is defined as protecting an adult's right to live in safety, free from abuse and neglect. In response to the requirements of the Act and our safeguarding responsibilities, all local authorities are charged with their partners, to review current practice, with relevant partners, to determine specific impacts, hence the updating of South Yorkshire wide adult protection policy, procedures and guidance which has been delayed but are now out for consultation.

11.4 The Care Act details the general duty of a local authority to promote well-being in relation to how adults are treated. There are six key principles of adult safeguarding that underpin all adult safeguarding work as follows:-

- Empowerment - Personalisation and the presumption of person-led decisions and informed consent.
- Prevention - It is better to take action before harm occurs.
- Proportionality - Proportionate and least intrusive response appropriate to the risk presented.
- Protection - Support and representation for those in greatest need.
- Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability - Accountability and transparency in delivering safeguarding

12.0 Local Authority Responsibilities for Safeguarding Adults

12.1 The Care Act sets out the legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. These are derived from

the Social Care Institute for Excellence (SCIE) Local Authority safeguarding duties which are summarised, below:

a) To lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens.
b) To make enquiries, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
c) Establish Safeguarding Adults Boards, including representation at the most senior level from the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy.
d) Carry out Safeguarding Adults Reviews when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them.
e) Arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

12.2 Safeguarding Duties, Including Making Enquiries

12.3 Safeguarding duties, including making enquiries apply to an adult who:

a) Has needs for care and support (regardless of any other input or some needs being met) and
b) Is experiencing, or is at risk, abuse or neglect, and
c) As a result of those needs is unable to protect themselves against abuse or neglect or the risk of it.

12.4 This means that the local authority must follow up any concerns or cause enquiries to be made about either actual or suspected abuse or if the local authority has reasonable cause to suspect that an adult in its area (regardless of residency) is at risk of abuse or neglect. Safeguarding Adults Boards have increased powers than previously set by “No Secrets”, which should be more transparent and will come under more scrutiny.

12.5 There are two types of Safeguarding enquiry arising from a safeguarding concern:-

1) Statutory Safeguarding Enquiry – (constitutes a formal Section 42 Enquiry under The Care Act)

   Local authorities are required to carry out Safeguarding Enquiries for any individuals who meet the above criteria. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what should happen and by whom.

2) Non-Statutory Safeguarding Enquiry

   These enquiries are safeguarding enquiries and can be carried out on behalf of adults who do not fit the criteria outlined under Section 42 of the Care Act. Local authorities are not required by law to carry out enquiries for these individuals and do so at their own discretion. These enquiries may relate to an adult who:
   - is believed to be experiencing, or is at risk of, abuse or neglect
   - does not have care AND support needs (but might just have support needs)

12.6 The Care Act, potentially, broadens the scope for Adult Safeguarding with the inclusion of the criteria for non- statutory enquiries outlined above. Adult social care is not currently resourced to carry out non- statutory enquiries.

12.7 The South Yorkshire procedures that are currently, subject to consultation, suggest that individuals that do not meet the safeguarding statutory criteria should be given advice and information and signposted to appropriate services. This is consistent with current practice.

12.8 The approach to safeguarding non - statutory services, including in particular, intervention through advice, information and signposting to suitable services, is consistent with the Authority's Corporate Plan priority of targeting resources to those in most need, supporting people to be independent and connecting them with their communities.

12.9 Who may be considered for statutory and non-statutory enquiries?

12.10 This may include people with learning disabilities, mental health issues, older people, and people with a physical disability or impairment including those subject to Deprivation of Liberty Safeguards (DoLs). It may also include adult victims of abusive care practices; neglect and self-neglect; domestic abuse; Child Sexual Exploitation (CSE); hate crime; female genital mutilation; forced marriage; modern slavery; trafficking and anti-social abuse behaviour.

12.11 Potential responses to a Safeguarding concern

12.12 There may be a number of potential responses when an adult safeguarding concern is discussed with Adult Social Care. At any stage in the process from initial consultation to raising a formal Section 42 response, it may be determined that:

a) The instance is not adult abuse or it is discounted following evaluation/assessment of the information received.
b) There is evidence of abuse and it appears more appropriate to address the problem in a less formal way e.g. through the provision of support services for a stressed carer.
c) There is no evidence of adult abuse but a care management assessment is instigated.
d) There is evidence of abuse but the victim is not in need of care and support and a referral to a more appropriate service may be suggested e.g. housing services.
e) There is evidence of abuse, the alleged victim is an adult at risk and a formal Section 42 Enquiry is raised.
f) The concerns relate to general poor standards of care in a regulated setting and referral to the Care Quality Commission (CQC) is more appropriate. The information may also be passed to the social service agency Contracts Team and the Commissioners of the service.
g) The adult at risk may not want any action taken.

12.13 What if the adult does not want any action taken?

12.14 The purpose of adult safeguarding is to secure or ensure the adult's autonomy and recovery, as far as possible. If the adult has capacity and they are not being unduly pressurised or intimidated they may not wish for any intervention. Their desired outcomes are paramount and should be recorded and respected. In this circumstance

when we have concluded that the adult(s) are deciding for themselves advice, information and signposting to appropriate services will be offered.

12.15 However where others, including children, may be at risk, this does not remove the responsibility to report concerns and where appropriate, or for enquiries to be made. In addition if a crime has been committed we have a duty to consult with the police regarding the allegations.

12.16 Safeguarding must aim to stop abuse or neglect wherever possible; prevent harm and reduce risk of it happening and enable adults at risk to have choice and control in how they live their lives.

12.17 The Care Act and its guidance in respect of safeguarding adults, supports the development in practice that '*Making Safeguarding Personal*' will bring. National feedback which suggested that adult safeguarding work currently focused on process and procedure whilst those using such services wanted a grater focus on resolution of their circumstances, with more engagement and control, will be reflected within changes in the practice of safeguarding adults.

13.0 Barnsley Safeguarding Adults Board (BSAB)

13.1 The main objective of the BSAB is to assure itself that local safeguarding arrangements with partners act to help and protect adults in its area who meet the criteria as above. The BSAB has a strategic role that oversees and leads adult safeguarding across the locality. The three core duties of the Board are:

1) To publish a strategic plan for each financial year
2) To publish an annual report outlining its achievements and objectives
3) Conduct Safeguarding Adults Reviews (SARs) in accordance with Section 44 of the Care Act

13.2 The current position of the BSAB in relation to these core duties is as follows:-

- A Business/Strategic plan has previously been produced each year. Changes in member organisational structures have impacted on the timeliness of the BSAB plan development for 2015/16.

- An Annual Report is published each year. The format of the Annual Report is being reviewed to take account of the feedback from the Adult Peer Review that took place in February 2015 and the Care Act requirements to involve 'Health Watch' (Barnsley) and the community in its production. The review and updated format will be completed ready for the Annual Report 2015 -2016.

- The BSAB has previously undertaken Serious Case Reviews (SCRs) and has policy and procedures in place. The Care Act refers to Safeguarding Adult Reviews (SAR) as a core duty of the Safeguarding Adults Board. The policy and procedures have been updated to take account of the Care Act's requirements and are out for consultation across BSAB partners.

13.3 The BSAB undertook a Board development day on the 24th July 2015 with the recently appointed Independent Chair to review its structures and sub –groups and set the Board's priorities. The business/strategic plan is in progress.

13.4 A review and update is being undertaken of the BSAB's Memorandum of Understanding which has two parts. Part 1 contains the Statement of Purpose,

obligations and roles and responsibilities which has been updated and is being consulted on with BSAB board members. Part 2 contains the Terms of Reference for the BSAB and its sub groups which is, now, being updated.

13.5 The Care Act places a duty on the local authority to ensure that information and advice on care and support is available to adults who are subject to a safeguarding enquiry or SAR. The Joint Commissioning Team for Adult Social Care, has developed a specification and has tendered for advocacy services to meet the requirements of The Act in respect of safeguarding requirements. The service is in place with a contact being awarded until April 2016.

14.0 Making Safeguarding Personal -A Fundamental Change to Safeguarding Practice

14.1 Making Safeguarding Personal (MSP) encompasses major changes from process led to person centred enquiries resulting in personalised safeguarding. This will lead to the achievement of an outcome focus on the enquiry. Practice must concentrate on what the adult wants, which accounts for the possibility that the individual, may change their mind on what outcomes they want through the course of the intervention.

The Safeguarding 'Enquiry' or SAR must be:

a) Person led and outcome focused
b) Ensure meaningful engagement with the adult and / or their carer
c) Identify the adult's individual needs
d) Offer choice and control to the adult.
e) Lead to improving the quality of life, wellbeing and safety of the adult.

14.2 The current position on the implementation of MSP in the Borough, is as follows:-

- South Yorkshire (SY) wide Safeguarding Procedures have been updated to reflect the Care Act's requirements and MSP. It has been based on a regional approach and there has been a delay due to the contracted providers, staff changes and issues with the contract which is being managed by Sheffield City Council, which has taken the lead for South Yorkshire. The policy and procedures have, recently, been the subject of consultation, across South Yorkshire Safeguarding Adults Boards. A multi - agency training plan is in draft and training will start upon publication of the SY Policy and Procedures, commencing in July 2015.

14.3 The project plans for embedding the new Adult Social Care model have been developed and take account of the requirements in the Care Act and MSP and implementation is in progress.

15.0 Information for staff, people who use care and support, carers and the public

15.1 Information for staff, people who use care and support, carers and the public should be made available in a number of formats. Information for staff should explain clearly, the following:

- Safeguarding multi-agency policies and procedures.
- What to do when staff suspect or encounter abuse and / or neglect.
- Information incorporated into staff manuals and handbooks.
- Information also detailed in terms and conditions of appointment and other employment procedures to ensure that each member of staff are aware of roles and responsibilities.

15.2 Information for adults, carers and the public should clearly explain the following:

- What abuse and neglect is
- How to raise a concern
- How to make a complaint
- That all concerns and complaints will be taken seriously
- Concerns and complaints will be dealt with independently
- That those affected will be central to the process and involved as much as they wish to be
- That they will receive help and be supported through the process or they can nominate an advocate or representative to act / speak on their behalf
- Their right to an independent advocate

15.3 The above requirements are embedded in the South Yorkshire wide procedures and processes for safeguarding adults. Training will be delivered to update the practice of staff. The culture & practice of Adult Safeguarding is changing and it will take time for the practice to develop.

15.4 The South Yorkshire wide procedures will be uploaded onto the BSAB Web page following consultation and sign-off by the Safeguarding Board and its constituent partners.

16.0 <u>The Designated Adult Safeguarding Manager (DASM)</u>

16.1 The statutory guidance accompanying the Care Act introduces Designated Adult Safeguarding Managers (DASM) in organisations concerned with adult safeguarding.

16.2 Each statutory member of the BSAB should have a DASM responsible for the management and oversight of individual complex cases and coordination where allegations of abuse or mistreatment are made or concerns raised about a person, whether an employee, volunteer or student, paid or unpaid. DASMs should keep in regular contact with their counterparts in partner organisations.

16.3 DASMs should be nominated individuals within:

- the local authority
- clinical commissioning groups
- police
- and other organisations, where agreed locally.

The local authority will need to establish a post to undertake the role of DASM.

16.4 The DASM is responsible for:-

- the management and oversight of individual complex cases
- co-ordinate incidents where there is an allegation of abuse or mistreatment made against a member of staff/ volunteer or student
- keeping in touch with counterparts in partner agencies
- highlighting how their organisation prevents abuse and neglect from taking place
- providing advice and guidance within the organisation
- liaison with other agencies
- monitor progress of cases and ensure they are dealt with in a timely fashion

- referrals to the Disclosure and Barring Service and other governing bodies including the CQC, General Medical Council, Nursing and Midwifery Council, or Health and Care Professions Council.
- Ensure systems are in place to support staff regarding investigations – ensuring there is no breach of rights to a fair trial (Article 6 of the European Convention of Human Rights)
- Recording systems are in place regarding decision making and recommendations
- Promote links with the LADO (Local Authority Designated Officer) for safeguarding children.

16.5 The LADO is based in the People Directorate's Safeguarding and Quality Assurance Service (Business Unit 2). The post is currently vacant and under review. As the roles of the LADO and DASM are broadly similar it is proposed to combine the roles into one post (*Please see Page 4, Paragraph 6.9)*.

17.0 The Role of Senior Managers, Chief Officers and Commissioners

17.1 Every organisation should identify a senior manager to take the lead role in organisational and inter-agency arrangements for safeguarding adults, including the BSAB. In order for the Board to be an effective decision making body, members need to be sufficiently senior and have the authority to commit resources and make strategic decisions. The BSAB is currently compliant with the statutory requirements concerning membership.

17.2 Statutory requirements recommend that Chief Officers should lead and promote the development of initiatives to improve the prevention, identification and response to abuse and neglect. Chief Officers should receive regular briefings of case law from the Court of Protection and the High Courts.

The Adult Social Care senior management team, the Executive Director and the BSAB receive briefings on case law from the Court of Protection and the High Courts on the reporting of Deprivation of Liberty Safeguards (DoLS).

17.3 Commissioners have the responsibility to assure themselves of the quality and safety of the organisations that they place contracts with and that those contracts have explicit clauses that hold the providers to account for preventing and dealing promptly and appropriately with any example of abuse or neglect.

17.4 Current contracts in adult social care contain requirements regarding Safeguarding. The specifications and contracts have been reviewed and updated for residential/nursing care and the contract has been updated. The specification and contract for Domiciliary Care is being reviewed and updated for tendering in April 2016 when the current contract comes to an end.

17.5 The processes for contract management have been reviewed and a more proactive system has been put in place for residential/nursing care homes which utilises an IT system already in use in other areas of the local authority. This will be rolled out to other contracts in adult social care.

18.0 Service Challenges Facing Adult Social Care and Safeguarding Adults

18.1 The Adult Assessment and Care Management Service is in the process of implementing and embedding a new operating model which commenced on April 13th

2015 whilst implementing the requirements of the Care Act including the changes in Safeguarding legislation and practice.

18.2 The delay in the publication of South Yorkshire wide procedures for safeguarding adults, means that the Service has had to take a pragmatic approach in dealing with safeguarding concerns and applying Care Act principles. More detailed multi – disciplinary training will commence in July 2015.

18.3 A project plan for phase two of the implementation of the operating model for Adult Social Care has been developed and is in progress which includes for example:-

- Workforce development
- Reviewing & updating policies and procedures
- Updating the 'Erica' system and other IT systems
- Developing the digital offer through a customer portal
- Developing performance measures for the new model

18.4 The new operating model is currently the subject of six month review. The outcomes of the review will be the subject of a separate report to Cabinet.

18.5 There remains considerable work to undertake to ensure that the service embeds the new operating model and the requirement of the Care Act. Many of the requirements will necessitate a fundamental change in the culture and practice of our services

19.0 Consideration of Alternative Approaches

19.1 This report outlines the local 'framework' in which activity aimed at safeguarding vulnerable adults and children and young people from abuse, exploitation, harm or mistreatment takes place. The approach taken is based upon legislation and statutory guidance which has helped the development of policies and procedures whose purpose is to provide the highest standards of protection and which take into account the choice of the individual.

20.0 Proposal and Justification

20.1 The Council's role, together with our partners in safeguarding vulnerable adults, children and young people accords with our Corporate Plan Priority of enabling such people to maintain their dignity, have the confidence and be empowered to achieve their potential without fear for their safety and to become active citizens in thriving communities.

21.0 Implications for Local People and Service Users

21.1 The local safeguarding framework provides assurance to our communities that the Council and its partners on both the BSAB and BSCB regards its mandate for ensuring the safeguarding and protection of vulnerable citizens, extremely seriously. Equally, all adults and children who are identified as being at risk of abuse or harm will continue to receive the support required in order to protect them.

22.0 Financial Implications

22.1 There are no direct financial implications arising from this report. Any associated financial costs arising from the development of an action plan which builds on the strengths and progress made so far and addresses areas for attention, will be

considered within the context of the resource envelope for People.

23.0 Employee Implications

23.1 An important element in safeguarding vulnerable adults, children and young people will be the development of a social care workforce equipped with the knowledge and skills to provide a high quality of service which is responsive and best meets the needs of service users. Improving the quality of professional practice is a cornerstone of our multi agency policies, plans and procedures *(Please also see Page 14, Paragraphs 29.1 – 29.2).* For example, a service review of the Children's Social Care Service is currently taking place which will help build resilience and support the local authority's responsibility to strengthen and improve statutory social work intervention for vulnerable children and families.

24.0 Communications Implications

24.1 No communications implications have arisen through the report.

25.0 Consultations

25.1 Consultation on the formulation of this report has been undertaken with the Cabinet Spokesperson (People – Safeguarding) and the Council's Senior Management Team.

26.0 Key Policy Considerations

26.1 Please see Paragraph 20.1 of the report.

27.0 Tackling Health Inequalities

27.1 Our policies and plans for safeguarding vulnerable adults, young people and children, including, for example, the elderly, adults with learning disabilities, victims of domestic abuse, children in care and care leavers, will help in ensuring their physical and emotional wellbeing is at the forefront.

28.0 Climate Change & Sustainable Energy Act (2006)

28.1 There are no implications for the Act emerging through the report.

29.0 Consideration of Risks

29.1 The framework for safeguarding vulnerable adults, children and young people will depend upon maintaining sufficient staff and resources. For example, in Adult Social Care Services, staffing numbers and skills mix have been developed using a combination of anticipated activity levels with Heads of Service input. This will need to be reviewed post implementation to ensure that the balance between the numbers and skill mix are appropriate to meet Safeguarding requirements and the new way of working.

29.2 There is a risk in the short term that the Adult Social Care Business Unit will not be able to deliver as effectively as expected during the transitioning period. This will be mitigated by robust stakeholder management, work force development and robust transition planning and monitored through the Business Unit 2 Operational Risk Register.

30.0 Health and Safety Implications

30.1 Staff in Adult Social Care are undergoing considerable change and there is a risk that staff will have anxiety and find it stressful developing the necessary changes to their practice having moved to new teams.

30.2 Managers will be alert to changes in staff behaviour and support them managing the change. Policies and procedures are being reviewed and updated to ensure staff are clear about their responsibilities. Training will be provided so that staff will be equipped with the knowledge they need.

31.0 Compatibility with the European Convention on Human Rights

31.1 The proposals are compatible with the Articles and Protocols of the Convention.

32.0 Promoting Equality, Diversity and Social Inclusion

32.1 The development of BSAB and BSCB policies, plans and procedures for the safeguarding of vulnerable adults and children, together with those developed on a South Yorkshire wide basis, are informed by an assessment of the needs of groups of people in the Borough who are protected under the Equality Act (2010).

32.2 Annual review of these policies, plans and procedures will be subject to an appropriate equality impact assessment as part of promoting equality and eliminating any potential or inadvertent discrimination in the treatment of adults and children in need of protection.

32.3 As part of the Council's Performance and Development Reviews policy and procedure for employees, all social workers will be encouraged to undertake appropriate equality related training to enable them to enhance their ability to identify and meet the needs of the above groups of people.

33.0 Reduction of Crime & Disorder

33.1 The Barnsley safeguarding framework will ensure that, through the provisions of The Care Act and our Tackling Child Sexual Exploitation Strategy and Action Plan, for example, no one should be subjected to abuse, harm or exploitation. Through multi agency partnership working, such plans will also help in identifying and bringing perpetrators to account.

34.0 Conservation of Biodiversity

34.1 The report has no implications for the conservation of biodiversity.

35.0 Glossary

35.1 None, applicable.

36.0 List of Appendices

36.1 There are no appendices to this report.

37.0 **Background Papers**

Background papers used in compiling this report are available to view by contacting the People Directorate, Barnsley MBC, PO Box 639, Gateway Plaza, Barnsley, South Yorkshire S70 9FH

Officer Contact:	Tel. No:	Date:
Tony Dailide (Interim Service Director: Business Unit 2 – Adult Assessment and Care Management Service)	(01226) 775650	October 23rd 2015
Melanie John Ross (Service Director: Business Unit 3 – Children's Social Care and Safeguarding)	(01226) 773665	

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Barnsley Safeguarding Adults Board

Annual Report

2015-16

Independent Chair's Foreword

Bob Dyson

I was appointed as the Independent Chair of the Barnsley Safeguarding Adults Board in April 2015. The decision had been made to move to an Independent Chair in recognition of the fact that Adult Safeguarding Boards had become a statutory requirement. Consequently this is the first annual report that I have been involved with.

I would like to recognise and acknowledge the work of the previous chair, Councillor Jenny Platts, together with board members. I have looked to build on the solid foundations that she had laid.

Soon after my appointment the board held a development day to identify what we needed to do next to take forward the work of the board and to implement the requirements of the Care Act. Together we developed an action plan that we have been working through during the last year. Actions taken include:

- Reducing the number of sub committees from five to two.
- Further improving the performance information received by the board in order that we can concentrate on the most relevant performance indicators.
- Undertook further work to ensure that there is a shared understanding of safeguarding across the partnership and of the Making Safeguarding Personal approach.
- Strengthened the reporting of activities in care homes in recognition that they are of particular public interest.
- Developed a joint approach with the Community Safety Partnership to establishing if individual cases require a Safeguarding Adult Review or a Domestic Homicide Review. There is now a joint executive panel which I chair that determines if any case referred meets the relevant criteria.
- Developed a communication strategy.
- Introduced a challenge process to the self-assessment completed by board members.
- Continued to monitor the strategy and action plan for the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Developed a three year strategy for the board and a business plan
- Revised the Memorandum of Understanding for board partners and their engagement in safeguarding adults in Barnsley.

My role as Independent Chair is to ensure that there is a commitment to agencies working together to keep people safe and that there is accountability and challenge within the working practices.

I am pleased to be able to report that I have witnessed a high level of commitment from partner agencies.

As we look ahead we recognise that there are challenges that we will meet including more work on the performance framework and agencies delivering services with reduced levels of funding. I am confident that there is a determination from the board to meet the challenges we face.

Contents

Introduction

This report looks at what the Barnsley Safeguarding Adults Board (BSAB) has done in the last year to safeguard adults at risk in Barnsley. During the year we have moved to new ways of working in accordance with the national guidance in the Care Act.

There continue to be high levels of public concern that vulnerable adults and older people are not always being protected from abuse and neglect - which we rightly have as our highest priority.

However, we also want to listen to what people want for themselves and making sure that they have as much control as they can over decisions that affect them in relation to safeguarding. We want to talk to communities and the general public and give them the chance to contribute to our thinking and planning.

In producing this year's annual report, we have tried to design it to appeal to a wider audience who have a professional or personal interest in adult safeguarding and want to know more about how it is led and managed in Barnsley.

It is important that we take the actions needed to ensure people are safe and well and, where possible, preventing abuse and neglect from taking place at all.

The key sections of this report include:

- What BSAB does and our vision and priorities
- Progress last year on implementing the Board's strategic plan through its sub groups
- What our partners have been doing to safeguard people
- Statistical information and case histories of people who have had experience of safeguarding
- Our plans for the year 2016/17

What is adult safeguarding?

The Care Act 2014 and associated Care and Support Guidance has for the first time provided a statutory framework for adult safeguarding.

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. There are many forms of abuse including physical abuse, domestic violence, sexual abuse, psychological abuse, financial abuse, discriminatory abuse and organisational abuse (e.g. in hospitals or care settings). The Care Act also includes self neglect, although it recognises that this will often be better dealt with outside the formal safeguarding enquiry process.

The Care Act guidance defines the aims of adult safeguarding as being to:

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs, i.e. those who would be eligible for social care support, even if not receiving it
- Stop abuse or neglect wherever possible and address what has caused the abuse or neglect.
- Safeguard adults in a way that supports them in making choices and having control about how they want to live.
- Promote an approach that concentrates on improving life for the adults concerned
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect.
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult.

In order to achieve these aims, it is necessary to:

- Ensure that everyone - both individuals and organisations - are clear about their roles and responsibilities.
- Create strong multi-agency partnerships that provide timely and effective responses to abuse or neglect.
- Support the development of a positive learning environment across these partnerships.
- Enable access to mainstream community resources and community groups that can reduce the social and physical isolation which in itself may increase the risk of abuse or neglect.
- Clarify how responses to safeguarding concerns deriving from the poor quality and inadequacy of service provision, including patient safety in the health sector, should be responded to.

The Care Act requires the local authority to make enquiries - or arrange for others to do so - if it believes an adult is experiencing (or at risk of) abuse or neglect. The Council therefore has a pivotal role in coordinating safeguarding arrangements. The police have a core role in any case where it is suspected that a crime has been committed.

Case Study: Person Living in the community and in receipt of support

Joan, who is in her seventies, lives in the community and is in receipt of support from a domiciliary care agency, providing personal care and dressing tasks, reminders to take medication, ensuring nutritional food and fluid intake is maintained, managing daily living tasks, maintaining skin integrity and preventing self neglect. Joan has a history of mental health problems and is in receipt of fortnightly injections to manage these.

Numerous concerns were received from partner agencies, including police, ambulance service, district nurses, home care, mental health and probation officers. These concerns were in relation to the potential risk of abuse from Joan's daughter, who lived with her and had her own mental health problems.

Joan did not find it easy to engage with her care staff, which increased the stress on her daughter of undertaking a caring role. The daughter was turning to drink, becoming verbally abusive and, at times, throwing objects around the house. Agencies were concerned about the risk of Joan being physically abused.

A safeguarding planning meeting was held to discuss the ongoing concerns, with all professional agencies involved. Visits were also carried out to speak to Joan in an attempt to ascertain her views and wishes. Unfortunately, she was not able to engage. Safeguarding staff were unable to invite her daughter - who was the source of risk - to the meeting due to her previous unpredictability. At the meeting it was recognised that there was a significant level of risk and that the home situation was volatile at times. However, Joan was considered to have capacity to decide what should happen and was aware of her surroundings and the potential risk.

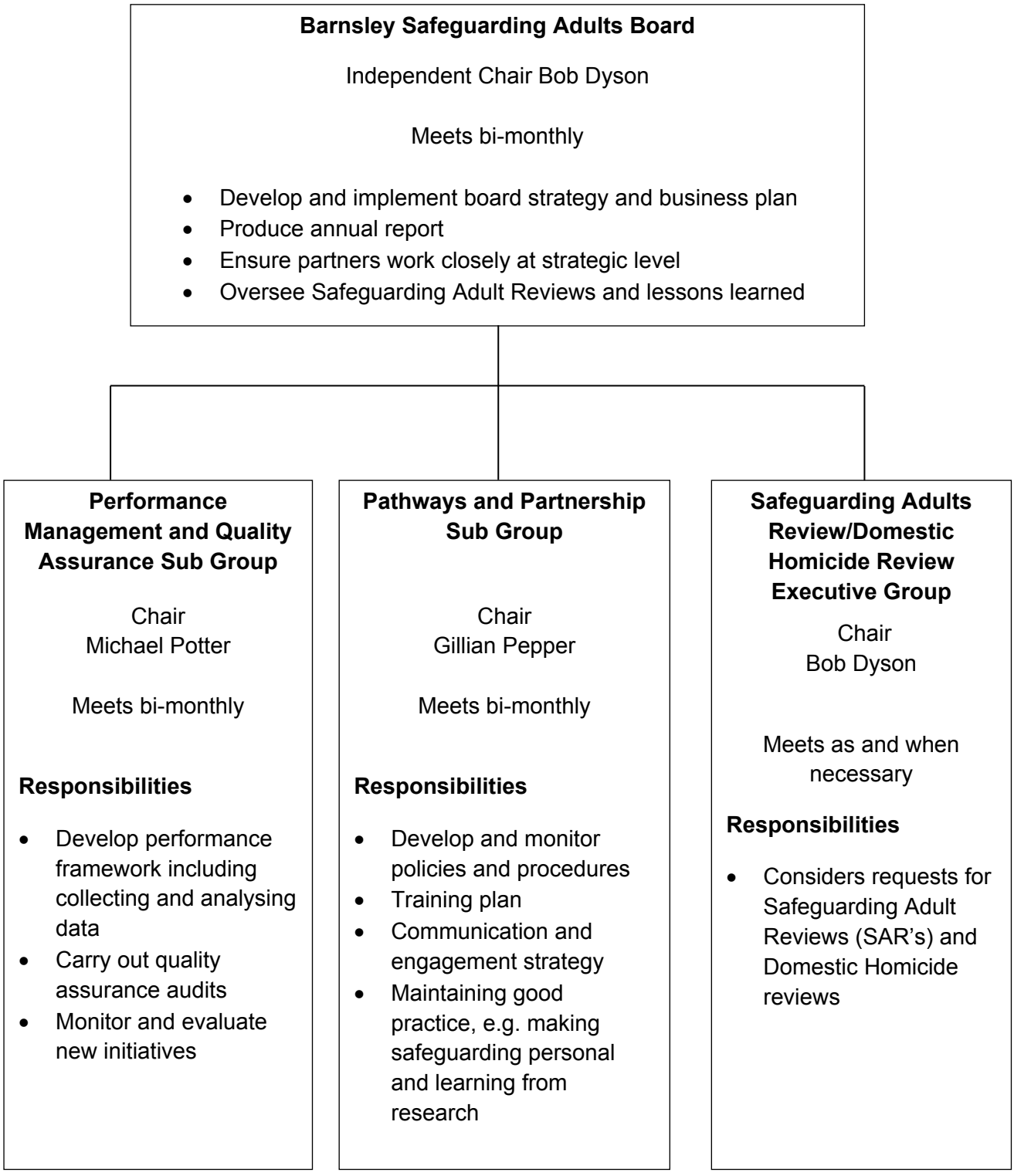
In an attempt to reduce the risk, agencies agreed to review the support they were providing and try to reduce Joan's daughter's caring role and the stress she was experiencing. It was agreed to assist her daughter to apply for rehousing. It was also agreed to coordinate agencies' input and reduce the number of duplicate referrals from outside agencies. Whilst it was difficult to reduce the risks in circumstances like these, effective partnership working was agreed to be the best way of doing so for this vulnerable adult.

Membership of Barnsley Safeguarding Adults Board (BSAB) – 2015-16

Note: Board members have often sent deputies if they cannot attend themselves. The percentage figures are for the main board member's attendance.

Name	Job Title	Organisation	Percentage of meetings attended
Bob Dyson	Independent Chair		100%
Councillor Margaret Bruff	Cabinet Spokesperson	Barnsley Council	100%
Rachel Dickinson	Executive Director	Barnsley Council	80%
Margaret Baker	Carer representative		100%
Michael Potter	Service Director	Barnsley Council	100%
Gillian Pepper	Designated Nurse	Barnsley Clinical Commissioning Group	100%
Tony Dailide	Interim Service Director	Barnsley Council	100%
Yvonne Butler	Safeguarding Adults Board Manager	Barnsley Council	60%
Katherine Allott	Family Intervention Service Manager	Berneslai Homes	80%
Alison Bielby	Deputy Director of Nursing	Barnsley Hospital NHS Foundation Trust	80%
Tim Innes	Chief Superintendent	South Yorkshire Police	60%
Julie Warren-Sykes	Assistant Director of Nursing, Governance and Safety	South West Yorkshire Partnership Foundation Trust	80%
Carrianne Stones	Manager	Healthwatch Barnsley	60%
Phil Briscoe	Assistant Principal	Barnsley College	40%
Dr Ken McDonald	GP	Barnsley Clinical Commissioning Group	60%
Brigid Reid	Chief Nurse	Barnsley Clinical Commissioning Group	80%
Denise Pozorski	Vice Principal	Northern College	60%
Judith Wild	Quality & Patient Safety Manager	NHS England	40%
Penny Greenwood	Acting Assistant Director	Barnsley Council	20%
Dawn Peet	Safeguarding Officer	South Yorkshire Fire and Rescue	50%
Maryke Turvey	Assistant Chief Executive	South Yorkshire Community Rehabilitation Company	20%

Barnsley Safeguarding Adults Board Structure



BSAB's vision and priorities

The Board's *vision* is that every adult - irrespective of age, race, gender, culture, religion, disability or sexual orientation - has a right to live a life free from abuse, neglect, exploitation and discrimination.

Citizens of Barnsley are entitled to a strong commitment from BSAB and its partner agencies to ensure that they are safeguarded. BSAB will do everything possible to maintain a robust and effective inter-agency safeguarding response directed at safeguarding and promoting the welfare of adults at risk in Barnsley.

The Board's *strategic priorities and outcomes* are as follows:

- Making Safeguarding Personal and supporting the adult at risk to achieve the outcomes they want.
- Preventing abuse and neglect from taking place and supporting people to feel safer.
- Making sure safeguarding works effectively.
- Making sure that all children who transition into adult services have their care and support needs met and are protected from further abuse and neglect.
- Making sure the Safeguarding Adults Board provides effective leadership and strategic direction for safeguarding in Barnsley.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a shift in culture and practice that arose out of a national initiative led by the Local Government Association in 2012/13 and cited as best practice in the Care Act Guidance. It links to the wider movement towards more personalised services and is about having conversations with people over how we can respond in safeguarding situations in ways that enhance involvement, choice and control, as well as improving quality of life, wellbeing and safety.

MSP requires changes in front line practice and strong leadership in order to embrace new ways of working that mean more positive risk taking. It is essential that all safeguarding interventions work to empower adults at risk and adopt a person-centred and outcome focussed approach.

BSAB is committed to embedding MSP in policy and practice, while recognising it is a huge change from how we have traditionally safeguarded people, which involved adhering to processes involving clear stages and timescales. Given that we have already seen how practice is changing in unforeseen ways, we now want to review our approach to MSP and bring in new local guidance to supplement the South Yorkshire adult safeguarding procedures. This also needs to be reflected in the multi-agency training and development programme.

Case study – Making Safeguarding Personal

Mrs L, aged 97 years, speaks a mixture of Polish and English and is widowed. She has four children who were in a dispute over her Lasting Power of Attorney (LPA) agreement which included all four children and enabled them to manage her financial affairs. Her sons wanted their sisters to be removed from the LPA and were putting pressure on their mother to action this. However Mrs L wanted her daughters to be the sole LPA and to manage her finances and property. This was because she was being financial abused by her sons who dealt with the majority of her correspondence and financial matters. It was found that there had been a number of high value transfers from Mrs L's bank account over the last six months. She did not want to involve the Police but wanted the assistance and support of social services to revoke the sons' LPA.

Council safeguarding staff arranged face to face meetings with a Polish interpreter without the family members being present in order to establish if Mrs L had capacity and to discuss the concerns that had been raised. During the meeting Mrs L was very distressed and crying, but also clear what she wanted to do. She had capacity and wanted to seek legal advice from a solicitor, which her daughters arranged and the social services agreed that a Polish interrupter would be present.

Under Making Safeguarding Personal, Adult Safeguarding was able to support Mrs L to decide what she wanted and to prevent further financial abuse, reducing risks and anxiety and acting in accordance with her wishes.

BSAB's wider links

BSAB has a reporting line to the Barnsley Health and Wellbeing Board, which formally receives this annual report. In addition, BSAB gives an account of its work to the Council's Overview and Scrutiny Panel, which has a key role in scrutinising safeguarding.

BSAB shares both its independent chair and some of its membership with Barnsley's Children's Safeguarding Board, with some issues being of joint concern, including domestic abuse, alcohol and substance misuse and the impact of mental illness. Some forms of abuse affect all age groups. In addition, we are able to share best practice in areas such as quality assurance.

BSAB has close links with the Community Safety Partnership (CSP), which has a remit to protect the wider community and reduce crime and disorder. The CSP's chair, Chief Superintendent Tim Innes, is also a member of the BSAB. We have agreed that the CSP will take the lead on some types of abuse, including hate and mate crime and domestic abuse. The CSP will also take a lead on the Prevent programme, which is a national initiative to tackle radicalisation.

Working with people using services and the wider community

One of the key changes in the Care Act is that local councils are expected to work much more closely with people using adult services and local communities, so that they have more say in how services are delivered. In relation to adult safeguarding, BSAB and its partner members are expected to engage with stakeholders, including adults at risk and their carers and advocates, community groups, and professionals involved in safeguarding, including front line practitioners and service providers such as hospitals and care homes.

It is a requirement that Healthwatch is represented on the Board and can use its voice to represent the interests of people using local health and care services. Healthwatch has excellent networks that we can tap into in working with people in Barnsley. However, we acknowledge that we have not done enough in the past year to involve people in our work who are outside the board and sub group structure and we need to do more, particularly in making use of our partners' networks. Given that last year we did not consult widely enough on BSAB's strategy and business plan; this year we are developing a communications and engagement strategy and actively exploring ways of regularly talking to service user and carer groups. In addition we have worked closely with Healthwatch to ensure this annual report is accessible to a wide audience.

We have had some feedback from Healthwatch on what their members and support networks think about safeguarding adults in Barnsley.

Healthwatch became aware that the deaf community needed support in understanding how they could better safeguard themselves and where to go if they needed support.
It was agreed to run an event supported by the Council and the CCG, which took place in March 2016 and 40 people attended. This looked at how we could set up training and support which would enable the deaf community and other vulnerable groups to use their networks to empower people to safeguard one another.

One man at the event stood up and talked about his own experiences of financial fraud, which had been ongoing for some time. He was not engaged with local services and was unaware that he was being taken advantage of until his brother noticed strange transactions on his bank statements.

This situation could have continued if it had not been for his brother stepping in to help him access support and an advocate. Perhaps this could have been identified earlier if more proactive awareness raising had been undertaken with the deaf community perhaps and this individual may have been better able to safeguard himself.

After the meeting, Healthwatch Barnsley called the charity Sign Health to ask if they had a BSL Communications video about what safeguarding is and how to keep safe. They were advised that this was not currently in their library and that they will consider creating this video.

Report on the work of the Board

The Board has strategic oversight of safeguarding and is responsible for producing the three year strategy (2015-18) and annual business plan. It has to ensure that the sub groups are achieving their objectives and working effectively.

As can be seen from the Board's membership (see page 7), partner organisations are represented at an appropriately senior level and attendance at board meetings is generally very good, showing a strong level of commitment.

A successful SAB development day was held in July 2015 which helped board members to set the strategic direction, but also to drill down into day to day practice by looking at a number of actual case studies.

The move to two sub groups has helped to ensure better attendance and more efficient use of people's time. However, it has been necessary to make use of time-limited task and finish groups in order to manage the workload.

In 2015-2016 Board partners completed a self-assessment tool so that the Board could assure itself that they were fulfilling their responsibilities in relation to safeguarding adults. The self-assessment process included challenge from the Board chair. For 2016/17, the self-assessment has been further developed to audit actions to prevent abuse and how they deal with low level safeguarding concerns that do not lead to a safeguarding referral.

The table below summarises the key board actions during 2015/16 and what progress was made.

Key action	Progress made
Appoint independent person to chair Safeguarding Adults Board	Bob Dyson (who was already chairing Barnsley Safeguarding Children Board) commenced duties in April 2015.
Review and consolidate sub group structure in order to make better use of capacity	The number of sub groups was reduced to two.
Revise and update memorandum of understanding with partner organisations and terms of reference of the Board and sub groups	These were approved by the Board in March 2016.
Hold Board development day	Event was held in July 2015.
Carry out a quality assurance exercise on partner's work in relation to safeguarding adults	A self assessment was completed by SAB partners and the chair held 'challenge' meetings.
Develop strategy and business plan in accordance with Care Act Guidance	This was signed off in March 2016 and has recently been updated for 2016/17.
Produce SAB annual report for 2014/15	This was published late last year.
Appoint Safeguarding Adults Board Manager	Post was filled on an interim basis in March 2016, with a permanent appointee starting in August 2016.

Pathways and Partnership Subgroup

Chair's report – Gillian Pepper

In July 2015 Barnsley Safeguarding Adults Board undertook a comprehensive review and made a decision to streamline the subgroups of the Board. Three of the groups were merged into the Pathways and Partnership subgroup, which met four times from its inception in September 2015 until March 2016. The subgroup meets on a bi-monthly basis.

