Public Document Pack

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 6 December 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 4th October, 2016 (HWB.06.12.2016/2) *(Pages 3 - 6)*

3 Minutes from the Children and Young People's Trust Executive Group held on 6th October, 2016 (HWB.06.12.2016/3) *(Pages 7 - 16)*

For Decision/Discussion

4 Sustainability and Transformation Plan (HWB.06.12.2016/4) *(Pages 17 - 24)*

5 Place Based Local Plan (HWB.06.12.2016/5) *(Pages 25 - 64)*

6 Joint Strategic Needs Assessment (HWB.06.12.2016/6) *(Pages 65 - 156)*

7 Healthwatch Annual Report (HWB.06.12.2016/7) *(Pages 157 - 166)*

8 Safer Barnsley Partnership Plan (HWB.06.12.2016/8) *(Pages 167 - 190)*

9 SEND Strategy (HWB.06.12.2016/9) *(Pages 191 - 228)*

For Information

10 Travel Assistance Policy (HWB.06.12.2016/10) *(Pages 229 - 254)*

11 Police and Crime Commissioners and Health and Wellbeing Boards (HWB.06.12.2016/11) *(Pages 255 - 258)*

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
Rachel Dickinson, Executive Director People
Wendy Lowder, Executive Director Communities
Julia Burrows, Director Public Health
Nick Balac, NHS Barnsley Clinical Commissioning Group
Lesley Smith, NHS Barnsley Clinical Commissioning Group
Tim Innes, Chief Superintendent
Emma Wilson, NHS England Area Team
Adrian England, HealthWatch Barnsley
Richard Jenkins, Barnsley Hospital NHS Foundation Trust

Rob Webster, Chief Executive, SWYPFT
Helen Jaggar, Chief Executive, Berneslai Homes

Please contact Peter Mirfin on 01226 773147 or email governance@barnsley.gov.uk
Monday, 28 November 2016

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 4 October 2016
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

MINUTES

Present

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Councillor Margaret Bruff, Cabinet Spokesperson - People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson - Communities
Rachel Dickinson, Executive Director People
Wendy Lowder, Interim Executive Director Communities
Julia Burrows, Director Public Health
Nick Balac, NHS Barnsley Clinical Commissioning Group
Lesley Smith, NHS Barnsley Clinical Commissioning Group
Adrian England, HealthWatch Barnsley
Sean Rayner, District Director
Diane Wake, Barnsley Hospital NHS Foundation Trust

24 Declarations of Pecuniary and Non-Pecuniary Interests

Councillor Platts declared a pecuniary/non-pecuniary interest in Minute 32 in her capacity as member of Barnsley Hospital NHS Foundation Trust Governing Body, in so far as discussion related to the trust.

25 Minutes of the Board Meeting held on 9th August, 2016 (HWB.04.10.2016/2)

The meeting considered the minutes of the previous meeting held on 9th August, 2016.

In relation to minute 17, the meeting noted the task group arrangements in place to take forward the Better Housing, Better Health action plan, which would be the subject of reports to future meetings of the Board.

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

26 Minutes from the Children and Young People's Trust Executive Group held on 4th August, 2016 (HWB.04.10.2016/3)

The meeting considered the minutes from the Children and Young People's Trust Executive Group held on 4th August, 2016.

The meeting noted that the Trust Executive Group had focused in particular on progress on the Early Help offer in relation to Healthy Weight and supporting an Active Lifestyle. The Group had also considered progress in access to emotional wellbeing services. The Director of Public Health reported that the 0-19 Healthy Child service had now formally transferred to the Council and the meeting noted progress made in the period up to the transfer of the service.

RESOLVED that the minutes be received.

27 Minutes from the Barnsley Community Safety Partnership held on 12th September, 2016 (HWB.04.10.2016/4)

The meeting considered the minutes from the Community Safety Partnership held on 12th September, 2016.

The Board noted that continuing work between the Council and South Yorkshire Police to create a new integrated approach to policing across Barnsley. In relation to minute 4, the progress on the Safer Barnsley Partnership Plan (2016-2020) was noted, and that it would come forward to the Board for consideration in due course.

RESOLVED that the minutes be received.

28 Minutes from the Provider Forum held on 15th June, 2016 and 14th September, 2016 (HWB.04.10.2016/5)

The meeting considered the minutes from the Provider Forum meeting held on 15th June, 2016, and 14th September, 2016.

RESOLVED that the minutes be received.

29 Minutes from the Stronger Communities Partnership held on 16th August, 2016. (HWB.04.10.2016/6)

The meeting considered the minutes from the Stronger Communities Partnership held on 16th August, 2016.

In relation to minute 6, the meeting noted the successful bid by SYHA to run an employee led skills pilot across the Sheffield City Region under the Building Better Opportunities fund.

RESOLVED that the minutes be received.

30 Health and Wellbeing Board Terms of Reference and Membership (HWB.04.10.2016/7)

The Board received a report reviewing the terms of reference and membership of the Board. The meeting noted the minor changes in membership, and, more significantly, the Board's role in approving the local version of the Sustainability and Transformation Plan, and monitoring its delivery, was clarified.

RESOLVED

(i) That the terms of reference for the Board and for SSDG be recommended to Cabinet for approval; and

(ii) That both terms of reference and membership be reviewed after a period of 12 months.

31 Health and Wellbeing Strategy (HWB.04.10.2016/8)

The Board received a report on a draft Health and Wellbeing Strategy 2016-2020. The report outlined the Vision and Principles of the Strategy and Key Objectives and Priorities.

The meeting noted the rationale for highlighting the areas to improve at section 3 and the need to emphasise the programme of work in other areas, particularly in relation to children and young people.

The meeting discussed how the strategy could be progressed, particularly through the CCG's locality arrangements, and the extent to which the Area Councils could support this. The meeting noted work being undertaken under Manchester's devolved arrangements to seek support from employers for carers who needed to work flexibly, which might merit consideration in Barnsley.

RESOLVED:

(i) that the draft Health and Wellbeing Strategy be approved and adopted, subject to the revisions now identified;
(ii) that, subject to the completion the further amendments, the Strategy be referred for consideration by the executive boards of partner organisations for approval and adoption, to be taken into account in their service delivery;
(iii) that, once amended, the final, interactive version of the Strategy be published online with steps to be taken to promote the document within local communities;
(iv) that regular reports concerning progress towards achieving the Key Objectives and Strategic Priorities of the Strategy, together with an analysis of any risks be submitted for the consideration of the Board;
(v) that the Council's Interim Executive Director Communities investigate the approach being taken in Manchester to seek the support of employers for people with caring responsibilities.

32 Sustainability and Transformation Plan update (HWB.04.10.2016/9)

The Board received a report on the progress of work on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan, and the associated Local Plan, noting the publication for consultation of a first, high level, plan on 31st October 2016. Partners continued to work together on the more detailed plans, with a further consultation due in January 2017 on the governance for delivery of a system wide plan and the preparation of individual cases for change in the plan in advance of Government approval.

The meeting noted that consultation on detailed plans for the Hyper Acute Stroke Unit and Children's Surgery at Barnsley Hospital would start during week commencing 10th October. This would outline the case for change in detail, but Members noted that no changes were proposed to the "general" stroke ward.

RESOLVED that the report be noted.

Chair

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Minutes of the Children and Young People's Trust Executive Group Meeting Held on 6 October 2016

Present:

Core Members:

Rachel Dickinson (Chair)	BMBC, Executive Director: People
Cllr Margaret Bruff	Cabinet Member: People (Safeguarding)
Julia Burrows	BMBC, Director of Public Health
Bob Dyson	Independent Chair of the Barnsley Safeguarding Children Board
Margaret Libreri	BMBC, Service Director for Education, Early Start and Prevention
Sean Rayner	SWYPFT District Director Barnsley/ Wakefield
Amanda Glew	BMBC Organisation Development Manager
Dave Whitaker	Executive Headteacher representing Secondary Schools

Deputy Members:

Jakkie Hardy	South Yorkshire Police Chief Inspector (for Tim Innes)
Paul Hussey	BMBC Interim Service Director, Stronger, Safer and Healthier Communities (for Wendy Lowder)
Sharon Galvin	Barnsley CCG Designated Nurse for Safeguarding/ Looked After Children (for Brigid Reid)
Debbie Mercer	BMBC Head of Service Children and Family Social Care (for Mel John-Ross)

Advisers

Richard Lynch	BMBC, Head of Commissioning, Governance and Partnerships
Julie Green	BMBC, Strategic Lead, Procurement and Partnerships Manager

In attendance

Andrea Hoyland	Strategy Lead Early Intervention and Prevention: Healthier Communities (for item 10)
Julie Govan	BMBC Children's Social Care and Safeguarding Improvement Programme Manager (for item 13)
Denise Brown	BMBC, Partnerships and Projects Officer

		Action
1.	Apologies	
	Brigid Reid — Barnsley CCG, Chief Nurse	
	Mel John-Ross — BMBC, Service Director of Children's Social Care and Safeguarding	
	Jenny Miccoli — Barnsley College, Vice Principal Teaching, Learning and Student Support	
	Gerry Foster-Wilson — Executive Headteacher representing Primary Schools	
	Tim Innes — South Yorkshire Police Chief Superintendent	
	Anna Turner — BMBC School Models and Governor Development Manager	
	Susan Gibson — Barnsley Hospital NHS Foundation Trust	
	Wendy Lowder — BMBC, Service Director for Stronger, Safer and Healthier Communities	
	Tim Cheetham — Cabinet Member: People (Achieving Potential)	