The remit of the pathways and Partnership subgroup is to:

- Ensure that the voice of the adult at risk of abuse is heard
- Develop adult safeguarding policies and procedures and monitor their effectiveness
- Identify training needs, implement training and monito the effectiveness of learning
- Supporting the disseminating of learning from research
- Overseeing and implementing the Safeguarding Adult Board's Communication and Engagement strategy

The subgroup has been well attended, with all partner agencies represented, and has a consistent and committed membership. It has been a productive year with a challenging work plan. The subgroup acknowledges the progress to date, but also the need to keep up the momentum of activity next year.

One of the key priorities for this year was the launch of the revised South Yorkshire Adult Safeguarding Procedures and to ensure they were embedded across the Borough. The subgroup has responded to feedback from front line staff and revised the safeguarding adult concern documentation to make it more user friendly.

The group established the use of case studies at each meeting to facilitate learning for all agencies and this had proved successful in providing a foundation for discussion and challenge.

Vulnerable Adult Risk Management Model (VARMM)
The Board recognised the need for have a VARMM approach to support the risk management for vulnerable adults, in particular with regard to people who are at risk of harm as a result of self-neglect. The group has developed a VARMM policy and protocol. The plan is to take forward training and guidance for staff in the use VARRM to protect vulnerable adults.

Training

The need to have a workforce with the required competences related to their role is essential and has been one of the key pieces of work for the group. There is a considerable amount of training being undertaken and this is reported in Appendix 1. A task and finish group has been established to coordinate the production of a safeguarding adults training plan for next year.

Communication and Engagement

In order to prevent abuse and neglect from taking place and supporting people to feel safer we need to ensure people can access information and advice and we need to develop ways of engaging and involving communities and stakeholders. Also the communications plan informs service users, carers and the wider community about the work of the Board, its aims, objectives and achievements.

As chair of the Pathways and Partnership Group, I would like to thank all group members for their continued support and commitment in 2015-2016 and look forward to continuing the work next year.

The table below summarises what the sub group has delivered in the 2015/16 year.

Key Action	Progress made
Develop a safeguarding adults training plan	Work is underway to develop an adult safeguarding training plan modelled on the national competencies framework. The group are developing an implementation plan and identifying resource implications
Develop quality assurance process for multi-agency training	The group are developing a process and approach to evaluate the impact of learning and development to include both qualitative and quantitative evaluations and reflective accounts from staff
Audit what single agency training partners are delivering and carry out a training needs analysis	An audit has been undertaken on the current training activity and training needs analysis based on competences
Develop and implement a Safeguarding Communication and Engagement plan	A task and finish group has been established to progress the implementation of the plan Work is well underway to have a user friendly adult safeguarding website.
Consider the need for a keeping Barnsley Safe forum	Work with Healthwatch Barnsley has progressed to look at the how the Board engages with local forums already in existence. The proposal to establish a Keeping Safe forum has been progressed and a paper will be prepared for Board in the near future.

Performance Management and Quality Assurance Subgroup

Chair's report – Michael Potter

The main aim of the Performance Management and Quality Assurance Subgroup is to support the Board and partner organisations to recognise, monitor, report, respond to and reduce the risk of abuse.

The objectives of the Subgroup are:

- To develop a performance framework and collaboratively work with partner organisations to develop data collection methods and processes.
- To collect, collate, monitor, analyse, review and challenge performance in line with national data collection requirements, in order to inform strategic development and improve operational and professional practices.
- To submit a quarterly performance report to the Safeguarding Adults Board to enable transparency, accountability and opportunity for discussion and challenge.
- To undertake regular quality assurance audits and assessments of the effectiveness of the operation of the South Yorkshire Safeguarding Adults Procedures and of professional practice.

The subgroup meets bi-monthly and is well attended, with all partner agencies represented, there was initially a lack of consistent membership but this was resolved through the year.

It has been a challenging but productive year for the subgroup, acknowledging progress to date, but also the need to keep the momentum of activity in the coming year.

2015-16 has been particularly challenging due to the austerity cuts facing local government and the reduction in funding. In April 2015 Barnsley Council completed a reorganisation which resulted in the centralisation of performance and research and intelligence functions and also a change to information services. Staff with specific knowledge around safeguarding performance left the service and it took time for the new staff to familiarise themselves with the requirements. A programme of developing knowledge and skills around this has taken place over the last 12 months. There was also a period of time when there was no Safeguarding Board Manager which also affected the rate at which the subgroup was able to progress.

Performance Framework and Reporting

The key priority for 2015-16 was to fundamentally review and evaluate the existing performance framework and reporting processes. This review was undertaken to ensure that it was fit for purpose and Care Act compliant, particularly in regard to Making Safeguarding Personal.

The findings from this review highlighted a number of changes that were required to the performance indicators included in the framework and how they were being measured; the systems in place to capture and report the data required, and address concerns over data quality; the inclusion of performance data from care providers; the inclusion of benchmarking data and finally the inclusion of an explanation of what the performance indicators and data are actually telling us. The changes have enabled the subgroup and the board to highlight achievements and areas for further follow up investigation through task and finish groups.

Once the performance framework has been embedded for 12 months and direction of travel data is available, it will be possible to set realistic targets and benchmark much more widely than is currently taking place. The subgroup will also start to look at wider information from partners outside of the performance framework, to further widen the oversight of the group and the Board.

Multi Agency Audits

A task and finish group was established to look at the development of an audit tool but also to develop a programme of audits ready for 2016-17. The programme of audits has been put in place and the group will consider themed topics that maximise the opportunity for learning.

The Subgroup will receive and review the findings from the audits in order to quality assure the Barnsley safeguarding system; to share learning and good practice; and to inform developments in procedures, practice and training.

Single Agency Audits

Each partner organisation is responsible for undertaking audits and quality assurance of their practice and procedures in relation to safeguarding adults. These are now in place for Barnsley Council as the lead safeguarding agency.

As chair of the Performance Management and Quality Assurance Subgroup, I would like to thank all group members for their continued support and commitment in 2015-2016 and look forward to continuing the work next year.

The table below summarises what the sub group has delivered in the 2015/16 year.

Key Action	Progress made
Develop comprehensive performance reporting framework and address gaps in reporting, particularly of outcomes	Work was delayed due to organisational changes and lack of a board manager, but commenced in March 2016. A new performance report is in place and a task and finish group has been set up to address gaps and data quality issues.
Develop multi-agency quality assurance audits and single agency case file audits to monitor safeguarding enquiries	Multi-agency audits have been piloted and were successful and will now be rolled out with a programme of audits every 4 months. Council single agency safeguarding audits are being piloted.
Carry out reviews in areas of concern identified by the Board or highlighted in performance reporting	A review is taking place regarding the way concerns are raised by South Yorkshire Police and Yorkshire Ambulance Service.

Activity of partner organisations during 2015-16

This part of the report highlights what the BSAB partner organisations have been doing during 2015-16 in relation to adult safeguarding.

Developments during the year

A number of agencies, including the Clinical Commissioning Group (CCG), Barnsley College and Northern College for Residential Adult Education have reviewed or updated their policies or systems in the light of the Care Act guidance.

In April 2015 Barnsley Council implemented a new operating model. This led to all safeguarding concerns being received into a single point of access, the Customer Access Team (CAT). Initial enquiries are carried out by the CAT and known cases directed to the long term care teams. The new approach is designed to incorporate Making Safeguarding Personal , with its emphasis is on the service user's wishes and feelings and desired outcomes.

The Council contracts team strengthened its monitoring of care services, putting in place a performance management framework; routine contract monitoring; better links with the Care Quality Commission, the CCG and adult assessment teams; and attending safeguarding meetings when there have been issues with the service provider.

The CCG has used quality assurance visits and activity monitoring through a quarterly safeguarding dashboard to assure itself that health providers are meeting standards. The continuing healthcare team carried out 'safe and well' checks. In addition the CCG carried out joint assurance visits with Barnsley Council's contracts team, utilising the CCG's expertise in infection control and prevention, and medicines management. The CCG was also part of a new pilot scheme called 'React to Red' aimed at the early detection and prevention of pressure ulcers.

South West Yorkshire Partnership Trust (SWYPFT) has worked closely with the BSAB sub groups through its Specialist Advisor for Safeguarding Adults. It has used its risk management system known as Datix to enable its safeguarding team to oversee all incidents involving safeguarding.

Barnsley Hospital Trust (BHNFT) has streamlined its system for recording and reporting safeguarding concerns and developed a dedicated intranet page that contains all the safeguarding information, including Deprivation of Liberty Safeguards (DoLS), which staff require. There has been an increase in DoLS urgent authorisations as staff awareness and understanding has increased.

Berneslai Homes undertook over 4,500 proactive visits as part of their vulnerability strategy 'Something Doesn't Look Right', leading to nearly 2,500 supportive interventions, including a number of cases where there were adult safeguarding concerns.

Healthwatch has engaged with over 3,000 individuals regarding health and social care services, gathering comments on people's experiences and identifying what is or is not

working well. It has introduced online feedback to enable people to share their experiences of health and social care services. In the 12 months they made five referrals to adult safeguarding.

South Yorkshire Fire & Rescue Service has created a new safeguarding officer role, which contributes to the SAB's work and develops and delivers safeguarding training. During the year, the service dealt with 16 safeguarding cases in Barnsley, mainly relating to self neglect.

South Yorkshire Police introduced a safeguarding adult team in all districts, including Barnsley - working with high risk domestic abuse, serious sexual offences and offences relating to safeguarding adults. The Police have also worked closely with other key agencies in implementing the Crisis Care Concordat, involving changes to policy and practice to protect vulnerable people, including actions in relation to mental health and dementia. They have rolled out integrated offender management (IOM), which is intended to more effectively target those at highest risk of reoffending, in collaboration with the South Yorkshire Community Rehabilitation Company (SYCRC) and the National Probation Service.

Following an internal audit, SYCRC has refocused on medium risk work including adult safeguarding and revisited its policies and strategies in Barnsley, producing revised practice guidance and holding a practice development forum in February 2016.

Training

Appendix 1 contains a training review for 2015/16 written by the Council's Learning and Development Manager, Peter Sheldon. In addition, partners have focused on the specific priorities below.

The CCG supported General Practices with training, advice and support to practice safeguarding leads.

SWYPFT has ensured that all new staff and volunteers undertake level 1 safeguarding training and fulfilling an expectation that all staff have refresher training every three years. Over 90% of Barnsley staff have accessed Level 1 or 2 training.

BHNFT has taken steps to raise compliance with mandatory safeguarding training. It has identified as a challenge training staff in the Mental Capacity Act.

Berneslai Homes provided safeguarding training to frontline staff, including courses on hoarding.

Barnsley College staff are expected to attend mandatory safeguarding training and refresher training every three years. There has been a focus on implementing the Prevent duty in the further education sector, aimed at tackling radicalisation.

Northern College has provided over 200 safeguarding and Prevent training attendances at various levels for its staff team.

South Yorkshire Police has reviewed its mental health and vulnerability training in order to meet new minimum standards.

Issues arising during the year

All partner agencies report significant financial pressures as a result of the Government's austerity measures. These will inevitably have an impact on their ability to maintain service levels and provide financial support to BSAB's work.

As part of a review of the new operating model, the Council has decided to revisit the safeguarding customer journey to ensure that the business process is safe, efficient and as effective as possible, whilst remaining customer focused.

Berneslai Homes is facing challenges following the Housing and Planning Act. The measures introduced by the Government will dramatically reduce the amount of affordable social housing in Barnsley, reduce security of tenure, and create new financial pressures for families.

SYCRC has identified that more needs to be done in Barnsley to raise awareness and knowledge of Vulnerable Adults Risk Review Meetings (VARRM).

Safeguarding Adult Reviews

One of the new requirements of the Care Act is that SABs must carry out Safeguarding Adult Reviews (SARs) when an adult at risk dies as a result of abuse or neglect, or suffers serious harm, and where safeguarding policies or practice were not working as well as they should have been.

The purpose of these reviews is not to apportion blame, but to ensure that lessons are learned so that we can reduce the risk of these serious incidents arising in the future. There is a senior group that oversees both SARs and Domestic Homicide Reviews and linking to the SAB and the Community Safety Partnership. Where situations are reported that require some kind of review but not the full statutory SAR process, we will develop learning exercises that are less costly and time consuming.

This annual report is expected to give details of Safeguarding Adult Reviews that have been held during the previous year; however, none have actually taken place during 2015/16.

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Safeguarding Performance Data

Introduction

This section of the report provides detailed information relating to safeguarding activities dealt with by the council between 1 April 2015 and 31 March 2016.

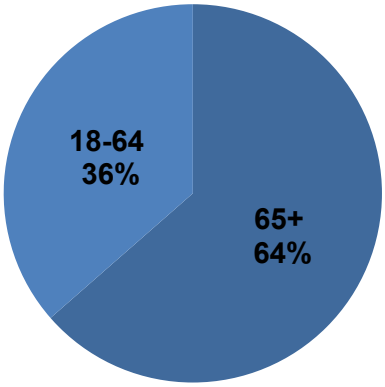
As highlighted elsewhere in the report, 2015/16 was a transitional year for the council, largely due to the introduction of a new operating model and the implementation of the Care Act and new South Yorkshire wide procedures.

To coincide with the introduction of the Care Act, the Health and Social Care Information Centre updated the requirements for the statutory collection relating to adult safeguarding. From 2015/16 onwards, councils are required to return a Safeguarding Adults Collection (SAC), which includes a number of changes from the previous Safeguarding Adults Return. One result of this is a loss of comparability with previous statutory returns, which impacts on our ability to benchmark our performance against that of our comparators. We expect the findings of the 2015/16 SAC to be published in the autumn of 2016.

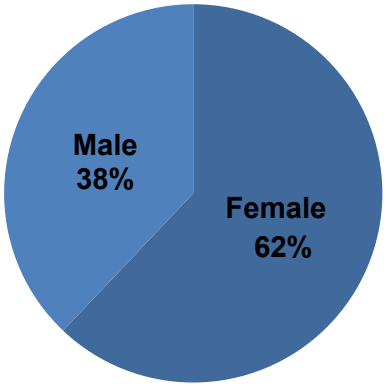
During the production of performance reports for the board, as well as this report, a number of data quality and process related issues have been identified. Critically, several gaps in case recording are highlighted in this report. A new case file audit process has been introduced which will provide further scrutiny on these issues. A customer focussed review of our operating model, including safeguarding, is ongoing and will help us to understand where we can make further improvements to processes.

Demographic information

Age Range of Concerns

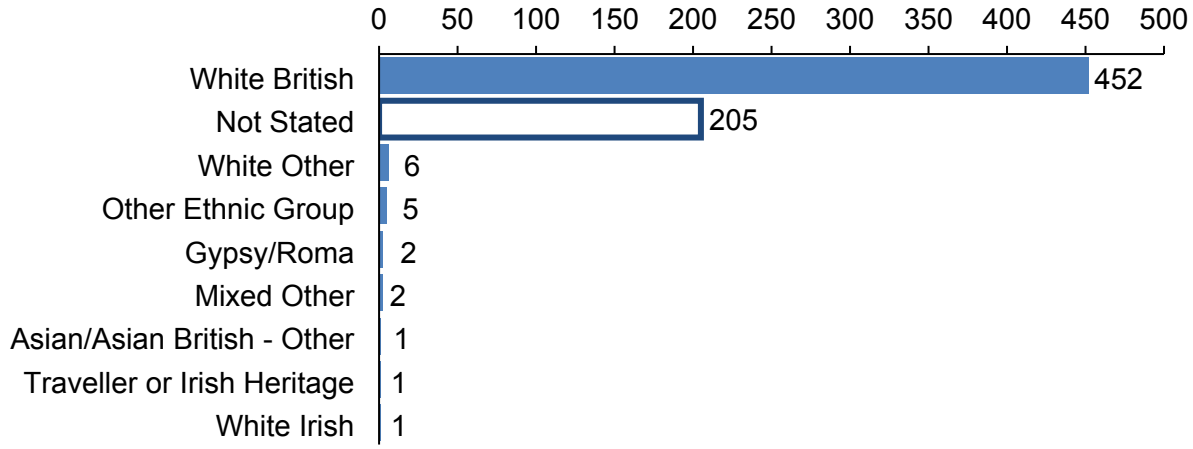


Gender of Concerns

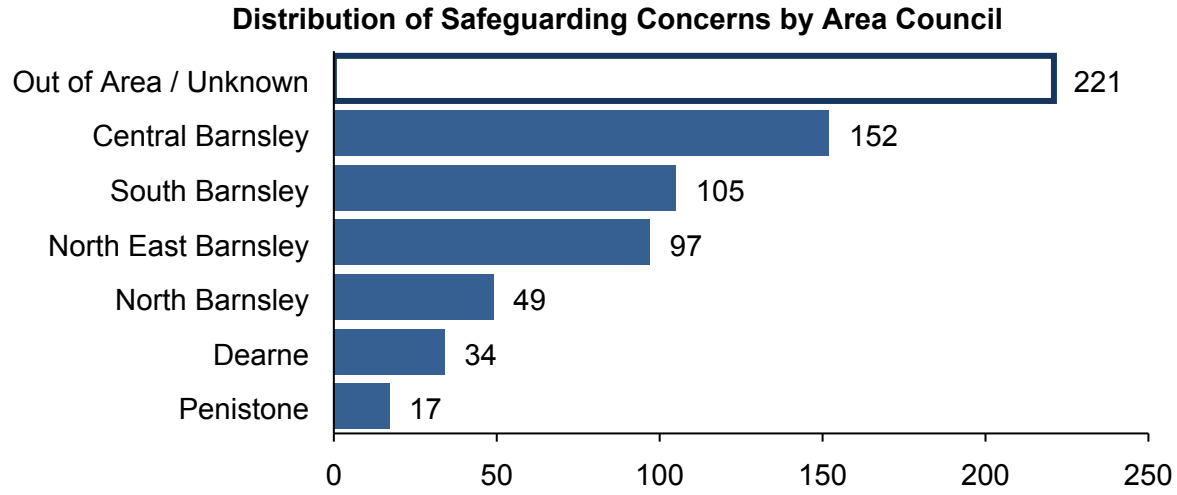


The proportion of safeguarding concerns the Council receives is heavily skewed towards the over 65 population. In 2015/16, 64% of concerns related to the over 65s, who only make up 23% of the Barnsley population; this is in line with the national average in 2014/15. We also receive disproportionate numbers of concerns relating to women, who made up 62% of all concerns, compared with 51% of the population. Again, this is broadly in line with national trends. A much larger proportion of concerns about women relate to those over the age of 65, with 71% (299) compared with 52% (134) for men.

Safeguarding Concerns by Ethnicity

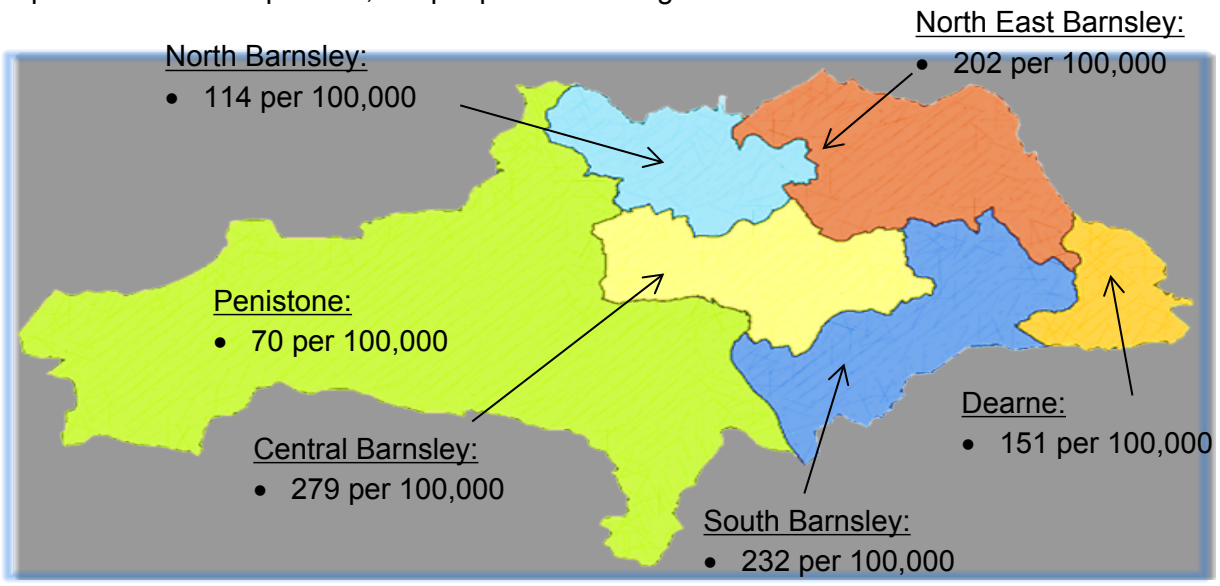


The vast majority (96.2% in the 2011 Census) of the Barnsley population are from a White British background. Excluding those concerns where ethnicity has not been stated, White British accounts for the ethnicity of 96.1% of all safeguarding concerns in 2015/16.

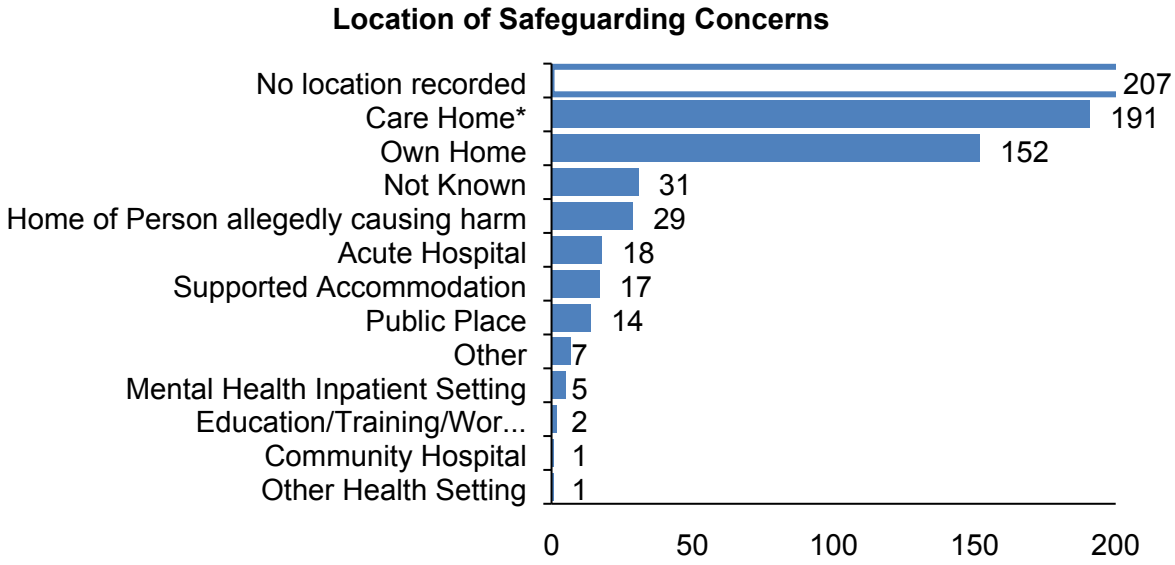


The chart above again highlights missing data in relation to safeguarding concerns, with out of area or unknown being the largest group; very few of which are likely to relate to individuals living outside of the borough.

The volume of concerns identified above is in line with the varying population sizes of the Area Councils. The only exception is the Dearne, which with a smaller population than Penistone has a higher number of concerns. This is probably a result of the significantly higher levels of deprivation in the Dearne area. The map below shows concern volumes expressed as a rate per 100,000 people over the age of 18:

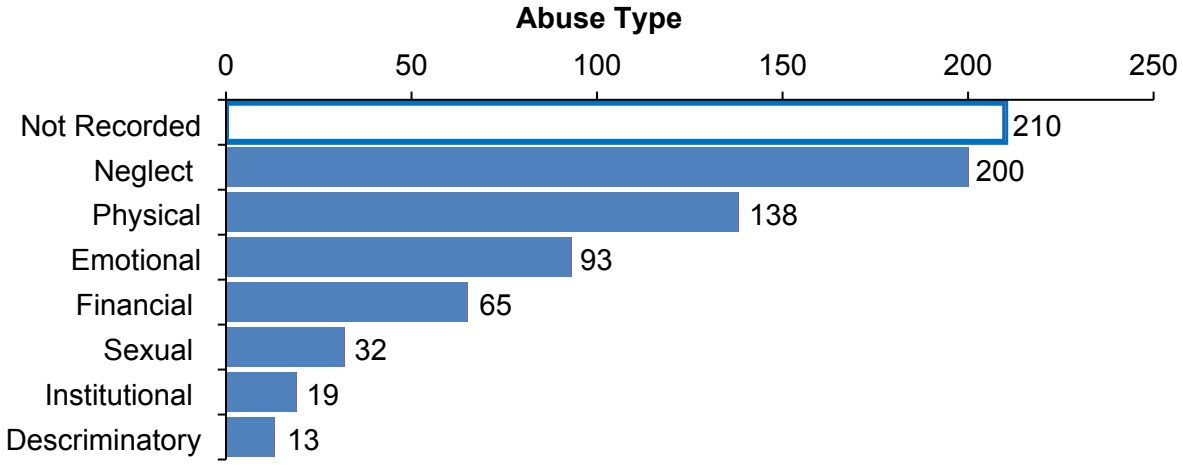


This shows that the Central Barnsley area has the highest rate of concerns, with Penistone having by far the lowest rate. There could be a number of factors influencing this pattern, including: location of care homes; concerns reported in public places; concerns reported by services based in or close to the centre of Barnsley. The three areas with the highest proportions of concerns have higher proportions of concerns relating to men between the ages of 18 and 64.



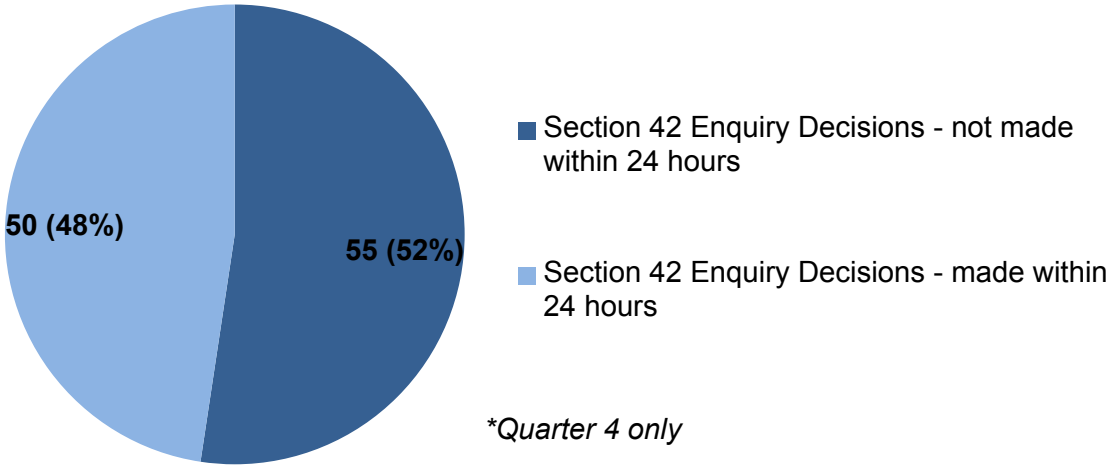
**Includes both permanent & temporary care home placements, as well as care homes with nursing*

Excluding concerns where a location was not recorded, the vast majority of episodes in 2015/16 took place in either a care home setting (41%), or in the victim's own home (33%). The most recent comparable national benchmarking information (2014/15) shows that 79% of all episodes fell into the same two categories, but with a greater proportion taking place in the victim's own home nationally (43%), rather than a care home setting (36%).



Where an abuse type was recorded, neglect was identified in 36% of cases, followed by physical abuse (25%). This corresponds broadly with the national picture in 2014/15. The remaining categories are also in line with the national picture, the only exception being that Barnsley appears to experience higher levels of emotional than financial abuse. These categories are reversed nationally.

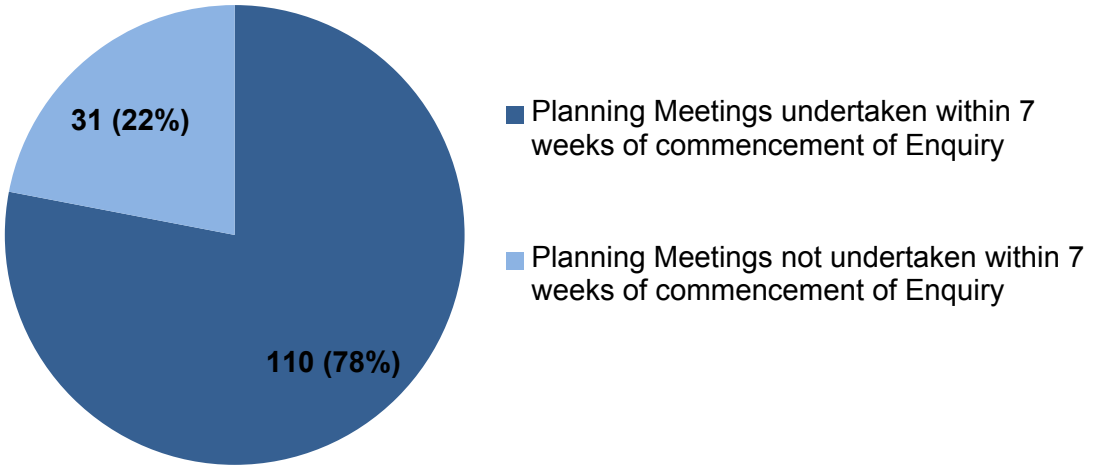
Safeguarding Timescales - Section 42 Decisions within 24 hours*



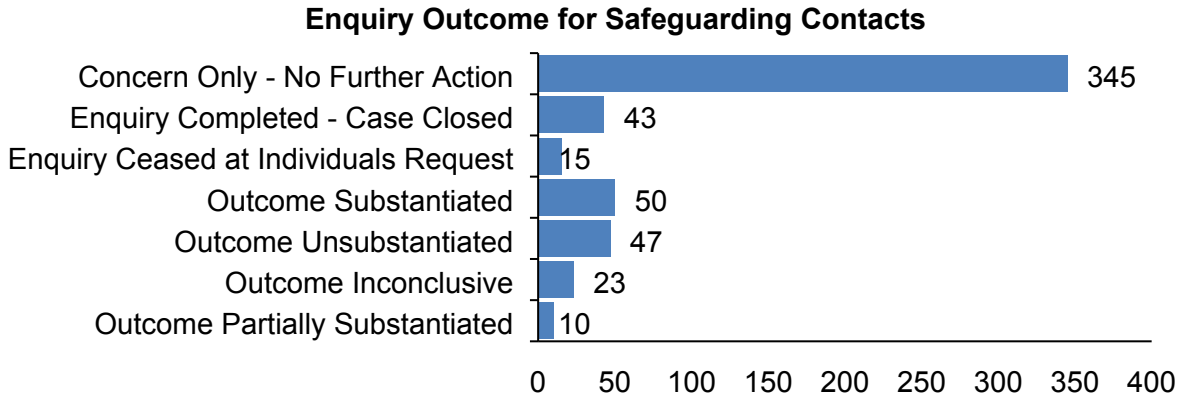
*Quarter 4 only

In accordance with the South Yorkshire Safeguarding Adults Procedures, we are expected to make decisions about whether to progress with safeguarding enquiries within 24 hours of receiving a concern. Due to issues affecting recording in this area, the chart above only relates to enquiries started in quarter 4 (January to March 2016). During this period, just 48% of decisions were recorded within 24 hours. However, the service was confident that most decisions were made within 24 hours, albeit not recorded in a timely way. The service has instructed safeguarding managers to record decisions when they are made and has set a corporate target for 100% of decisions to be made within 24 hours.

Safeguarding Timescales - Planning Meetings undertaken within 7 weeks of commencement of Enquiry

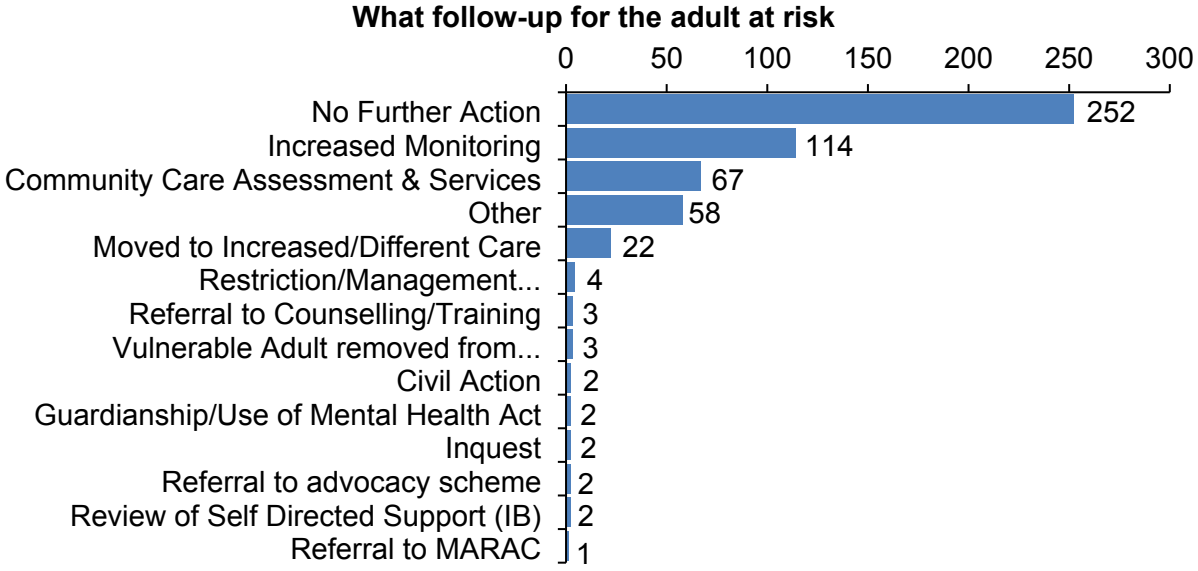


We are expected to hold planning meetings within 7 weeks of safeguarding enquiries commencing. The chart above shows that this took place in 78% of cases. Cases can be closed before a planning meeting, although it should take place early in the enquiry process.



When enquiries conclude, we record our main findings on closure, as summarised above.

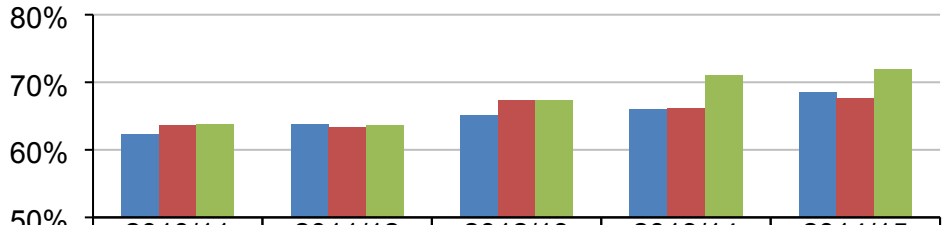
When, as part of the outcome, it was determined whether abuse had actually taken place, in 54% of cases this was either unsubstantiated or inconclusive. This is broadly in line with the national figure from 2014/15 of 51%.



We recorded what follow-up, if any, was provided to adults at risk on closure of the safeguarding enquiry. In 47% (252) of cases this was recorded as 'No Further Action'. There are inconsistences in the above data which will be considered as part of a forthcoming data quality exercise.

Adult Social Care Outcomes Framework – Domain 4: Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

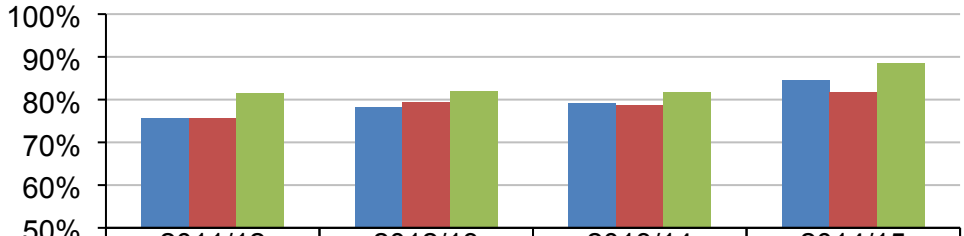
Proportion of people who use services who feel safe



	2010/11	2011/12	2012/13	2013/14	2014/15
England	62.4%	63.8%	65.1%	66.0%	68.5%
Yorkshire & Humber	63.6%	63.3%	67.3%	66.2%	67.7%
Barnsley	63.8%	63.6%	67.4%	71.0%	71.9%

As part of the annual Adult Social Care Survey, service users are asked about their feelings of safety. Responses to this question form part of the Adult Social Care Outcomes Framework; the chart above shows how perceptions of feeling safe have changed over the last 6 years. The figures presented demonstrate that service users in Barnsley experience higher levels of feeling safe when compared with the regional and national picture. Men have the highest levels of feeling safe in Barnsley, followed by the over 65s. The group feeling the least safe are those between the ages of 18 and 64, which corresponds with regional and national figures.

Proportion of people who use services who use services who say that those services have made them feel safe and secure



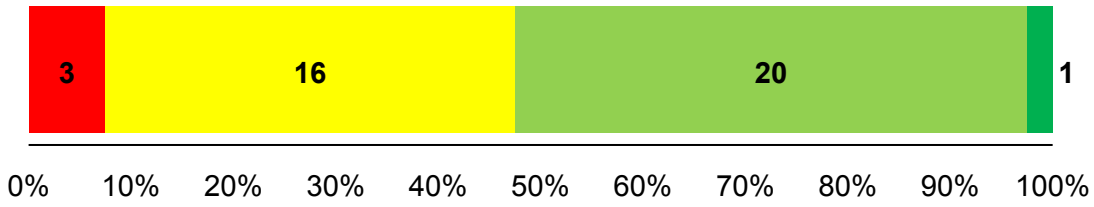
	2011/12	2012/13	2013/14	2014/15
England	75.5%	78.1%	79.1%	84.5%
Yorkshire & Humber	75.6%	79.4%	78.7%	81.8%
Barnsley	81.4%	81.9%	81.8%	88.5%

A further question in the Adult Social Care survey asks those accessing services whether they feel safer as a result of accessing those services. The chart above shows that service users in Barnsley have greater levels of satisfaction with services, when compared with the regional and national figures. Those aged 18 to 64 expressed the highest levels of feeling safer as a result of accessing services in Barnsley, with males and those over 65 experiencing the lowest.

Commissioning

Care Quality Commission Published Ratings

including contracted Domiciliary Care Provision



At the end of 2015/16, Barnsley had a total of 46 care homes for older adults, 14 of which included nursing. 48% of care homes were inspected under the new Care Quality Commission approach, with 19 rated either 'Requires Improvement' or 'Inadequate' at year end. Where the Council's contracts team are informed of a new 'inadequate' or 'requires improvement' rating, they take action with the provider, either through their performance management process or through an action plan.

The contracts team are now undertaking monitoring visits to care homes; with 26 completed to date. Homes have been visited and visits will continue throughout 2016. As a way of tackling quality issues, performance management meetings are now held on a monthly basis with good representation from agencies. These meetings share information and decide what collective action should be taken to support and improve care homes.

Issues raised through the Low Level Concern process

The Adult Joint Commissioning team received 65 notifications from professionals following visits to providers in 2015/16. The team used this data to identify patterns and escalate concerns for further action where appropriate.

At the start of 2015/16, professionals were required to identify areas for improvement following visits to providers and then expected to follow up improvement actions with providers, which presented challenges for some. The new process will be launched early in 2016/17 which allows professionals to raise concerns and associated actions, which are then sent to Adult Joint Commissioning, who will ensure actions are implemented.

Case study - care home for older people

This home has approximately 30 beds. Single safeguarding enquiries were started in November 2015 following a continuing healthcare review, which found concerns for a resident called John. These concerns included nutrition, support to eat and record keeping. A planning meeting was held and John's daughter was present. During the meeting it was evident that the home's management were unable to provide sufficient information on this man and the care of the other residents. A safeguarding plan was put in place to ensure the needs of John would be met by the home.