		Action
	Change to the agenda Item 6 on the agenda, vulnerable children with SEN, was withdrawn and deferred to January's meeting. School Governor representation Rachel stated that a challenge had been received regarding School Governor representation on the Trust Executive Group and the process for communicating back to School Governors. Richard responded that by the end of this term a process would be in place. This had been conveyed to the person concerned who had been satisfied with the response.	Margaret Libreri Richard
2.	Shared experiences from the front line Rachel had accompanied a social worker from Future Directions on a visit to a young woman who is a care leaver. Rachel was very impressed by the strong relationship that existed between the young woman, her social worker and carers. The young woman had a disability and was struggling to find an appropriate apprenticeship, which is a continuing challenge. Cllr Margaret Bruff had visited a young man leaving care who is very confident, positive about himself, wanted to work and knew what he wanted to do. He had had a number of jobs and was always looking for new opportunities. Margaret Libreri had attended the BSARC open day, and found it a very good and informative event; was impressed by the building and the friendly staff. Julia reported that the 0-19 Service had joined the council and despite some teething problems, including some issues which IT were working on, staff members were positive about the move. Paul had attended the Barnsley in Bloom event and had been impressed by the number of schools and young people involved. Awards were handed out and there were dedicated categories for young people and the contribution they are making. It was also encouraging to see young people working with older people on shared projects. Rachel thanked everyone for their contributions and commented that it is pleasing to note the evident commitment to children and young people.	
3.	Identification of confidential reports and declarations of any conflict of interest The following reports are to be treated as confidential: Item 12, Barnsley Safeguarding Children Board Minutes of 9 September 2016, and item 13, Continuous Service Improvement Plan. There were no conflicts of interest declared.	
4.	Minutes of the previous TEG meeting held on 4 August 2016 The minutes were approved as an accurate record of the meeting subject to an amendment on page 11, item 14. The second to last paragraph should read: 'After reviewing the plan it was agreed that Margaret Libreri would be asked to review the outcomes for vulnerable children with SEN for consideration at the January TEG meeting.'	

		Action
4.1	Action log 9 – Denise to confirm with Paul and Wendy what this action is about. *[Following the meeting an e-mail was sent to Paul who undertook to discuss this action further with Jayne Hellowell]* 5(ii) –Improving outcomes for care leavers; uptake of pupil premium and connectivity with the Barnsley Alliance. Margaret Libreri had attended the Anti-poverty Delivery Group where it was identified where this work links with the Alliance Board. A number of action points were identified including more of a focus on the uptake of pupil premium, identifying young people eligible for school meals, and a focus on vulnerable groups such as those with special educational needs. Follow up groups were identified including teen parents and those with mental health issues. Margaret had undertaken to attend the next meeting to follow up on the actions identified. 5(iii) – Use of the Family Star Assessment Tool. Paul confirmed that the Think Family programme is using the Family Star Assessment Tool and that it is being promoted to current commissioners. Those using the tool are finding it very useful. 6(i) Early Help – Rachel expressed concern that whilst there is now an Early Help Action Plan there is no Strategy in place. It was noted that work needs to take place to develop an all age strategy. 6(ii) – Findings and key deliverables of universal information and advice across all partnerships to be considered at a future TEG meeting. Denise to be advised when to schedule this for. Paul undertook to follow up this action. 9(ii) – Daily Mile programme. Margaret stated that as the Alliance Board agenda had been full this item had been presented to the Primary Headteachers meeting. Information would be circulated via the e-bulletin in the hope of getting a better response. The programme had not been to Secondary Schools yet. Rachel requested an update around Easter time regarding the number of schools that had signed up to the programme. 11 – Rachel asked Richard to contact the Children Society to obtain written confirmation that it had been made clear in their report that the case study used is not a young person from Barnsley. 14 – As agreed earlier, the review of vulnerable children with SEN would be considered at the TEG meeting in January.	Paul Paul Margaret Richard
5.	2016 Education Outcomes and draft Barnsley Alliance Improving Education Strategy 2016-18 The report provided an overview of 2016 education outcomes for children and young people aged 5-18 in educational settings in Barnsley and, where applicable, the progress made from 2015 final results. It was noted that the results are subject to change when final validated results are published in January 2017. Overall there was an improving picture, however, there are also some problematic areas, particularly around certain groups of children, that need to be addressed. The following points were highlighted:	

		Action
	• The rate of improvement for disadvantaged pupils (pupil premium) is lower than for non-disadvantaged pupils, and the gap for pupils with SEN has widened since 2015. • The Barnsley Alliance Board had undertaken to get the data to provide an analysis about those schools that are not closing the pupil premium gap. The effective use of pupil premium is important. • Dave pointed out that moving away from modular examinations had had a negative impact on SEN pupils and that there had been a national dip for that reason. • The significant gap at KS4 between pupil premium and non-pupil premium is also linked to persistent absence and exclusions. The bar has been raised in terms of acceptable behaviour which has resulted in more exclusions, particularly for SEN pupils. There needs to be a strong link into the Troubled Families Programme in relation to poor attendance. • There has been an increase in the number of applications for home education, and an article is to be published in the Barnsley Chronicle on 7th October. • At the BSCB Meeting it had been suggested that there be a peer review on children missing education. • A third of children are not ready for school, and everything possible needs to be done to improve this. Earlier identification and intervention is vital, as is the integrated two year old check-up. It was agreed that an update would be provided on how well that is working. • Outcomes for reading and writing are particularly low for each key stage and it was suggested that a campaign be championed to get Barnsley reading. It is also important that parents be encouraged to interact with their children and talk to them more. The Trust Executive Group agreed to: • Challenge the Barnsley Alliance Board to address the areas of concern in terms of finance, exclusions and SEN progress. It was agreed that it would be helpful to undertake a deep dive in relation to exclusions of pupil premium pupils and those with SEN and that the results would be presented to the January TEG meeting. • Challenge Secondary Schools to engage more with the early help offer. It is important that children and young people with complex needs are identified and that they have access to the right services earlier to prevent more complex issues from developing. • Challenge the Early Help Action Group to ensure that everything is being done to identify and support under achieving young people as early as possible, and to gain a deeper understanding of what is happening to cause increased fixed term exclusions for 14-15 year olds. • Receive an update from the BSCB in terms of a peer review on children missing education. • Consider championing a campaign to get Barnsley reading. Margaret stated that the Barnsley Alliance Improving Education Strategy 2016-18 that had been circulated with the agenda is due to go to White Cabinet next week. Rachel asked that the next version of the strategy be re-circulated.	Margaret Libreri Margaret Libreri