Formal performance management procedures across the whole home were commenced, this being the way the Council manage concerns about the quality of care. Further concerns came to light over the following week regarding the service being provided to other residents in the home. The provider's senior management were asked to meet with the council's contracts team and spent upwards of six months making the changes required to deliver a higher quality service to all the residents in the home. The home was taken into an overarching safeguarding process to ensure that all the residents were safeguarded, which has involved unannounced visits by the contracts team taking place to ensure that the home has maintained the changes required.

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

The Mental Capacity Act 2005 continues to provide a legal framework for taking action and making decisions on behalf of individuals (adults aged over 16 years) who lack the 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 Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards - called the Deprivation of Liberty Safeguards - are needed if the restrictions and restraint used will deprive a person of their liberty. These can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.

Care homes or hospitals must ask the local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation. There are six assessments which have to take place before a standard authorisation can be given. If it is given, one key safeguard is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend. Other safeguards include rights to challenge authorisations in the Court of Protection, and access to Independent Mental Capacity Advocates (IMCAs).

The Supreme Court made a landmark judgement in March 2014 (the Cheshire West ruling) and introduced a simplified test to determine whether someone is being deprived of their liberty.

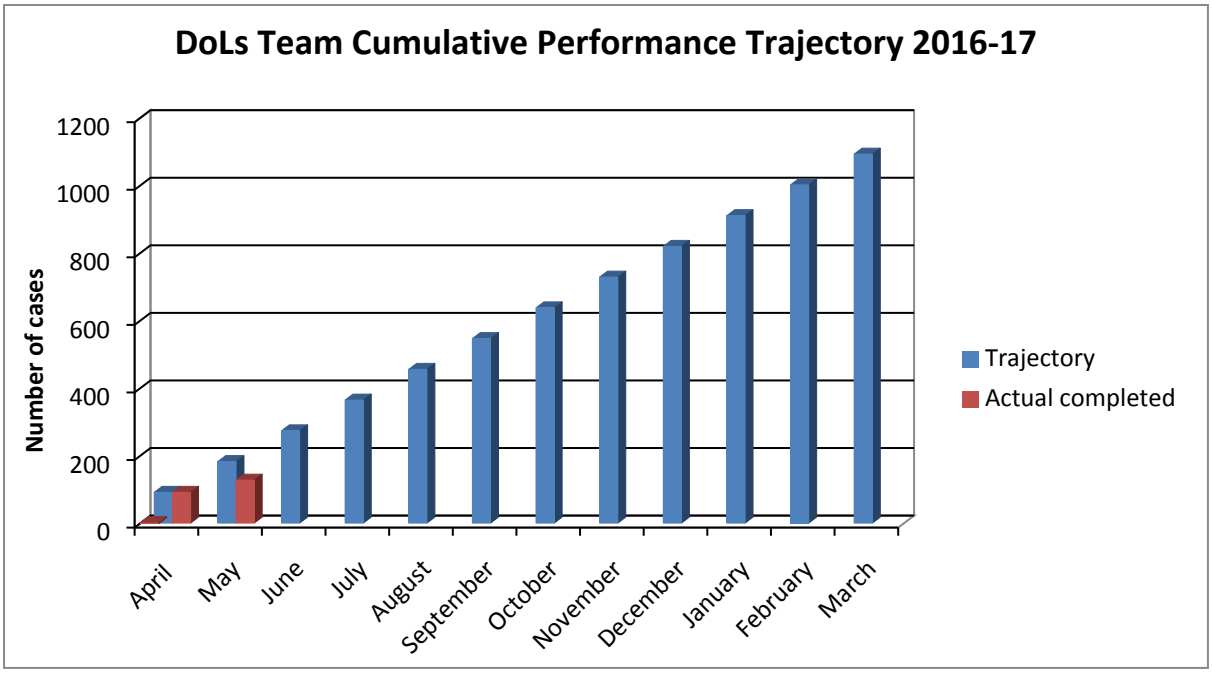
The ruling broadened the criteria of those deemed deprived of their liberty to the extent that in previous years the local authority received around 100 assessments each year; whereas between April 2014 and March 2015 over 750 requests were received. From April 2015 to March 2016 we have seen that total rise to 1085.

Supervisory Body	Number of applications received	Number of applications not granted	Backlog as at 31 March 2016	Number of cases requiring Court of Protection involvement
Barnsley	1085	150	302	19 ongoing with a further potential for 130

The increase in requests brought with it a backlog of cases, which at March 2016 stood at the 300 mark, posing a considerable legal risk. Assessors have managed to complete 107 cases, reducing the backlog by late May to 195. The workload is prioritised to ensure that those that cannot wait are dealt with first.

There is also increased activity in terms of applications to the Court of Protection for situations whereby an individual may be deprived of their liberty but not in a care home or hospital. This may include young adults in residential schools (age 18+), Shared Lives or Supported Living.

Barnsley has five full time Best Interest Assessors (BIAs), 31 trained BIA's, of whom 25 are currently practising. Even with these staff resources, the Council (in common with most other local authorities) will struggle to keep pace with the anticipated workload during 2016/17, as shown in the following chart.



Case study - use of the deprivation of liberty safeguards

Brenda is a lady in her eighties, who was admitted to a care home originally for respite, following an admission to hospital, at the request of her family. She has a diagnosis of dementia and a number of complex physical problems that mean she requires a high level of support. She is largely immobile and requires staff to assist her with washing, dressing, eating etc. and to regularly re-position her throughout the day and night, in order to avoid her developing pressure sores.

Brenda made it very clear at the outset that she wished to return home as soon as possible, but she was unable to understand the amount of support she required or the implications of returning home, or to remember that when at home before, she had previously complained of feeling lonely. Her family did not agree that she should return home.

Brenda was assessed as not having the mental capacity to make a decision about where she should live, due to her dementia, and was independently assessed under Deprivation of Liberty Safeguards and an authorisation made, enabling the local authority to decide – in her best interests – where she should stay.

Under DoLS, individuals have the right to a representative whose role is to represent their best interests. Brenda's advocate mounted a legal challenge so that the Court of Protection could decide whether she should remain in care or return home. After a thorough airing of the case, the judge determined that it was not in her best interests to return home because the complexity of her needs means that there would be too many risks.

BSAB's plans for the next 12 months until March 2017

The actions in this table are the most significant ones in the Safeguarding Adults Board business plan for 2016-17. This is an ambitious plan and we may not be able to deliver all these improvements during the year.

What we intend to do	By when
Devise new data collection methods and user surveys to monitor 'Making Safeguarding Personal'	March 2017
Carry out regular file audits (both Council and multi-agency) to quality assure frontline practice	June 2016
Review and refresh our approach to 'Making Safeguarding Personal'	March 2017
Audit how partner organisations prevent abuse and deal with low level concerns	September 2016
Develop framework and policies for people in positions of trust who pose a risk	December 2016
Update SAB communications and engagement strategy and develop new ways of engaging with stakeholders and communities	September 2016
Work with the other three local councils to ensure South Yorkshire Safeguarding Procedures are effective and up-to-date and develop local guidance in Barnsley Council	March 2017
Review use of thresholds to screen concerns and decide what needs a safeguarding enquiry	September 2017
Address gaps in our performance reporting so that the SAB has a good understanding of how well people are being safeguarded and can take action where necessary	March 2017
Carry out training needs analysis and develop safeguarding training plan, so that partners have a competent workforce	September 2016
Consider how to strengthen training, e.g. multi-agency trainer	September 2016
Monitor child protection incidence for young people in transition, to ensure they are protected while moving into adulthood	September 2016
Partner organisations to carry out self assessment on their safeguarding work, with SAB independent chair to hold challenge events	October 2016
Agree new safeguarding adult review protocol and develop methods for carrying out learning exercises	September 2016
Publish annual report for 2015/16 year	July 2016

Develop and launch SAB website as resource for partners, professionals and the public Review budget to pay for SAB's work and how much statutory partners contribute	July 2016 November 2016

Appendices

Appendix 1 - Training Review 2015/16

Safeguarding Adults Training

Across the Council, the NHS, the Police and many other major organisations there has been a lot of effort put into providing training for Safeguarding Adults.

The Council's Workforce Development service offers Safeguarding Adults training to their own staff, independent care providers and many other organisations and groups across the borough. They have been doing this very well for many years. Their basic 'Safeguarding Awareness' sessions are also useful for many other people even those not involved in health and social care work. As well as training people in a classroom style they also offer awareness training as an e-learning course or as a mixture of the two. The Council also works with the other South Yorkshire Councils to make sure the more detailed training is the same in Barnsley as it is in Sheffield, Doncaster or Rotherham.

Colleagues from Health currently deliver basic safeguarding and Prevent training. They offer classroom, e-learning and workbook training. The Police and Barnsley College also provide their own Prevent training. Prevent awareness is part of the government's counter-terrorist strategy to stop people from becoming radicalised. Some basic Safeguarding training delivered by our NHS partners is often shorter in length when it is aimed at staff who do not have much contact with the public.

The basic training provided across Barnsley is of a high quality. The more detailed training, which is often specific to people's job roles, is also of high quality. Unfortunately, there has been less opportunity to deliver the more detailed training this year and this has been mainly due to three things: -

- The arrival of the new South Yorkshire Procedures
- The Care Act and the new demands it made of organisations and people
- Making Safeguarding Personal

Safeguarding adults covers a great number of areas and all major organisations have being trying their best to ensure vulnerable people are kept safe right across the borough. This is why we are now providing courses on Domestic Violence, Hate Crime, Modern Day Slavery, Female Genital Mutilation and others. All the major organisations in the table below have been working together to make sure we have better information on what training is happening and ways in which we could make it better.

Over 10,000 people have taken advantage of some form of safeguarding adults training during 2015/2016. This is equivalent to 28 people being trained every day of the year across health and social care, the police, local colleges and housing organisations. This is a great achievement but now we need to look at continuing this good work, offering training to other groups of people and also creating a greater range of training.

Mental Capacity Act/Deprivation of Liberty Safeguards Training (MCA/DoLS)

The need for Mental Capacity Act training is extremely important to anyone who deals with service users or patients. To be able to decide if someone does or does not have 'capacity' to make their own decisions or not has always been a difficult area for workers in front line services. This training helps people

understand what we mean by capacity and how we can best deal with situations where they may be a doubt about it.

Deprivation of Liberty Safeguards training describes the legal processes involved in preventing someone leaving their place of residence for their own safety. This is particularly helpful to those working with people who may have problems with capacity or who have been assessed as lacking capacity to make decisions around their personal safety.

A great deal of training has been offered in these areas for health and social care workers and over 1,200 people have taken advantage of it. Most of the training offered is basic awareness either in a classroom setting or e-learning. But there is also training available on record keeping and how we make sure that information we write or record is not only clear and truthful but is in line with what the Mental Capacity Act requires.

Providing training on Mental Capacity Act and the Deprivation of Liberty Safeguards is an important part of Safeguarding Adults and both the Council and the NHS in Barnsley have made this training high priority for their staff.

Peter Sheldon
Learning and Development Manager, Barnsley Council

For the tables below please use the following key: -

** Independent Care Providers includes PA's*
*** Higher Education Institutes, Police, Probation, Berneslai Homes and other local authorities*
**** BHNFT = Barnsley NHS Foundation Trust*
**** SYPFT = South West Yorkshire Partnership NHS Foundation Trust*
***** B/College = Barnsley College*

MCA/DoLS TRAINING ATTENDANCE ANALYSIS (April 2015-March 2016)

Course	BMBC	Indep Sec(*)	Health Orgs	Other(**)	BHNFT	SWYPFT	B/College	Berneslai Homes	Police
BMBC face to face MCA/DoLS Related Training	144	489	52	30	246	11	0	0	0
NHS face to face MCA/DoLS Related Training	0	0	0	0	68	168	0	0	0
NHS e-learning MCA DOLS Training	0	0	0	0	43	25	0	0	0
Totals	**144**	**489**	**52**	**30**	**357**	**204**	**0**	**0**	**0**
Grand Total	**1276**								

SAFEGUARDING ADULTS TRAINING ATTENDANCE ANALYSIS (April 2015-March 2016)

Course	BMBC	Indep Sec(*)	Health Orgs	Other(**)	BHNFT	SWYPFT	B/College	Berneslai Homes	Police
BMBC face to face Safeguarding Related Training (all levels)	263	605	61	12	0	66	13	22	0
BMBC e-learning Safeguarding Related Training (all levels)	42	82	0	0	0	0	0	0	0
NHS face to face Safeguarding Related Training (all levels)	0	0	0	0	610	830	0	0	0
NHS e-learning Safeguarding Related Training (all levels)	0	0	0	0	685	724	0	0	0
Police face to face Safeguarding Related Training (all levels)	0	0	0	0	0	0	0	0	20
Barnsley College face to face Safeguarding Related Training (all levels)	0	0	0	0	0	0	747	0	0
Berneslai Homes face to face Safeguarding Related Training (all levels)	0	0	0	0	0	0	0	47	0
Face to Face and e-learning Prevent/Channel Training (all organisations)	1849	0	4	2	1418	402	1878	48	0
Totals	**2154**	**687**	**65**	**14**	**2713**	**2022**	**2638**	**117**	**20**
Grand Totals	**10430**								

Appendix 2 - Useful Links

How to report abuse
https://www.barnsley.gov.uk/services/adult-health-and-social-care/keeping-safe/report-adult-abuse/

Barnsley Safeguarding Adults Board
https://www.barnsley.gov.uk/services/adult-health-and-social-care/keeping-safe/barnsley-safeguarding-adults-board/

Link to South Yorkshire Adult Safeguarding Procedures
https://www2.barnsley.gov.uk/media/3810435/south_yorkshire_procedures.pdf

Care Act 2014 – Care and Support Statutory Guidance
https://www.gov.uk/guidance/care-and-support-statutory-guidance

Financial Abuse 'Under the Radar'
https://www.citizensadvice.org.uk/about-us/how-citizens-advice-works/media/press-releases/financial-abuse-going-under-the-radar/

Social Care Institute of Excellence (SCIE)
http://www.scieorg.uk/

Care Quality Commission
http://www.cqc.org.uk/

Healthwatch Barnsley
http://healthwatchbarnsley.co.uk/

Action on Elder Abuse
http://elderabuse.org.uk/

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annual report 2015-16

barnsley safeguarding children board

May 2016

Contents

Contact us through the Barnsley Safeguarding Children Board website
safeguardingchildrenbarnsley.com

Chair's foreword

I am pleased to introduce the Annual Report of the Barnsley Safeguarding Children Board (BSCB) for 2015/16.

Over the last financial year the board has continued to play a significant role in ensuring that improvements continue to be made to the arrangements for safeguarding children and young people in the Borough.

The board plays a significant role in monitoring the Continuous Service Improvement Plan that arose from the Ofsted Inspection in 2012 and is regularly reviewed to ensure it keeps pace with the changing environment. The plan features at every board meeting with members being encouraged to appropriately challenge, to identify new issues for the plan and to be satisfied that the intended action has been taken. The plan is a living document that has had many new actions added as the service and the board moves forward towards 'Good' and beyond. I have attended the Officer Improvement Group which drives the actions and I am satisfied that it is a robust process. I consider the Continuous Improvement Plan to be an area of good practice which BMBC and the public can take confidence in.

The board has had an impact in many other areas including:

- The creation of a task and finish group to explore the issues related to Female Genital Mutilation (FGM). This followed it being established that six patients in the Barnsley Hospital Maternity Unit had been found to have been the victims of FGM. The task and finish group developed a strategy and procedures. Subsequent audit of cases has found that the procedures had been followed in all cases.
- The board and Barnsley Metropolitan Borough Council submitted a joint letter to the Department for Education expressing our shared concerns at the current policies associated with Home Education. There has been a marked increase in the number of children being removed from mainstream schooling to be educated at home. Whilst the board fully appreciates that many of those will be receiving a full and planned education we are concerned that there are insufficient checks and balances to ensure that applies to all children and that they are being appropriately safeguarded.
- The board, and its members, signed up to a new county wide procedure dealing with the issue of children who go missing or absent. This gives much clearer instruction and guidance as to the action to be taken when reports are received.
- Child Sexual Exploitation (CSE) continues to be a priority for the board. During the year the CSE Strategy was revised and the action plan updated. More recently a new CSE Assessment Tool has been approved by the board.
- A Communications Strategy has been developed which will see much more information being proactively shared with the public, staff and other stakeholders. We believe that it is important that we continue to send out the message that Safeguarding is everyone's business.
- We continue to have a highly regarded training programme that delivers a wide range of training to individuals working with Children and Young People. The evaluation of courses is very positive.

- The board has continued to receive comprehensive performance data and has demonstrated that it is prepared to challenge when there are identified areas of concern. Many performance indicators have shown an improvement during the year.
- The board, and its partners, has signed up to changes in working practices at the front door of Children Social Care, the point where professionals and the public report any concerns. This has resulted in a significant reduction in the number of concerns being recorded which has allowed resources to be better targeted at those children, and families, that are in need of support. The number of children on Child Protection Plans has increased from 332 to 422 over the year which is seen as evidence that thresholds to access services are being applied more effectively.

During the year the board published three Serious Case Reviews; more details can be found on page 44 of this report. The cases were all published on the board's web site,

https://www.safeguardingchildrenbarnsley.com/

Last year, I expressed concern and disappointment at the reduced level of safeguarding self-assessments received from schools. I am pleased to be able to report a 100% return this year. The board recognises the hugely important role that schools play in the lives of children and young people including the vital role they have in safeguarding. It is therefore reassuring to get a full return.

Looking forward, we will see the establishment of a Multi-Agency Safeguarding Hub (MASH) during the summer of 2016. This will see staff from a range of agencies including Police Officers, Social Workers and Health staff working in the same building. This will be to the benefit of children and case management as they will be able to better share information and make joint decisions on actions to be taken.

In conclusion, I am satisfied that the board and its member organisations consistently demonstrate their commitment to keeping children and young people safe.

Bob Dyson QPM,DL
Independent Chair, Barnsley Safeguarding Children Board.

Introduction and local safeguarding context

Barnsley Safeguarding Children Board comprises of representatives from a range of statutory partners, who are passionate about promoting the safeguarding and welfare of local children, young people and families in Barnsley.

Our vision is that:

Every child and young person should be able to grow up safe from maltreatment, neglect, accidental injury/death, bullying and discrimination, crime and anti-social behaviour.

Children are entitled to a strong commitment from the BSCB and its constituent agencies to ensure that they are safeguarded. Where possible, this will be done in partnership with parents and carers, and by engaging the active support of the public. We will do as much as we can within the resources available to us and, with every agency providing services, we can maintain an inter-agency safeguarding system directed at safeguarding and promoting the welfare of all Barnsley's children.

We will endeavour to ensure that every child is safe, well cared for and thereby supported to fulfil their potential to make the transition from childhood to adulthood.

The board's prime responsibilities are:

- To co-ordinate what is done by each person or body represented on the board for the purpose of safeguarding and promoting the welfare of children in the area, and
- To ensure the effectiveness of what is done by each person or body for that purpose.

The board oversees work undertaken by partners to provide integrated services for children and families, with particular focus on safeguarding and promoting the welfare of children and young people.

This Annual Report provides:

- An outline of the main activities and achievements of the Barnsley Safeguarding Children Board during 2015 and 2016.
- An assessment of the effectiveness of safeguarding activity in Barnsley.
- An overview of how well children are safeguarded in Barnsley.
- Ambitions for future service developments and identification of key priorities.

Early Help and Family Centres

The emphasis of the work undertaken by the board and partners continues to move towards effective early intervention and prevention. Early Help services in Barnsley form part of the continuum of help and support to respond to the different levels of need of children and families. The way practitioners work together, share information, put the child and family at the centre, move swiftly to provide effective support to help them solve their problems and find solutions at an early stage is at the heart of a strong Early Help approach.

It is recognised that Early Help is everyone's responsibility across the partnership. There is commitment at all levels to work more closely together to build upon what we do for and offer to children and families. The focus of the work over the last period has been to

strengthen understanding of the approach across the partnership ensuring that the shift to Early Help is embedded and is sustainable. Barnsley's whole family approach to working with families continues with the implementation of the Early Help Assessment.
Family Centres deliver integrated services for children pre-birth up to 19 years (or 25 years if the young person has a disability) offering a variety of provision according to the needs of local families. Family Centres bring together practitioners from a range of universal, targeted and specialist services in each local area including schools, police, social care, private and voluntary sector and some adult services. Services delivered will vary in each area depending on the needs of families and the wider community.

Early help services are co-ordinated and delivered through Family Centres and:

- Support children to be ready for school and thrive in school
- Support parents and carers to develop their parenting skills
- Support parents and carers to develop personal skills, access training and education and enhance their ability to access employment
- Support parents and carers to keep children safe
- Help children to achieve their full potential and reduce inequalities in their health and development
- Support the development of healthy lifestyles for children
- Support families to build their own resilience

Services for adults play an essential role in our early help approach as these can impact on adults parenting capacity and family life. Some adults have additional needs which can impact negatively on family life if not supported. Services which predominantly work with either children and young people or adults need to adopt a 'think family' approach to secure better outcomes for children, young people and families with additional needs, through co-ordinating the support they provide.

Local relationships

The board is strongly committed to further strengthening its relationship with other strategic partners, including the Children and Young People's Trust Board, the Health and Wellbeing Board and the local strategic partnership, 'One Barnsley'.

The One Barnsley Board, of the Local Strategic Partnership (LSP) is responsible for agreeing the overall strategic direction for achieving the economic and social wellbeing of the Borough, the vision and objectives are outlined in the following two strategies:

- Barnsley Health and Wellbeing Strategy (2013-16) - responsibility for delivery rests with the Barnsley Health and Wellbeing Board

- Barnsley Jobs and Business Growth Plan (2014-17) responsibility delivery with the Barnsley Economic Partnership

The role of the One Barnsley Board is to provide co-ordination and coherence across these two principal partnerships and to challenge partners in both partnerships, ensuring their performance contributes to the successful delivery of outcomes.

To affirm all these relationships, the board has approved a protocol covering governance arrangements and the degree to which they enable partners to assess whether they are fulfilling their statutory responsibilities to help, protect and care for children and young people. The board

also articulates clear improvement priorities in its Business Plan, with actions to accomplish improved outcomes.

A chart of the structural relationship between the BSCB and its strategic partners is shown on page 12.

To ensure effective safeguarding and child protection, the BSCB operates under an up-to-date information sharing agreement to which all partners are signed up, however this policy will need to be reviewed over the course of this year.

Local demographic context

Barnsley is part of a broad South Yorkshire conurbation located around traditional community bases of former mining and market towns. The latest data from the Office for National Statistics (ONS) (2014) shows the population of those under 18 years is approximately 21% of the total population at 49,600 (ONS Mid-Year Estimates 2014) and is expected to increase by approximately 4% by 2020 to 51,700. The predicted population increase has implications for increased demands on all services, including those providing child and family support. The School Census (January 2016) shows that 8.4% of primary school pupils and 6.0% of secondary school pupils are from minority ethnic origins.

Growing Up in the UK report (2013) recognises a link between infant mortality and deprivation; those born to the most deprived parents have a higher infant mortality rate per 1,000 live births compared to babies born to the least deprived. The Public Health Outcomes Framework (2016) shows infant mortality rates at 3.4 deaths per 1,000 live births. This is lower than the regional and national averages of 4.3 and 4.0. The Index of Multiple Deprivation 2015 ranks Barnsley as the 39th most deprived local authority in England.

Women living in deprived areas are more likely to smoke during pregnancy than their more affluent neighbours (Graham, 2003) with smoking in pregnancy being a major contributor to increased infant mortality in England (Public Health England, 2013). The rate of women smoking during pregnancy in Barnsley is 20.4% of the maternal population; this is higher than regional average of 15.6% and national average of 11.4% (Public Health Outcomes Framework 2016).

In Barnsley, unemployment is higher than national average for those aged 16-64 years; 6.0% compared to 5.1% nationally (Modelled Annual Population Survey, 2015) and the rate of children living in out-of-work benefit claimant households aged under 19 years is 21.5% (Department for Work and Pensions, May 2014 and 2014 Mid-Year Estimates). This is higher than the national rate of 17%. Child poverty in Barnsley is higher than the England average, with 23.8% of Barnsley's children under 16 years living in low income families according to the Children in Low-Income Families Measure (previously the Revised Local Child Poverty Measure or National Indicator) compared with an 18.6% national rate (HMRC, 2013).

The ONS's study into teenage conception rates in England found that rates were highest in the most deprived areas (ONS, 2014). The latest data shows Barnsley's teenage pregnancy rate is 36.3 per 1,000 of the population (ONS, 2014). This is higher than the national and regional averages of 22.8 and 26.4.

Nationally, individuals with a low level of educational attainment are almost five times more likely to live in poverty than those with high levels of education (Household Income and Expenditure

Analysis, ONS, 2014). Although educational attainment continues to improve in Barnsley, results at age 16 remain below the national average in relation to the proportion of children attaining 5 A* to C grades at key stage 4, including English and Maths (49.6 % compared to 53.8%, Research & Business Intelligence Team, 2015).

Children from deprived backgrounds are more likely to have complicated health histories over the course of their lifetime, including a lower life expectancy; professionals live on average eight years longer than unskilled workers (ONS, 2011). In Barnsley, life expectancy is slightly lower than the national average, with an expectancy of 78.4 for males and 81.8 for females compared to 79.5 and 83.2 nationally (ONS 2012-2014). However, there is a significant inequality in life expectancy across the borough, with those living in the wards with the highest levels of deprivation dying on average 6 years sooner than those in the least deprived wards (Public Health England 2012-2014).

Coordinating local work to safeguard and promote the welfare of children

Governance and accountability

The Board has six planned business meetings each year, together with additional sessions, to allow time for member development and reflection on specific issues. Special meetings are convened when required, for example to receive the findings from Serious Case Reviews or discuss key member financial contributions.

To promote optimum focus on priority issues, the board revised its sub-committee structure in 2012. These arrangements were largely retained in 2013-14, 2014 -2015 and 2015 - 16 with the addition of two new sub-groups with direct reporting lines to the board in recognition of emerging priorities relating to child sexual exploitation/missing and services to children with disabilities and complex health needs. The current subcommittee structure will be maintained for 2016/2017. The terms of reference and the membership for each subcommittee will however be reviewed over the course of the year and task and finish groups will be established to help progress some subgroup priorities, for example; Female Genital Mutilation (FGM).

The current sub-committee structure, as depicted in Appendix 1, provides for focus on our priorities and promotes activities aligned to the board's statutory functions. The functions of the sub-committee and sub-groups, which all meet at least six times a year, are:

Performance, Audit and Quality Assurance Sub-Committee (PAQA)

- Provides oversight of performance management data, review of a rolling programme of audit activity and improvement to service quality

Policy, Procedures and Practice Development Sub-Committee (PPPD)

- Ensures that policy and procedures are current, implemented, embedded and reflective of practice

Workforce Management and Development Sub-Committee (WMD)

- Addresses all aspects of multi-agency safeguarding training including; evaluation of impact and reviews, aspects of workforce management

concerned with safer recruitment and supervision

Serious Case Review Sub-Committee (SCR)

- Oversees commissioning and management of SCRs, ensuring agencies are accountable for implementing recommendations and action plans and promotes strategic learning from local and national reviews, including Domestic Homicide Reviews. (A separate, independently chaired, Serious Case Review Panel is convened to review individual cases as required)

Child Death Overview Panel (CDOP)

- Examines the deaths of all Barnsley children, in accordance with statutory guidance and reports directly to the board

The CSE Strategy Group

- This group is responsible for the strategic development of Barnsley's response to CSE. This includes the newly refreshed CSE Action Plan and CSE Strategy. Progress is monitored by the group and scheduled audits in relation to CSE are conducted and submitted to the board.

  The multiagency CSE team currently operate as a CSE Multi Agency Safeguarding Hub which considers and agrees the level of CSE risk in each referred case. In order to do this they utilise an agreed CSE risk assessment tool. Once the risk has been agreed then they jointly agree the actions required and monitor progress against the actions.

Children with Disabilities and Complex Health Needs Sub-Group (CWDCHN)

- Provides more robust oversight under the board's governance and support to the increased vulnerabilities of this group of children and young people ensuring continued provision and a multi-agency response

  This structure provides the board with a mechanism for multi agency development and review of safeguarding practice ensuring existing and emerging priorities are identified and addressed. It also ensures a valued input from adult services in areas of mutual safeguarding concern such as domestic abuse, adult mental health and substance misuse.

  Communication between the board and sub-committees is strengthened through the regular Sub-Committee Chairs Briefing held before each Board Meeting. During the briefing each of the subcommittees escalates any areas of concern to the BSCB Chair which are flagged to the board for action. It is evident that partners increasingly feel confident to use respectful challenge as a means of improving services to children and young people. Briefings provide beneficial support to the sub-committee chairs and reinforce their relationship with the board and their responsibilities as Subcommittee Chairs. This meeting also helps to retain a focus on key priorities as explained below.

Focus on priorities

Each year, the board reviews its current Business Plan to identify success in achieving objectives and identify new priorities for next year. The BSCB Chair and the Sub Committee Chairs meet regularly to review progress and ensure that workload is managed and

implemented effectively, in line with the Business Plan. These meetings also consider emerging issues of interest or concern in light of the board's priorities.

When testing effectiveness the BSCB draws on both performance data and quality assurance activity that examines in detail the quality and effectiveness of front line practice ensuring a 'line of sight' to practice at the front line. All board members and specialist advisors have a strategic safeguarding role in relation to their own agencies. Accountability to local communities is promoted through the two lay representatives.

The BSCB provides a forum to hold partners to account and test effectiveness of multi-agency working to safeguard children. The BSCB 'holds the ring' on challenging performance providing a forum for partners to challenge across the piece.

Effective partnership working and relationships with strategic partners

The board's functions and responsibilities complement those of the Children and Young People's Trust and provide for leadership and ownership of safeguarding at all levels in the council and partners.

The Children and Young People's Trust, chaired by the Executive Director for People, secures the cooperation of partners to strategically plan and align service commissioning to improve children's outcomes. These arrangements encompass all strategic partners, with a focus on working together to improve the wellbeing, life chances and outcomes of every local child.

The BSCB refers to the Children and Young People's Trust matters that have commissioning implications. The chair of the BSCB escalates matters to the governance structures of partners and / or the Health and Well-Being Board where it is considered that agencies are failing to discharge responsibilities under 'Working Together' (2015).

Our high aspirations for children and young people, relating to their ability to secure optimum health, safety, educational attainment and contribution to their communities, recognises that families need support across the whole spectrum of services, including social care, education, health, police, voluntary organisations, safeguarding and other stakeholders.

Responsibility for establishing a secure continuous service improvement approach for children, young people and families rests with the Children and Young People's Trust and the BSCB.

The shared ambition of the Barnsley Children and Young People's Trust and BSCB is to go beyond Ofsted's judgement of 'requires improvement' and to deliver the best possible outcomes for local children, young people and families. This means collectively working together to deliver services which are judged to be at least good. In order to achieve this ambition services for children, young people and families will use the Continuous Service Improvement Framework.

The framework is made up of a number of dynamic elements. It is understood that it is the people (officers, elected members, non–executive officer, independent chairs) operating at different levels with different functions in their organisations who will make the children's system work effectively. This requires everyone operating within the system to discharge their responsibilities effectively and to be held to account. These elements include:

- The Children and Young People's Trust
- The Safeguarding Children Board
- Elected Member led challenge
- A Continuous Service Improvement Officers Group
- A Continuous Service Improvement Plan
- External Review and Challenge
- Culture of Respectful Challenge
- The Voice of the child
- Joint review of the framework.

At the annual joint meeting of the BSCB and the Children and Young People's Trust Executive Group (CYP TEG) held on 23 October 2015 key areas for discussion included: An understanding of the responsibility of both boards; the Continuous Service Improvement Plan; the combined risk register; further consideration of the ways in which both boards could work more effectively together in future to achieve improved outcomes, and enabled shared priorities.
The group identified the following key areas for joint development and focus:

- Keeping the needs of children at the centre of all activities.
- Keeping children safe.
- Early Help
- Improving Education, Achievement and Employability
- Tackling Child Poverty and Improving Family Life
- Membership roles and responsibilities
- Supporting all children, young people and families to make healthy lifestyle choices
- Encouraging positive relationships and strengthening emotional health
- Improving staff skills to deliver quality services

The Children's Plan is currently being refreshed for 2016-19

The Children and Young People's Trust Children and Young People's Plan 2016 – 19 will continue to recognise the nature and value of its relationship with the BSCB through its three main safeguarding priorities:

- Improving the safety of children by developing the engagement and focus of all partners via the BSCB.
- Increasing confidence and understanding of referral processes and thresholds
- Developing data use, information and quality assurance.

During the year, these priorities were progressed as the BSCB continued to hold individual agencies to account in discharging their responsibilities to keep children safe.

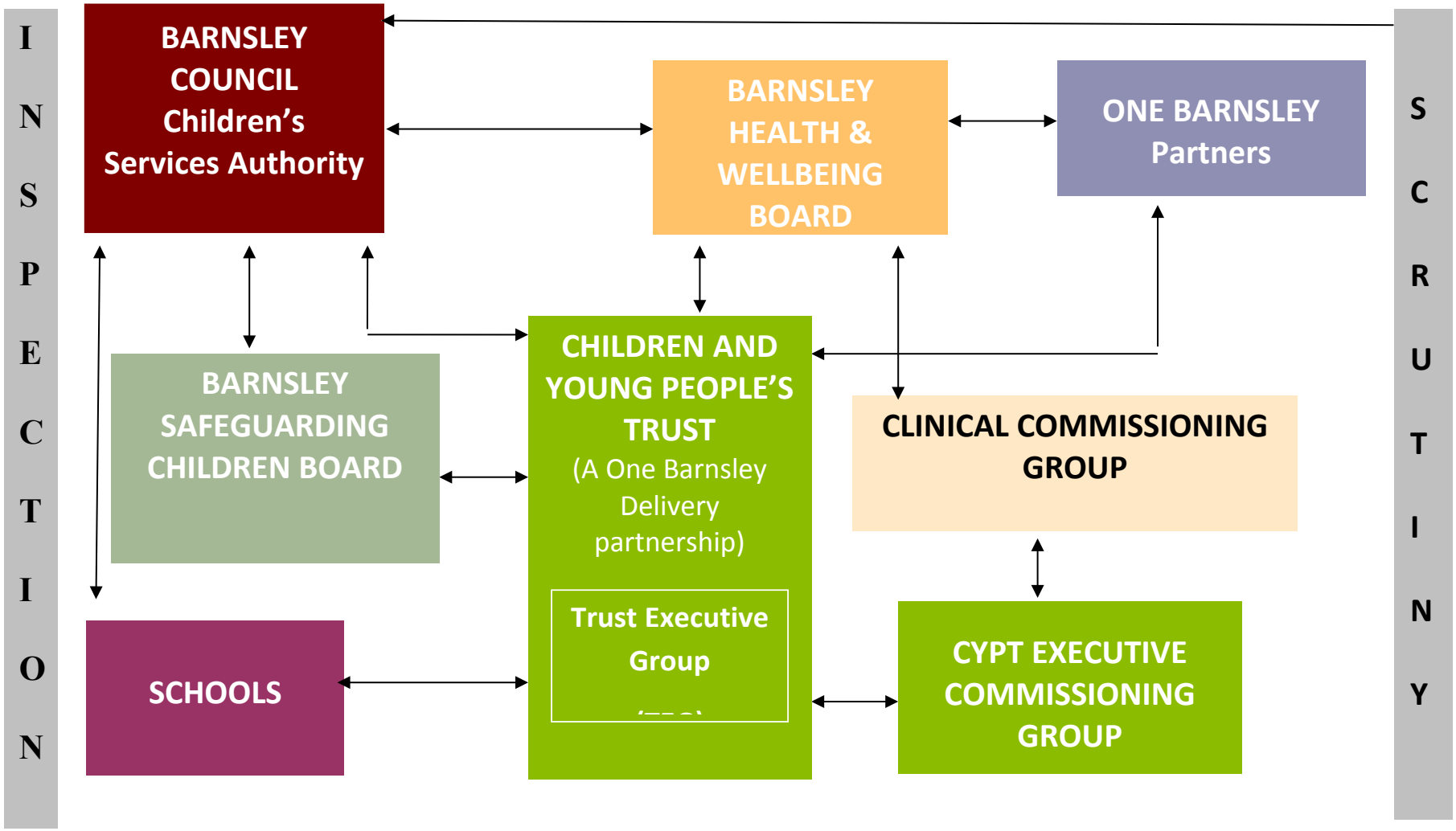
Through 2013-16, the Children and Young People's Trust and partners identified the following as continuing priorities:

- maintain oversight of and take forward actions from the Continuous Service Improvement Plan relevant to the BSCB
- To continue to improve performance management and quality assurance systems to ensure robust and continuous service improvement, supported by workforce development programmes to secure safe practice.
- Ensure that the board maintains a comprehensive overview of the work of partner agencies involved with safeguarding, including the voluntary sector.
- Ensure the implementation of actions within the Child Sexual Exploitation Strategy.
- Ensure all board members are up-to-date with changes in policies, guidance and practice to provide strategic direction and scrutiny of core

safeguarding and child protection processes and data, and provide effective challenge.

These were addressed as major priorities in the BSCB Business Plan 2014-15.

WORKING TOGETHER Partnership Groups



Progress on key priorities and achievements in 2015-2016

Last year's key priorities relating to the coordination of local safeguarding activity and promotion of children's welfare are set out below, with commentary on the extent to which they were achieved. More detail and examples of specific activities relating to each priority is contained in the sections of this report which outline the work of the subcommittees throughout the year.

Maintaining a strong commitment to continuous improvement and challenge through oversight and taking forward relevant actions from the Ofsted Improvement Programme and new governance structure

The board has maintained oversight of activity under the Improvement Programme though regular updates, Section 11 interviews, individual reports on particular areas of concern, and evidence from specific audit activity. The board has sought to encourage more open challenge during debates in order to secure service improvement and embraces its new role in monitoring the Continuous Service Improvement Plan under the direction of the Executive Director for People.

Continue to develop and refine our Performance Management Framework

The board is now able to secure systematic reporting of valid and useful KPIs, with sufficient contextual analysis to understand and identify improved performance across all partner organisations.

Address the increasingly high profile risk relating to Child Sexual Exploitation, (CSE) in conjunction with relevant partners

We have seen a problem profile which supports the current position that there is little evidence of organised CSE criminality in Barnsley, this is not to say that we do not remain alert to the possibility and monitor trends and events. Trends continue to be monitored and managed through partnership working.

A new risk assessment tool has been introduced for CSE which focuses the minds of practitioners on the signs they should be looking out for that may indicate that a person is vulnerable or subject to CSE.

We have reviewed the CSE strategy and associated action plan.

The Terms of Reference for the multiagency CSE team have been reviewed and operational guidance developed to support the work of the team and ensure that practitioners are clear of expectations and responsibilities.

The multi agency team has been strengthened by establishing the role of a specialist nurse within the team to share information and provide links to the broader health community by way of liaison and awareness raising and to take a lead role in direct work with young people where health implications arise from risks of CSE, in line with broader multi-agency plans for intervention.

Multi Agency Meetings have been established in relation to CSE which review and assess cases of CSE utilising all the information available from partners involved with the child and family of either the victim or offender. This ensures robust and effective risk assessment, management plans and progress monitoring to reduce the risk to the child.

- Regular Deep Dive Audits are undertaken in relation to CSE investigations.
- Ongoing work continues to be undertaken with Local Businesses in relation to raising awareness of CSE.
- Ongoing training specific to CSE continues to be delivered.
- Increased funding has been accessed to improve therapeutic support to those who have been subject to CSE.
- A new structure has been put in place to manage return home interviews of children who are reported as missing from home, this supports ongoing interventions and support for the child and seeks to identify with partners where children may be at risk of CSE and any persons who present a risk to children.

Going Forward:

- Continue to work as a partnership to support victims reporting CSE and to pursue and prosecute offenders.
- Undertake gap analysis to identify any professionals who require further training or awareness raising.
- Introduce an offender management tool that will help identify any offenders who present a risk in relation to CSE in order that they can be appropriately managed. Links with local offender management teams will be further developed to support this.
- Undertake a review of the problem profile to ensure that the CSE picture is up to date to ensure appropriate response and allow for planned preventative work.
- Establish full children's MASH to bring together children's front door assessment, investigators and CSE team to improve information sharing and multiagency working.
- Continue to work with the private sector to raise awareness of CSE.
- Improve links with minority ethnic communities to raise awareness of CSE.
- Establish a service directory for CSE to ensure that those working with victims of CSE are aware of what support is available.

Improve our learning from Serious Case Reviews

The SCR Sub-Committee has continued to disseminate learning through multi-agency training activity and specific single agency learning events in relation to SCR action plans. Action plans are monitored by the committee to ensure implementation of actions and an evidence bank to illustrate the changes to practice has been established. This work will continue next year as additional case specific action plans are completed in relation to ongoing SCRs. A priority for 2016/17 will be to develop more robust commissioning arrangements in relation to the commissioning of SCRs.

Continue to promote activities to mitigate the risks to children arising from domestic abuse, adult mental health, substance misuse and digital technology

These areas of safeguarding are progressed by the PPPD Sub-Committee. Maintaining oversight of all these vital areas, together with other emerging areas such as bullying, and promoting activities to mitigate the risks, has been difficult and had limited success. More effort will be required next year to ensure sufficient resources are available and deployed to address these areas in a more systematic and consistent way.

Oversight of Children who are Missing from Home, Care and Education

A weekly Multiagency meeting has been developed since the new CSE arrangements came into place to ensure there is scrutiny of all the episodes and circumstances where a child is reported as being missing to the police.
This is attended by the Police, Missing from Home Co-ordinator, Targeted Youth/Early Help and Youth Offending Team representative , Education Welfare Service, CSE Social Worker and LAC health colleague.

The purpose of the meeting is to ensure the effectiveness and robustness of response to any child who is reported as missing, to prevent any further missing episode and ensure that the South Yorkshire Missing Protocol and Safeguarding Procedures are being followed and to alert and escalate cases inappropriate.
The group track each case and will identify any emerging themes and feedback to the CSE Strategic Group, Corporate Parenting Panel and Children at high risk of Multiple Violence and Complex Abuse (MVCA) Panel

The development of the CSE team and Multiagency arrangements for CSE had led to the CSE forum being replaced by a broader monthly multiagency meeting to ensure oversight of any Young Person aged 10-18 years who may be at risk of Multiple Violence (including CSE) and complex abuse (which may include CSE). This meeting is chaired by the Head of Service to identify and track the most challenging Child Protection/LAC cases. This allows for the development of a central list and tracking process that can ensure a focus and effort into ensuring that the top 10 cases are identified and considered as part of the Empower and Protect Innovation opportunities across South Yorkshire or to strengthen safeguarding arrangements for those children who are often placed from out of the area.
This group reports into the CSE Strategic Group, Corporate Parenting Panel and Senior Safeguarding leadership group.

Accelerate joint working arrangements with the Barnsley Safeguarding Adults Board where this could be mutually beneficial

The Safeguarding Adults Board is represented on the BSCB and its sub-committees to facilitate joined up working around those issues that mainly affect adults, but also impact on their children. The focus on joint practice needs to be maintained in order to ensure a whole family approach to policy, practice and assessment.

A focus on and review of the 'Front Door'

Over the course of 2014 the 'Front Door' has been through a period of development.
As a response to this review we have associated realignment of thresholds and supported by a re-launch of the BMBC threshold for intervention. This is to embed a shared understanding of threshold for intervention. An integral part of this approach has been to be more responsive to children living in neglectful situations and to address more chronic neglectful parenting which relates to parental substance misuse, and domestic abuse.

As the service has developed and the threshold realigned, the volume of work has continued to increase with more children accepted for tier 3 interventions and numbers of assessments increasing.

As pressure on capacity in the service has increased, strategies focusing on timely and good quality assessment and both social work and management capacity has increased to respond to this.
Data and feedback from service shows increase in children in need opened for referral and assessment and conversion rate from referral to assessment shows marked increase over the course of 2014 and into 2015.

There has been an appropriate rise in numbers of children subject to a child protection plan from 200 in December 2013 to circa 340 in March 2015. Significant increase in those categorised as 'neglect'. This increase in numbers per 10,000 brings us in line with national average and closer to statistical neighbours.

More agency partners now contact their own safeguarding lead to seek advice to divert low level contacts *however it* is important that all agency partners develop this practice to divert low level contacts and reduce growing pressures on the 'Front Door'. The board will ensure this continues to be a key priority throughout 2016/17.

Workforce management and development

The Workforce Management and Development Sub-Committee's remit includes oversight of partner agencies' workforce responsibilities with regard to agency compliance with Working Together to Safeguard Children and statutory guidance. This includes the planning design, delivery and evaluation of the multi-agency Safeguarding Children Training Strategy and Programme. Adult services and community representation maintain a strong link with adult workforce training and promote a wider overview and input to safeguarding training.

During 2015-2016 there has been continued high demand for multi-agency training. An extensive programme of multi-agency training, lunchtime seminars and events were attended by a total of 2324 practitioners from across partner agencies. This is an excellent example of partnership working and learning together. There are strong links with the adult workforce training and we try to take a whole family approach to safeguarding training.

The training programme has been developed and delivered in response to statutory requirements, local and national Serious Case Reviews, local audits, current research and report findings.
The need to provide early help, remain alert to child sexual exploitation, neglect and the recognition of how the co-existence of key issues such as domestic abuse, parental mental illness and parental substance misuse can significantly contribute to the abuse and neglect of children have remained a priority for 2015-2016.
In addition to the variety of multi-agency courses and popular lunchtime seminars, further new topics have been added to the programme. These include:-

- Child Development
- Motivational Interviewing
- Human Trafficking
- Safeguarding Children with Disabilities
- Disguised Compliance
- Understanding Attachment
- The Mental Capacity Act and the Deprivation of Liberty Safeguards for Young People and Adults
- Adolescent to Parent Violence and Abuse

*in addition to "classroom" taught sessions an extensive programme of E-learning is available.

Contribution from partner agencies

Many of the courses benefit from partner agency colleagues co-delivering training with the Multi-Agency Trainer or sole delivery this and the use of free venues helps to gain maximum benefit from the training budget.

Key achievements

Monitoring of the impact of training on staff and outcomes for children continues via the Section 11 Audit Challenge, Staff Professional Development Reviews and supervision. The feedback obtained from the above methodology is used to inform the future training programme.
The sub-group continues to engage with Faith Communities to ensure that they have up to date local information and resources to enable them to safeguarding children. Contact with Asylum seekers and Migrant Communities has continued to raise awareness of Female Genital Mutilation and ensure that clear messages are given that this is illegal in The United Kingdom and other countries across the World.

In these times of Austerity the Board requested that this subgroup look at ways of saving/generating income to maintain the excellent quality of our training programme. We have tightened up on charging for late cancellation of a place on a course this will ensure that the course administrator is notified in a timely manner and can ensure the number of course attendees is at capacity. The subgroup have developed a charging policy so that only the agencies that contribute to the Board can access the Multi-agency training, other agencies can access training but they will be charged a very reasonable sum for such high quality training.

There have been improvements to the monitoring of the impact of training and feedback to inform the training programme.
The impact of training has been added to the Section 11 Challenge Visit that the Safeguarding Board Chair and Safeguarding Board Manager undertake with all Safeguarding Board member agencies.

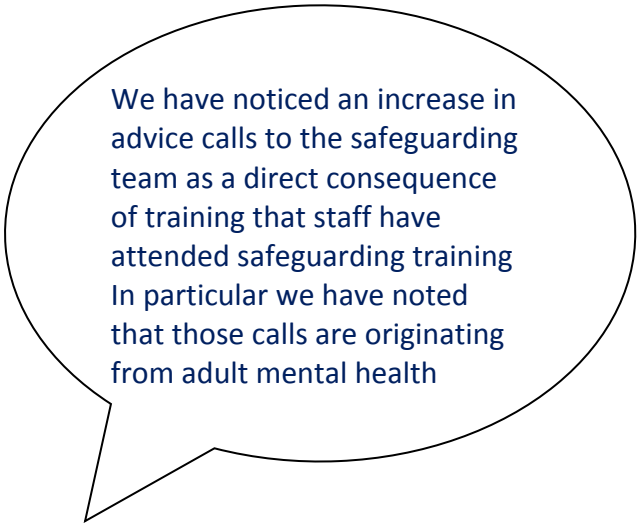
Managers are expected to assess the impact of training during the member of staff's annual appraisal and during supervision.

Ofsted Inspectors commented on the quality and variety of the multi-agency training programme.
This sub-group has continued to engage with Faith Communities to ensure that they are adequately safeguarding children. Links with travelers, asylum seekers and migrant communities have also been made.

A full day conference was held on neglect which was oversubscribed, and a conference on Domestic Violence 'Behind Closed Doors', held which received very positive evaluations.

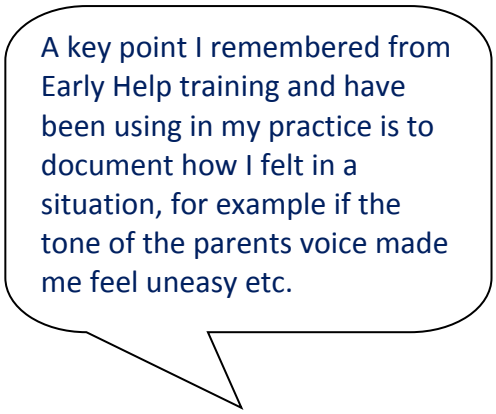
Evaluation of multi-agency training

Training receives very positive feedback:



Named Nurse, health provider organisation.

Member of staff working in an Acute Trust.



Member of staff working in a Nursery

Future Plans

The sub group are planning a conference for later this year the theme will be the Toxic Trio and Neglect.

The conference is scheduled to take place on the 13th October 2016 at The Core in Barnsley.

The number and nature of multi-agency courses delivered in 2015-16 and agency attendance is set out in the table:

	Number of courses	BMBC - People Directorate (Children)	BMBC - People Directorate (Other)	Schools, Colleges and Academies	Berneslai Homes	BMBC - Other Directorates	Health, including BHNFT	Police	Probation	Voluntary, Community, Charitable and Independent Sector	Foster Carer	Other	TOTALS
Becoming Culturally Competent	**2**	11	0	2	2	0	3	0	0	8	8	2	**36**
Operation Klan - Child Internet Abuse Seminar	**1**	8	1	2	2	0	1	0	1	8	6	0	**29**
Raising Awareness of Child Sexual Exploitation	**5**	15	2	5	4	1	23	24	0	26	17	3	**120**
Forced Marriage, Honour Based Violence and Female Genital Mutilation	**3**	29	0	11	2	1	12	0	1	15	4	2	**77**
Understanding Thresholds - Continuum of Assessment	**3**	20	0	13	2	0	12	0	0	22	0	0	**69**
Multi-Agency Public Protection Arrangements	**2**	3	4	4	4	0	9	12	0	10	3	1	**50**
Working Together to Safeguard Children and Young People	**8**	25	4	4	7	4	43	35	1	66	6	1	**196**
Safeguarding Children Online	**2**	12	0	6	0	0	2	2	0	8	11	0	**41**
Helping You With Early Help	**13**	87	1	50	6	0	94	2	0	42	10	1	**293**
Managing Allegations Against Staff	**1**	3	0	2	0	0	1	0	0	8	2	0	**16**
Understanding Autistic Spectrum Disorders	**1**	1	0	5	1	0	3	0	0	11	2	1	**24**
Domestic Abuse and the Effects on Children and Adults	**3**	26	0	7	4	2	19	2	0	10	6	1	**77**
Sexual Exploitation of Children and Young People	**3**	18	1	14	1	1	10	4	2	11	1	1	**64**
Safeguarding Children and Adults	**2**	13	0	3	2	1	10	0	0	15	7	0	**51**
Parental Problematic Substance Misuse	**2**	9	0	8	2	0	16	0	0	15	1	0	**51**
Young People Affected by Intimate Partner Abuse	**1**	3	0	2	1	0	0	0	0	9	3	0	**18**
Signs of Safety' - Changes to Child Protection Conferences	**4**	28	0	6	7	0	35	5	0	16	9	1	**107**
The Role of the Substance Misuse Carer	**1**	4	0	1	3	0	0	0	0	2	2	1	**13**

Domestic Abuse, Risk Assessment & MARAC	**3**	14	2	4	2	1	17	11	1	17	3	2	**74**
Safeguarding Children through Safer Recruitment	**2**	6	0	14	1	0	7	0	0	20	0	0	**48**
Self Harm Awareness	**2**	10	0	7	1	1	9	0	0	9	1	0	**38**
Working with Parents with Mental Health Issues and Safeguarding Children	**2**	15	0	13	0	0	5	0	1	7	6	1	**48**
Working with Parents with Learning Disabilities and Safeguarding Children	**1**	9	0	3	0	0	0	0	0	4	2	0	**18**
Communicating Effectively with Children, including those with Special Needs	**1**	8	0	1	0	0	0	0	0	3	5	0	**17**
Working with Resistant Families	**2**	23	0	4	3	0	6	0	2	8	1	0	**47**
Learning Lessons from Serious Case Reviews	**2**	18	0	2	0	0	8	2	0	8	0	2	**40**
Fabricated and Induced Illness	**1**	7	0	0	0	0	9	0	0	8	5	1	**30**
Recognising and Responding to Children and Young People Who Display Concerning or Harmful Sexual Behaviour	**1**	6	0	3	0	0	5	0	0	9	4	0	**27**
Introduction to Child and Adolescent Mental Health Issues	**1**	4	0	1	0	0	2	0	0	9	0	0	**16**
Conferences and Core Groups	**3**	22	0	13	3	0	17	0	3	18	0	0	**76**
Working with Neglect	**3**	18	0	7	3	0	17	2	2	20	4	1	**74**
Pathways Role Within the Co-ordinated Community Response	**1**	7	0	8	0	0	5	0	0	2	0	0	**22**
Court Room Skills	**2**	10	0	6	0	0	11	1	0	12	0	2	**42**
Teenage Brain Development and Engaging Teens	**2**	9	0	6	0	0	7	0	0	11	10	2	**45**
Sleep: Issues and Impacts	**1**	1	0	2	1	0	3	0	0	5	8	0	**20**
Achieving Best Evidence Through Interviewing Skills	**1**	4	4	2	0	3	4	0	1	5	0	1	**24**
Information Sharing in Difficult Situations	**1**	5	0	3	0	0	2	0	0	6	8	0	**24**
Awareness of Female Genital Mutilation	**1**	12	2	6	0	0	6	1	1	6	3	0	**37**
Introduction to Safeguarding	**2**	4	0	6	2	1	16	1	0	14	7	0	**51**

Every Child Deserves the Best Start in Life	**1**	4	0	1	2	1	2	0	0	5	8	0	**23**
Workshop to Raise Awareness of PREVENT (WRAP)	**1**	2	0	28	0	1	0	1	0	6	0	0	**38**
Sexual Abuse: The Investigative Process	**1**	12	0	3	0	0	6	0	1	2	0	0	**24**
The Role of the Specialist Health Visitor for Migrant Health, Asylum Seekers and Roadside Gypsy Travellers	**1**	1	0	0	2	0	0	0	0	3	5	0	**11**
"We Don't Just Put Out Fires": Safeguarding and the Role of the Fire Service	**1**	3	0	2	0	1	3	0	0	3	7	0	**19**
Physical Abuse and the Role of the Paediatrician	**1**	9	0	5	0	0	3	3	0	3	0	1	**24**
When a Child Dies	**1**	11	1	11	3	0	3	2	0	3	1	0	**35**
	99	**569**	**22**	**306**	**73**	**19**	**466**	**110**	**17**	**528**	**186**	**28**	**2324**
	Number of courses	BMBC - People Directorate (Children)	BMBC - People Directorate (Other)	Schools, Colleges and Academies	Berneslai Homes	BMBC - Other Directorates	Health, including BHNFT	Police	Probation	Voluntary, Community, Charitable and Independent Sector	Foster Carer	Other	TOTALS

Safeguarding vulnerable children and young people

Children in Care

The Barnsley Safeguarding Children Board's oversight of children and young people in care is maintained through membership of the Care4Us Council and receipt of individual reports, including the Children in Care KPI Scorecard. The Care4UsCouncil, which comprises of young people in care, board members and relevant council officers, meets regularly to address issues which are important to this group. During 2016-17, the council, led and chaired by young people:

- A new Full time dedicated Participation Worker was employed on 1st April 2016 to drive the CICC forward and work with Care Leavers. This post will enable, develop and deliver a participation service. It will further the work of the children in care council to ensure it continues to impact on service design and delivery within the Local Authority, especially Corporate Parenting. It will also enable time to work directly with children, young people and care leavers to empower them to share their views and build resilience and to improve outcomes for these children more effectively.
- Children in Care took part in take over Challenge and were awarded 'silver' commendation from the Children's Commissioners Office. This was a great success and will be a yearly event.
- The Pledge has been revised through consultation and now used within the Review process by the IRO's. The Participation worker has sent a copy to all LAC placed out of the Local Authority and also taken some out personally to meet the Young People. The Participation Worker will also take a copy of the Pledge out to Children who become Looked After when aged 10 or above when appropriate.
- 2 Care Leavers have attended The February Young People at Cabinet meeting to present the Pledge (which all members signed up to) and one of them presented a report regarding future 16+ accommodation including his own account of young people living in supported accommodation.
- Apprentices at Council have been very successful securing 2 young people's places to continue for a further period of time.
- CICC are attending the Yorkshire & Humber Children's Social Work Matters Conference. The conference aims to celebrate and promote good social work practice. Some of the Young People participated in some one minute film clip interviews to talk about their positive care experiences.
- One Care Leaver announced that she has just been offered a permanent Youth Coordinator post with Rotherham Council
- A Care Leaver will be attending a New Beginnings Dissemination Event in London. This is to raise engagement with Care Leavers, raising aspirations in employment, education and training. It also involves preparation for independence and health and well being.
- Celebration Event is an annual event due to its great success in 2015.
- LAC will be attending a Summer School at Sheffield University as part as the Go Further, Go Higher

campaign looking at LAW to raise aspirations to further their education and give them a different experience other than school.

- Care Leavers have produced a White Goods Catalogue to help with independence and provides information of were to go for the best priced essential items when moving into their own property and contact details of services they may need.

Proposals for 2016-2017 include:

Facebook for care leavers
Consultation on the review process and documentation (already started)
Consultation on the Welcome pack (again already started but name needs to change and it is not being used)

Health of Children in Care

Work is continuing to build on the substantial improvements already achieved in terms of performance and health outcomes for children in care. Data collection and audits of LAC health assessments show that 96.6% of review health assessments are completed within timescale and 100% of LAC have access to dental care. This is better than our statistical neighbours and the national average. 99.2% have up to date vaccination status which is excellent but at present there is no data available for comparison. The Timeliness of Initial health assessments has improved month on month since the appointment of a new Designated Doctor for Looked after Children in spring 2015. The delays are usually as a result of a delay in notification from an outside placing authority when a child is placed in by a Local Authority outside Barnsley. To improve notification quarterly meetings are held with Private providers and this has improved notification of Children in Care placed in Barnsley by outside authorities. The Clinical Commissioning Group (CCG) has also written to every CCG in the country requesting that they encourage notification of children placed in Barnsley.

Children and young people in care in Barnsley receive consensual and holistic health assessments. Assessments are carried out at times and in venues that minimise disruption to the child and their education. All our children in care have excellent access to and use primary care to promote their health and development. Older children and young people are given the opportunity to be seen alone, this has recently been identified as key to empowering LAC to speak freely and honestly about their health and care.

There is a monthly meeting between the Designated Doctor and Service Managers for Children in Care to ensure actions related to the health of Children in Care are implemented. This includes the need to improve waiting times for the Children and Adolescent Mental Health Service (CAMHS) for Children in Care and that the improvement in timescales for health assessments and dental checks are maintained.

The Health and Wellbeing of Children in Care and Care Leavers Steering Group, reporting to the CCG Quality and Patient Safety meeting, meets every six weeks to identify service improvements to address the health needs of this group and to ensure ongoing improvement. In addition to this CQC made some recommendations that would improve practice and lessons were learned from a serious case review.

Together all these are or have:

- Ensured that the completion and use of Strengths and Difficulties Questionnaires (SDQ) continue to be embedded into practice and inform a wider assessment of emotional health and wellbeing.
- Prompted the Designated and Named Nurse for LAC to provide revised training to health professionals undertaking health assessments to further increase awareness of the health needs of LAC and quality of health assessments.
- Developed a process for gaining consent from young people age 16 years and over to release GP summary records.
- Incorporated processes for ensuring GPs and CAMHS contribute to health assessments.
- Initiated the Named Nurse to undertake live audit of Review Health Assessments of children placed both in and out of Barnsley. This allows for timely challenge of assessments that don't meet the required standard, and feedback to health professionals to support continuous improvement.
- Instigated a process of follow up and monitoring of Barnsley LAC who are placed out of area to ensure their health needs are met by the receiving area.
- Ensured that the CCG have reviewed the Service Specification for Children in Care and Care Leavers, to ensure it remains appropriate in light of new statutory guidance. They have also liaised with Public health to ensure LAC provision is considered within the new commissioning arrangements for 0-19 children's community services.

What difference have these made:

- Better use of the SDQ both within individual health assessments and data collection to identify themes and trends.
- Health professionals that undertake LAC health assessments have received training to support competency requirements recommended in the Looked after Children: Knowledge, skills and competences of health care staff

(INTERCOLLEGIATE ROLE FRAMEWORK March 2015)

- Young people's right to consent or dissent is supported and upheld.
- Information from a wider range of health provision is used to inform health assessments.
- There is closer timely monitoring of health assessments by provider agencies, and any problems are escalated including to the CCG when appropriate.
- Children and young people placed out of Barnsley are not disadvantaged in terms of their health needs.

Continuous Improvement

There is a commitment to constantly challenge and improve practice and services to LAC. Areas of focus for the coming year are:

- Ensure that consideration of ethnicity, faith and identity is incorporated and documented in health assessments.
- Strengthen the voice of LAC and use

feedback to influence service improvement.

- Work with LAC to improve information for them regarding health assessments.
- Reinforce the use of existing health screening tools to support and enhance health assessments, particularly in terms of emerging issues such as child sexual exploitation, female genital mutilation and radicalisation.
- Continue to develop systems and processes to ensure significant health information is chronicled and follows the child.

Arrangements for Private Fostering Support in Barnsley

The Board oversees local arrangements to safeguard privately fostered children and young people and monitors the extent to which the local authority undertakes its responsibilities. A private fostering arrangement is one made without the involvement of a local authority for the care of a child under the age of 16 (under 18, if disabled) with someone other than a parent or close relative for 28 days or more. Anyone involved in, or knowing about, such an arrangement must notify the local authority at least six weeks before it begins and the fostering service takes active steps to advertise this responsibility through a range of measures:

- information disseminated via specific information sessions and training
- distribution of an updated Statement on Private Fostering to key stakeholders, including schools, school nurses, health visitors, GPs, children's social care teams, housing and voluntary sector professionals, setting out notification requirements, the local authority's duties and the role of local professional agencies
- distribution of a private fostering flyer to the same stakeholders

Specific awareness raising activity, supported by the board, has continued throughout the year, including local advertising. Information leaflets are available for carers, parents, children and young people and professionals. Leaflets, posters and business cards are displayed in major public buildings and information is available on the board and council websites.

Parents, carers, children and young people can receive advice and support, including training opportunities, from the private fostering social worker.

The requirements on a local authority under private fostering span both child and carer focussed services. The service in Barnsley is currently based with the Fostering Service and the balance is more towards ensuring this is a suitable placement for the child. The needs of the child/young person remain very much to the fore while the suitability of the placement is assessed. However should the child need more support through services for children in need or children in need of protection the Private Fostering Worker will liaise with Assessment and Safeguarding Services.

Numbers of private fostering arrangements have continued to decrease in recent years and there is a need to maintain the focus on awareness-raising with other agencies. A twice yearly report is provided to the Board so progress can be monitored and to remind partnership agencies of

the need to maintain a focus on identification of private fostering arrangements within their own organisation.

The current Private Fostering Worker has been undertaking a programme of regular visits to agencies to raise the profile of private fostering across the Borough. This has particularly focussed on ALCs.

Colleagues within the CCG have worked specifically with GPs and publicity materials have been developed for schools and other agencies to raise awareness across the Borough.

The Board specifically funds this publicity as private fostering still remains a priority of the Board. Work to ensure assessments are child-focussed as well as addressing the carer's needs is taking place alongside a focus on involving birth parents more within the process.

Above all assessments need to be timely to ensure children do not drift in unsuitable home conditions or emotionally unsupportive environments. Improvements are being made but this is still work in progress and work will continue around all aspects of private fostering in 2016/17.

The table shows the figures for private fostering for the last four years.

		31.3.13	31.3.14	31.3.15	31.3.16
1	Number of children in private fostering arrangements as at 31 March	18	12	5	4
2	Number of new private fostering arrangements which commenced over the last 12 months	18	14	2	14
3	Number of private fostering arrangements that ended during the past 12 months	17	20	9	8
4	Number of arrangements that were visited within timescales	100%	100%	100%	100%
5	Number of arrangements initially assessed as suitable	12	14	2	Unavailable
6	Number of arrangements initially assessed as not suitable	0	0	0	Unavailable
7	Number of arrangements that ended following an assessment by the local authority that the arrangement was no longer suitable	0	0	0	Unavailable

Children with disabilities, complex needs and/or special educational needs

The Children with Disabilities and Complex Health service has continued to work with a range of partner agencies, children, young people and the Barnsley Parents and Carers Forum to develop and improve services for children and young people with disabilities and complex health needs.

The key areas of work undertaken during 2015/16 have included:

- Continued review and development of services around short breaks and use of direct payments
- The continued development of Education, Health and Care Plans and the Local Offer outlining all local service.
- The development of a Disability Register
- The extension of person centered planning, transition planning the development of the Autism pathway and Strategy.

The Disabled Children Programme Board has met throughout the year and continues to steer and challenge progress of related sub groups and to ensure coordination of service delivery.

There has also been some very positive and productive work around awareness of Safeguarding of children with disabilities and complex health needs. This work has resulted in increases in children subject to child protection plans and the number who are looked after.

Children with Disabilities and Complex Health Needs Sub- Committee

Work undertaken:

- Revised Terms of Reference
- Established multi agency themed audits around issues to do with children with disabilities and complex needs
- Considered learning from SCRs both internal and external to inform the groups action plan
- Review of the OFSTED thematic report into Safeguarding Disabled Children to strengthen safeguarding arrangements for this group. The Sub group regularly reviews the data from the Disabled Children's Team against the whole data for Children's Social Care and this has supported action to increase the number of section 47's and CP plans for this vulnerable group of children and young people.

Education Welfare Service (EWS)

The Education Welfare Service works in partnership with schools to support and advice on attendance and safeguarding issues. School attendance is tracked, including vulnerable groups such as children in care, children subject to a child protection plan or child in need, those at risk of child sexual exploitation, children who have special educational needs (SEND) and children who are involved or at risk of criminal activity.

The EWS also oversees children missing education (CME) and those whose parents elect to provide education at home (EHE). Since 2014 a central record keeping system has been used which schools complete and return on a half termly basis to the LA. This identifies pupils who are

not in full time education provision with a focus on the most vulnerable groups. This became an Ofsted requirement following the publication of "Pupils missing out on education" published in November 2013. The service also contributes to a number of the board's sub-committees and related multi-agency safeguarding forums, including child sexual exploitation and missing forum.

The Education Welfare Service and the Early Help Offer

The service will work with schools for earlier identification of pupils who display early signs of irregular attendance including nursery and non-statutory school age. Education Welfare Officers will play a key role in undertaking and supporting early help assessments.

Policies are updated annually by the EWS These include promoting good school attendance, incorporating model school attendance policies for schools including nursery schools, and policies on Children Missing Education and Elective Home Education. Revised policies are taken to the Policy and procedures sub-group for approval before going out to schools for consideration at governors meetings. Updated policies form part of the annual head teachers safeguarding report and are located on the BSCB website.

The EWS delivers school designated safeguarding lead including, together with the schools S175/157 safeguarding training. The service audits case files to ensure minimum standards are met.

The service has taken part in a number of multi-agency audits including children who were identified at risk of child sexual exploitation and quality of early help assessments through the thresholds continuum of assessment group. The service also completed its third year of work with vulnerable families over the summer holiday period which included:

As part of the Education Welfare Service on-going attendance strategies, the service continued to raise the importance of school attendance throughout the summer holiday period. A number of initiatives took place they included;

- Attendance sweeps to parents whose children's attendance was less than the schools attendance target,
- Home visits and contact with families who were open cased to the EWS, identified as vulnerable (needing additional support throughout the summer holidays) or whom required a safe and well visit.
- Year 6 to Year 7 transition
- Monitoring and tracking of children missing education
- Elective home education monitoring
- Visits for pupils without an identified school place in September for both primary and secondary schools
- Support with Springwell Special School summer school

A total of 178 home visits were made to pupils and families during this period. Each term time Education Welfare Officer (EWO's) were asked to refer their most vulnerable cases to the senior management team of the service, for allocation, this was based on the criteria that no other service would be making contact during the summer holiday period.

The service were also provided with a list of 83 pupils from admissions who had not registered for a school place in September, 75 were for nursery into primary school and 18 for Primary into secondary. We were able to identify school places for those who had not applied for September,

locate families that had moved out of the borough and follow up with admissions the parents application forms that had already been submitted. All but 4 of these cases have been resolved. These are now registered as children missing education and are being monitored and tracked through the Children Missing Education SEWO

There were 3 requests for elective home education that were followed up with parents.

There was joint working with the Police, School Health, Family Intervention Service, Child and Adolescent Mental Health Service, Youth Offending Team, Stronger Family's Team and Social Care. Education Welfare Officers attended core group meetings, case conferences, Child in Need meetings, Team around the child meetings, Multi-Agency Area Group forums, Fostering Panels, Case planning meetings, Looked after children reviews.

Dealing with allegations against professionals

The Ofsted Inspection Report published on 8 August, 2014, identified that:

"*There are very good arrangements in place to make sure that children are protected when allegations of abuse are made against professionals.*"

This indicates that practice has remained consistently good from the previous inspection findings.

In the period April 2015 to March 2016 contact was made with the LADO in relation to 171 cases. This represents a significant reduction (27%) on the previous year. Since this reduction marks a departure from previous trends it will be important to monitor this during the coming year and to ensure that the role of the LADO, in terms of both advice and formal action, continues to be highlighted at times of staff changes and induction.

Of the 171 cases discussed with the LADO 73 were deemed to meet the criteria of indicating a risk of harm to children, or a possible criminal offence committed against or related to a child.

The majority of behaviours reported were of a physical nature (44%) which is consistent with previous data for Barnsley and nationally. Sexual abuse allegations accounted for 24% of the total, a decrease of 4% on last year. Emotional abuse and neglect accounted for 9% and 5% of allegations respectively.

The referrals were made by a wide range of statutory and voluntary agencies. Education providers in the borough (Primary, Secondary, Special Schools and College) accounted for 41% of all referrals reflecting the frequency, duration and intensity of the direct work with children in the education sector.

Awareness raising activities have taken part during the year with training provided to a multi- agency audience and bespoke training to foster carers and taxi drivers and the designated safeguarding leads within schools.

Records evidence that referrals made to LADO received a timely and robust initial response which ensured that children and young people were protected. The majority of allegations were investigated by management investigations undertaken by the employers and in total 69% of the allegations had been concluded by the end of the year. Of these 24% were concluded as being substantiated in that there was sufficient evidence to prove the allegation.

A further 26% were concluded as unsubstantiated because there was insufficient evidence to prove or disprove the allegation. The remainder were concluded as unfounded or false, with only one case considered to have been malicious during the year. The Board will continue to monitor the level of referrals to encourage all partners to refer to the LADO appropriately.

Equality, diversity and participation

The board is strongly committed to promoting equality of opportunity and ensuring that all safeguarding activities take account of the diverse needs of all children and young people in the borough.

The council's Equality Scheme 2012-15 reaffirmed this commitment, to be achieved through development and provision of relevant, appropriate and accessible services.

Equality objectives for children and young people include:

- providing support to schools and settings to meet their public sector equality duty
- helping schools and settings identify, record and deal with bullying and harassment in schools
- narrowing the gap between different sections of the community, including where different levels of achievement are related to disability, gender, ethnicity or economic background
- challenging the barriers faced by looked after young people
- fulfilling the 'Pledge' to children in care.
- meeting the needs of children and young people with special educational needs, learning difficulties, disability and complex health needs
- implementing/reviewing the One Path One Door strategy
- continuing to reduce the number of young people not in education, employment or training and address the needs of specific groups
- undertaking work to improve transition of vulnerable groups, particularly those with learning difficulties

All newly developed strategies, policies and procedures are subject to an equality impact assessment. Active steps taken to facilitate inclusion include the provision of appropriate support for families to enable them to participate fully in child protection conferences and representation of young people's views at the board's sub-committees. Where necessary, specialist support, for example, interpretation and translation services are engaged to support families.

Key points of development within the Continuous Service Improvement Plan for the BSCB are:

- The needs arising out of ethnicity, faith and identity should be consistently considered and reflected within assessments.
- The introduction of systematic use of cultural competence tool (completed July 2014)
- Review BSCB training to ensure ethnicity, faith and identity are included in all relevant training.
- Monitor impact and outcomes through multi and single agency case file auditing and S11 audit process

Current Position and the Improvement Journey		
EFFECTIVNESS		
What we need to do	**How are we doing and what difference did it make?**	**How do we plan to improve?**
Overall: 'good' characteristics are widespread and 'common practice'	"Good" characteristics are not yet consistently embedded in daily practice.	Actions are ongoing to improve performance and embed good practice through our continuous service improvement programme.
Overall: How effectively LSCB evaluates and monitors the quality and effectiveness of partners	Multi agency performance data was provided but the Board was not satisfied that it routinely reported the right measures. Special meetings in February and March 2014 identified the KPIs to be routinely monitored by the Board and PAQA Sub-Committee. From April onwards appropriate data collection has taken place and is routinely reported to the Board and PAQA where it is explored to ascertain areas of progress and areas for development/further exploration. The Section 11 audit challenge process evaluates and monitors the quality of partners' effectiveness. Further supporting information has been requested from partners this year to ensure actions/impact is able to be demonstrated.	The PAQA Sub-Committee will continue to refine its suite of KPIs and monitor audit outcomes from the single and multi-agency audit schedule. Work has been undertaken to develop the schedule of audits and audit reporting during 2014/15. This work has been further developed during 2015/16 and assisted by increased resource identified to support quality assurance activities. A programme of multi-agency audits will continue to be undertaken to examine priority areas of concern and identify key actions which will be monitored by PAQA through the development of specific action plans. Audit finding will be disseminated by PAQA into the relevant services.
Complies with its statutory responsibilities in accordance with the Children Act 2004	The Board was established on 1 April 2006 and CDOP on 1 April 2008 in accordance with legislation. The Annual Report and Business Plan are produced and published each year.	The Board will undertake more rigorous and systematic review of its Business Plan objectives to ensure continuing relevance and evidence of achievement.
Complies with the Local Safeguarding Children Board Regulations 2006.	Enshrined in Constitution. Board and CDOP established in accordance with legislation. SCRs are commissioned when criteria are met and findings published.	Where criteria for holding SCRs are not met the Board will undertake alternative learning events in compliance with its Learning and Improvement Framework to promote and disseminate learning.
Able to provide evidence that it coordinates the work of statutory partners in helping, protecting and caring for children in its local area	Section 11 self assessments to demonstrate compliance and impact. Multi-agency training programme The Board produces multi-agency policies, procedures and	Section 11 challenge process to be more rigorous. Interviews take place and evidence bank introduced however further review work throughout the year could be introduced which would focus on key areas for

	strategies. A multi-agency Sub-Committee structure is operational Action plans are created and monitored for SCRs, Learning Lesson events and specific strategies/polices/pathways are developed as a result.	development and support reporting against actions within the Continuous Improvement Plan. The Board needs to review its policies and procedures more systematically to ensure they are all up to date and relevant. Action Plans from SCRs, other learning events and strategies need to be SMART and implementation of actions and impact clearly able to be demonstrated.
There are mechanisms in place to monitor the effectiveness of those local arrangements	Section 11 challenge process Multi-agency training evaluation process Action plans monitored Multi agency audit programme in place and findings reviewed by PAQA Committee.	A more systematic review of multi and single agency audit activity. Improve evaluation process for multi-agency training to evidence impact of training more effectively. Improvement in this area has been made during 2014/15 with agencies demonstrating how they are recording and monitoring the impact of training. These improvements can be used to drive further development during 2014/15.
Multi-agency training in the protection and care of children is effective and evaluated regularly for impact on management and practice.	Comprehensive programme of multi-agency training provided. Evaluation process in place with plans to develop this further to evidence improved outcomes for children. Guidance published to encourage management support in ensuring that messages from training are embedded in practice. Regular monitoring of evaluations by the WMD Sub-Committee	Training will continue to be monitored and developed to address emerging priorities. Evaluation of impact will continue to be improved.
LSCB checks that policies and procedures in respect of thresholds for intervention are understood and operate	New thresholds document was approved and disseminated in February 2014. Staff summary leaflet developed. Multi-agency training provided on thresholds. Multi agency thresholds group working to further develop	There is clear evidence to suggest that the Escalation Policy is being used but further work was undertaken during 2015/16 to review the current policy and improve the process for formally recording and collating

effectively and identifies where there are areas for improvement	and embed understanding of thresholds across all agencies. Development and endorsement of the Barnsley Assessment Framework January 2015 which is consistent with Early Help development. Safeguarding leads encouraged to use escalation policy re thresholds.	escalations which will increase reliability of data and allow for themes and tends to be identified. This will continue into 2016/17. Further work required to raise partner agency understanding of thresholds, increase the use of agency safeguarding leads and 'hold the ring' on early help. Multi-agency audit on thresholds and work to collate data in relation to the pressures on the font door.
Challenge of practice between partners rigorous and leads to improvement	Section 11 challenge Encourage challenge on debate at Board and Sub-Committee meetings Log of challenges and outcome is developing. Use of Escalation policy is encouraged and monitored	Maintain and strengthen challenge relating to attendance and representation at the Board and Sub-Committees. Continue to monitor challenges made to identify themes, trends and response/outcome.
Casework auditing is rigorous and used to identify where improvements can be made in front-line performance and management oversight	Substantial audit work undertaken however quality of audits undertaken need to be improved.	The programme of single and multi agency audits reported to PAQA Sub-Committee needs refining and more systematic scrutiny. The Board will undertake an agreed programme of multi-agency audits.
Serious case reviews, management reviews and reviews of child deaths are used by the local authority and partners as opportunities for learning and feedback that drive improvement.	SCRs undertaken when criteria met - where not met learning lessons reviews commissioned if appropriate. Action plans monitored by SCR Sub-Committee. Multi agency training provided on SCRs Individual reviews disseminated through relevant forums e.g. Head teachers meeting	The Board will continue to disseminate lessons derived from SCRs and similar reviews and develop specific multi-agency training to address identified need.
The LSCB provides robust and rigorous evaluation and analysis of local performance that influence and inform the planning and	Performance management system still developing. Safeguarding Board's set of key indicators identified for regular review at each meeting. Wider set also identified for the PAQA Sub-Committee to review and escalate issues	Further strengthen the role and function of the BSCB through building on current work to improve performance management, including: Coordination of the process to evaluate the impact of

delivery of high-quality services.	of concern to the Board. Supplementary audit programme to evidence practice improvements. Much improved data for LAC. Areas of poor performance identified for action as part of the Continuous Improvement Plan monitored by the BSCB.	multi-agency training. Performance data and audit activity integrating child protection and IRO activities to provide learning from quality assurance.
WHAT GOOD LOOKS LIKE		
What we need to do	**How are we doing and what difference did it make?**	**How do we plan to improve?**
The governance arrangements enable LSCB partners (including the Health and Well-Being Board and the Children's Trust) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people.	Clear relationship articulated between SCB and Children's Trust (TEG report November 2013) Common members on all 3 bodies i.e. SCB/TEG/HWB provides opportunity for mutual reporting Protocol agreed to articulate relationship between SCB, TEG and HWB.	Embed the developing performance management process to clarify and understand how well statutory responsibilities are fulfilled.
The LSCB effectively prioritises according to local issues and demands and there is evidence of clear improvement priorities identified that are incorporated into a delivery plan to improve outcomes.	Priorities are set out in Board's Business Plan and Annual Report. New priorities identified as local issues arise and action taken. Sub-Committees review their Business Plan priorities regularly for achievement and relevance. Reports to the BSCB are required to show the link between the subject of the report and the board priorities.	The Board needs to monitor its own priorities more systematically and develop a clear delivery plan. This should feed directly into the Continuous Development Plan monitoring Process. More formal evidence of Board and Sub-Committee achievement required to ensure continuing validity of the purpose, values and vision. This should include specific developments in relation to identified vulnerable groups and key areas of development priority. The Board will improve its oversight of the extent of neglect as a local feature and the processes in place to monitor the efficacy of interventions to ensure that all partner agencies are addressing neglect robustly and without compromise.