		Action
6.	Vulnerable children with SEN This item was withdrawn from the agenda and deferred to the meeting in January 2017.	
7.	CYP Plan Strategic Priorities Julie stated that meetings are progressing with TEG Champions to finalise the monitoring schedule which should be available for the next TEG meeting. No performance highlights or risks were raised for escalation.	Julie Green
8.	Stronger Communities Partnership update The Stronger Communities Partnership (SCP) is a sub-group of Barnsley's Health and Wellbeing Board, reporting via the Senior Strategic Development Group (SSDG). The report lists the performance measures the SCP is seeking to influence and sets out key areas of activity and achievements so far. The Partnership's quarterly meetings have an in-depth focus on a relevant topic, and to date these have included: Social Prescribing; Falls Prevention; and Universal Information & Advice. The SCP would like to establish whether or not the information provided in the report chimes with members understanding of the role of the SCP; whether there is an opportunity to build an evidence base regarding what is working, what isn't and why, and what can be done about it; and whether it is possible to co-design some of the solutions. The following comments were noted: • There needs to be more pace around provision of good information, advice and guidance, benefitting the Early Help agenda. Information is being garnered into one system to give timely access to key information and advice. It was hoped that the pace of that activity would speed up and that a solution would be in place by next financial year. • The Community Safety Partnership is working closely with South Yorkshire Police in relation to domestic violence. • Rachel queried whether there was enough of a focus on local area coordination, including GPs? Paul stated that they are moving in that direction to help shape the local offer and identify the right families to work with, and that there is good representation from health and primary care providers. There needs to be further discussion to ensure that all the different workstreams are linked into this work. • It was acknowledged that there is a lot of activity at a community level commissioned through area councils that is not currently reflected in the SCP programme, and which the Children's Trust should be sighted on. • Most area councils have commissioned some enforcement with private landlords. It was agreed that it is important for the SCP to establish an ongoing relationship with the TEG and to provide updates to future meetings. Further comments to be sent to Paul Hussey via e-mail: PaulHussey@barnsley.gov.uk	Work programme

		Action
9.	Public Health Strategic Priorities to support children, young people and families to make healthy lifestyle choices	
9.1	Smoke Free Barnsley (Kaye Mann) The presentation given highlighted the following statistics: • Barnsley is nearly the worst in the region with 10.7% of 15 year olds being smokers • 17.6% of pregnant women were smoking at the time of delivery • 32% of households with a smoker in Barnsley fall below the poverty line. If these smokers were to quit, 2140 households would be lifted out of poverty. It was noted that the key objectives of the Smoke Free Barnsley Action Plan 2016-18 had been signed off by the Health and Wellbeing Board. It was felt that the best approach was to change social norms and to make smoking 'invisible' to young people. A Smoke Free Barnsley Programme, approved by both the Health and Wellbeing Board and Cabinet, will introduce designated smoke free areas in Barnsley including: hospital grounds; outside school gates; town centre zones; and selected play parks. The ban will be voluntary and not enforceable by law. A Tobacco Enforcement Officer is working to stop the sale of fake cigarettes in Barnsley, and is also working with trading standards to try and prevent a Shisha facility from opening in the town centre by making sure that they are compliant with a number of regulations. It was suggested that a leaflet designed by children to encourage parents to stop smoking would carry a powerful message. It was also suggested that young people in the Youth Council be encouraged to start a group to lobby against smoking. An update on progress would be presented to a future TEG meeting.	Kaye/ work programme
9.2	Oral Health (Anita Dobson) Anita provided a verbal update on progress and the following points were noted: • At its meeting on 9 August, the Health and Wellbeing Board had ratified the Oral Health Action Plan. • Anita had met with Public Health England to discuss improving the offer and take up of fluoride varnish on children's teeth when they visit the Dentist. Although it is part of the offer it is unclear whether Dentists are offering the treatment, whether take-up of the offer is being recorded, or whether parents are refusing it. • A discussion had been held at the Health and Wellbeing Board in relation to fluoridating the water supply. This is not part of the action plan but a meeting is being held with Yorkshire Water to discuss this option further. It was noted that there is a massive anti fluoridation lobby group. • Work is underway with 6th Form College media students to write and perform a short play to promote oral health on U-tube. • Family Centres across Barnsley will be equipped to run tooth brushing clubs. The community shop in the Dearne has been encouraged to promote tooth brushes and tooth paste. These are also included in food parcels provided through foodbanks.	