		The Board aims to improve oversight of missing children and continue to develop its strategic approach to CSE which includes Female Genital Mutilation in line with local and national developments.
Regular and effective monitoring and evaluation of multi-agency front-line practice to safeguard children identifies where improvement is required in the quality of practice and services that children, young people and families receive. This includes monitoring the effectiveness of early help.	Regular audits. Performance reporting with escalation from PAQA Sub-Committee.	Regular reports on effectiveness and monitoring of Early Help to the Board.
Partners hold each other to account for their contribution to the safety and protection of children and young people (including children and young people living in the area away from their home authority), facilitated by the chair.	Board Chair encourages open debate at Board meetings and culture where respectful challenge is encouraged. Performance information provides transparency to rate partners' performance.	More clarity and systematic reporting needed on children placed out of district. A report to the Board to highlight recent work undertaken by key partners facilitated by PAQA.
Safeguarding is a priority for all of the statutory LSCB members and this is demonstrable, such as through effective section 11 audits. All LSCB partners make a proportionate financial and resource contribution to the main LSCB and the audit and scrutiny activity of any sub-groups.	Revised more rigorous Section 11 self assessment. LSCB partner contributions have been reviewed during 2015/16 to try to increase levels of funding to the Board in order to maintain its current programme of work including facilitation of SCRs. Sub-Committees have multi-agency representation. Multi-agency audits undertaken. Additional contributions in kind considered e.g. the provision of training venues and meeting rooms.	Feedback to be provided by school representatives to all schools through the weekly bulletin following key meetings (BSCB, Schools Forum, SEE, Improvement Board, Trust Executive Group, Challenge Board, Children and Families Act Project). Sub-Committee attendance will continue to require proactive oversight and action to address unsatisfactory attendance The Board will need to meet challenges posed by partner

		agency reorganization and impact on attendance. Further work to address resourcing issues in relation the Board to be addressed.
The LSCB has a local learning and improvement framework with statutory partners. Opportunities for learning are effective and properly engage all partners. Serious case reviews are initiated where the criteria set out in statutory guidance are met and identify good practice to be disseminated and where practice can be improved. Serious case reviews are published.	Learning and Improvement Framework approved and published on the SCB website. Learning lessons opportunities undertaken with frontline practitioners and resulting action plans monitored through SCR Sub-Committee. SCRs initiated where criteria are met and are published Learning from SCRs and learning events disseminated by partner agencies and through multi-agency training.	Learning from SCRs and learning events will continue to be disseminated to partner agencies and through multi-agency training.
The LSCB ensures that high-quality policies and procedures are in place (as required by *Working Together to safeguard children*) and that these policies and procedures are monitored and evaluated for their effectiveness and impact and revised where improvements can be made. The LSCB monitors and understands the local application of thresholds.	Policies and procedures in place and accessible via website. Continued focus of the Board in relation to thresholds. Work to improve the monitoring and reporting of escalations through the Continuous Improvement Plan.	Undertake more regular and systematic review of the Board's Polices and Procedures to ensure they are comprehensive, up to date and relevant. Need better evidence of the effectiveness and impact of policies and procedures and when they are revised following review. Application of thresholds needs to be more consistent and better understood by partner agencies which can be demonstrated via appropriate data and regular progress reporting to the Board. This should include input from partner agencies.
The LSCB understands the nature and extent of the local issues in relation to children missing and children at risk of sexual	SCB received reports on children missing and at risk of CSE in January 2014. Local CSE Strategy and Action Plan in place. Strategic CSE Group maintains coordinated oversight and monitors CSE Strategy Action Plan. CSEM Forum monitors	The Strategic CSE Group will monitor and periodically report on achievement of the CSE Strategy Action Plan. Regular audits in relation to CSE undertaken and

exploitation and oversees effective information sharing and a local strategy and action plan.	individual cases. Review of CSEM Forum TORs and practice. The Board is represented on the South Yorkshire Police and Crime Commissioner's county wide forum and is participating in the county wide CSE campaign lead by the PCC. In March 2014 the Board agreed a county wide addendum to the information sharing Protocol re CSE.	reported.
The LSCB uses case file audits including joint case audits to identify priorities that will improve multi-agency professional practice with children and families. The Chair raises challenges and works with the local authority and other LSCB partners where there are concerns that improvements are not effective.	Case file audits undertaken including multi-agency audits to identify priorities for improvement. Log of challenges developing to evidence challenge from Chair and Board to partners, including the local authority. Board minutes evidence challenge by partners to improve effectiveness of services e.g. health service DNA polices.	Findings from the multi - agency and case file audits will be incorporated into Action Plans where appropriate for monitoring by the PAQA Sub-Committee and report back to the Board. In overseeing partner effectiveness the Board will provide challenge in respect of any areas of concern
Practitioners and managers working with families are able to be involved in practice audits, identifying strengths, areas for improvement and lessons to be learned. Experiences of children and young people are used as a measure of improvement.	Practice audits undertaken by managers. Developments ongoing to capture voice of young person e.g. in cp conference reports.	More development is needed to capture and use the experiences of children and young people as a measure of improvement and to inform service delivery
The LSCB is an active and influential participant in informing and planning services for children, young people and families in the area and draws on its assessments of the effectiveness	The LSCB has influenced service delivery e.g. continued concerns on thresholds has led to additional work. The report on private providers of Children's homes led to new meetings and additional work to ensure compliance. DNA concerns led to additional work to ensure effectiveness. The SCB contributes to the C&YP plan.	The Board will continue to influence the planning of services for children in areas of identified need e.g. next neglect, appropriate resources to support young people who have been victims of CSE. Ensure the Board clearly communicates commissioning

of multi-agency practice. It uses its scrutiny role and statutory powers to influence priority setting across other strategic partnerships such as the Health and Well-being Board.	The Chair has influenced the Health and Well Being Section of the C & YP Plan to ensure that CSE was captured under the Sexual Health section in response to a consultation on the draft plan. The Board had approved a Protocol to clarify relationships between the SCB, TEG and HWB	priorities to the Children's Executive Trust.
The LSCB ensures that sufficient, high-quality multi-agency training is available and evaluates its effectiveness and impact on improving front-line practice and the experiences of children, young people, families and carers. All LSCB members support access to the training opportunities in their agencies.	The Board provides a comprehensive programme of high quality multi-agency training which is flexible and adapted to meet newly identified needs e.g. response to CSE. Effectiveness and impact on frontline practice evaluated through new evaluation process. Multi-agency membership of Sub-Committee promotes take up of training plus wide promotion through website, flyers etc. Managers are encouraged to ascertain impact on practice through guidance approved by Sub-Committee and published on website	Better evidence of the impact of multi-agency training is required and should be reported with supporting evidence within Section 11 Audits. Sustainability of the MA Training Programme should be explored and issues around access by private providers considered and addressed via commissioning and contract arrangements.
The LSCB, through its annual report, provides a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness and the causes of those weaknesses, and evaluates and where necessary challenges the action being taken. The report includes lessons from management reviews, serious case reviews and child deaths within the reporting period.	LSCB's Annual Report provides assessment of performance and effectiveness of local services, including areas of weakness and future priorities for action. Annual Report includes information from SCRs, lessons learned reviews and child deaths.	Consideration should be given to the develop of a monitoring timetable for activities of the board and sub committees which could be used to develop the report and ensure that board priorities are being met and are consistent with the priorities outlined in the annual report and business plan.

Monitoring the effectiveness of local work to safeguard and promote the welfare of children

The work of the Board is progressed largely through its sub-committees and sub-groups who have undertaken the following work over the last year:

Performance, audit and quality assurance sub-committee

This is the key forum through which the Board examines and verifies the quality of individual agency safeguarding practice. It oversees performance management, scrutinises a developing suite of key performance indicators (KPIs) and secures quality assurance through findings from single and multi-agency audit activity.

Performance management and quality assurance framework

Remit

- Implement an effective strategy to monitor quality & effectiveness though analysis of relevant safeguarding performance information from partner agencies including, where appropriate, service users' views.
- Develop and oversee a planned programme of single and multi-agency audit review and quality assurance in relation to safeguarding activities.
- Secure quality assurance and performance management through receipt of reported audit activity arising from agencies and Sub-Committees.
- Co-ordinate Section 11 self-assessment audits and analysis, monitoring agency action plans by reviewing summary data and determining response in respect of non-compliance
- Oversee the Section 175 and 157 audit process relating to schools and outcomes
- Undertake reviewing activity and performance data analysis, providing regular updates/recommendations to the BSCB to mitigate risk, highlight trends, areas of concern and recommendations for further activity / monitoring designed to improve quality and promote good practice.
- Commission specific audits, thematic reviews or case management reviews at the request of the Safeguarding Children Board.
- Ensure that findings from case audits and other enquiries are communicated effectively to frontline staff and managers
- Ensure that messages from inspection, case reviews, audit and quality assurance are acted upon to address inspectorate recommendations and improve practice, through regular learning events.
- Embed performance issues into other Sub-Committees to evaluate and monitor the work of single agencies and reflect the Sub-Committee's role as an external quality check.
- Highlight and disseminate required improvements and areas of good practice through the Policy, Procedures and Practice Developments and Workforce Management and Development Sub-Committees

A Quality Assurance and Performance Management Framework is in place and has been endorsed by the Board. This confirms the need for continuous service improvement and delivery to be driven through quality standards, monitoring of improvement targets and focus on a suite of selected KPIs.

The Board and sub-committee have held development sessions to determine the data to be received by the Board and sub-committee. Respective scorecards of multi-agency KPIs have been identified for regular

reporting. The sub-committee will escalate any issues of concern to the Board. The Board has developed a more effective performance management culture through increasing focus on performance and quality assurance. More valid data with contextual information will enable constructive challenge and provide proper reassurance about safeguarding from partner agencies.

The Board's own set of KPIs, framed around the child's journey from early intervention through to Tier 4 and looked after status includes:

Early Intervention

1. Number of Early Help assessments

Contacts, Referrals and Assessments

2. Number of contacts received
3. % of contacts to referral
4. Numbers of referrals
5. % of referrals to assessment under S17 and S47
6. % of Section 47 Investigations converting to initial child protection conference
7. % of assessments completed within 20 days
8. % of assessments completed within 45 days and those out of timescale

Child Protection

9. % of children becoming the subject of a CP Plan for the second or subsequent time within 2 years
10. % of open CP Plans lasting 2 years or more

Children in Care

11. Looked after children missing from care incidents (episodes)
12. Police Data. In May 2015 new police measures and safeguarding performance data was provided by South Yorkshire Police (SYP) across a range of categories
13. During 2015/16 the numbers of unallocated assessments to Children's Social Care have been reported.

Assurance from audit activity

The sub-committee promotes practice improvement through review of audit outcomes, drawn from an evolving programme of planned single and multi-agency agency audits For 2015 – 16 the sub-committee considered the following findings from partner and multi-agency audits:

- PAQA Scorecard of Indicators (at every meeting)
- Monthly Social Care Scorecard (at every meeting)
- Education Data Performance Reports (children missing, excluded, elected home educated)
- Youth Offending Data Performance Report
- Multi Agency Deep Dive into S47s
- Health Assessment of LAC placed outside the Borough
- Quarterly Multi Agency CSE audits
- Private Fostering; arrangements and performance
- Education Welfare Assessment Audit
- Audit Report relating to children being subject to a child protection plan lasting for two years or more.
- Audit of children on a CP Plan for
- the second or subsequent time
- Record Keeping - Special Care Baby Unit Audit
- The quality of agency reports to Child Protection Case Conferences

Overview of vulnerable groups:

In fulfilling its objective to review the welfare of vulnerable groups of children, the sub-committee questioned information on the following during the year:

- Children Missing Education (CME): This relates to children of compulsory school age, not on school roll or educated otherwise, who have been out of any educational provision for at least four weeks. The sub-committee sought information on local numbers and how the children were monitored to ensure they receive suitable education and are safeguarded. Although potential complications relate to school transfer and relocation to another area, the EWS request a safe and well visit to ensure a child's welfare as soon as relocation is known. The service has revised its CME policy and procedure guidance during the year in response to a national consultation. Ofsted has commended our procedures as robust.

  The sub-group have also looked at performance information and safeguarding arrangements for children who are excluded from school and children who are home educated.
- Looked After Children (LAC): The sub-committee continue to closely review performance indicator data relating to looked after children.
- Child Sexual Exploitation (CSE): Quarterly multi agency audits are undertaken by the CSE Strategic Group and reported in to PAQA. Audits are showing an improvement in joined up responses to young people.

Priorities for 2016-2017

- Improve a systematic reporting of single and multi-agency practice in terms of identifying key themes for learning and improvement, informing priority areas and promoting multi-agency contribution
- Develop an analysis of Police data to better understand and inform priority areas for multi-agency contribution
- Continue to undertake quarterly multi agency audits:
  - Q1 Children and young people who are cared for by parent/s who misuse substances;
  - Q2 Children and young people who are missing from home, education, school
  - Q3 Children and young people who present risky behaviours
  - Q4 Children who are neglected

Policy, procedures and practice developments sub-committee

Ensures that policy and procedures are current, implemented, embedded and reflective of practice

This sub-committee oversees a range of areas of safeguarding practice. In acknowledgment that many safeguarding issues relevant to children and young people are derived from adult behaviours, membership of the sub-committee contains representation from adult services. These clear links to adult mental health and substance misuse provide for more cohesive working in these areas of safeguarding concern and forge stronger alliances with relevant partner agencies. The sub-committee has found this

extensive remit to be a challenge in terms of addressing all issues thoroughly, and has therefore established periodic time-limited task groups to address particular pieces of work. Last year, it built on this approach in its considerations to:

- Develop and consult on new multi-agency protocols, policies and procedures on specific safeguarding issues or in response to Serious Case Review findings
- Ensure relevant communications to frontline staff
- Identify any gaps in safeguarding practice that need to be addressed through development of new safeguarding policies/procedures
- Respond to national and local policy changes and advise the Board of the implications of relevant publications and safeguarding developments
- Work with the Serious Case Review Sub-Committee to undertake 'lessons learnt' reviews, and identify required amendments to policy and procedure
- Ensure development of a holistic approach to the safe use of digital technology and ensure that e-safety safeguards are audited and evaluated within the Board's Performance Management Framework
- Provide advice and support on digital technology safeguarding requirements
- Maintain oversight of interagency arrangements to protect young people who are vulnerable/exposed to risk of harm through sexual exploitation and/ or running away from home and/or substance misuse. Receive reports from the Sexual Exploitation and Young Missing Forum. Report on specific areas of unmet need to advise the Board of potential and necessary resources/services to meet these needs
- Ensure multi-agency training on the impact of adult mental health on parenting children and promote shadowing opportunities for relevant staff in partner agencies
- Strengthen engagement of young people with the Board through maintenance of links with relevant forums, such as the Youth Council, to secure the voice of the young person
- Promote better awareness of the impact of adult mental health, learning difficulties, substance misuse and domestic abuse.
- Ensure that work relating to anti bullying policies and strategies reflects a zero tolerance approach.

Development of new policies and procedures

The Board's web enabled policies and procedures were revised and updated in September 2015 and March 2016. In response to identified needs or recommendations from SCRs/learning events, the Board approved the following new policies and procedures, developed with multi-agency consultation:

- Missing from Home or Care and Runaways - Multi-agency protocol - April 2015
- Barnsley CSE Strategy 2015-2017
- Revised Missing Children Procedures
- Revised CSE Joint Investigation Team Protocol
- The Assessment Framework
- Anti Bullying Policy
- Person Posing Risk Policy
- FGM Policy

Serious case review sub-committee

The information and findings from SCRs and learning events are used to ensure that we continue to improve practice in Barnsley to safeguard children and young people.

During the last 12 months the sub-committee has taken a more robust approach to evidencing that actions arising from reports have been completed and that there is an audit trail to show the work completed.

Serious Case Review Panel

During the last 12 months the serious case review panel met on 3 occasions to consider if individual cases met the criteria for a serious case review to be commissioned. The criteria for a serious case review (SCR) is set out in chapter 4 of Working Together 2015 and includes individual cases where a child or young person has died or suffered significant harm, where abuse or neglect is suspected and where there may be concerns about partnership working to safeguard the child. Where an SCR is commissioned an independent author is appointed who has no connections to any of the agencies involved; this ensure that there is an independent review. The purpose of an SCR is not to apportion blame but to identify lessons that will help to safeguard other children.

During 2015/16 three Barnsley Serious Case Reviews (SCRS) were published. They can be found in full on the Barnsley Safeguarding Children Board web site: https://www.safeguardingchildrenbarnsley.com/professionals-and-partners/serious-case-reviews.aspx

Brief details of those individual cases are as follows:

Child M: this SCR relates to a 14 week old baby that was found to have a number of significant non accidental injuries including fractured ribs and four fractures to its leg bones. A police investigation was undertaken to attempt to identify who was responsible for inflicting the injuries. A number of adults who had caring responsibilities for the baby were questioned but the investigation did not result in a criminal prosecution due to a lack of evidence. The baby was taken into the care of the Local Authority to ensure its future safety.

Child N: This SCR was commissioned following the tragic death of a 14 year old boy who was in the care of Barnsley Local Authority and died in a private care home in Rochdale having taken an overdose of methadone which he is believed to have acquired during a visit to family and friends in Barnsley. There was a police investigation into his death. At the Coroner's inquest the Coroner made a finding of death by misadventure. It is worthy of note that both in the Coroner's findings and the SCR that there are positive comments regarding the support provided to Child N by his Barnsley Social Worker.

Children P: This SCR relates to the sad death of two young brothers who died as a consequence of a deliberate house fire started by their father who also died in the incident. A police investigation took place into the circumstances of their deaths. The Coroner's inquest resulted in a finding of unlawful killing. Both the Coroner's inquest and the SCR found that no agency had fundamentally failed the family.

In each of the SCRs recommendations were made by the independent authors. Those recommendations were incorporated into

action plans which were robustly monitored by the members of the SCR sub committee. The action plans for each of the SCRs described above have been now shown as complete with the supporting evidence having been scrutinised by the committee; the completed action plans have then been tabled at the main safeguarding board for their oversight and agreement.

Where appropriate the lessons learned from SCRs have been incorporated into training programmes.

What have we learnt?

Examples of lessons learnt from reviews that have been completed and actioned are:

- Ensuring that agencies policies and procedures for following up where children Do Not Attend (DNA) for medical appointments are fit for purpose and are being complied with. This includes the auditing of cases to ensure effective practice.
- Actions around the training of staff in relation to Common Assessment Frameworks (now revised to become Early Help Assessments)
- The review and development of the multi agency process for their collective response to critical incidents involving children. The process and policy is in place and was the subject of a half day dedicated training event attended by staff from a range of agencies.
- Improving the transitional arrangements for children moving from primary schools to secondary schools. Transitional arrangements are in place for all secondary schools.
- Ensuring professionals are inquisitive about significant others involved with families and that they share information on any concerns.
- Ensuring that birth visits are conducted by health visitors within 10 to 14 days of a baby's birth even if the baby is still in hospital
- Ensuring that the record keeping on the Special Care Baby Unit meets national recording standards
- Ensuring the correct action is taken to complete risk assessments around domestic violence and notifications to other agencies
- Ensuring a co-ordinated approach to effective bereavement follow up.

The board will assess how well this learning is embedded in practice through evidence from quality assurance and audit findings.

Child Death Overview Panel

1. Introduction

Following the death of Victoria Climbé in 2000, national guidance was produced in the form of Working Together to Safeguard Children. This Guidance states that that all agencies who have a responsibility towards children should work together to look at ways to keep children safe. This led to the formation of Child Death Overview Panels (CDOPs) who are accountable to the Local Safeguarding Children Boards.

The child death review process is not about apportioning blame but aims to learn lessons in order to improve the health, safety and wellbeing of children and to seek to reduce the number of deaths.

Compared to national data, Barnsley has relatively few child deaths. However, the circumstances surrounding the death of each child are considered on an individual basis in order that any modifiable factors identified may form the basis of recommendations to the Barnsley Safeguarding Children Board (BSCB). Consideration is given to how local services

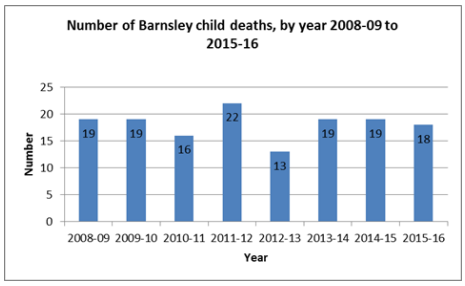
can work together to mitigate future harm to children and young people. The findings from all child deaths inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children and young people in Barnsley.

Barnsley CDOP is a multi-agency panel responsible for reviewing information on all children and young people under 18 years who reside in Barnsley. The CDOP meet quarterly and by exception. The Terms of Reference, including membership, are available to download from the BSCB website.

2. Number of child deaths notified

From 1 April 2015 to 31 March 2016 there were 18 deaths notified to Barnsley CDOP. Figure 1 shows the number of Barnsley child deaths by year, 2008-09 to 2015-16 and Figure 2 shows the number of these that were expected and unexpected. Figure 3 illustrates the number of deaths by month.

Figure 1



Source: Barnsley CDOP Database

Figure 2

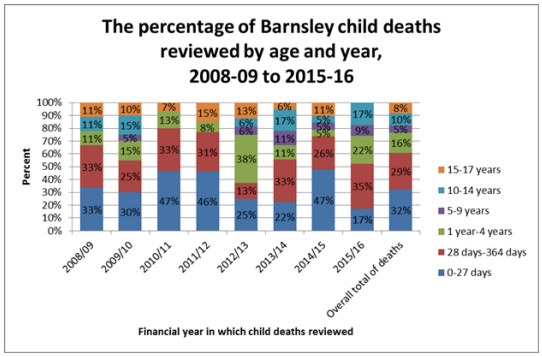
Barnsley Child Death Notifications, by financial year (1st April - 31st March)			
	Expected	Unexpected	Total
2008/09	13	6	19
2009/10	11	8	19
2010/11	7	9	16
2011/12	12	10	22
2012/13	8	5	13
2013/14	13	6	19
2014/15	13	6	19
2015/16	9	9	18
Totals	86	59	**145**

3. Cases Reviewed

The panel met 5 times (quarterly plus an additional panel was convened specifically to review neonatal deaths) and 24 reviews were completed during the April 2015 - March 2016 reporting period. Due to the small numbers of deaths that occur each year in Barnsley, identifying trends and patterns is difficult. An analysis has been undertaken of the child death information held on the CDOP database over the period 2008/09 to 2015/16 to provide a picture of what is happening over a longer time period.

Figure 3 shows the breakdown of child deaths reviewed by CDOP by age over the period 2008-09 to 2015-16 (total 133).

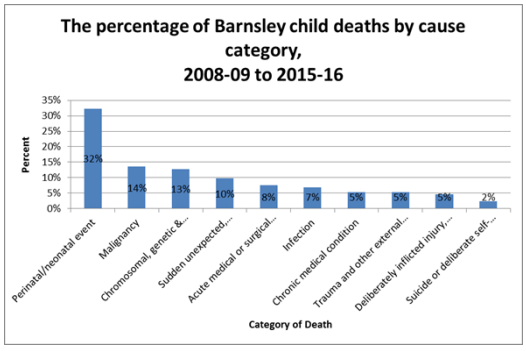
Figure 3



Source: Barnsley CDOP Database

Figure 4 shows the percentage of child deaths reviewed by cause category over the period 2008-09 to 2015-16.

Figure 4



Source: Barnsley CDOP Database

The findings show that the pattern of child deaths seen locally reflect those identified in national findings with approximately a third of deaths being associated with premature birth.

4. Progress against 2015-16 recommendations

In accordance with the previous year's proposed service developments, the following have been successfully completed:

- An audit has been undertaken of the governance and administrative processes.
- In light of the review and revision of Working Together to Safeguard Children Guidance, initial rapid response multi-agency meetings are being piloted for unexpected and unexplained deaths
- The leaflet for parents/carers explaining the child death review process and the role of the Child Death Overview Panel has been revised.
- Multi-agency training has been jointly delivered by the BMBC Multi-Agency Trainer and Public Health Specialist Technical Officer (CDOP Administrator).

In addition to the above:

- A training session relating to the CDOP procedures was delivered specifically to School Nurses and Health Visitors in June 2015 which provided an understanding of the CDOP and what is expected in completion of Agency Report Form B.

- Links have been strengthened with the Histopathology secretaries at Sheffield Children's Hospital for inviting the Consultant Paediatric Pathologists to multi-agency case review meetings for unexpected child deaths to present findings from their medical examinations and all post mortem reports are provided to CDOP.

5. Recommendations for 2016-17

The Panel has discussed and agreed participation with South Yorkshire CDOPs in a peer audit review around decision making for modifiable factors.

6. Further references

Barnsley Joint Strategic Needs Assessment: https://www.barnsley.gov.uk/services/public-health/joint-strategic-needs-assessment-jsna

Working Together to Safeguard Children, 2015: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Partner agency contributions to safeguarding

The Board values the contributions of all partner agencies in promoting and monitoring the effectiveness of safeguarding in the area. An effective Board requires all partner agencies to participate fully, engage in the Board's business and transfer the safeguarding ideology into their own sphere of activity.

Barnsley Hospital NHS Foundation Trust (BHNFT)

BHNFT continues to meet the requirements of an ever challenging safeguarding agenda. The safeguarding children team fulfils regular commitments to training, supervision, advice, support, audit, supporting the child death process and representing the Trust at various Board sub-committees.

The team is promoting awareness of the Thresholds for Intervention to ensure early initiation of offers of help and support. Staff are encouraged to seek advice where required to ensure that cases do not become 'stuck' and also to provide challenge where there might be a professional disagreement.

BHNFT undertakes regular audits of records, child protection reports and court reports to ensure they meet minimum quality standards and identify improved actions, planning and decision making.

The Safeguarding Children Training Strategy states staff who have significant involvement with children must be knowledgeable and access training in relation to domestic abuse, sexual exploitation and the WRAP prevent agenda. We also continue to raise awareness and knowledge through single agency training, multi-agency training and learning events.

The hospital's 'Did Not Attend' policy has been revised and updated to ensure that, when a child misses a hospital appointment, a safeguarding review is undertaken to assess risk. Cancelled appointments are also reviewed to assess issues of veiled compliance to ensure improved health outcomes for children and addressing of neglect.

To improve their experience, the team actively seeks the views of children and families through an evaluation questionnaire, the findings from which are reviewed. The ongoing audit programme seeks to ensure effective high quality practice.

BHNFT has updated its Safeguarding Supervision Policy to ensure that community midwives and community nurses receive individual and group supervision to enhance their knowledge and ensure they are supported in their work.

Additionally BHNFT have developed good working relationships with substance misuse services and staff follow procedures in relation to this and refer young people into services. Feedback from Commissioners is that they feel this sets BHNFT above the national average for this. Additionally feedback from this demonstrates we are having a beneficial impact on these young people. The safeguarding department have a comprehensive audit schedule to provide assurance that standards outlined in policy and guidance are being met. Moreover, any breaches in policy are investigated under Datix, Serious Incident or SCR procedures.

NHS Barnsley Clinical Commissioning Group

In addition to safeguarding requirements incorporated into closely monitored contracts with health care providers, the Designated Nurse for Safeguarding Children, the Designated Nurse for Adults and the Named Doctor have developed a Safeguarding Vulnerable People Section 11 Audit to inform the forth coming 'safeguarding stock take' of primary care.

The issue of children failing to attend health appointments has featured in national and local child deaths and remains of concern to the Safeguarding Board. Steps have been taken to address this issue and the Board has received assurance that health providers are monitoring failure to attend medical appointments and poor engagement with services more effectively to assess risk to children.

We have a Commissioning Strategy which includes meeting the needs of children and young people in Barnsley and reflects our

vision and values which are fair and equitable access to reduce known inequalities. Furthermore as part of the Executive Commissioning Group for the Children and Young People Trust we are committed to partnership working to achieve the Trust's aims e.g. we are leading on developing the offer for emotional wellbeing

South West Yorkshire Partnership Foundation Trust (SWYPFT)

South West Yorkshire Partnership Foundation Trust covers four local authorities and Safeguarding Boards across the region. The strength of that spread is that learning experience and confidence can be shared across the service for the direct benefit of children, young people and their carers.
Services provided for children include health visiting, school nursing, family nurse partnership, therapy services, child and adolescent mental health services and early intervention in psychosis for young people from 14.

The service also promotes the think family agenda and offers services across health and wellbeing and mental health.

Key achievements last year have been:

- The service has met the section 11 challenge and continues to strive towards demonstrating improved outcomes for children and young people who have contact with SWYPFT services
- Excellent attendance by staff at Initial and review child protection conferences
- A proactive response which seeks to offer an extensive programme of training for all staff groups as identified within the Intercollegiate Document 2014

SWYPFT provides the following messages to it's staff in relation to safeguarding:

- Assessments should be thorough and utilise all information available; systematic risk assessment should look at all aspects of the child's journey and all adults involved in the delivery of care. The wishes and feelings of the child need to be heard throughout our assessments
- To be aware of the importance of Early Help Assessments and the instrumental role for health within this arena
- The rule of optimism should be understood by all staff and objective assessment of the facts should take place taking account of all the interrelated dynamics, always ask is this child safe and healthy? Is this the whole picture?
- Compliance with supervision supports staff to develop professional resilience and is instrumental in improving outcomes for children and young people
- non-attendance at appointments should always be assertively challenged and risk assessed.
- children should not be invisible, all children – grandchildren, partners children.
- be observant and ask key questions.
- share information – understand the NHS code of confidentiality and when it is important to share information.
- good record keeping is essential to facilitate high quality care.
- families can be vulnerable, vulnerable adults can be perpetrators – Think Family.

South Yorkshire Police

Protecting Vulnerable People is a priority within the Police and Crime Plan 2013/2017. The Barnsley located Police Public Protection Units fall under the

central control of Specialist Crime Services, reporting to an Assistant Chief Constable who holds responsibility for all areas of Protecting Vulnerable People. However, the provision of services in terms of safeguarding children is locally delivered, with strong ties to the Barnsley district command who has responsibility for local children's safeguarding.

In recognition of the importance of effective, locally based partnership working, the force is disbanding the Central Referral Unit and introducing Multi-Agency Safeguarding Hubs. The Barnsley M.A.S.H. is based within Barnsley District and incorporates partners from Police, Social Care and Health, working together to safeguard children. This means that all child protection referrals will be received and actioned by a dedicated team of professionals within the M.A.S.H., who are also able to progress joint investigations and ensure services required by children and families are signposted to the relevant partner agency without delay.

Over the last year, Barnsley PPU has gradually increased in size as a result of increased funding provision from the Police and Crime Commissioner. The team now has additional staff across all areas, with increased capacity available for child abuse and child sexual exploitation investigations. In Barnsley there is also a new team dedicated to vulnerable adult investigations, which includes all high-risk domestic abuse cases. It is acknowledged that the impact on children living in families where domestic abuse features can be immense and negative affect a child's quality of life. This team has strong links to child protection colleagues and partners within the M.A.S.H., which means that the risk to any children is identified and managed at the earliest opportunity.

This strengthened approach to partnership working in Barnsley will enable a more timely and effective response to safeguarding which will provide greater reassurance to victims and families.

Berneslai Homes

Berneslai Homes' primary contribution to Safeguarding is via its established Vulnerability Strategy: 'Something Doesn't Look Right'. Through this approach, they provide practical support and interventions to address identified issues to prevent progression to other services for example social care or the police. Their 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, they are able to provide practical support, make referrals to other appropriate support providers and carry out housing application assessments as part of their response to the early identification and intervention with tenants in need.

Berneslai Homes continues to undertake proactive visits to Council properties specifically to identify any support or vulnerability issues early.

During the last year they carried out over 4, 500 support visits, with nearly 2,500 resulting in supportive interventions. This included a number of cases where there were safeguarding concerns around the safety of children and adults. During the year we have also continued to visit vulnerable individuals affected through Universal Credit although this is still to be fully rolled out across the borough and we continue to support those affected by welfare reform.

Berneslai Homes Family Intervention Service (FIS) provides cross tenure family support and interventions to families across

the Borough, often 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 270 families ranging from those requiring early intervention to those requiring intensive support during the last year.

The primary aim of this work 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.

Barnsley College

Barnsley College is committed to safeguarding the total college community, including learners, staff and visitors. In 2015 - 16, the College continued to embed safeguarding across all College activity by:

1) having a robust safeguarding structure led by the Assistant Principal (Access to Learning), operationally led by the Head of ALS, Counselling & Safeguarding. The College continues to provide dedicated frontline support through the work of the Safeguarding Team Leader, Safeguarding Officer, Safeguarding Advisors and Departmental Safeguarding Representatives. These staff provide a range of advice, guidance and safeguarding support to learners, staff and visitors;

2) Linking up with secondary schools and other key agencies to support the transition of learners into College;

4) Continuing professional development for staff to improve skills and knowledge and excellent partnership working arrangements, so the workforce is able to safeguard the college community. College delivers safeguarding awareness training in-house so that the training can be tailored towards how best to safeguard the College community.

5) The college will continue with its approach to embedding safeguarding throughout College activity in 2016 - 17, with a particular focus on:

- further CPD for staff, in particular in key safeguarding roles, leading to a recognised safeguarding qualification
- reviewing and refreshing the College's safeguarding policy to ensure that it reflects recent legislative and statutory guidance updates
- ensuring that the Prevent agenda is fully embedded into College policies and procedures and that staff are suitably trained to meet their statutory duties.

Voluntary and community sector

Over the past year, a lot has been achieved in the voluntary and community sector in relation to safeguarding children, young people and vulnerable adults.

The consortium has voluntary and community sector representatives on the Safeguarding Board, the Serious Case Review Sub Committee, the Think Family Board.

As a consortium, safeguarding is vitally important and should be evidenced as such. However, due to the diverse nature of the voluntary and community sector, Section 11

requirements may be covered in a different way that meets the individual needs of that service and, for some groups, completing the Section 11 is not always appropriate.

Integrated working with partners

Integrated and partnership working is a particular local strength and all the individual partner agency contributions to safeguarding are valued. The Board maintains links with partners and contributes to local initiatives on a variety of safeguarding themes, through representation on a range of multi-agency working groups.

Planned future developments and key priorities for 2016 - 17

Barnsley Safeguarding Board's strong commitment to continuous service improvement and addressing the needs of the most vulnerable children and young people is evidenced through the objectives in our 2015 -16 Business Plan. Future aims and priorities are identified in the context of significant change, nationally and locally, particularly in the light of continuing budgetary pressures. The continuing effectiveness of the Board's work will continue to be subject to close scrutiny. The synergy obtained from strong partnership working remains an essential element of effective safeguarding. The objectives of the Board and sub-committees/groups for the coming year have been determined with multi-agency input and will be subject to regular review throughout the year to measure their achievement and impact.

Oversight and progress of actions from the Continuous Improvement Programme

The Board will assume responsibility for driving forward and monitoring practice to secure mainstreamed continuous improvement. It will assimilate learning from the Improvement Programme and use it to inform future safeguarding developments through partner agency participation. The Board will also require regularly updated reports of specific case file thematic audit and general audit activity.

Encourage challenge

The Board will seek to strengthen and evidence its own effectiveness through rigorous challenge, participation and engagement. This will include challenge sessions for each refresh of the Section 11 self assessment, encouraging challenge at Board debates, monitoring use of the escalation policy and promoting participation and engagement of stakeholders wherever possible. The Section 11 challenge will also seek evidence that current austerity measures and budget reductions are not having an adverse effect on the ability of partner agencies to fulfil their responsibilities.

Child Sexual Exploitation

Although the Board has an approved strategic approach in relation to CSE there is a need for continuous focus which will include a strategy refresh and procedure update. The development of the Multi-Agency Safeguarding Hub (MASH) will support the early identification and intervention for children at risk of CSE.

Promote understanding on thresholds and monitor pressures on the front door

Continued work to ensure that the thresholds are understood and correctly applied by partner agency staff and that effective use is made of the escalation process in cases where there are concerns about the decision making.

To encourage agencies to ensure that non urgent referrals and contacts into social care are quality assured and discussed with agency safeguarding leads prior to children's social care.

That developments in relation to Early Help are supported and monitored.

Strengthening work with partners

The Board will seek to improve its overview of the work of partner agencies involved with safeguarding children, including the voluntary and community sector and local faith groups through issues reported and escalated by the sub-committees. It will actively seek to strengthen existing links with the VCS and associated groups and continue to explore the benefits of closer co-operation through multi-agency working, building on establishment of the Joint Investigation Team and the development of the MASH.

Performance management and quality assurance

Development of the Board's Performance Management Framework and routine reporting of key indicators has continued to be refined during the year. The Board is now able to scrutinise performance in a more informed and systematic way and challenge areas where it appears that improvements are required. This approach will continue to evolve to ensure the Board receives the necessary information to be assured about the safety and quality of frontline services. Responsibility for regular mainstream scrutiny rests with the PAQA Sub-Committee, who will escalate areas of concern to the Board through exception reporting.

Through oversight of a comprehensive audit programme, the PAQA Sub-Committee will continue to scrutinise findings from commissioned single and multi-agency audits to ensure actions are embedded through practice changes. The Board has also agreed to receive themed presentations on performance from partners for challenge at Board meetings. The Board are keen to retain a key focus in relation to CAMHS and monitor improvements within this service.

Developing stronger means of engaging with young people and their families to be clear about how they feel safe in the borough

Securing the voice of children and young people to inform strategic and service planning is underdeveloped and an area for further work. There are examples of engagement with young people for specific activities and the Board maintains participative links to the views of young people through membership of the Care4Us Council and the Youth Council which is represented on the Policy, Procedures and Practice Developments Sub-Committee. Although the Board is addressing this through plans to hold meetings in schools, and enter a dialogue with young people about their priorities/ views on safeguarding, more systematic engagement is required.

Learning from serious case and other reviews to inform practice

Continue to assimilate and act on the learning and improvements derived from Serious Case Reviews, the CDOP, and other learning events in order to improve practice and service delivery. The SCR Sub-Committee will continue to inform local practice through examining findings from SCRs held elsewhere to identify lessons with local resonance for dissemination to agency practitioners.

Board Attendance

Board membership represents all key local partner agencies. Last year saw a limited number of membership changes. The majority of changes were in relation to school membership and the replacement of interim staff with permanent staff members.

Member attendance at Safeguarding Children Board meetings in 2015 - 16

From March 2015 until March 2016 there were six ordinary meetings and a joint meeting with the Children's Trust Executive Group (TEG).

The Board maintains regular oversight of attendance to promote regular and consistent participation. Analysis shows that attendance and participation is generally very good, especially by key stakeholder representatives from the local authority, health services, secondary schools, Barnsley College, the police and the voluntary and community sector.