		Action
	• It is important to identifying whether or not progress is being made, and if not this would need to be escalated to the Health and Wellbeing Board.	
10.	Think Family/ Troubled Families (Andrea Hoyland) The report provided an update on Barnsley's Think Family Programme which is the local delivery mechanism for the Government's national Phase 2 Expanded Troubled Families Programme 2015-20. The report set out the five year delivery requirements, progress to date, and future plans. Also attached was a presentation 'Qualitative Evaluation of the new Troubled Families programme' by Ipsos Mori with a summary of 'wave 1' findings for Barnsley. The aim is to ensure that in meeting the programme delivery objectives the funded work supports local strategic developments for targeted early intervention that take a whole family and integrated working approach, to deliver better outcomes for children, young people and families. The data in the report shows that the required milestones in the programme are being met, and there is good feedback from the frontline. Funding is available to 2020, and anything commissioned or developed needs to be sustainable to continue beyond the life of the programme. A key outcome is the ability to be more focused on resources at our disposal in terms of early help. Need to expand the support offer; develop IT solutions; and look at sustainability planning. It is important to ensure that this is not a one-off piece of work and that every opportunity is used to invest in wider solutions. The Police and other local partners are working in partnership to explore this further, including the development of an IT solution. Sean Rayner suggested that family members who smoke should be referred to 'stop smoking' support. Andrea stated that early work is also taking place with Education Welfare to develop a business case for earlier intervention in terms of attendance issues.	
11.	Children's Workforce Development (Amanda Glew) The attached update was provided in respect of workforce development, highlighting work that had been undertaken as a result of suggestions made at previous TEG meetings. The following points were noted: • The development of the programme for 2017-2018 is progressing well with more than 80 courses planned and booked, including 'hearing the voice of the child', which had been requested by TEG at a previous meeting. • The new programme focuses on the Early Help agenda, and the impact of the programme will be evaluated through the Early Help Steering Group audits. • The multi-agency programme will include a new suite of domestic abuse courses, including more advanced training for staff who would like to become Domestic Abuse Champions within their own agency. • A Toxic Trio conference is being held on 13 October, and another one is being planned to take place in July 2017. • A programme of safeguarding awareness training is currently being delivered to a variety of employees, and there are plans to reinstate Safeguarding Children and Adults Champions.	

		Action
	• A charging policy is now in place, including a charge for non-attendance. Training continues are free for Barnsley agencies working with children and young people who contribute financially or deliver training for Barnsley MBC. Further details of the policy are available on request. • Following a previous TEG meeting work is underway to identify how the workforce can be developed to have a greater understanding of child poverty and actions that can be taken to address this. • Progress continues to be made against improving staff skills in relation to the priorities of the Children and Young People's Plan. The Workforce Management and Development Group will be working to develop key performance indicators to evidence progress and impact as a result of the plan. Rachel thanked Amanda for the helpful update and was encouraged by the amount of activity, particularly in relation to early help. Performance data would be welcomed when available. It was noted that South Yorkshire Police staff are unaware of the training available and it was agreed that Jakkie and Amanda would discuss this further outside the meeting. Amanda stated that following a presentation at a previous TEG meeting from the Barnsley Carers and Parents Forum around personalised budgets, she had tried unsuccessfully to contact the group to get an understanding of the particular issues in order to ensure that intervention is targeted at the right people and at the right level. Richard agreed to support Amanda to take this action forward.	Jakkie/ Amanda Amanda/ Richard
12.	<u>Barnsley Safeguarding Children's Board Meeting held on 9 September 2016 - confidential</u> The minutes of the above meeting had been circulated for information, and the following points were highlighted: • Dan Foster from Greenacre School is now the Headteacher Representative on the BSC Board. • Schools had been invited to sign up to the Anti Bullying Charter and whilst there had been a lot of interest from primary schools only one secondary school had expressed an interest. • Operation Make Safe works with private businesses whose staff may witness child sexual exploitation or safeguarding concerns. It was noted that this role no longer exists in the Police, and Chief Superintendent Tim Innes had undertaken to commission a review of the programme to determine how it might be delivered locally, and would provide the Board with an update at their next meeting. • In the performance report it was noted that the proportion of contacts progressing to referral is stable at 26% in Quarter 1. This suggests that over 70% of contacts could potentially have been better addressed through the Early Help pathway. Bob commented that it would be good to see assessments being closed as well. • Barnsley has a high level of domestic violence and member agencies have been asked to undertake a self-assessment by the end of September. • It was agreed that the next Peer Review would be undertaken on Children Missing from Education, including children educated at	

		Action
	home, and children on part-time timetables. It was noted that an article is due to appear in the Barnsley Chronicle on 7th October regarding the increase in the number of home-schooled pupils in Barnsley. Rachel confirmed that the Trust Executive Group formally agreed with the proposal that a peer challenge be undertaken on children missing from education. • The BSCB meeting had been held at Holy Trinity School, followed by a meeting with 15 young people from the school. They all had a very good general awareness of safeguarding issues, they reported feeling safe, and were not aware of any issues of bullying in the school. They spoke positively about school and there was no lack of aspiration. They highlighted the benefits of having the same form teacher all through school. This provided continuity and enabled them to build a good relationship with the form teacher.	
13.	<u>Continuous Service Improvement Plan</u> (Julie Govan) Comments from the last TEG meeting have been incorporated into the revised version of the CSI Plan. An evaluation is being undertaken of the plan to ensure that it is up-to-date and to confirm whether or not the 'completed' actions are still complete. There are some areas where the RAG rating is out of date, e.g. domestic abuse, care leavers and SEND. The review will be an opportunity to focus on different areas where there are emerging issues. Rachel issued a challenge to Debbie to shift the current amber rating for 'increased timeliness of LAC and CP statutory visits and audit effectiveness' (Voice of Child, page 14) The next version of the plan is due at the end of October and will be discussed at the joint TEG and BSCB meeting on 18 November. Evidence is also being gathered to prepare for the Ofsted inspection.	
14.	<u>TEG Work Programme</u> (Richard Lynch) The work programme and future agenda items were considered and it was agreed that the Public Health items would be deferred to a later meeting. The update on the review of paediatric services to be considered by the Executive Commissioning Group. Members confirmed that, subject to the agreed amendments, they are comfortable with the work programme.	Denise
15.	<u>TEG Terms of Reference – annual review</u> (Richard Lynch) The TEG Terms of Reference were last approved by the Board in July 2015, and states that the Vice-Chair needs to be appointed on an annual basis in September. It was noted that currently the role of Vice-Chair is shared between Bob Dyson and Brigid Reid. Bob confirmed his acceptance of the role of Vice-Chair to the TEG and, following the meeting, Brigid did likewise. The following amendments were agreed: • The Barnsley Health and Wellbeing Board Strategy to be updated with	

		Action
	the latest version as soon as it is available, as will the JSNA and Joint Commissioning Framework • The Barnsley Alliance Strategy; SEND Strategy and BSCB Business Plan to be added to the list of key documents. • Membership: It was noted that Sue Gibson, Head of Midwifery for Barnsley Hospital, was leaving and Rachel undertook to follow up Barnsley Hospital NHS Foundation Trust representation at TEG. • LMC representation needs to be followed up as it was noted that Clare Bannon had not attended TEG since June. • Representation of School Governors to be addressed. Margaret suggested that the person representing School Governors on the Barnsley Alliance Board be asked to also attend TEG, which would improve the connections between TEG and the Barnsley Alliance Board, and this was agreed. • TEG minutes are sent to the Health and Wellbeing Board and also the Barnsley Alliance Board for comment/ information. • In relation to the appendix 1, partnership arrangements, it was noted that the Anti-Poverty Board still meets. • Stronger Communities Partnership to be added alongside the Community Safety Partnership. • In relation to appendix 2, The Ofsted Improvement Board is now the Ofsted Officer Group; Child Health Programme Board to be deleted and also the Think Family Programme Board. The Terms of Reference to be amended as agreed.	Rachel Denise Margaret Denise
16.	<u>Any Other Business</u> • Margaret Libreri circulated posters at the meeting, highlighting the importance of good school attendance and punctuality. These will be displayed at schools; GPs Surgeries; libraries; Alhambra Centre; Interchange; Barnsley Market, etc. • Safeguarding Week is being held in Bradford from 17 – 21 October. • A 'Playing Out' Pilot event took place on 24 September where designated streets were closed to allow children to play out in safety, and was reported to have gone really well. A short paper is being prepared for SMT.	

REPORT TO THE HEALTH AND WELLBEING BOARD

Tuesday 6 December 2016

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

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Report Sponsor:	Lesley Smith and Julia Burrows
Report Author:	Jade Rose
Received by SSDG:	
Date of Report:	6 December 2016

1. Purpose of Report

1.1 To share with the Health and Wellbeing Board the South Yorkshire and Bassetlaw Sustainability and Transformation Plan published 11 November 2016.

2. Recommendations

2.1Health and Wellbeing Board members are asked to:-

- support the vision, ambition and priorities of the plan and to work with STP partners at a South Yorkshire and Bassetlaw level on the priorities and to support the direction of travel.

3. Introduction/ Background

3.1 The South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) have been published.

It sets out the vision, ambitions and priorities for the future of health and care in the region and is the result of many months of discussions across the STP partnership, including with patient representative groups and the voluntary sector.

It is being shared widely, with views sought from staff, patients and the public on the high level thinking about the future of health and care services in the region. All feedback will be taken into account before any further work takes place.

The South Yorkshire and Bassetlaw STP is the local approach to delivering the national plan called the Five Year Forward View. Published in 2014, it sets out a vision of a better NHS, the steps we should take to get us there, and how everyone involved needs to work together.

It is based on the five locally developed place based plans within South Yorkshire and Bassetlaw, ours being The Barnsley Plan.

25 health and care partners from across the region are involved in the STP, along with Healthwatch and voluntary sector organisations.

A full version of the plan can be found at www.smybndccgs.nhs.uk

4. Summary

4.1 The goal of the STP is to enable everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and to live longer. The thinking starts with where people live, in their neighbourhoods, focusing on people staying well. Introducing new services, improving co-ordination between those that exist, supporting people who are most at risk and adapting the workforce so that people's needs are better met are also key elements.

Prevention is at the heart – from in the home to hospital care, supported by plans to invest in, reshape and strengthen primary and community services. At the same time, everyone should have improved access to high quality care in hospitals and specialist centres and that, no matter where people live, they get the same standards, experience and outcomes for their care and treatment.

Partners want to work together more closely to provide the care in the right place, at the right time and by the most appropriate staff. To do this, innovative, integrated and accountable models of care will be developed and the work of the Working Together Partnership Acute Care Vanguard will be built on.