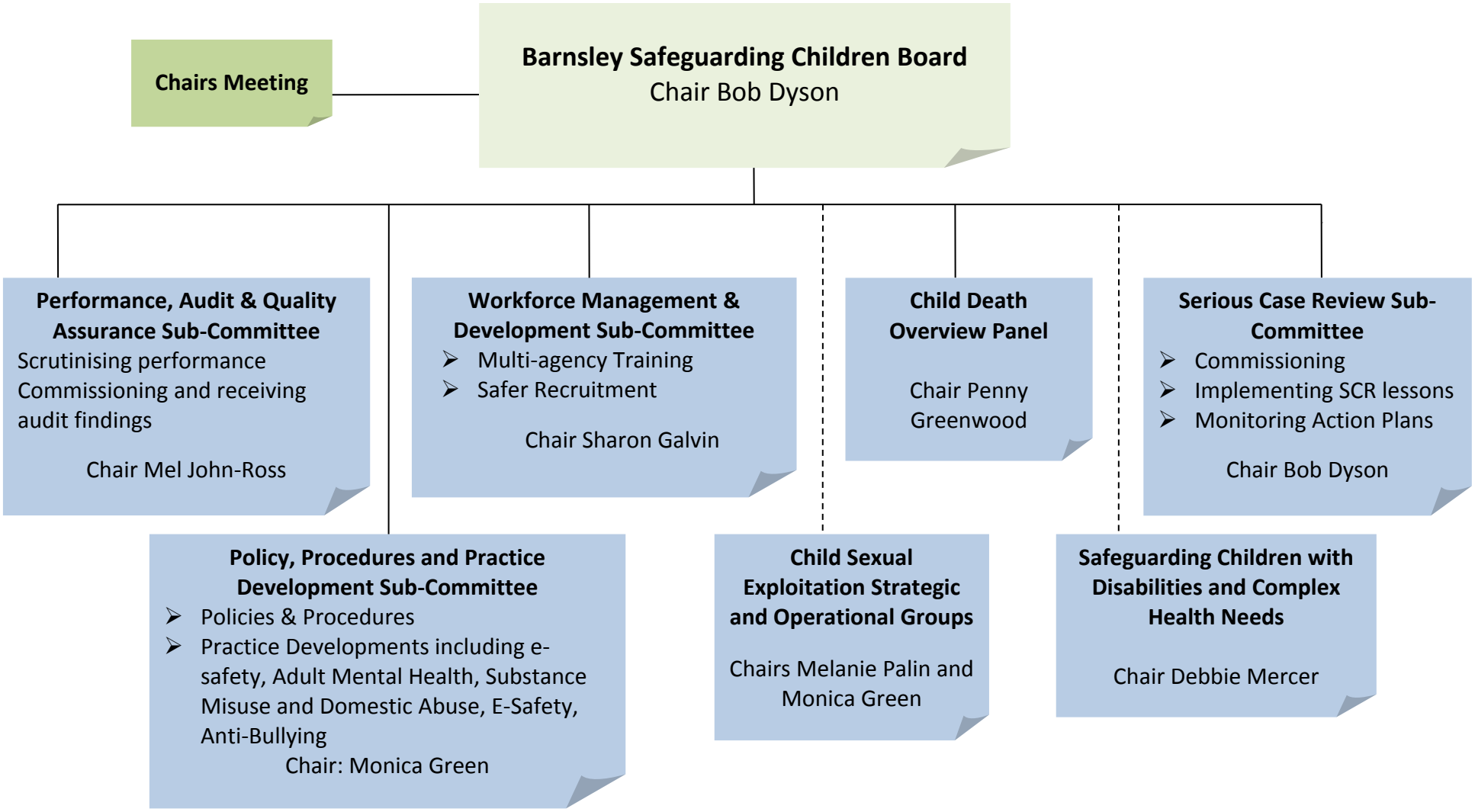
The BSCB Budget 2015 - 16

The Board is funded by contributions from partner agencies, in accordance with a locally agreed formula. The budget breakdown and contributions made by member organisations for the 2015 - 16 year are shown in appendix 3.

There was a pressure on the budget last year due to the increased level of Serous Case Review Work which resulted in the budget being overspent.

Appendix 1

BARNSLEY SAFEGUARDING CHILDREN BOARD GOVERNANCE STRUCTURE



Appendix 2

MEMBERSHIP AND ATTENDANCE

The list of members and advisors to the Barnsley Safeguarding Children Board, as at 3 May 2016, is set out below.

Members	**Representative Agency**
Bob Dyson	Independent Chair
Susan Barnett	Barnardos/Voluntary and Community Sector representative
Tim Breedon	Director of Nursing, South West Yorkshire Partnership NHS Foundation Trust
Tim Innes	Temporary Chief Superintendent
Rachel Dickinson	Executive Director People, BMBC
Ben Finley	Service Manager Barnsley Youth Offending Team,
Jo Nolan	Secondary Head Teachers' Association
Max Lanfranchi &	Director of Probation , Barnsley
Heather McNair	Chief Nurse Barnsley Hospital NHS Foundation Trust
Brigid Reid	Chief Nurse, NHS Barnsley Clinical Commissioning Group
Pat Sokell	Lay Member
Steven Szocs	Lay Member
Sue Symcox	Service Manager, CAFCASS
Phil Briscoe	Assistant Principle, Barnsley College
Judith Wild	Quality & Patient Safety Manager, NHS England SY and Bassetlaw
Advisors	**Representative Agency**
Philip Shire	Service Manager, Safeguarding Adults, BMBC
Steve Eccleston	Assistant Director, Legal Services, Sheffield MBC
Sharon Galvin	Designated Nurse Safeguarding Children, Barnsley CCG
Pete Horner	Head of Public Protection Unit South Yorkshire Police
Mel John-Ross	Assistant Executive Director of Children's Services, Safeguarding, Health and Social Care, BMBC
Dr Saqib Iqbal	Designated Doctor, Barnsley Hospital NHS Foundation Trust
Dave Fullen	Director of Housing Management Berneslai Homes
Kathryn Padgett	Assistant Director of Children's Health Improvements, SWYPFT
Dawn Peet	Safeguarding Officer South Yorkshire Fire & Rescue
Nigel Leeder	Safeguarding Children Board Manager
Penny Greenwood	Assistant Director of Public Health
Cllr Margaret Bruff	Cabinet Spokesperson
Monica Green	Head of Service for Safeguarding

Barnsley Safeguarding Children Board Budget 2015/16			
Income £		**Expenditure £**	
Partner Contributions			
Barnsley MBC	£94,788	Staffing	£107,007
NHS Barnsley CCG	£49,175	Multi-agency Training	£17,456
Probation	£1,157	Professional Fees including SCR	£27,203
South Yorkshire Police	£12,024	Service Developments	£0
Cafcass	£2,500	Running Costs	£7,978
Connexions	£0	Training Income	£0
TOTAL	£159,644	TOTAL	£159,644

REPORT TO THE HEALTH AND WELLBEING BOARD

9 August 2016

Oral Health Improvement Action Plan

Report Sponsor: Julia Burrows
Report Author: Anita Dobson
Received by SSDG: 20 June 2016
Date of Report: 21 July 2016

1. Purpose of Report

1.1 To present the oral health improvement action plan which outlines local ambitions to improve oral health and to present key facts on water fluoridation.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Support and agree the oral health improvement plan.

3. Introduction/ Background

3.1 National context

3.1.1 From April 2013, local authorities became responsible for improving the oral health of their communities and for commissioning oral health improvement services and water fluoridation schemes *(NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 SI 3094).* Performance is monitored through the public health outcomes framework (rate of tooth decay in five-year-old children). BMBC Public Health has identified oral health as a key area for action.

3.1.2 Tooth decay is the most common oral disease affecting children and young people (CYP) in England, yet it is largely preventable. While children's oral health has improved over the past 20 years, almost a third (27.9%) of five-year-olds in England still had tooth decay in 2012.

3.1.3 Poor oral health can affect CYP's ability to sleep, eat, speak, play and socialise with other children. Poor oral health also causes pain, infections, and impaired nutrition and growth.

3.1.4 Oral health is an integral part of overall health. When children are not healthy, this affects their ability to learn, thrive and develop. Good oral health can contribute to school readiness.

3.1.5 Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012-13. Dental treatment under general anaesthesia (GA), presents a small but real risk of life-threatening complications for children.

3.1.6 Tooth extractions under GA are not only potentially avoidable for most children but also costly. Extracting multiple teeth in children in hospitals in 2011-2012 cost £673 per child with a total NHS cost of nearly £23 million.

4. Local Context

4.1 The dental public health epidemiology programme for England oral health survey of 5year old children (2015) shows that dental health among five-year-olds in Barnsley has improved over a three-year period. Between 2012 and 2015 the severity of tooth decay in Barnsley five-year-olds dropped from 1.6 teeth per child which were decayed, missing or filled to 1.1.

4.2 Barnsley is compared among 16 statistical neighbours in the PHE oral health survey of five-year-olds. This comparison shows between 2012 and 2015 Barnsley progressed from fourth highest in terms dental decay severity among five-year-olds to sixth lowest. However, Barnsley's latest figure of 1.1 decayed, missing or filled teeth per child is still significantly higher than the England rate of 0.8. Yorkshire and Humber range from York 0.5, Wakefield to 1.6.

5. Oral Health Improvement Action Plan

5.1 The Oral Health Improvement Action Plan's vision is for all Barnsley residents to achieve a standard of oral health that enables them to feel physically, mentally and socially well and socially engaged. This will be achieved through improving overall oral health and reducing oral health inequalities with a particular focus on those children and young people who experience the worst oral health.

5.2 *Commissioning Better Oral Health* (PHE 2014) sets out guidance for LAs and provides a framework for the strength of evidence against a number of oral health improvement recommendations. As well as prioritising actions based on their level of evidence, the range of activities cross the five Ottawa Charter areas for health improvement (WHO, 1986) form the basis of the Oral Health Improvement Action plan for Barnsley.

5.3 Key objectives of the plan include:

- Build healthy public policy by working collaboratively through Barnsley's Oral Health Improvement Advisory Group.

- Creating supportive environments by establishing tooth-brushing clubs across a range of early years and educational settings.

- Reorienting health services to prevention by the increased use of fluoride varnish by dental practices in Barnsley.

- Developing personal skills through the promotion of Making Every Contact Count.

- Strengthen community actions using media campaigns to raise community awareness.

Whilst the plan focuses on optimising exposure to fluoride to prevent tooth decay through the establishment of tooth brushing clubs, it does not consider the possibility of a community water fluoridation scheme, which is recommended in *Commissioning Better Oral Health*.

6. Consultation with stakeholders

6.1 The action plan has been developed in consultation with Public Health England, Adult Joint Commissioning BMBC, Healthwatch Barnsley, Person Shaped Support, Early Start and Families BMBC, SWYPFT, BHNFT, Local Dental Committee, Rotherham Foundation Trust (Community Dental Service) BMBC Communications, NHSE.

7. Further consideration - Water fluoridation

Following the approval of the oral health action plan at the Senior Strategy Development Group, members recognised that the single most effective intervention which will impact on reducing oral health inequalities is fluoridation of the water supply.

7.1 Water fluoridation is associated with reductions in tooth decay in populations. Other sources of fluoride for dental health include toothpaste and professionally applied fluoride varnish. Water fluoridation is felt to have an effect over and above that achieved by these other methods. Advantages of water fluoridation over other fluoride delivery mechanisms are that it does not require any individual behaviour change or attendance at a dental service, there is no direct cost to the individual and it does not involve a healthcare professional to administer it. Water fluoridation involves adjusting the fluoride level in drinking water supplies to an amount that is optimal for dental health

7.2 Following implementation of the Health and Social Care Act 2012, responsibility for making proposals and undertaking public consultation on water fluoridation schemes transferred from primary care trusts to local authorities.

7.3 If public consultation supports water fluoridation, the relevant local authority or authorities will request the secretary of state for health to ask the water company to fluoride the drinking water supplies.

7.4 Evidence on effects of fluoridation

7.4.1 The effects of water fluoridation have been studied extensively over the last 50 years. Water fluoridation is found to have an effect over and above that of other sources of fluoride, particularly toothpaste.

7.4.2 A report from PHE on water fluoridation in March 2014 found that:

- Five-year-old schoolchildren were 15% less likely to have tooth decay and when deprivation and ethnicity were taken into account, they were 28% less likely to have tooth decay;

- Twelve-year-old schoolchildren were 11% less likely to have tooth decay and when deprivation and ethnicity were taken into account, they were 21% less likely to have tooth decay;

- Reductions in tooth decay levels appeared greatest in children living in the most deprived local authorities; and
- There were 45% fewer hospital admissions of children aged 1-4 years for tooth decay.

7.4.3 The safety of water fluoridation has been confirmed in several studies, which failed to find any evidence that water fluoridation has a negative effect on general health. The only proven associated effect, other than a reduction in tooth decay levels, is dental fluorosis which appears as mottling of the tooth surface. In the UK, fluorosis is mainly a cosmetic problem.

7.5 Costs of water fluoridation schemes

7.5.1 The annual operating costs of a water fluoridation scheme have been estimated to be in the region of £0.35 to £0.40 per person. For the Barnsley population of 231,220 this would mean annual operating costs of approximately £81,000 to £92,500. The capital costs of developing a scheme include the cost of installing plants and equipment and the costs of a public consultation would also need to be considered and benchmarked against an estimated cost to Barnsley of £403,800 per year, based on an average of 600 children admitted to BHNFT per year for tooth extraction at a cost of £673 per child.

7.6 Feasibility of a water fluoridation scheme in Barnsley

7.6.1 The feasibility of a water fluoridation scheme in Barnsley is dependent on water flows and water treatment works and their accessibility. A feasibility study would have to be commissioned and there would need to be clarity over who would meet the costs of this.

7.7 Steps to be taken in considering a water fluoridation scheme in Barnsley

7.7.1 The steps to be taken in considering a water fluoridation scheme are shown below (Table 1).

Table 1 Summary of key steps towards a new fluoridation scheme

Phase	Content
1	Preliminary scoping phase (non-statutory) and informal discussion with any other affected local authorities.
2	Commencement of statutory process – making an initial proposal, perhaps with multiple proposers.
3	Assessment of operability and efficiency, including agreement of secretary of state to proceed.
4	Consultation with other affected local authorities (if any), and securing their consent to proceed.
5	Public consultation and subsequent decision-making including, in the case of multiple local authorities, joint committee arrangements. In the latter instance, decisions may need to be made by a process of weighted population voting
6	Making an agreement between the secretary of state and the water company including issuing an indemnity to the company.
7	Scheme implementation.

8. Conclusion / Next Steps

8.1 Further exploration of fluoridation of Barnsley's water supply if required by the Health and Wellbeing Board

9. Financial Implications

9.1 The financial implications are identified in 7.5 Costs of water fluoridation schemes.

10. Appendices

10.1 Appendix 1 – Oral Health Action Plan

PH Strategy priority action plan oral healtl

11. Background Papers

11.1 Improving Oral Health: A community Water Fluoridation Toolkit for Local Authorities

https://www.gov.uk/government/publications/improving-oral-health-community-water-fluoridation-toolkit

Officer: Anita Dobson
Contact: anitadobson@barnsley.gov.uk
Date: 21.07.2016

Oral Health Action Plan

VISION: For all Barnsley residents to achieve a standard of oral health that enables them to feel physically, mentally and socially well and socially engaged. This will be achieved through improving overall oral health and reducing oral health inequalities with a particular focus on those children and young people who experience the worst oral health.

Having good oral health is essential for general health and wellbeing. A healthy mouth and smile means that we can eat, speak and socialise without pain or discomfort and play our parts at home and in society. Having poor oral health can lead to pain and toothache and the need to take time off work or school to get dental treatment.

Oral health has improved in Barnsley over the last forty years but there are still areas of the borough where levels of tooth decay remain high and by the time they start school, more than a third of our children have several decayed teeth. Tooth decay and other oral health problems are largely preventable and we need to take further action to improve oral health and reduce oral health inequalities. The Barnsley Public Health Strategy has identified oral health as a priority for action.

Barnsley Council is responsible for improving the oral health of its residents and this action plan has been developed to support the achievement of one of the oral health priority in the public health strategy. It sets out the actions that the Council and partners will undertake to ensure the oral health of the people of Barnsley is improved across the life course.

Performance

	2016-17			
Performance indicator	**Q1**	**Q2**	**Q3**	**Q4**
Mean severity of tooth decay in children aged five years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted – decayed/missing/filled teeth (d3mft)	*This frequency of reporting of this indicator is dependent upon the annual survey cohort decision at a national level.*  Mean d3mft in Barnsley and stat nei  d3mft in Barnsley and stat neighbours 2			
Rate of admission to hospital for dental caries in children aged 1-4 years per 100,000 population				
% of fluoride varnish applications undertaken in general dental practice				
% uptake of MECC training by Barnsley dental service providers				
% of Be Well Barnsley clients who have attended a dentist				
Number of Toothbrushing clubs established in reception year				
Number of Toothbrushing clubs established in year 1				
Review OHIAG Terms of Reference		September 2016		
Attendance monitoring at OHIAG	 Governance attendance monitorin			

Recommendation 1: Build healthy public policy					
Ambition	**Why**	**Planned activities**	**Responsibility**	**Progress update**	**Milestone dates**
(i) To establish the Oral Health Improvement Action Group (OHIAG)	To provide a system to drive forward oral health improvement across the borough of Barnsley in line with the Oral Health Improvement Strategy and Action Plan. To deliver the Barnsley Public Health Strategy priority of improving the oral health of children.	Agree terms of reference and membership	OHIAG	**Terms of reference and membership agreed**	**Complete** Terms of Reference
		Establish quarterly meetings	Anita Dobson (AD)	**Quarterly meetings established**	**Complete** OHIAG 2016 Meeting Dates
		Agree governance and reporting structure of OHIAG.	OHIAG	**Reporting into Public Health Department Management Team at this moment in time**	
		Review the evidence base to inform policies which will contribute to the improvement of oral health and the reduction of health inequalities.	OHIAG	**OHIAG received report on hospital admissions data February 2016**	**Complete** NHS Atlas of Variation Map 79 Rate
			Anita Dobson (AD)	**AD and KJ met with Bob Kirton (BHNFT) and Austin Smith 30 March 2016**	**Complete**

Recommendation 2: Creating supportive environments					
Ambition	**Why**	**Planned activity**	**Responsibility**	**Progress update**	**Milestone dates**
(i) Tooth brushing clubs to be established in early years, nurseries and reception year settings across Barnsley	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 home, at school and in the dental practice.	To include tooth brushing clubs in the 0-19s service specification	Anita Dobson (AD)	**Oral health promotion is in the current specification and further detail will be included re tooth brushing clubs.** **Meetings ongoing to shape and develop 0-19s service.**	**Ongoing**
		To facilitate the development of tooth brushing clubs in Early Years settings. • Development of e-learning training	Anita Dobson (AD) / Laura Hammerton (LH) Anita Dobson (AD) / Kate Jones (KJ)	**AD met with Sharon O'Rouke on 17/3/16 to scope roll out of tooth brushing clubs in family centres. AD/LH to take this work forward – meeting scheduled 19/5/16** **AD met with BMBC Bold Training Dept**	**Ongoing** **Ongoing**
(ii) Tooth brushing packs to be distributed via foodbanks	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. Foodbanks provide the opportunity for targeted distribution of tooth brushing packs to people whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services in line with NICE guidance (PH55).	Work with Communities Directorate to enable the distribution of tooth brushing packs via Barnsley Foodbanks	Anita Dobson (AD) / Jayne Hellowell (JH)	**Foodbanks distributing tooth brushing packs** **Planned evaluation to review future distribution arrangements**	**Complete** **December 2016**

Recommendation 3: Reorienting health services to prevention					
Ambition	**Why**	**Planned activity**	**Responsibility**	**Progress update**	**Milestone Dates**
(i) Increased use of fluoride varnish by dental practices in Barnsley	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 home, at school and in the dental practice.	Working with NHS England to influence increasing the use of fluoride varnish by dental practices in Barnsley	Garry Charlesworth (GC) / Anita Dobson (AD)	**Meeting held with NHSE. GC provided information on the Local Professional Network to AD.**	**March 2016**
		Provide dental practice level data and confirm if the Community Dental Service are included in the 61% of Barnsley dental practices applying fluoride varnish	Kate Jones, PHE (KJ)	**Final year figures expected in June – 61% does include CDS.**	**June 2016**
		Healthwatch to work with young champions and parents around access to dentists and will raise awareness of fluoride varnish	Jade Bligh (JB) Healthwatch Barnsley	**Questionnaire provided by Jade for comment prior to work with young people** **JB to provide an update to OHIAG**	**March 2016** **August 2016**

Recommendation 4: Developing personal skills					
Ambition	**Why**	**Planned activity**	**Responsibility**	**Progress update**	**Milestone Dates**
(i) Oral health promotion to be part of Every Contact Counts in social care	The oral health of adults has improved significantly over the past 40 years. Many more people are retaining more of their natural teeth into older age. However almost a third of adults had active tooth decay. In general, people from higher socio-economic groups had better oral health indicators than people from lower socio-economic groups.	To share the service specification to see exact wording as to what is included in terms of oral health	Shiv Bhurton (SB)	**SB provided an extract from the service spec confirming denture and mouth care is included.**	**March 2016** Email from SB
		To share online training links and the latest NICE guidance with Care Homes	Kate Jones (KJ)	**KJ to share online training links and the latest NICE guidance with SB.** **KJ and SB to discuss a pilot online training scheme with two care homes.**	**May 2016**
(ii) Dental service providers in Barnsley to be encouraged to undertake training in Making Every Contact Count (MECC) including brief interventions aimed at alcohol and tobacco use	By working together to support individuals, families and communities to make healthy choices and begin to tackle the wider determinants of health, we aim to maximise individual and community potential and ensure that oral health improvement remains a key focus	Dental practices in Barnsley to be encouraged to undertake training in Making Every Contact Count	Kaye Mann (KM)	**Currently still in the scoping stage. An options paper went to PH DMT on 25.4.16. A final decision on how we take it forward is yet to be made.**	**May 2016**
		Be Well Barnsley to establish if Barnsley Stop Smoking Service can identify referrals from dentists.	Clare Gray (CG)	**BWB have looked into referral sources there are no referrals received from dentist's**	**May 2016**
		Be Well Barnsley to provide monitoring data on clients who have attended a dentist in the last 12 months.	Clare Gray (CG)	**We ask clients if they are registered with a dentist not if they attended in the last 12 months, this data has been collected since January 2016 so far 10 % of clients were not registered with a dentist.**	**May 2016**

Recommendation 5: Strengthen community actions					
Ambition	**Why**	**Planned activity**	**Responsibility**	**Progress update**	**Milestone Dates**
(i) Public Health communications campaigns will provide access to information to enable our population to be proactive and take to take responsibility for their own oral health and wellbeing.	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 home, at school and in the dental practice.	Re-launch of 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.	Kevin Smith (KS)	**BMBC media release Improved dental health among five-year-olds published 31 May 2016, via barnsley.gov.uk/news, Open Mail and social media platforms. This communication includes messages on brushing twice a day, the Superhero campaign and image, regular dentist visits and application of free fluoride varnish.**	
		Evaluate the impact of communications campaign (post March 2015) on dental practice activity.	Mick Speakman (MS) and Anita Dobson (AD)	**Final year figures expected in June before evaluation can be undertaken**	**November 2016**
(ii) Communications will be borough wide with targeted work in areas of additional need.	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.	Targeted communications approach utilising inequalities and oral health intelligence	Kevin Smith (KS) Research & Business Intelligence Team	**Targeted communications in areas of additional need. This work will be progressed according to the milestone date given.**	**August 2016**

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REPORT TO THE HEALTH AND WELLBEING BOARD

9th August 2016

Inspiring a Smoke Free Generation in Barnsley

Report Sponsor: Julia Burrows
Report Author: Kaye Mann
Received by SSDG: 11 July 2016
Date of Report: 26 July 2016

1. Purpose of Report

1.1 This report gives an overview of a programme of work which aims to inspire a smoke free generation across the borough through implementation of a number of smoke free zones including, but not limited to, play parks; town centres zones; school gates and hospital grounds.

2. Recommendations

2.1 Board members are asked to:-

- Support this programme of work which will include:
    - Following public consultation, the introduction of town centre smoke free zones, to be developed and managed through the Town Centre Safety and Security Group.
    - Following public consultation, the introduction of a smoke free play park in each of the 6 Area Councils with a long term ambition of ensuring all 24 key play parks across the borough are smoke free.
    - Following public consultation, the development of proposals which consider the implementation of smoke free hospital grounds using a social norms approach.
    - Following public consultation, the development of proposals which consider the implementation of smoke free school gates and entrances.

3. Introduction and Background

3.1 Hundreds of children start smoking every day[1] and one in two who become long-term smokers will die early as a result[2]. Two-thirds of smokers report

[1] Hopkinson, N. Child uptake of smoking by area across the UK. Thorax doi:10.1136/thoraxjnl-2013-204379.

[2] Smoking statistics illness and death, Action on Smoking and Health, June 2016

that they took up smoking before the age of 18[3]. This programme of work to inspire a smoke free generation across the borough aims to de-normalise smoking and ultimately make it invisible, thereby reducing the number of children and young people who decide to start.

3.2 Research shows that the more spent on comprehensive tobacco control programmes, the greater the reduction in prevalence. Interventions with the biggest, quickest and most sustainable impact on smoking prevalence are those aimed at changing social norms and de-normalising tobacco use.

3.3 Since 1st July 2007 it has been against the law to smoke in virtually all enclosed and substantially enclosed public places and workplaces. The introduction of smoke free zones to project children and young people would not be law but managed through a voluntary code.

3.4 Three out of four children are aware of cigarettes before they reach the age of five, irrespective of whether or not their parents smoke.

3.5 Children and young people are influenced by adult behaviour and are less likely to start smoking if they do not view it as a normal part of everyday life. As smoking becomes less visible and less socially acceptable it will reduce smoking uptake by young or smokers.

4. Proposal and justification

4.1 Smoking prevalence in Barnsley is reducing but rates remain higher than the regional and national average.

4.2 The prevalence of smoking at aged 15 in Barnsley is 10.7%, significantly worse than the England average of 8.2%.

4.3 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%.

4.4 Although smoking in pregnancy has recently reduced to 17.6%, this is still significantly higher than the England average of 10.6%.

4.5 Smoke Free Town Centre Zones

In February 2015, two commercially owned squares in Bristol, the Millennium Square and Anchor Square, became the UK's first major outdoor spaces to become smoking-free zones. Over 60% of people consulted in Bristol said that the squares would be a better place if they were smoke free and 72% of

[3] Young people and smoking, Action on Smoking and Health, July 2015

smokers in Bristol said a smoke free high street was 'not a problem'. Early results showed that a third of smokers had modified their behaviour as a result.

4.6 No other Local Authority has introduced smoke free town centre zones so Barnsley could be the first and lead the way. Smoke free town centre zones will contribute to making a town that is attractive, safe & welcoming but more importantly will help to ensure smoking becomes invisible to protect children's health.

4.7 Smoke Free Play Parks

Cheshire and Merseyside implemented voluntary smoke free play parks between October 2011 and February 2013. An evaluation identified that almost 99% of residents who were consulted supported the code. Sheffield is currently in the process of implementing smoke free playparks after they held a consultation last year which showed that overall 91% of those asked were in favour of a voluntary code (with 58% strongly agreeing).

4.8 The benefits of implementing smoke free zones in Barnsley would be:

- the de-normalisation of smoking so that children and young people are less likely to start to smoke and their health protected;
- a reduction in second hand smoke; and
- an environment that supports quit attempts for people who have chosen to stop smoking.

5. Financial Implications

5.1 Low, medium and full cost proposals to be developed within public health's invest to improve proposals.

6. Consultation with stakeholders

6.1 Consultation about the smoke free programme has already taken place with BMBC's Place and Communities' Directorates, in addition to Barnsley Hospital NHS Foundation Trust. The report has been agreed by SMT and is part of the wider tobacco control plan, which was approved at the Health and Wellbeing Board. Public consultation will form part of each project within this programme of work.

Officer: Kaye Mann **Contact:** 01226 787423 **Date:** 26th July 2016

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REPORT TO THE HEALTH AND WELLBEING BOARD

9th August 2016

REVIEW OF THE BOARD'S RISK REGISTER

Report Sponsor:	Rachel Dickinson (Executive Director: People, Barnsley MBC)
Report Author:	Karen Sadler (Health and Wellbeing Board Project Manager, Barnsley MBC)
Received by SSDG:	17th May 2016
Date of Report:	27th July 2016

1.0 Purpose of Report

1.1 To present for consideration and review the current version of the Board's Risk Register.

2.0 Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Consider the risks outlined in the Risk Register and to review the management and mitigation actions for each risk.
- Consider if any additional risks should be included in the Register for future review.

3.0 Introduction/ Background

3.1 As part of its programme of activity during 2015/16, Barnsley MBC's Internal Audit Service conducted an evaluation of the governance arrangements of the Board. The findings and recommendations emerging through the evaluation were outlined in the final report, published in January 2016.

3.2 Among these findings was that there appeared to be "…..*No regular and timely review of risks and progress of mitigating actions".* As a result, and as part of the review of the Terms of Reference of the Board and the Senior Strategic Leadership Team (SSDG) an updated risk register was submitted for consideration and review by SSDG at its meeting held on 17th May 2016.

3.3 In addition, the Internal Audit evaluation also found that "…..*No risk register for the Better Care Fund had been established".* Through the review of the Terms of Reference of the Board, it has, recently, been established that the management and mitigation of any potential risks concerning performance

against the objectives and priorities of the Better Care Fund, should best form part of the Board's overall risk register.

4.0 Conclusion/ Next Steps

4.1 An updated risk register is, therefore, attached to the report and the Board is recommended to consider and review the set of risks in accordance with its terms of reference.

5.0 Financial Implications

5.1 There are no financial implications arising through reviewing the risk register

6.0 Consultation with stakeholders

6.1 Consultation has taken place with the Council's Internal Audit and Risk Management Service in formulating and updating the risk register.

7.0 Appendices

7.1 Appendix 1 – Barnsley Health and Wellbeing Board Risk Register (July 27th 2016)

8.0 Background Papers

8.1 Barnsley MBC Internal Audit Evaluation of the Governance Arrangements of the Barnsley Health and Wellbeing Board (January 2016)

Officer: Karen Sadler

Contact: Tel. No. (01226 773836 or e-mail karensadler@barnsley.gov.uk

BU 1: Health and Wellbeing Board - as at 27/07/2016

Risk No	Risk Title	Risk Consequences	Risk Owner	Existing Control Measures	Current Score	Prob. & Impact	Target Score	Prob. & Impact	Risk Mitigation Action	Owner	% comp	Review Date	Recovery Plan
3453	Failure to ensure engagement and consultation with stakeholders	Lack of engagement with communities and partners; Board objectives not achieved; Reputational and political implications for the Board;	Health and Wellbeing Board	Engagement Hub; Communications Group; Consultation process ensuring partners/stakeholders views influence the shaping of the H&WB Strategy; Senior Stakeholder Group in place;	Category 3	P = L F = M OI = H	Category 5	P = VL F = M OI = M	Develop Communication Plan 16/17 Formulation of a coherent, relevant & meaningful Strategy and ToR of the Board currently being pursued. Steps to be taken to ensure these are submitted to the executive boards of all member organisations (including Full Council & Area Councils) as part of ensuring individual & collective ownership & adoption of the Strategy. This will include a communications plan to collate the views of service users & public as part of informing the development of the refreshed Strategy & promoting the Strategy. Better Care Fund submission 16/17 - final updates to be undertaken with resubmission due August 2016	Karen Sadler Karen Sadler Karen Sadler	0 70	31/12/2016 31/12/16 31/12/2016	
3454	Failure to produce and refresh the JSNA	JSNA may not fully identify and reflect the ongoing and evolving needs of communities and other stakeholders.	Health and Wellbeing Board	JSNA 2013 - 2016 in place; Timeline for refresh agreed by the Board. Joint Intelligence sub group; BU 15 includes research and business intelligence function;	Category 5	P = VL F = L OI = H	Category 5	P = VL F = L OI = H	New JSNA being developed by Research and Business Intelligence Team and Public Health - due October 2016	Liz Pitt	40%	31/12/2016	
3455	Failure to develop and refresh the H&WB Strategy	Board does not meet its objectives; Health and wellbeing needs of communities and barnsley residents not fully identified; No clear strategic lead;	Health and Wellbeing Board	Strategy 2014 - 2019 agreed by the Board June 2014 - with milestones in place; Senior Strategic Development Group established; Strategy to be developed in 2016 which will include the revised Public Health strategy;	Category 5	P = VL F = L OI = H	Category 5	P = VL F = L OI = H	Refreshed H&WB strategy in development - due October 2016 (strategy to reflect and link to Local Plan for Barnsley)	Karen Sadler	70	31/12/16	
3456	Ensuring that partners consider the strategic elements of the H&WB Strategy in their commissioning plans	Disjointed commissioning of services by partners; Requirements of communities and residents may suffer from poorly commissioned and/or ineffective delivery of services; Potential reputational and political issue for the Board;	Health and Wellbeing Board	Partner input into agreed strategy; Programme boards (reporting to the H&WB) established to commission and deliver services; Joint Commissioning Sub Group established; Performance management metrics and associated targets developed by the Board and performance dashboard developed;	Category 4	P = M F = M OI = M	Category 5	P = M F = L OI = L	As part of the formulation of the revised H&WB Strategy & ToR a Memorandum of Agreement & information/data sharing protocols are to be agreed to support the effective overview & monitoring of the Strategy & Action Plan - engagement taking place at Board level.	Karen Sadler	70	31/12/2016	
3457	Failure to effectively manage partner relationships and expectations	The objectives and priorities of the H&WB may not be fully met; Potential for breakdown of partner working relations, creating tensions within the Board; Reputational and political implications for the Board;	Health and Wellbeing Board	Board membership includes partners; Senior Strategic Development Group established; Work programme and milestones in place; Sustainable Transformation Group in place; Internal Audit report 15/16 - actions complete;	Category 3	P = L F = L OI = H	Category 6	P = VL F = L OI = L	Outcomes of recent development session & learning from evidence based best practice (eg Wiltshire Council) to be implemented. To be complemented by ToR & Memorandum of Agreement as part of ensuring a place based approach - engagement taking place at Board level and via SSDG	Karen Sadler	70	31/12/2016	
3458	Failure to deliver 16/17 priorities	Reputational and political implications for the Board; Partners may become disenfranchised leading to tensions amongst board members; Loss of stakeholder / communities confidence in the Board's ability to deliver expected outcomes;	Health and Wellbeing Board	Programme boards established to deliver priorities; Robust programme management arrangements established; H&WB Strategy 2014 -2019;	Category 3	P = L F = H OI = H	Category 5	P = L F = M OI = M	As part of the refresh of the Strategy & revised ToR, a Memorandum of Agreement, updated risk register & information/data sharing protocols will allow for a more robust overview of performance & risks & enable remedial action to be taken to keep improvements in outcomes on track.	Karen Sadler	70	31/12/2016	

3460	Failure to enable the delivery of a systems/service re-design & integrated pathways	Poor outcomes for Barnsley Communities and residents - expectations not met; Potential reputational and political issue for the Board;	Health and Wellbeing Board	Better Care Fund submission; Senior Strategic Development Group; H&WB Strategy 2014 - 2019; Programme Manager for Stonger Barnsley Together now in post; Joint planning processes in place for Childrens and Adults Partnerships; SSDG and System Resilience Group in place; Role & scope of the Barnsley Stronger Communities Partnership & Strategic Housing Partnership identified & established;	Category 4	P = M F = M OI = M	Category 5	P = L F = L OI = M	Integration will be a strategic priority in the Strategy and reflected in the Barnsley Plan. Going forward, work will continue to build on Barnsley's strong foundations for commissioning and service transformation and integration.	Karen Sadler		31/12/2016	
3795	Failure to deal with the impacts of the emerging Devolution Deal upon local health and wellbeing polcies	Implications for local service delivery; Impact of change upon local service delivery; SCR undertking scrutiny activity regarding health and wellbeing activity;	Health and Wellbeing Board	Health and Wellbeing not included as part of Devolution Deal; If the Mayor of the City Region feels there are opportunities to deliver health functions in a different / improved way there is scope within the Devolution Deal for them to direct change; Consultation taking place August 2016;	Category 4	P = M F = L OI = M	Category 5	P = M F = L OI = L	Monitor and review 16/17	Karen Sadler	25	31/12/2016	
3845	Failure to achieve the outcomes sought throught he local Better Care Fund plan	Short term impact on reducing hospital, residential and nursing care admissions, delayed discharges and improving the re-enablement of older people living indepenently; Long term impact on transformation of health and social care;	Health and Wellbeing Board	Section 75 Agreement between Barnsley MBC and Barnsley CCG setting out commissioning arrangements, risk share and performance against targets managed through Adult Joint Commissioning Services; Monitoring of the local BCF plan;	Category 3	P = L F = M OI = H	Category 5	P = L F = M OI = M		Lennie Sahota, Jane Wood, Jamie Wike			

REPORT TO THE HEALTH AND WELLBEING BOARD

9th August 2016

LOCAL DIGITAL ROADMAP

Report Sponsor:	Lesley Smith
Report Author:	Jade Rose
Received by SSDG:	20 June 2016
Date of Report:	27th July 2016

1. Purpose of Report

1.1 To share with the Health and Wellbeing Board the final version of the Local Digital Roadmap that was submitted to NHS England on the 30th June 2016.

2. Recommendations

2.1Health and Wellbeing Board members are asked to:-

- Note the content of the Local Digital Roadmap
- Retrospectively endorse the Local Digital Roadmap

3. Introduction/ Background

3.1 The Five Year Forward View makes a commitment that, by 2020, there would be "fully interoperable electronic health records so that patient's records are paperless". This was supported by a Government commitment in Personalised Health and Care 2020 that "all patient and care records will be digital, interoperable and real-time by 2020". This has been distilled into the ambition that health and care professionals will operate 'paper-free at the point of care' by 2020.

In September 2015, a three-step process began to enable local health and care systems to produce Local Digital Roadmaps (LDRs) by **30 June 2016**, setting out how they will achieve the ambition of 'paper-free at the point of care' by 2020. The first step was the organisation of local commissioners, providers and social care partners into LDR footprints. The second step was for NHS providers within LDR footprints to complete a Digital Maturity Self-assessment. Both of these steps have now been completed and each LDR footprint is asked to develop and submit its own Local Digital Roadmap by the June deadline.

Local Digital Roadmaps will be assessed in July 2016 within the broader context of the assessment of Sustainability and Transformation Plans (STP). Further details on the process will be published in due course. It is understood that all footprints are

expected to be 'investment ready' by November 2016 to be in a position to access 2016/17 Drive Digital Funds.

The attached final LDR and associated appendices have been in development since the publication of the guidance in late April with partners from across the system.

4. Appendices

4.1 Appendix 1 – Barnsley Digital Roadmap Narrative
4.2 Appendix 2 – LDR App1 Capability Deployment Schedule
4.3 Appendix 3 – LDR App 2 Capability Trajectory
4.4 Appendix 4 – LDR App 3 Universal Capabilities Delivery Plan
4.5 Appendix 5 – LDR App 4 Barnsley Information Sharing Approach
4.6 Appendix 6 – LDR Appendix 5 – Barnsley LDR

Officer: Jade Rose **Contact:** jade.rose2@nhs.net **Date:** 27th July 2016

BARNSLEY DIGITAL ROADMAP

NHS
Barnsley Clinical Commissioning Group
Putting Barnsley People First

Barnsley Healthcare Federation

Barnsley Hospital NHS
NHS Foundation Trust

BARNSLEY Hospice

BARNSLEY
Metropolitan Borough Council

South West Yorkshire Partnership NHS
NHS Foundation Trust

Barnsley Digital Roadmap

Contents

Section

1. General

The Barnsley Local Digital Roadmap (LDR) has been endorsed by the Chief Officer of NHS Barnsley CCG on behalf of NHS Barnsley CCG Governing Body.