The plan is also about developing a networked approach to services across South Yorkshire and Bassetlaw to improve the quality and efficiency of services, in areas such as maternity services. It is also about simplifying the urgent and emergency care system so that it is more accessible.

It also focuses on other factors affecting health, including education, employment and housing, to not only improve the health, wellbeing and life chances of every person in the region but also to deliver a more financially sustainable health and care system for the future.

People's health is also shaped by a whole range of factors – from lifestyle and family backgrounds to the physical, social and economic environment. At the same time, NHS services tend to focus on treating people who are unwell. The partners want to look at the connections between the £11 billion of public money that is spent in South Yorkshire and Bassetlaw and the £3.9 billion that is focused on health and social care.

By working more closely and in new ways, contributions will be made to the region's economic growth. Helping people to get and stay in work, as well as supporting their health and wellbeing, will help to keep South Yorkshire and Bassetlaw economically vibrant and successful.

We will work better together to get the best value and services for everyone. If we don't work differently now, in five years' time, there would be increasing demand on our services and we would have an estimated financial shortfall of £571 million. Therefore, doing nothing is not an option. The way we are organised is out of date compared to people's needs – we therefore need to rethink and improve how health and care services are delivered.

4.2 Case for change

There have been some big improvements in health and social care in South Yorkshire and Bassetlaw in the last 15 years. People with cancer and heart conditions are experiencing better care and living longer. There has also been improvement in mental health and primary care services. On the whole, people are more satisfied with their health and care services.

However, people's needs have changed, new treatments are emerging, the quality of care is variable, and preventable illness is widespread.

Quality, experience and outcomes vary and care is often disjointed from one service to another because our hospitals, care homes, general practices, community and other services don't always work as closely as they should. STP organisations have had some good Care Quality Commission feedback but there are areas for improvement.

In addition, there are some people admitted to hospital beds who could be cared for in the community if the right support was in place, people go to A&E because they are cannot get to see their GP when they need to and there are growing waiting times for many services.

In some areas, there is a national shortage of clinical staff. Indeed, we are already consulting on proposed changes to hyper acute stroke services and some children's surgery in the region because such shortages are already having an impact.

Furthermore, there are high levels of deprivation, unhealthy lifestyles and too many people dying prematurely from preventable diseases and there are significant inequalities across the region.

There are also significant financial pressures on health and care services - with an estimated gap of £571 million in the next four years.

4.3 Working together

The plan is built on a history of strong relationships and being able to quickly develop a strong partnership, where all can see the opportunities and are motivated to deliver significant improvements for the 1.5 million population. It is about working together even better, and in new ways.

It is based on the five 'places' within South Yorkshire and Bassetlaw – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

The plans are the foundation of what will be delivered in each area and they set out how the improvements from the new ways of working and prevention will be made.

The place plans focus on aligning primary and community care, putting the greatest emphasis on helping people in their neighbourhoods and managing demand on services. They also hone in on improving health and wellbeing and the other factors that affect health, such as employment, housing, education and access to green spaces.

Work on place alone won't address the challenges, and so there are also eight priority areas of focus:

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities
- Urgent and emergency care
- Elective and diagnostic services
- Children's and maternity services
- Cancer
- Spreading best practice and collaborating on support services

4.4 Taking decisions together

To deliver the change needed in South Yorkshire and Bassetlaw, the statutory organisations involved in health and social care have formally agreed to interim governance arrangements to help them to start to work and take decisions together.

An Oversight and Assurance Group will provide oversight governance, a Collaborative Partnership Board (CPB) will set the vision, direction and strategy and an Executive Partnership Board will support the CPB and develop policy and make recommendations to the Board. Already in place are a Joint Committee of NHS Clinical Commissioning Groups (JCCCGS) and an NHS Provider Trust Federation Board.

All these will run in parallel with partners' governance and help make decisions. This interim arrangement will remain in place until April 2017 during which time a review will take place to establish the right governance.

The members of these groups come from all statutory South Yorkshire and Bassetlaw health and social care organisations plus national bodies as appropriate (NHS England, NHS Improvement, Health Education England and others), as well as other providers and representatives from primary care, the voluntary sector and patients, including Healthwatch.

A key principle of the governance arrangements is that local commissioning will remain a local responsibility. The JCCCG will only take precedent over local decisions where it agrees that it would be more efficient and effective for decisions to be made at a South Yorkshire and Bassetlaw level.

4.5 Rethinking and reshaping health and care

In rethinking and shaping how partners currently work, the focus is on:

- Putting prevention at the heart
- Reshaping primary and community based care
- Standardising hospital services

Partners want to radically upgrade prevention and self-care, to help people to manage their health and look after themselves and each other. This will require improvements in how health and care services connect with people to help them stay well and also in how illness is detected and diagnosed.

Investment in health at community levels will be transformed. Focusing more on helping people where they live will also have an impact on people's employment and employability. Primary care services will be improved through the transformation of community based care and support and with GPs coming together at the forefront of new ways of working. Through wider GP collaborations, it will be possible to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt the workforce to better meet people's health and care needs.