During the development of the LDR, draft versions of the document have been shared in a number of forums for comment including the;

- Barnsley CCG Governing Body
- Barnsley Senior Strategic Development Group;
- Barnsley IT Strategy Group
- Barnsley CCG IT Group
- Barnsley Healthcare Federation Executive Team
- South Yorkshire and Bassetlaw LDR Development Group
- South West Yorkshire Partnership Foundation Trust IT Forum and Executive Management Team

The Barnsley LDR has been developed by a small multi-agency sub group of the Barnsley IT Strategy Group. Lead individuals from all organisations have met to understand the Digital Maturity Index and baseline position across Barnsley. The small multi-agency group have then collaboratively developed the LDR and shared this within their individual organisation for comments and feedback. The LDR has been shared across the system in organisational and system wide meetings to ensure that there is a broad understanding of the direction of travel, approval of the LDR content and ambition and commitment at a very senior level to support the implementation of the LDR. It has also been shared with a wider audience outside of formal meetings to ensure as much input as possible from across the system including across the Local Authority and Barnsley Hospice.

Yorkshire Ambulance Service is a key partner in the delivery of health and care services across Barnsley. For the purposes of the Digital Roadmap, the information that they have shared with all partners will be submitted for assessment within the Sheffield Digital Roadmap.

There are strong links between the development of the Barnsley LDR and the South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformation Plan. This has primarily been through the Barnsley CCG Accountable Officer who is the CCG Accountable Officer Lead for the South Yorkshire and Bassetlaw STP and also Chair of the Barnsley IT Strategy Group, member of the Barnsley Health and Wellbeing Board and Barnsley Senior Strategic Development Group. The CCG lead for the development of the LDR is also one of the Leads for the Digital work stream within the Sustainability and Transformation Plan. The Barnsley CCG lead is also part of the South Yorkshire and Bassetlaw LDR leads group which allows joint working and a regional approach to the development of the LDR. This offers significant opportunity for cross pollination and alignment of the two plans during the current development phase.

Significant contributions have been made to the Barnsley LDR by;

Barnsley Clinical Commissioning Group
South West Yorkshire Partnership Foundation Trust
Barnsley NHS Hospital Foundation Trust
Barnsley Healthcare Federation
Barnsley Metropolitan Borough Council
Barnsley Hospice

The final version of the LDR has been endorsed by the IT Strategy Group. Following submission at the end of June a final version will be shared widely across the system including:

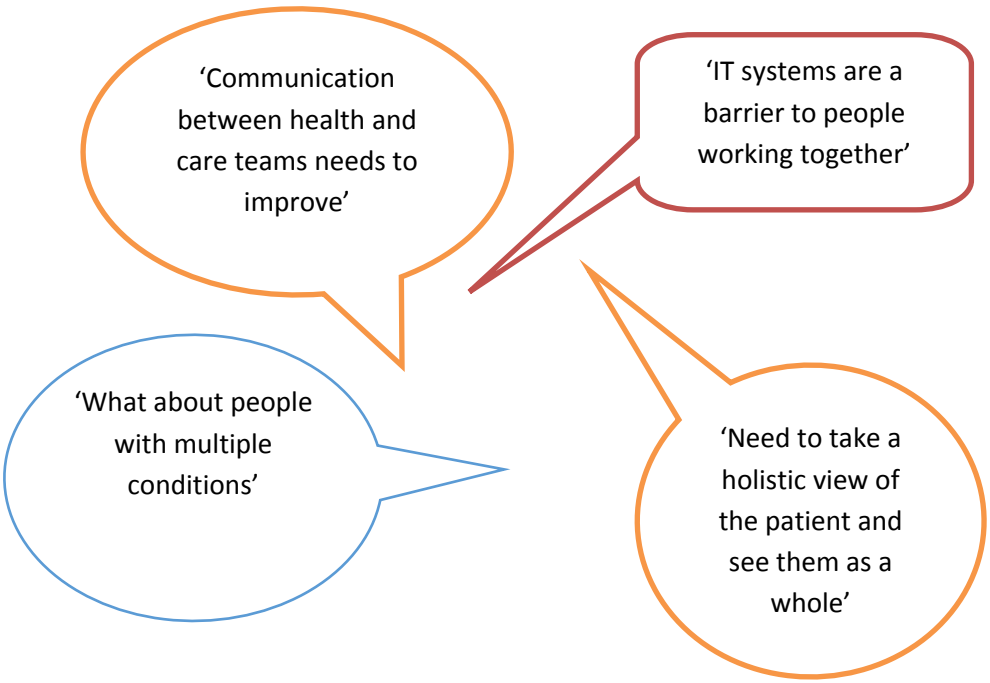
Organisation	Endorsed by	Date
	Barnsley Health and Wellbeing Board	10th August 2016
	Senior Strategic Development Group	13th July 2016
NHS Barnsley CCG	Governing Body	14th July 2016
Barnsley Hospice	Board of Trustees	4th August 2016
Barnsley NHS Foundation Trust	Trust Board	28th June 2016
South West Yorkshire Partnership Foundation Trust	South West Yorkshire Partnership Foundation Trust IT Forum and Executive Management Team	August 2016

2. Vision

In Barnsley, we know from a range of engagement activity over the past few years that our communities are frustrated when communication between services and between services and patients fail – this also leads to waste in the system and poor experiences. Simultaneously, as growing numbers of people have increasingly positive experiences of digital technology in everyday life, the disparity between commercial services and the health sector is becoming more and more apparent.

We are also starting to see examples of patients choosing to be digital innovators. Where this is right, safe and beneficial for the citizen, it can work extremely positively. We actively acknowledge that there is some hesitancy and concern within the community, especially older people, and that patients need to be assured that their data will be safe.

An indication of current challenges relating to digital capabilities within Barnsley is illustrated below from an engagement event held in February 2016. The theme of the event was 'Integration' in the broader sense. Attendees included representation from patient reference groups, the Patient Council and other interested citizens from across Barnsley.



Barnsley Digital Vision

Within Barnsley our vision for digital maturity is clear. We will;

- ✓ Transform the way in which we engage with citizens; empowering them to maintain their own health and wellbeing through digital solutions
- ✓ Transform the way in which health and care providers, our voluntary and charitable sector organisations engage with patients within their communities
- ✓ Accelerate mechanisms that promote record sharing and support access to data for those working within a community setting
- ✓ Enabling clinicians to provide the best care in all settings by the use of mobile technology.

Barnsley IT Strategy

The Barnsley wide IT Strategy sets out two key priorities to support the delivery of the above vision. These are;

- Supporting the development of universal information and advice to enable citizens to self-care and self-manage their health and wellbeing
- Enable the sharing of information and the integration of health and care records

The digital priorities for Barnsley fall within the wider vision as set out in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) Digital Work Stream which is below.

Within Barnsley there is a set of key principles that we apply to the implementation of digital. These are;

1. To improve the way we work together
2. To have a user centred design
3. To reduce rather than exacerbate health inequalities

South Yorkshire and Bassetlaw STP Digital Vision

Our digital health strategy has three essential elements.

- Citizen and Patient Empowerment
- System integration and operational efficiency
- Strategic decision support

Our future technology enabled communities will therefore be characterised by:

- Enabling health and care providers' access to appropriate patient clinical electronic data across traditional boundaries, agnostic of staff employer or organisation. Having a Shared Care Record in place, accessible to clinical staff or those who need it wherever they are, is the single most important change we need to make. As we develop plans for clinical services across the wider SYB footprint, we will inevitably see our patients moving between organisations to receive care. Therefore it makes sense that our ambition for Shared Care Records extends across this larger footprint. Access to Shared Care Records is particularly important for urgent and emergency care, but such a system would have significant benefits for clinical care. This ambition:

- Will require up to date hardware and wireless networks so that access to data is fast and easy for our citizens, patients, carers, staff or wider health and care communities.
- Will require us to develop clear rules within which we operate to ensure appropriate governance and security for patient data as well as interoperability of systems and technologies now and into the future. Consequently, data, data management and systems will be subject to agreed national and local standards supporting ongoing interoperability.
- Will incorporate data from multiple sources including NHS and social care as well as other public and voluntary or charitable organisations and include citizen generated data from citizen controlled devices and innovations
- Will mean citizens and patients take greater ownership for their health and wellbeing. They will be supported to do this through technology which promotes prevention as well as self-care and management.

- Innovation and learning will be part of our DNA, translated into rapid deployment of technology (e.g. related to access, devices, apps etc.) and signposting where helpful to achieve improved health and wellbeing outcomes. This will need us to also concentrate on improving digital literacy so that interventions help to bridge, not exacerbate, the digital health divide and health inequalities across our broad socio-economic communities. Personal health and wellbeing digital data needs to be as 'consumable' for health and care professions as for citizens and patients in order to maximise potential.

- Robust population based analytics, supporting risk stratification and system alerts which result in rapid response and appropriate interventions tailored to the individual's needs.

Within the next five years our system will therefore deliver a new way of supporting and working in partnership with communities to achieve improvement in health and wellbeing outcomes and address current health and care challenges.

Gap	**How we will address the Gap**
Care and quality	- Shared records offering increased access to relevant, real time, information about a patient by health and care providers as well as patient authorised viewers - Develop interoperability to enable effective transfer of care across providers through e-referral and discharge processes - Promote mobile working of practitioners through Wi-Fi accessibility and roll-out of mobile devices for practitioners
Health and	- Citizens will have significantly more control over their care, and experience better outcomes through improved treatment

wellbeing	and medication adherence as well signposting to appropriate services within their community - Proactive care will reduce frequency of exacerbation, and co-ordinated care will address their health and care needs holistically - including mental health - Promotion of remote monitoring, new forms of consultation (e.g. video, phone) and mHealth will also support care based in the citizen's own home, reducing the burden of routine care on patients, their cares and families, and health professionals. - We will develop new integrated self-care technologies to support citizens, patients and carers to manage their own wellbeing - We will develop a universal advice and information approach and offer to citizens
Finance and sustainability	- We will develop combinatorial technologies to promote increased efficiency in the ongoing care and management of patients. - Greater integration of care will mean increased opportunity for admission avoidance - Increased reliance on validated risk stratification and population analytics will enable more efficient case finding and targeted intervention - Remote monitoring and surveillance will mean earlier intervention to avoid unnecessary use of secondary care resources and effective use of community based resources - Better tracking and scheduling of staff resources will enhance operational efficiencies - Reduced DNAs through easy access to GP booking systems, reminders, patient self-reporting/recording and active self-management - Clinicians able to use their time more effectively through the use of technology

3. Baseline Position

In preparation for the development of the Local Digital Roadmap the two secondary care providers in the Barnsley footprint carried out a Digital Maturity Assessment in between November 2015 – January 2016. A summary of the results from this initial assessment of the two providers is shown in the table below.

Section	Type	BHNFT	SWYPFT	National Average
Strategic Alignment	Readiness	85	63	76
Leadership	Readiness	95	70	77
Resourcing	Readiness	90	75	66
Governance	Readiness	50	70	74
Information Governance	Readiness	88	92	73
Records, Assessments & Plans	Capabilities	12	45	44
Transfers Of Care	Capabilities	49	29	49
Orders & Results Management	Capabilities	59	14	52
Medicines Management & Optimisation	Capabilities	9	3	29
Decision Support	Capabilities	13	73	36
Remote & Assistive Care	Capabilities	8	42	33
Asset & Resource Optimisation	Capabilities	35	35	42
Standards	Capabilities	29	6	41
Enabling Infrastructure	Enabling Infrastructure	70	70	68
Readiness Average	**Readiness**	**82**	**74**	**73**
Capabilities Average	**Capabilities**	**27**	**31**	**40**
Enabling Infrastructure Average	**Enabling Infrastructure**	**70**	**70**	**68**

As can be seen from the table above the assessment scores for the Barnsley footprint identify that our current level of development is consistent with the national position. A key insight is that our organisational readiness is strong but capabilities still need to be developed. Nationally the capability areas where it has been identified that there is particular room for growth are medicines management, decision support and remote care. Our scores indicate that these are also key development areas for Barnsley along with transfers of care, orders and results management, asset and resource optimisation and standards.

In addition to the above exercise, Barnsley CCG has submitted a Digital Maturity Assessment for primary care and BMBC has been asked to complete a Digital Maturity Assessment via the Local Government Association. Analyses of the results for these assessments are still to be published for the Local Authority. The primary

care results were published towards the end of June and will be interpreted locally with national support through advertised webinars to be included in further iterations of the LDR.

An overview of the current digital maturity of the primary, secondary and social care providers within the Barnsley LDR footprint along with a summary of their recent achievements and current initiatives is given below:

Primary Care

Overview of Maturity

There are 36 GP Practices in Barnsley, 28 of which are member practices within a single GP Federation, Barnsley Healthcare Federation. There is a range of digital maturity across these practices. There are currently 2 dominant clinical systems in use across Barnsley practices and a range of document management systems in place. There is currently a move towards paper light and paper less working in some practices. Most practices are already operating 'paper free at the point of care' with no reference to paper based notes during patient consultations. Despite developments towards paper light and paper less working, there is still a reliance on fax communication in some areas.

Key recent achievements within primary care include:

- Over 85% take up of the Medical Interoperability Gateway (MIG) by local practices to enable real time sharing of clinical data between health and social care organizations.
- Primary Care Access to Secondary Care Radiology reporting and imaging
- Wi-Fi enabled in 35 of the 36 practices
- 100% rollout of electronic requesting of medical imaging from within the ICE system.
- The ability of Barnsley GPs now to see lab results and x-ray reports from South Yorkshire and Bassetlaw hospitals which their patients have attended as well as those from the local hospital.
- GPs can receive electronic copies of hospital inpatient discharge letters (D1s) into their clinical systems as well as NHS 111 and out of hours reports from deputising service.

Current initiatives within primary care include;

- Roll out of MIG to remaining primary care practices
- Roll out of MIG to wider system including BHNFT, SWYPFT, Barnsley Hospice in phase 1. This will allow clinician access to patient's own GP records when needed both in and out of hours
- Minimum 10% of patients registered for online services at each GP Practice for 2016/17 (rising to 20% in 2017/18)
- Develop a collaborative approach towards paperless/light running across all Practices

Barnsley Hospital NHS Foundation Trust

Overview of Maturity

Core Capability	Barnsley Hospital Maturity Q1 2016/17 Status
Records, assessments and plans	Very Immature (Missing Capability)
Transfers of care	Immature (Some Capability – Not Tested)
Orders and results management	Fairly Mature(not all specialities) – In operation
Medicines management and optimisation	Very Immature (Missing Capability)
Decision support	Very Immature (Missing Capability)
Remote care	Very Immature (Missing Capability)
Asset and resource optimisation	Immature(More optimisation required)

Barnsley Hospital NHS Foundation Trust is fairly immature in their use of technology to support patient care. Although there is excellent technology in use at departmental level the organisation as a whole is dependant paper records throughout the trust as the formal record of care. There are also some fundamental technical and clinical functionality which need to be developed.

As part of this digital roadmap the hospital is embarking on an aspirational journey towards paperless 2020 where it is seeking to deliver prescribing, digitisation, clinical portal and assessment missing capabilities.

Key recent achievements include;

- Primary Care Access to Secondary Care Radiology reporting and imaging
- Electronic Radiology requesting
- E-forms capability initiated
- Lorenzo Optimisation programme established
- Digitisation capability established
- Vital Signs Business Case agreed at Trust Board
- Medworxx system flow bed management project established
- Bluespier Theatre replacement project established
- Radiology reporting

Key current initiatives

- Dermatology Electronic records
- Endoscopy Reporting and Requesting
- Results and reporting programme
- Working towards sending outpatient letters direct to all GP clinical systems in Barnsley

South West Yorkshire Partnership Trust

Overview of Maturity

Core Capability	South & West Yorkshire Partnership FT Maturity Q1 2016/17 Status
Records, assessments and plans	Immature (Limited Capability)
Transfers of care	Immature
Orders and results management	Limited capability
Medicines management and optimisation	Very Immature (No Capability)
Decision support	Reasonably Mature
Remote care	Fairly Mature (Limited Deployment)
Asset and resource optimisation	Immature(More optimisation required)

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) has over the last 2 years made significant inroads in terms of their use of technology to support patient care through its ever expanding service transformation programme of works. The Trust's main two clinical information systems, RiO for Mental Health Services and SystmOne for Community/Children's Services are core components of the SWYPFT electronic care record (which are both National Spine enabled) which all care professionals utilise to capture clinical interventions as part of the formal record of care including clinical notation, clinical assessments and care planning. There remains a degree of immaturity in relation to archived/historic paper records dependencies but solutions are being implemented that will address this during 2016/17. Whilst the Trust remains relatively immature in respect of medicines management/ePrescribing capabilities, a programme of work is in the planning stage to address this area for development.

In support of the wider digitisation agenda, the Trust has a major investment programme that is well established that has enabled approximately 2000 staff to work in an agile manner with the capability to access and record clinical care information electronically. As part of the Trust's digital roadmap and drive towards a paperless 2020, clinical information systems interoperability (integration) capabilities were established during 2015/16 and work is actively progressing the flow of eDischarge summaries to primary care together with improved integration between the Trusts main clinical information systems.

Aligned to this work, SWYPFT has also commissioned and is developing its own Trust-wide clinical portal which serves to improve accessibility to holistic virtual electronic care record information. SWYPFT is also working collaboratively with partners (primary care, secondary care and health and social care providers) across its geographical boundaries in exploring wider clinical interoperability opportunities in response to CCG/Commissioner SDIPs requirements, the Trusts integration

roadmap reflects the opportunities that these collaborations will bring and the key objective of this development will be to deliver shared care capabilities to clinical services to improve the delivery of patient care and personalised care.

Key recent achievements include;

- Mobile working Phase 1 (up to 2000 staff)
- Telecoms replacement Phase 1
- VPN replacement
- Unified Comms – Skype for business
- Year 1 infrastructure development
- SystmOne EPRCore
- SystmOne Full Clinical Deployment
- Smoking Cessation

Key current initiatives

- RiO Upgrade to Version 7
- Clinical Portal Phase 1 and 2
- Mobile working Phase 2 (800 staff)
- Wi-Fi accessible on all Trust sites
- Wi-Fi accessible on all Partner sites
- Year 2 infrastructure development
- Medicines Management / e Prescribing
- Business Intelligence development
- Medical records scanning
- Digital dictation
- Review of options available to the Trust to re procure the Mental Health clinical information system within the next 1- 2 years
- Investigation & development of apps to support and improve service user care and recovery

Barnsley Metropolitan Borough Council

Overview of Maturity

Barnsley Metropolitan Borough Council (BMBC) has some pockets of digital maturity across the organisation but overall it is in a state of digital immaturity. The base provision to enable paperless service provision is currently being rolled out to staff. This includes mobile devices, tablets or laptops and a secure VPN connection back to all of our systems. It is not currently possible to connect to a number of systems directly, particularly those used by Children and Adults social care. Neither department can currently access, amend or add records in either a live or offline capability. This function will be delivered to both social care teams within the next few years beginning with the Adult Social Care team. It is envisaged this would be achieved via direct access to the system rather than via offline and syncing technologies. This will allow for real time updates. A pilot will take place during 2016 with a full rollout to Adult Social Care completed during 2017 and Children Social Care by the end of 2018.

0-19 staff are moving back to the BMBC and will be given access to SystmOne, mobile equipment and Wi-Fi access. This will be completed in 2016.

Further developments of integrated working with South Yorkshire Police (Public Services Hub) are likely to create additional technology developments that enable greater integration of systems to enable effective deployment of resources across the system, particularly in relation to people and families with multiple and complex needs.

Key recent achievements include;

- VPN solution for social care staff

Key current initiatives and known requirements include;

- Mobile devices for all social care staff
- Access to SystmOne for 0-19 provision
- Wi-Fi across all sites for both BMBC staff and partners
- Development of system integration capabilities between South Yorkshire Police and the Council
- Potential development of system integration capabilities between South Yorkshire Fire and Rescue and the Council
- Digital Development Programme
- Prevention and Early Intervention including Assistive Living Technology
- Universal Advice and Information to create an accessible information standard
- Specific Independent Living project to connect systems with partner systems

Barnsley Hospice

Overview of Maturity

Barnsley Hospice currently uses iCare as its main clinical System. Through this it has introduced 'paper light' meaning all care plans, assessments and patient notes are created and stored digitally across the Inpatient Unit and Daycare services, with expansion into Therapy Services on the roadmap.

Patient and GP letters are now created and stored electronically through use of mail merge within the iCare system across all Hospice Services with the exception of Bereavement Support and Complementary Therapies, which are currently in the process of being introduced.

External professionals are also using the system when attending patients on the Inpatient Unit, which has eliminated the need to keep paper based 'Multi-disciplinary Team' records (Pharmacists access relevant doctors notes, and the Physiotherapist and Social Worker both use the system to access notes and to create their own electronic notes. The Physiotherapist also has an electronic assessment document).

The Hospice has an N3 connection which is separate to the Hospice network and is restricted to a small number of computers providing access to ICE, Impax and EPR core.

The current level of access to patient records, for example, X-rays is via ICE via the hospital, and we have to still rely on faxes via a dedicated fax machine for receipt of referrals and we still obtain paper records/ patient notes from the hospital.

Key recent achievements include;

The Inpatient Unit is currently using a combination of laptops and hand held devices to carry out assessments at the point of contact with a patient using the Hospice's secure Wi-Fi connection (unsecure Wi-Fi is available separately for Hospice patients and visitors). This is paving the way for mobile working should the Hospice decide to move to remote hosting for its patient information system - an option which is perfectly feasible with the current system, but brings financial considerations - meaning two way access to Hospice records would be available for domiciliary visits, and for any future remote clinics, should the Hospice be in a position to fund the remote hosting option.

The key current initiatives are;

The Hospice shares information holistically across all its departments and is due to implement the MIG imminently, which will enable access to wider community healthcare electronic records. However this is presently not reciprocal as the Hospice is unable to import information to the shared portal without rolling out use of (for example) SystmOne which is in the Hospice's strategic plan

Financial constraints and current infrastructure restrict the deployment of the services across the network and limits the wider use of shared systems currently.

Yorkshire Ambulance Service

YAS can provide world-class care for the communities it serves by providing and coordinating access to Urgent and Emergency Care in Yorkshire and Humber, ensuring the right care to patients close to home following their first contact.

Key recent developments include the implementation of a new digitally enabled model of care ensuring the right care to patients close to home following their first contact. Inclusion within the Urgent and Emergency Care Vanguard in West Yorkshire Urgent and Emergency Care Network has meant that this new "Hear, See and Treat" model can be deployed across the wider Yorkshire and Humber Region. The "Hear and Advise" element of the service (or the Clinical Advisory Service) can be broken down into two elements:

Clinical Advice focuses on the development of a multidisciplinary team to provide specialist clinical advice to patients and frontline staff.

Care co-ordination ensures that patients are proactively and appropriately navigated or signposted to key services by booking and liaising with the relevant services.

The "See and Treat" element of the model concentrates on the development of services that will respond to a patient's urgent need in their home or in situ; avoiding emergency services where appropriate. The development of both elements requires mobile working in combination to access to data and records that support our practitioners to understand the needs of the patient better and sign-post them appropriately.

Barnsley Citizens

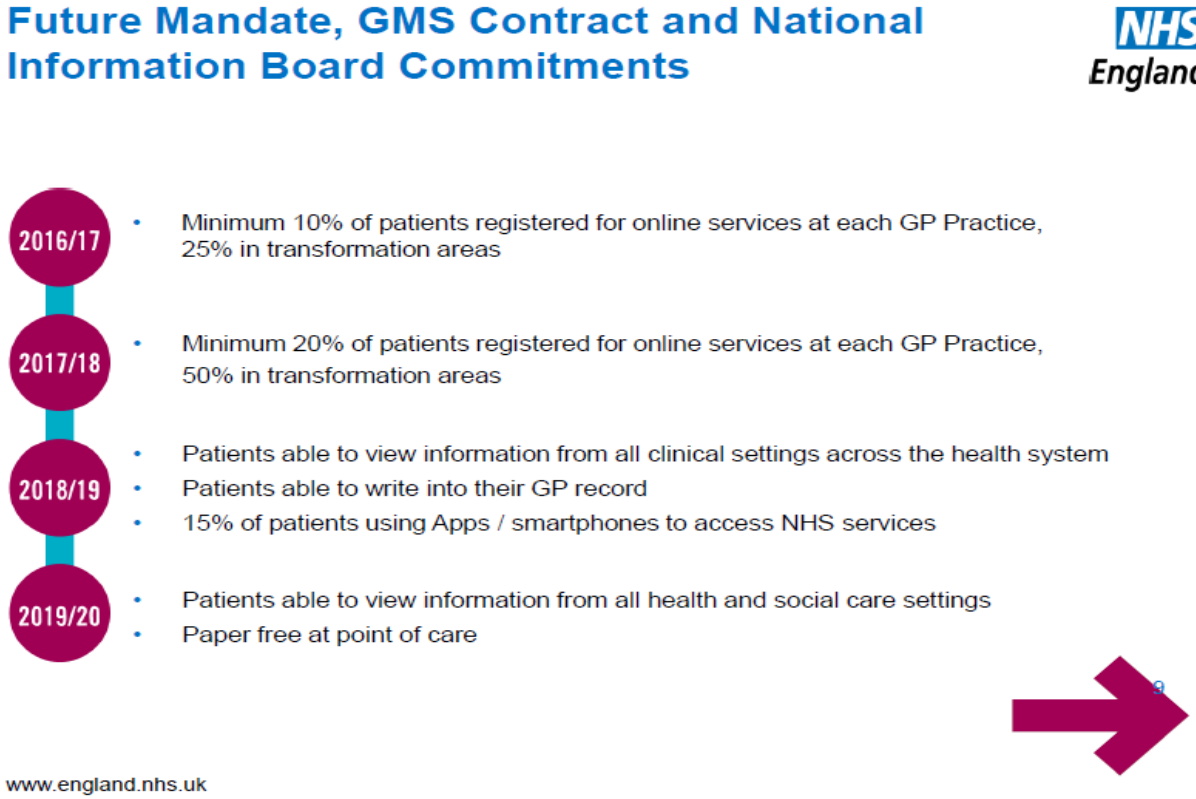
Recent information published by the Office of National Statistics on Internet Users in the UK, 2016[1] is set out in the table below.

Persons aged 16 years and over												%
	Used in the last 3 months						**Used over 3 months ago/Never used**					
	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
UK	**79.4**	**80.9**	**83.3**	**85**	**86.2**	**87.9**	**20.3**	**18.9**	**16.5**	**14.8**	**13.5**	**12**
Yorkshire and the Humber	**78.4**	**78.8**	**82.4**	**83.6**	**85.3**	**85.9**	**21.4**	**21**	**17.4**	**16.3**	**14.4**	**13.6**
Barnsley, Doncaster and Rotherham	80.4	74.4	79.2	82.2	81.9	78.3	19.3	25.5	20.3	17.8	17.9	21.7

The table above demonstrates that although internet use is common across Barnsley, Doncaster and Rotherham, it is still below the Yorkshire and Humber and UK average. This needs to be considered as part of all digital initiatives to ensure that the use of modern technology does not widen the pre-existing health inequalities across Barnsley. In addition to this, local surveys during the development of local services in Barnsley have also found that 85% of residents surveyed have access to a smart device.

Whilst we recognise there are opportunities for development in our digital maturity, we understand as a community where the greatest resource and effort needs to be applied in order to support our delivery of our transformational agenda. Our capability trajectory demonstrates a clear intent for how our secondary care providers will develop its seven PF@PoC capabilities over the next three years and achievement of the National Information Board commitments (see below).

[1] http://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2016
http://www.ons.gov.uk/file?uri=/businessindustryandtrade/itandinternetindustry/datasets/internetusers/current/internetusers2016datatables.xls



Rate Limiting Factors

There are a number of rate limiting factors in progressing paper free at point of care delivery across the system. The key factors have been identified as;

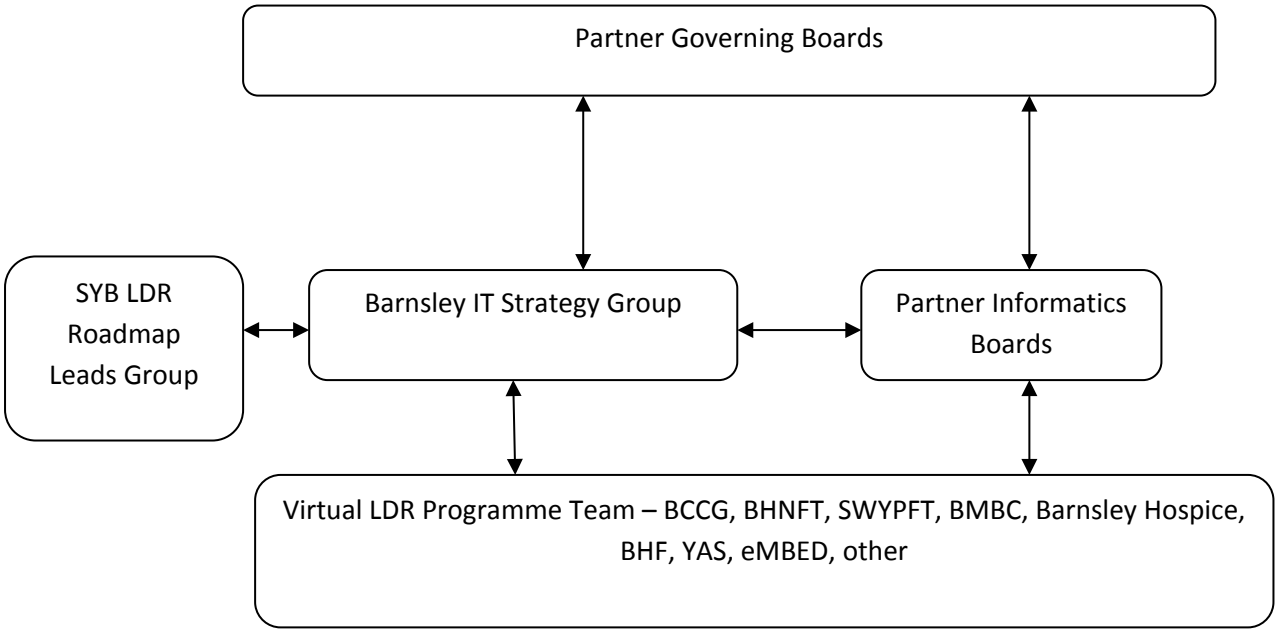
1. Limited project management resource across the system
2. Limited development resource across the system
3. Limited change management resource across the system
4. Limited clinical time for clinical engagement across the system
5. Limited technical expertise capacity across the system
6. Funding for infrastructure and technology
7. Feedback on capital funding bids delays ability to move forward with IT improvements and efficiencies
8. Lack of interoperability within the health and social care community
9. Information governance and data sharing
10. Number of primary care providers and utilisation of different systems
11. Alignment and cohesiveness from NHS and LGA national bodies to support the delivery of the digital vision, paper free at the point of care, tackling variation and delivering universal capability

4. Readiness assessment

The health and care organisations across Barnsley have a strong history of integration and working effectively together.

There is an established system wide IT Strategy Group across Barnsley which has Officer/Director representation from the organisations involved in the roadmap and also has two CCG Governing Body GPs within the membership who are the IT Leads within the CCG. The seniority of the group provides strong leadership for digital transformation within respective organisations and across the system. The baseline maturity index shows that we scored highly for digital leadership for organisations across Barnsley. Our average score was 77%. This indicates that we are in a strong position to take forward the digital transformations that are set out within the LDR for Barnsley.

It is expected that the progression of system wide IT developments will continue to be reported to the IT Strategy Group and pre-existing organisational governance arrangements as shown in the diagram below. This may be reviewed as stronger links are developed across the South Yorkshire and Bassetlaw footprint and especially as the Digital work stream of the Sustainability and Transformation Plan gains traction.



Barnsley does not currently have a shared Programme Management Office or project resources. Therefore initial delivery of the LDR will be managed using the collective resource of the partner organisations working together to ensure that changes are managed and communicated effectively.

Monitoring and reporting on the LDR delivery will be carried out by Barnsley CCG as part of their responsibility to the Barnsley IT Strategy Group. Over the course of the LDR programme, we will review and assess the structure and resources required to support effective delivery through the IT Strategy Group and make changes as required. We will also continue to participate in the development of potential programme/project resources at the SYB STP level to identify where resources supporting the LDR could be best shared across the wider area.

The Chief Officer is the Officer Lead for IT within the CCG. The CCG currently contract with eMBED to provide IT support. This arrangement is embryonic having been in place for only 3 months at the time of LDR submission.

The Practice Managers across Barnsley are also engaged in digital developments and there are 4 individuals that routinely work with the CCG in different capacities with a keen interest in driving digital development across the Borough to support patient care.

It is understood that the deployment of technology alone will not deliver the change that we collectively want to see for our patients and citizens. A strong change management approach is required to deliver the benefits of digital transformation through behaviour change and new ways of working with technology. In the past we have used a range of change models including Microsystems, PDSA Cycles and the NHS Change Model across the system. We will seek to localise the best approach for Barnsley. For any change programme across the Barnsley system we expect to deploy a standard change and programme management approach ensuring that engagement of and communication with our stakeholders is paramount. We currently have different Project Management Offices across the different organisations. We expect that we will use this resource across the system to ensure that change is managed and communicated effectively and that teams can work virtually across organisational footprints.

Across the extended South Yorkshire and Bassetlaw footprint, we have the Working Together Provider Collaborative. Within this, there is a dedicated work stream looking at IT provision across the 7 acute trusts within this collaboration. There is also the potential to share resource, knowledge, information, learning, skill and so on across this wider footprint. Again, this may progress with additional pace once the Sustainability and Transformation Plan for SYB is approved and the Digital Work stream can develop at scale.

Within the LDR footprint there is not a common benefits management approach. Discussions across the system have identified that currently the approach to manage technology enabled change and benefits management at an organisational level does not follow a standard methodology. Our discussions on benefits management in particular have raised awareness that partner organisations may not currently have the required skills or resources to provide a formal benefits management

programme. We are clear to that to achieve benefits requires addressing 3 elements; people, process and technology. It also requires significant documentation of the baseline position so that variances from baseline can be observed and accounted for. We will therefore identify appropriate benefits management models and implement them within our LDR community. These requirements have also been discussed at the SYB LDR Leads Groups and are noted as a common requirement across several of the constituent LDR footprints. We will therefore seek to assess if these skills and resources could be provided and shared on a wider footprint.

The existing budgets for IT Capital and Revenue are already over committed throughout Barnsley. It is expected that to drive digital maturity further and faster in Barnsley that we will need access to additional funding. There are a number of potential sources for this including;

- The Driving Digital Maturity Investment Fund
- NHSE Strategic Estates and Technology Transformation Fund
- GP Access Fund (previously known as Prime Minister's Access Fund*)
- Integrated Pioneer Site Funding (Barnsley is a Pioneer site)
- Additional funding opportunities, for example, through Local Government and charities

* Of note, the Barnsley Healthcare Federation has received £2.3 million in 15/16, £760k in 16/17 and funding has been agreed through to 2021.

There is a strong history of partnership working across Barnsley. It is anticipated that this will form the bedrock of the LDR. It is clearly understood that we need to utilise our scant resources more effectively through information sharing, economies of scale, sharing expertise and so on. By working on a health and care system across Barnsley we will focus on how best to spend the 'Barnsley pound' to ensure that we get the best outcomes and digital advances for patients and citizens of Barnsley.

5. Capability Deployment Strategy

Operating Paper Free at the Point of Care is about ensuring health and care professionals have access to digital information that is more comprehensive, timelier and better quality, both within and across care settings. Its scope is defined by the following seven groups of capabilities;

- Records, assessments and plans
- Transfers of care
- Orders and results management
- Medicines management and optimisation
- Decision support
- Remote care
- Asset and resource optimisation

The current level of maturity of Barnsley's secondary care providers for the above groups of capabilities, as assessed by the digital maturity assessment is detailed below:

Group of Capabilities	BHNFT	SWYPFT
Records assessments and plans	12	45
Transfers of care	49	29
Orders and results management	59	14
Medicines management and optimisation	9	3
Decision support	13	73
Remote Care	8	42
Asset and resource optimisation	35	35

The above table identifies that the level of maturity across our two secondary care providers for these capability groups is variable with some low levels of maturity for both providers in certain groupings. The assessment indicates that there is further work to be done across all capability groupings to enable Barnsley to realise the ambition of operating paper free at the point of care.

As described in our vision the partners in the Barnsley LDR footprint are committed to the further delivery of digitised and shared care records across Barnsley as there will be essential to the delivery of many of our strategic ambitions. We are also committed to working with our wider partners across the wider South Yorkshire and

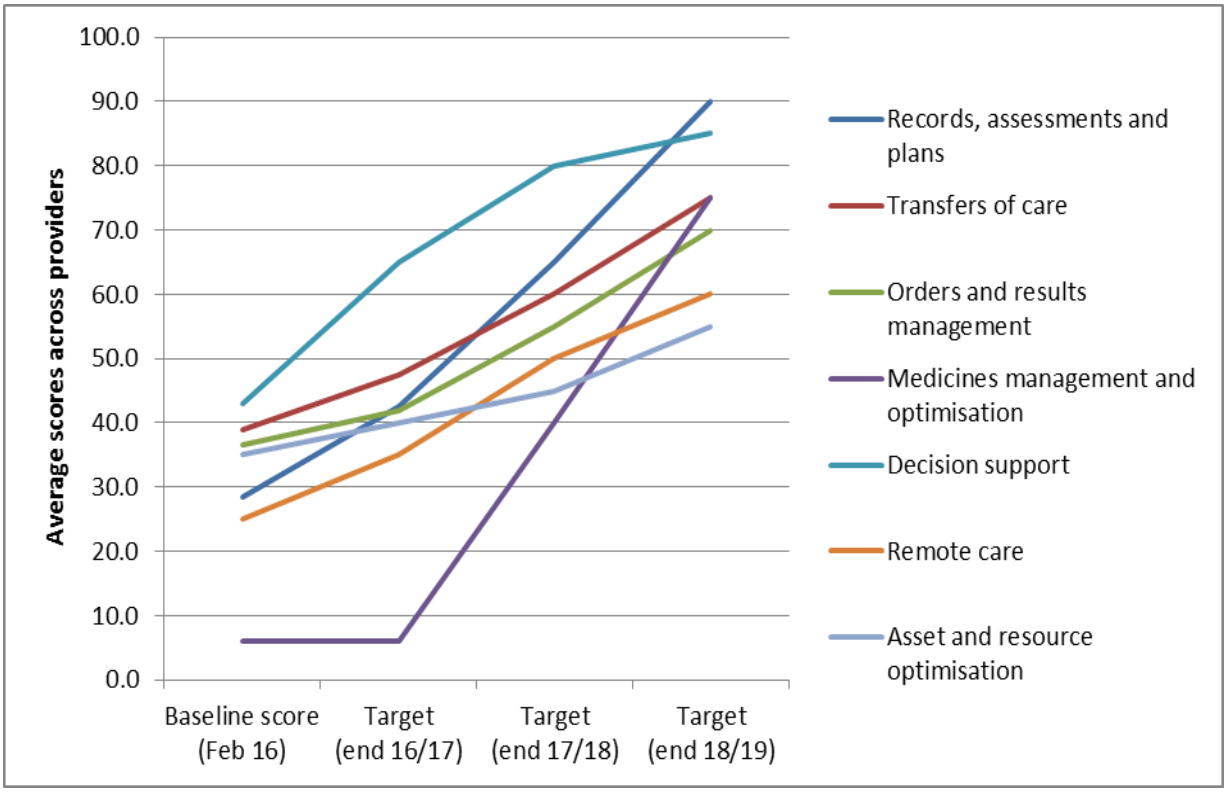
Bassetlaw STP footprint to deliver shared care records across the whole STP footprint.

To address the growth areas above we have identified a range of projects across the Barnsley LDR footprint that will support development of the necessary capability. The outputs form these projects have been captured in the Capability Deployment Schedule (Appendix 1). The deliverables for 2016/17 are based on in flight projects that will be delivered this year. Deliverables for future years are aspirational and will be dependent on approved business cases and funding. To deliver on our roadmap we will require finance and support and will make bids against the available technology funds for this.

Over the course of the next three years, as we deliver on the ambitions set out in this roadmap, our capabilities for the delivery of paper free care will be significantly increased. The estimated trajectories for the overall increase in the capabilities of our secondary care providers is shown in the Capability Trajectory Score and diagram below (Appendix 2)

Capability Trajectory Scores

	Average scores across providers			
Capability group	**Baseline score (Feb 16)**	**Target (end 16/17)**	**Target (end 17/18)**	**Target (end 18/19)**
Records, assessments and plans	28.5	42.5	65.0	90.0
Transfers of care	39.0	47.5	60.0	75.0
Orders and results management	36.5	42.0	55.0	70.0
Medicines management and optimisation	6.0	6.0	40.0	75.0
Decision support	43.0	65.0	80.0	85.0
Remote care	25.0	35.0	50.0	60.0
Asset and resource optimisation	35.0	40.0	45.0	55.0



6. Universal Capabilities Delivery Plan

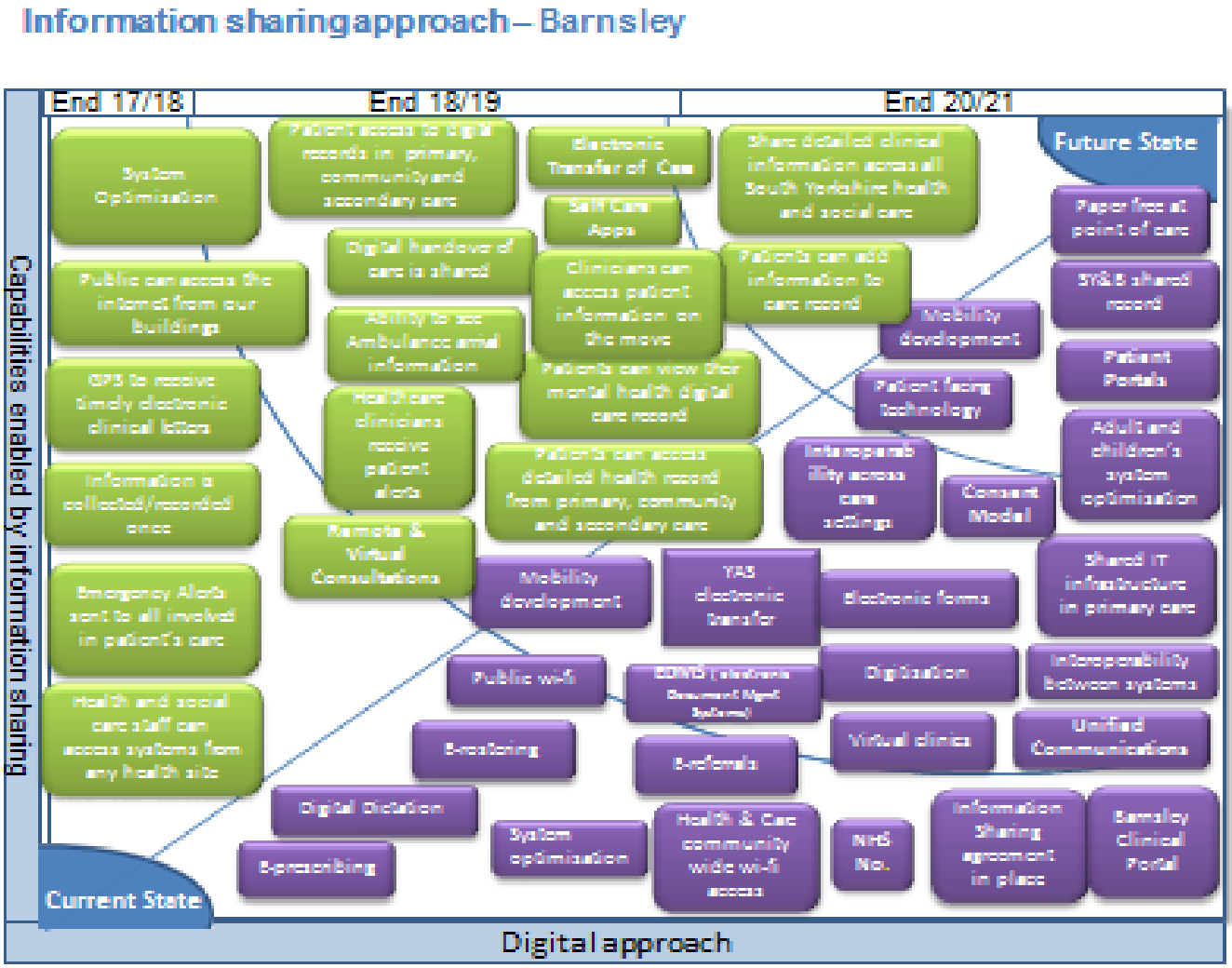
The Barnsley health and care system will make progress against 10 universal capabilities listed below;

1. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
2. Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
3. Patients can access their GP record
4. GPs can refer electronically to secondary care
5. GPs receive timely electronic discharge summaries from secondary care
6. Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care
7. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
8. Professionals across care settings made aware of end-of-life preference information
9. GPs and community pharmacists can utilise electronic prescriptions
10. Patients can book appointments and order repeat prescriptions from their GP practice

Our approach for addressing each of these capabilities is detailed in the Universal Capabilities Delivery Plan (Appendix 3). The delivery plan details the baseline, ambition, key activities and approach to evidencing progress for each of the capabilities.

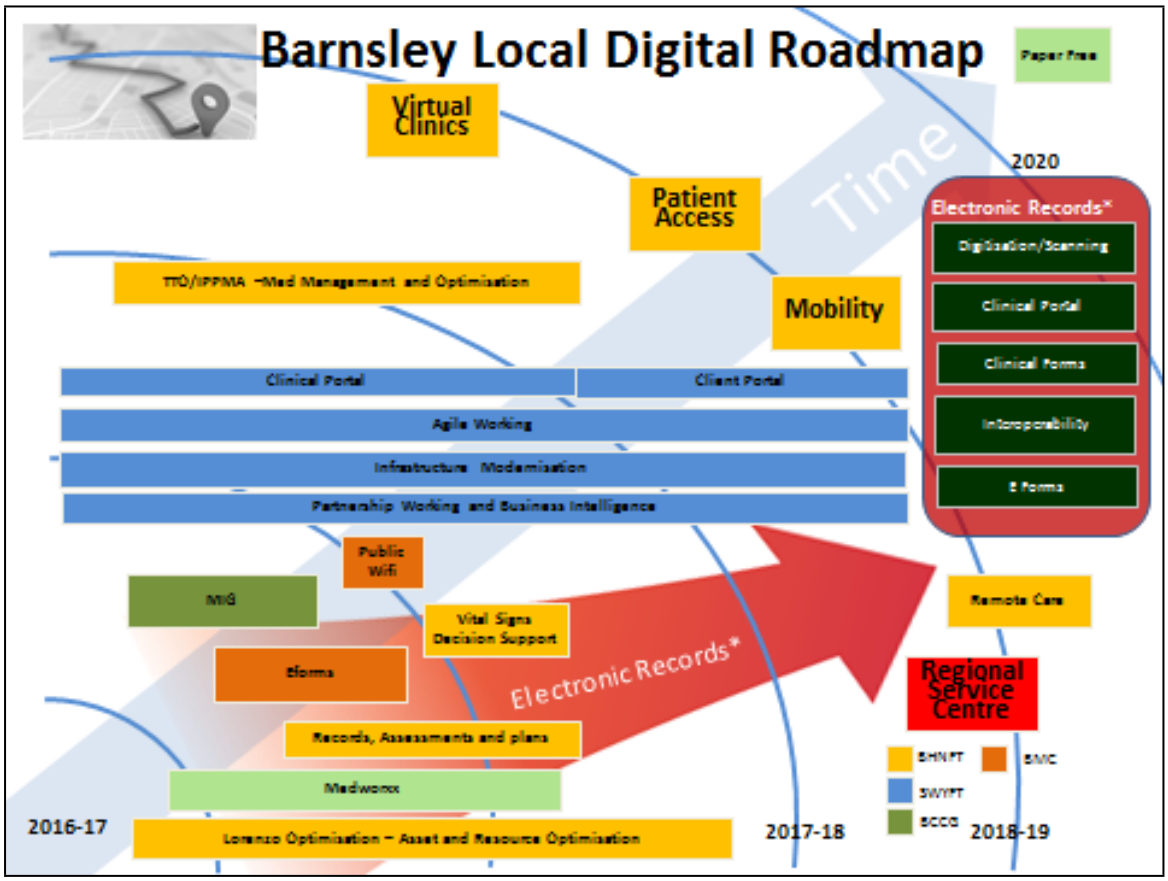
7. Information Sharing

A diagram showing how new information sharing capabilities will be deployed in Barnsley over the next 5 years and the corresponding solutions that will enable this information sharing is shown below and also in Appendix 4.



The Information Sharing diagram in appendix 4 shows how we will optimise information from the variety of existing source systems to enable patients, GPs, providers and carers to get an integrated view of a patient record across multiple systems. The actions detailed in the Capability Deployment Plan in 2016/17 and 2017/18 will underpin progress to achieving this vision.

The diagram below is a local interpretation of the template above. The length of each box provides reference to the length of time it is expected to implement each element of our roadmap locally and is colour coded to reflect the lead organisation for separate elements to be delivered across the Barnsley system. This can be seen in full in Appendix 5.



The health and care organisations within Barnsley are currently signed up to the Yorkshire Inter-Agency Information Sharing Protocol which has over 60 signatories from a variety of organisations across the Yorkshire and Humber region, including NHS Foundation Trusts, Clinical Commissioning Groups, Mental Health Trusts, Local Authorities, Ambulance Service, Voluntary Sector Organisations, Police and Fire Services. This protocol covers the sharing of person-identifiable confidential data, where a legal basis exists to allow information sharing (where this is not the

explicit consent of the individual, another legal or statutory basis for the sharing must be identified).

In Barnsley, we have developed an Information Sharing Agreement to enable the sharing of real time clinical information across health organisations. This has been taken up by over 85% of General Practices and is currently being rolled out to enable access to real time patient information within the Barnsley Hospice, Barnsley Hospital NHSFT and South West Yorkshire Partnership Trust via the Medical Interoperative Gateway (MIG). The Information Sharing Agreement is a framework on how we will share information with all the agencies involved in our patients' care. A privacy impact assessment will be put in place to ensure we have measured all the risks associated with the information sharing approach. It is the trusts duty to share information for effective patient care with all legitimate parties. As part of the local digital roadmap we will aspire to deliver a clinical portal technology, incorporating existing information sources (MIG and SCR), across the Barnsley health community in line with other health community successful models including the Bristol and Leeds Care Records. We will ensure we comply with all the regulatory requirements to ensure the safe interoperability of information throughout the health community and beyond whilst recognising that we have a duty to share information to enable the provision of safe care to our patients.

As part of our work within the wider SYB footprint we recognise the need to have a shared approach to information sharing (through both an information governance framework and technical solutions). Our intention is to engage in a wider joint approach across all SYB health and care organisations and we will be seeking to take this work forward with the SYB STP governance arrangements. We also recognise that we will need to develop an approach to appropriate information sharing with other organisations including emergency services and the voluntary sector.

The current level of adoption of NHS numbers across the local health and care system in Barnsley is strong. Across secondary care providers, the NHS numbers are used consistently in over 98-99% of the time. It is expected that the project to enable NHS number matching within social care will be completed by the end of 2016/17.

In order to extract the most value from the sharing of information, we will explore the roll out of SNOMED-CT and Dictionary of Medicines and Devices information coding standards across the local health and care system.

8. Infrastructure

The development of network connectivity between sites and mobile infrastructure has progressed in Barnsley over recent years. In the future we aim to further develop this capability to allow seamless mobile working for health and care practitioners across all health and care sites in Barnsley.

A summary of current mobile working capability in Barnsley and plans to develop this further is shown below:

Organisation	**Mobile working capacity**
SWYPFT	Deployed laptops/tablets to 40-50% of clinical staff (circa 2000 devices across South and West Yorkshire) as well as supporting remote and home working through VPN tokens.
BHNFT	Increasingly using IPads and supports remote and home working through VPN technology.
BMBC	Rolling out deployment of laptops and tablets throughout 2016/17 with VPN access and Wi-Fi available for all staff Roll out of public Wi-Fi across the town centre Roll out of GovRoam across Barnsley
Primary care	Plans to roll out mobile working for health care practitioners, funding notwithstanding. This is supported in principle by the CCG and a bid will be made to the 2016/17 Strategic Estates and Technology Fund for capital funding. Plans to develop a shared IT infrastructure across primary care Expand infrastructure for digital consultation via email, Skype

Further rollout of mobile working is reflected within the digital roadmap or is already completed and reliant only upon equipment distribution except for mobile working across primary care. A bid for this has already been developed and submitted to the Strategic Estates and Technology Transformation Fund.

We need to collectively assess the infrastructure across the system in order for us to have a clear baseline from which we can develop our plans for example, Medworxx, medicines management and patient facing technologies

There is an understanding that there needs to be greater collaboration between professionals from different organisations. Practically, we have already redesigned a number of specifications to enable clinicians to work across different organisations for example Intermediate Care and Community Nursing. The use of technology

needs to support the way staff can work outside of traditional care settings to ensure that safe, responsive and effective care can be delivered. This becomes ever more pressing locally as we implement a Multi-specialty Community Provider integrated delivery pathways for Respiratory Services and Diabetes providing care in new settings outside of hospital. This will also be a key requirement as we explore the development of an Accountable Care Organisation across Barnsley. This will also be a key element of the Sustainability and Transformation Plan and the Working Together Provider Collaborative Transformation work streams to enable multi-agency and inter-agency working. Whilst there are no robust plans in place for the digital enablement of this yet, it is expected that these will be required to support the delivery of new clinical pathways and out of hospital care.

As our LDR and STP develop we will use opportunities provided by working in partnership to identify where infrastructure, systems and IT services could be shared across the Barnsley footprint or possible wider across the STP or Working Together footprints.

9. Minimising Risks Arising from Technology

All partners within the Barnsley LDR footprint have their own well established Information Governance functions and will remain responsible for minimising risks associated with data security, clinical safety, data quality, data protection, privacy, business continuity and disaster recovery. This will continue but to reflect the partnership working across the system with regards to the overall delivery of the LDR, pertinent risks will also be shared with the IT Strategy Group to ensure that these are understood across the system and mitigated where possible.

Current risks identified are as follows:

RISKS IDENTIFIED	**Key Mitigating Actions**
Lack of financial investment	Maximise opportunities for accessing external funding e.g. Primary Care Estates and Technology Transformation Funding
Staff and citizen engagement	Develop effective Organisational Development initiatives; Communications and Engagement strategies; Digital Literacy programmes
Existing workforce skills and training	Development of effective OD initiatives supporting change management and digital literacy; undertake training needs analysis; deliver programmes for IT/digital skills development
Unintended negative impact on health inequalities	Robust development of business and technical requirements; identification of benefits; ongoing management/oversight of benefits/costs and risk through PMO approach
Governance	Mature local and SYB STP governance arrangements related to digital/IT work streams supporting ongoing coordination and collaboration across footprints.
HSCIC/national standards	Delivery of key programmes and deliverables currently within the remit of HSCIC

GS1 barcodes are at the heart of the NHS drive to make UK healthcare safer and more efficient. BHNFT are committed to a roadmap of using GS1 standards; GS1 Barcoding for Patient Identification, Device Management, Records, Stock and Medicine identification.

10. Appendices

Appendix 1 – Capability Deployment Schedule
Appendix 2 – Capability Trajectory
Appendix 3 – Universal Capabilities Plan
Appendix 4 – Barnsley Information Sharing Approach
Appendix 5 – Barnsley Digital Roadmap

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Footprint:	Barnsley

Capability				Locally defined attributes ->		
Who	What	Year	Capability group			
BHNFT	Clinicians in secondary care have full access to electronic versions of paper records - Digitisation	16/17	Records, assessments and plans	digitisation		
SWYPFT	Clinicians in Mental Health & Community care have full access to electronic versions of paper records - Digitisation	16/17	Records, assessments and plans	digitisation		
BHNFT	Clinicians can transfer care effectively across departments in secondary Care - Eforms	16/17	Transfers of care	Eforms	Referrals	
BHNFT	access comprehensive detail - Clinical Portal	16/17	Records, assessments and plans	Portal		
BHNFT	alerted to any Deterioration in the patient.	16/17	Decision Support	Vital Signs		
BHNFT	Clinicians in secondary care can capture all clinical information electronically - Eforms	16/17	Records, assessments and plans	Eforms		
BHNFT	care for all inpatient wards	16/17	Medicines management and optimisation	Eprescribing		
SWYPFT	Clinicians in mental health & community care Can prescribe and administer medicines digitally at the point of care for all clients	16/17	Medicines management and optimisation	Eprescribing		
BHNFT	Clincians in Secondary Care can request and report on all forms of diagnostic and secondary care treatment	16/17	Orders and results management	Ereferrals		
BHNFT	Secondary Care infrastructure is assessed and upgraded to support the digital needs of the above programme	16/17	Asset and resource optimisation	Storage		
SWYPFT	digital needs of the health community	16/17	Asset and resource optimisation	networks		
Primary Care	Clinicians in Primary Care have full access to electronic versions of paper records - Digitisation	16/17	Records, assessments and plans	digitisation		
Primary Care	comprehensive detail - Clinical Portal	16/17	Records, assessments and plans	Portal		
Primary Care	Clinicians Can record and access information about the vital signs status of patients and be alerted to any Deterioration in the patient.	16/17	Decision Support	Vital Signs		
Primary Care	Clinicians in Primary Care can capture all clinical information electronically - Eforms	16/17	Records, assessments and plans	Eforms		
Primary Care	Clinicians in Primary care Can prescribe and administer medicines digitally at the point of care for all inpatient wards	16/17	Medicines management and optimisation	Eprescribing		
Primary Care	Primary Care infrastructure is assessed and upgraded to support the digital needs of the above programme	16/17	Asset and resource optimisation	Storage		
BHNFT	clinicians and social care across the community have access to secondary care records - Digitisation	17/18	Records, assessments and plans	digitisation		
SWYPFT	clinicians and social care across the community have access to Mental Health & Community care records - Digitisa	17/18	Records, assessments and plans	digitisation		
BHNFT	Clinicians in secondary care can capture all clinical information electronically - Eforms	17/18	Records, assessments and plans	Eforms		
BHNFT	Clinicians in secondary care Can prescribe and administer medicines digitally at the point of care for all inpatient wards	17/18	Medicines management and optimisation	Eprescribing		
SWYPFT	Clinicians in mental health & community care Can prescribe and administer medicines digitally at the point of care for all clients	17/18	Medicines management and optimisation	Eprescribing		
BHNFT	Clincians in Secondary Care can request and report on all forms of diagnostic and secondary care treatment	17/18	Orders and results management	EReferrals		
BHNFT	All Clinical communication is digitally transferred to all Barnsley Health Community Organisations.	17/18	Transfers of care	ClinicalLetters		
	Clinical communication is digitally transferred to all Barnsley secondary , community and social care organisations.	17/18	Transfers of care	ClinicalLetters		
BMBC	Public and staff access to online Adult social care referal process	17/18	Remote Care	Eforms		
BMBC	Access to Adult social care records for clinicians and third parties	17/18	Transfers of care	Access to social care		
BHNFT	Secondary Care infrastructure is assessed and upgraded to support the digital needs of the	17/18	Asset and resource optimisation	Networks		
SWYPFT	Mental health & community Care infrastructure is maintianed and developed to support the digital needs of the health community	17/18	Asset and resource optimisation	networks		
Primary Care	clinicians and social care across the community have access to Primary Care records - Digitisat	17/18	Records, assessments and plans	digitisation		
Primary Care	Clinicians in Primary care can capture all clinical information electronically - Eforms	17/18	Records, assessments and plans	Eforms		
Primary Care	care for all inpatient wards	17/18	Medicines management and optimisation	Eprescribing		
Primary Care	All Clinical communication is digitally transferred to all Barnsley Health Community Organisations.	17/18	Transfers of care	ClinicalLetters		
Primary Care	programme	17/18	Asset and resource optimisation	Networks		
BMBC	Public and staff access to online Adult social care referal process	18/19	Remote Care	Eforms		
BHNFT	Clinicians can transfer care effectively across the Barnsley Health Community - Eforms	18/19	Transfers of care	Eforms	Referrals	
BHNFT	Clinicians across the barnsley health community can access a summary of patient care - Clinical Portal	18/19	Records, assessments and plans	Portal	MIG	SCR
BHNFT	Clinicians in secondary care can capture all clinical information electronically - Eforms	18/19	Records, assessments and plans	Eforms		
BHNFT	Clinicians in secondary care Can prescribe and administer medicines digitally at the point of care for all inpatient wards	18/19	Medicines management and optimisation	Eprescribing		
BHNFT	secondary care treatment	18/19	Orders and results management	Ereferrals		
BHNFT	Patients Can safely access where appropriate their own health records	18/19	Remote care	PatientAccess		
SWYPFT	Patients Can safely access where appropriate their own health records via a patient portal	18/19	Remote care	PatientAccess		
BHNFT	Secondary Care infrastructure is assessed and upgraded to support the digital needs of the above programme	18/19	Asset and resource optimisation	Desktop		
SWYPFT	Mental health & community Care infrastructure is maintianed and developed to support the digital needs of the health community	18/19	Asset and resource optimisation	networks		
Primary Care	Clinicians can transfer care effectively across the Barnsley Health Community - Eforms	18/19	Transfers of care	Eforms	Referrals	
Primary Care	Clinicians across the barnsley health community can access a summary of patient care - Clinical Portal	18/19	Records, assessments and plans	Portal	MIG	SCR
Primary Care	Clinicians in Primary care can capture all clinical information electronically - Eforms	18/19	Records, assessments and plans	Eforms		
Primary Care	care for all inpatient wards	18/19	Medicines management and optimisation	Eprescribing		
Primary Care	Clincians in Barnsley Health Community can request and report on all forms of diagnostic and secondary care treatment	18/19	Orders and results management	Ereferrals		
Primary Care	Patients Can safely access where appropriate their own health records	18/19	Remote care	PatientAccess		
Primary Care	programme	18/19	Asset and resource optimisation	Desktop		
BMBC	Access to Children social care records for clinicians and third parties	19/20	Transfers of care	social care		
BHNFT	Clinicians in secondary care Can prescribe and administer medicines digitally at the point of care for all inpatient wards	19/20	Medicines management and optimisation	Eprescribing		
BHNFT	At the Point of Care Secondary Care Clinicians can access Real Time Data Analytics of patient care and conditions	19/20	Decision Support	BI		
BHNFT	Secondary Care infrastructure is assessed and upgraded to support the digital needs of the above programme	19/20	Asset and resource optimisation	Infrastructure		
SWYPFT	digital needs of the health community	19/20	Asset and resource optimisation	networks		
Primary Care	Clinicians in Primary Care can prescribe and administer medicines digitally at the point of care for all inpatient wards	19/20	Medicines management and optimisation	Eprescribing		
Primary Care	programme	19/20	Asset and resource optimisation	Infrastructure		
BHNFT	Clinicians in secondary care Can prescribe and administer medicines digitally at the point of care for all inpatient wards	20/21	Medicines management and optimisation	Eprescribing		
BHNFT	Patients Can upload their records for review at next clinical interaction.	20/21	Remote care	Wearables		
BHNFT	Patients can electronically access Clincial care independent of their geographic setting	20/21	Remote care	VirtualClinics		
BHNFT	Secondary Care infrastructure is assessed and upgraded to support the digital needs of the above programme	20/21	Asset and resource optimisation	Wireless		
SWYPFT	Mental health & community Care infrastructure is maintianed and developed to support the digital needs of the health community	20/21	Asset and resource optimisation	networks		
Primary Care	Clinicians in Primary care Can prescribe and administer medicines digitally at the point of care for all inpatient wards	20/21	Medicines management and optimisation	Eprescribing		
Primary Care	Patients Can upload their records for review at next clinical interaction.	20/21	Remote care	Wearables		
Primary Care	Patients can electronically access Clincial care independent of their geographic setting	20/21	Remote care	VirtualClinics		
Primary Care	Primary Care infrastructure is assessed and upgraded to support the digital needs of the above programme	20/21	Asset and resource optimisation	Wireless		
SWYPFT	Clinicians can review information from the separate community & mental health systems across services within the Mentral health and community Trust - portal		Records, assessments and plans	Portal		

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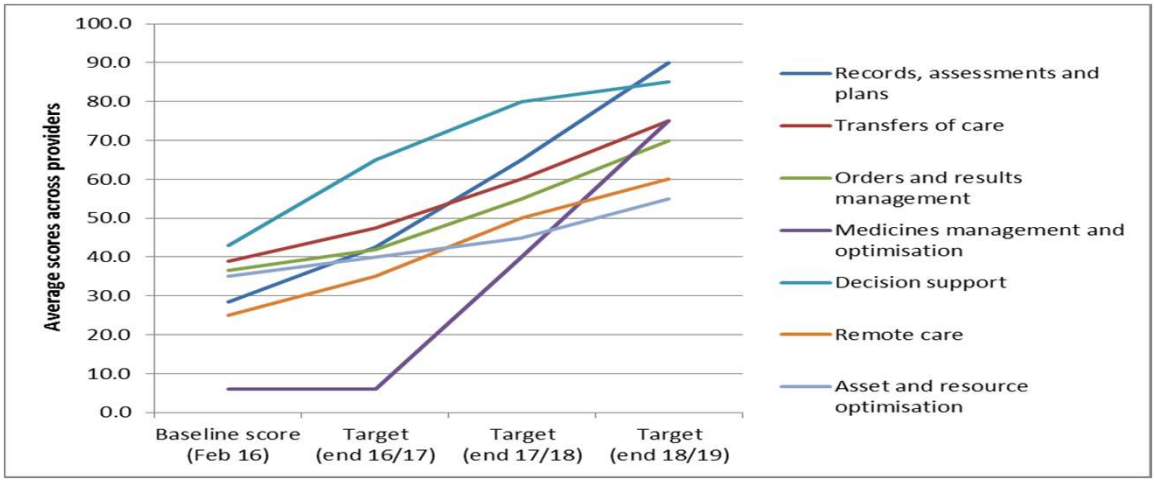
Appendix 2 Capability Trajectory (Secondary Care)

Capability group	Average scores across providers			
	Baseline score (Feb 16)	Target (end 16/17)	Target (end 17/18)	Target (end 18/19)
Records, assessments and plans	28.5	42.5	65	90
Transfers of care	39	47.5	60	75
Orders and results management	36.5	42	55	70
Medicines management and optimisation	6	6	40	75
Decision support	43	65	80	85
Remote care	25	35	50	60
Asset and resource optimisation	35	40	45	55



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Appendix 3

UNIVERSAL CAPABILITIES PLAN

Footprint:	Barnsley

Instructions for Completion

- Please indicate your Local Digital Roadmap Footprint above
- Complete questions A to E in the subsequent pages – the same structure is used for each of the 10 universal capabilities
- For further guidance, refer to:
  - Sections 6.24 to 6.30 of the Developing Local Digital Roadmaps Guidance
  - The Universal Capabilities Information and Resources document
- This template and the documents referenced above can be downloaded from the LDR page on the NHS England website

Universal Capability:	A. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
Capability Group:	Records, assessments and plans
Defined Aims:	• Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients) • Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

The Summary Care Record is in use <10% The Medical Interoperability Gateway has been rolled out across 85% of General Practices and I HEART Barnsley to enable real time sharing of primary care information subject to current consent models

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	SCR >20% + MIG roll out across all primary care, secondary care and the Hospice
17/18	SCR >80% + MIG roll out across secondary care

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Baseline
16/17 Q2	• Training Needs Analysis + Policy + SOPs • MIG roll out across Barnsley Hospice • Commence MIG roll out BHNFT
16/17 Q3	• Training Phase 1 • Commence MIG roll out SWYPFT • Commence MIG roll out BHNFT • Commence MIG rollout YAS
16/17 Q4	• Training Phase 2
17/18 Q1	• Training Phase 3
17/18 Q2	• Evaluate
17/18 Q3	• Ongoing
17/18 Q4	• Ongoing

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

MIG – Additional information for Barnsley Patients not available on National Infrastructure.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

SCR access reports % KPI to Exec Team.
MIG deployment reports

Universal Capability:	B. Clinicians in U&EC settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
Capability Group:	Records, assessments and plans
Defined Aims:	• Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations • Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients)

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

The Summary Care Record is in use <10%
The Medical Interoperability Gateway has been rolled out across 85% of General Practices and I HEART Barnsley to enable real time sharing of primary care information subject to current consent models

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	SCR >20% + MIG roll out across all primary care, secondary care and the Hospice
17/18	SCR >80% + MIG roll out across secondary care

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Baseline
16/17 Q2	• Training Needs Analysis + Policy + SOPs • MIG roll out across Barnsley Hospice • Commence MIG roll out BHNFT
16/17 Q3	• Training Phase 1 • Commence MIG roll out SWYPFT
16/17 Q4	• Training Phase 2
17/18 Q1	• Training Phase 3
17/18 Q2	• Evaluate
17/18 Q3	• Ongoing
17/18 Q4	• Ongoing

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

SCR access reports % KPI to Exec Team. MIG deployment reports to the Barnsley IT Strategy Group

Universal Capability:	C. Patients can access their GP record
Capability Group:	Records, assessments and plans
Defined Aims:	• Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition • Patients who request it are given access to their detailed coded GP record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Patient online is deployed in 100% of practices although utilisation is variable

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Increase number of patients using patient online services
17/18	Increase number of patients having access to their detailed coded record

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Preliminary discussions with NHS England re uptake, reporting and promotion
16/17 Q2	• Promote patient online with practices via system optimisation programme
16/17 Q3	• Set up local report to review patient online access against 2016/17 target
16/17 Q4	• Provide practices with report
17/18 Q1	• Report on monthly uptake
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Provide patient online statistics per practice to the CCG IT Group and Practice Manager's Forum

Universal Capability:	D. GPs can refer electronically to secondary care
Capability Group:	Transfers of care
Defined Aims:	• Every referral created and transferred electronically • Every patient presented with information to support their choice of provider • Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability) • [By Sep 17 – 80% of elective referrals made electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

GPs already refer to BHNFT via Choose and Book for 90%+ appointments. No plans to change.

Due to mental health system supplier constraints this functionality is not currently available for SWYPFT

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Test e-referrals from primary care to SWYPFT
17/18	Roll out e-referrals from primary care to SWYPFT

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	•
16/17 Q2	•
16/17 Q3	• Develop messaging solution in conjunction with Mental Health System Supplier
16/17 Q4	• Test & deploy to pilot group of GP's
17/18 Q1	• Training provision & roll out to all GP Practices once solution proven
17/18 Q2	• Ongoing Review & maintenance
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Project milestones and KPIs to be met and shared with SWYPFT Board and IT Strategy Group

Universal Capability:	E. GPs receive timely electronic discharge summaries from secondary care
Capability Group:	Transfers of care
Defined Aims:	• All discharge summaries sent electronically from all acute providers to the GP within 24 hours • All discharge summaries shared in the form of structured electronic documents • All discharge documentation aligned with Academy of Medical Royal Colleges headings

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

77%% D1s in 5 days.
Not in AMRC heading defined locally in partnership with CCG based upon AMRC. – No current plans to change.
SWYPFT – Work commenced to implement this functionality Q1 2015/16 but due to supplier issues this functionality is not yet available

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	SWYPFT – e-discharge messaging from Mental Health System
17/18	

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Resolve messaging issues with Mental Health System Supplier
16/17 Q2	• Test & deploy to pilot group of GP's
16/17 Q3	• Training provision & roll out to all GP Practices once solution proven
16/17 Q4	• Ongoing Review & maintenance
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Project milestones and KPIs to be met and shared with SWYPFT Board and IT Strategy Group

Universal Capability:	F. Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care
Capability Group:	Transfers of care
Defined Aims:	• All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

There is currently no e-Referrals system in place

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Baseline Capability in association with Social Care Build Electronic Eforms. SWYPFT – investigate option with Trust integration software
17/18	Deliver capability.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Investigate the potential of the use of eforms to provide E-referral capability (Replace fax)
16/17 Q2	• SWYPFT – investigate potential to utilise Trust Integration software.
16/17 Q3	• Build and pilot e-form from NHS to BMBC
16/17 Q4	•
17/18 Q1	• Explore potential and pilot direct access to social care system for NHS Staff
17/18 Q2	•
17/18 Q3	• Roll out preferred option
17/18 Q4	• Evaluate

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Project milestones and KPIs to be met and shared with SWYPFT and BMBC project teams and IT Strategy Group

Universal Capability:	G. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
Capability Group:	Decision support
Defined Aims:	• Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children) • Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details • The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Safeguarding alerts added to Lorenzo PAS solution. No access to CYPSD info, waiting for availability on SCR in conjunction with SCR plans. – No additional plans.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	NHS Numbers in Social Care Systems.
17/18	Enable clinical access to the social care system for both read and record access across a full range of appropriate disciplines

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Investigate the potential of submitting CYPSD data to SCR from Barnsley Social Care and Child Protection departments.
16/17 Q2	• Develop an action plan
16/17 Q3	• Implement action plan
16/17 Q4	•
17/18 Q1	• Consider development of read/write access to social care systems by health clinicians
17/18 Q2	• Test concept
17/18 Q3	• Stakeholder and public engagement
17/18 Q4	• Pilot

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress reports sent to the Barnsley IT Strategy Group

Universal Capability:	H. Professionals across care settings made aware of end-of-life preference information
Capability Group:	Decision support
Defined Aims:	• All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care • All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Internal End of Life preferences gathered at hospital level.

End of Life preferences gathered internally at community level.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Establish access via MIG. Possibility of sending preferences to GP electronically. EPACCS – Solutions..
17/18	Look at using strategic solutions.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	•
16/17 Q2	• Develop business case to consider options
16/17 Q3	• Bid for funding for preferred option
16/17 Q4	• Commence implementation if funding bid successful
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Project milestones and KPIs to be met and shared with Project Team and IT Strategy Group

Universal Capability:	I. GPs and community pharmacists can utilise electronic prescriptions
Capability Group:	Medicines management and optimisation
Defined Aims:	• All permitted prescriptions electronic • All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic • Repeat dispensing done electronically for all appropriate patients • [By end 16/17 – 80% of repeat prescriptions to be transmitted electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

ETP – What is the current baseline for Barnsley?
SWYFT – currently no Trust medicines management system in place – utilise pharmacy systems from other organisations.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	SWYPFT – project initiated to investigate / review / procure a trust wide medicines management & prescribing systems.
17/18	SWYPFT – implement medicines management & prescribing system

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Establish Project Team and understand baseline position
16/17 Q2	• Review systems & develop Business case
16/17 Q3	• Secure funding
16/17 Q4	• Tender for system
17/18 Q1	• Commence implementation activities
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Project milestones and KPIs to be met and shared with SWYPFT Board and IT Strategy Group

Universal Capability:	J. Patients can book appointments and order repeat prescriptions from their GP practice
Capability Group:	Remote care
Defined Aims:	• [By end 16/17 – 10% of patients registered for one or more online services (repeat prescriptions, appointment booking or access to record)] • All patients registered for these online services use them above alternative channels

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

All practices enabled to provide ordering of repeat prescriptions, appointment booking and access to patients record.

All practices are live with EPS Release 2 functionality

All pharmacies (except 1) are live with EPS Release 2 functionality

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Provide all patients with the opportunity to access and book appointments, order repeat prescriptions and view their detailed care record
17/18	Optimise online appointments to increase number available

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	•
16/17 Q2	• Promote patient online via system optimisation programme. Access reporting information and act on it
16/17 Q3	• Promote patient online via system optimisation programme. Access reporting information and act on it
16/17 Q4	• Promote patient online via system optimisation programme. Access reporting information and act on it
17/18 Q1	• Promote patient online via system optimisation programme. Access reporting information and act on it
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

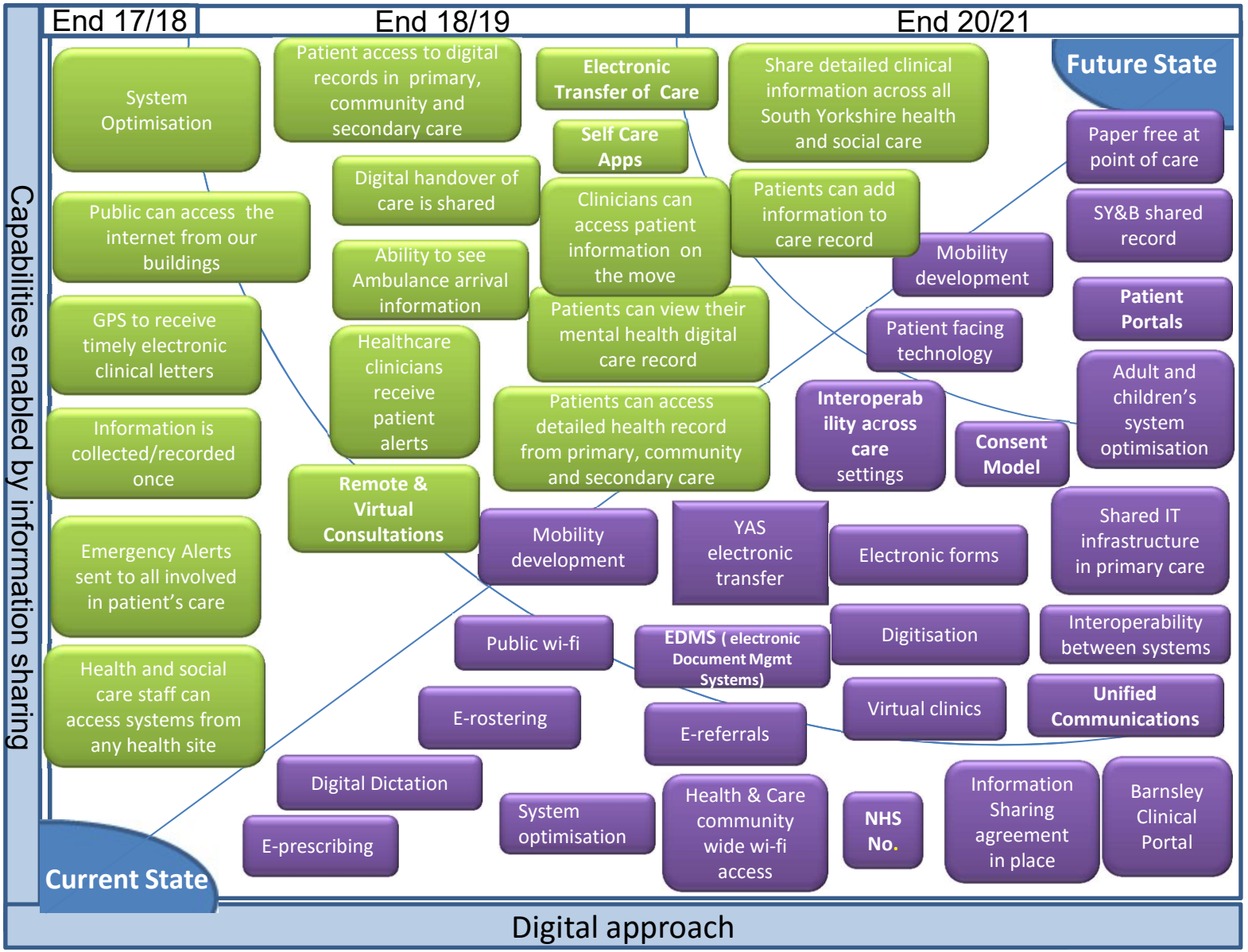
In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Provide reports to IT Strategy Group on utilisation.

Information sharing approach – Barnsley (Appendix 4)



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Barnsley LDR (Appendix 5)

Paper Free

Virtual Clinics

Patient Access

Mobility

Time

2020

Electronic Records*

- Digitisation/Scanning
- Clinical Portal
- Clinical Forms
- Interoperability
- E Forms

TTO/IPPMA –Med Management and Optimisation

Clinical Portal

Client Portal

Agile Working

Infrastructure Modernisation

Partnership Working and Business Intelligence

Public Wifi

MIG

Vital Signs Decision Support

Eforms

Electronic Records*

Remote Care

Regional Service Centre

Records, Assessments and plans

Medworxx

BHNFT

BMC

SWYFT

BCCG

2016-17

Lorenzo Optimisation – Asset and Resource Optimisation

2017-18

2018-19

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