At the same time, everyone should have better access to high quality care in specialist centres and units and, no matter where people live, they get the same standards, experience, and outcomes for their care and treatment. This will be done by standardising hospital care and developing a networked approach to services.

Spreading best practice and collaborating on support services, such as estates, procurement and pharmacy management, will also enable partners to meet the challenges. Technology and digital integration will also play a major role in helping shape the future of health and care services.

Developing and supporting staff is the only way these ambitions will be achieved. The right people, with the right skills in the right place and the right time are needed – whether this is in general practice, the community and neighbourhoods or in hospitals.

Rethinking and reshaping the workforce, developing ways of working that help people live healthy lives in their homes and communities and supporting GPs to be as effective as possible will also be key.

A flexible workforce that comes together to offer people the best and most appropriate care is envisaged.

4.6 Early implementation

A number of priorities, led by NHS Commissioners Working Together and the NHS Providers' Working Together Partnership Vanguard, are already being progressed. Partners agree they want to take these forward using the governance that has been put in place.

The areas are:

- Spreading best practice and collaborating on support services
- Children's surgery and anaesthesia
- Hyper acute stroke services
- Acute gastrointestinal bleeds
- Radiology
- Smaller medical and surgical specialties

5. Next Steps

5.1 Health and Wellbeing Board members asked to support the vision, ambition and priorities of the plan and to work with STP partners at a South Yorkshire and Bassetlaw level on the priorities and to support the direction of travel.

6. Financial Implications

6.1 £3.9 billion is currently invested on health and social care for the 1.5 million population of South Yorkshire and Bassetlaw. This includes hospital services, mental health, GP services, specialist services and prescribed drugs, as well as public health and social care services.
After taking into account the resources that are likely to be available and the likely demand for health and social care services over the next four years, it is estimated that there will be a financial shortfall of £571 million by 2020/21.

If nothing is done to address this, £464 million will be the health service gap, while £107 million will be the social care and public health gap. To achieve the ambitions laid out in the plan, the £3.9 billion investment needs to work differently.

The high level planning assumes a significant reduction in demand for hospital services and potential changes to services which, if fully developed into cases for change, would require public consultation.

7. Consultation with stakeholders

7.1 There are 25 partners involved in the STP; six local authorities, 18 NHS organisations, and one children's services trust involved in the STP. The plan has been developed in consultation with them. They are:

Barnsley Metropolitan Borough Council
NHS Barnsley Clinical Commissioning Group

Barnsley Hospital NHS Foundation Trust
NHS Bassetlaw Clinical Commissioning Group
Bassetlaw District Council
Chesterfield Royal Hospital NHS Foundation Trust
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Doncaster Children's Services Trust
NHS Doncaster Clinical Commissioning Group
Doncaster Metropolitan Borough Council
East Midlands Ambulance Service NHS Trust
NHS England
Nottinghamshire County Council
Nottinghamshire Healthcare NHS Foundation Trust
NHS Rotherham Clinical Commissioning Group
Rotherham, Doncaster and South Humber NHS Foundation Trust
The Rotherham NHS Foundation Trust
Rotherham Metropolitan Borough Council
Sheffield Children's Hospital NHS Foundation Trust
Sheffield City Council
Sheffield Health and Social Care NHS Foundation Trust
NHS Sheffield Clinical Commissioning Group
Sheffield Teaching Hospitals NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trist
Yorkshire Ambulance Service NHS Trust

It has also been developed in partnership with:

Healthwatch Barnsley
Healthwatch Doncaster
Healthwatch Nottinghamshire
Healthwatch Rotherham
Healthwatch Sheffield
Voluntary Action Barnsley
Bassetlaw Community and Voluntary Service
Doncaster Community and Voluntary Service

Between December 2016 and March 2017, STP partners will connect and talk with the staff in each partner organisations and local communities about the plan. They also will be working with Healthwatch and voluntary sector partners to ensure connectivity with all groups and communities.

All views will be taken into account and fed back into the plans

Officer: Jade Rose **Contact:** 01226 433756 **Date:** 06 December 2016

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REPORT TO THE HEALTH AND WELLBEING BOARD

06 DECEMBER 2016

BARNSLEY PLACE BASED PLAN

Report Sponsor: Rachel Dickinson
Report Author: Jade Rose
Received by SSDG: 15 November 2016
Date of Report: 23 November 2016

1. Purpose of Report

1.1 To update H&WBB members of the progress that has been made in the development of the Barnsley Place Based Plan
1.2 To request that H&WBB members consider and approve the Barnsley Place Based Plan

2. Recommendations

2.1Health and Wellbeing Board members are asked to:-

- To consider the content of the Place Based Plan (PBP) particularly in the context of the recently published STP.
- To approve the Place Based Plan for wider circulation and endorsement by all Partner Boards

3. Introduction/ Background

3.1 In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England was asked to produce a multi-year 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 of better health, better patient care and improved NHS efficiency.

3.2 As part of the development of the STP across South Yorkshire and Bassetlaw, each of the five localities has developed a Place Based Plan. The Place Based Plan is a key building block of the STP. It sets out the local challenge and how greater integration across place can deliver significant benefits against the triple aim.

3.3 The place plan focuses on aligning primary and community care, putting the greatest emphasis on helping people in their neighbourhoods and managing demand

on services. It also hones in on improving health and wellbeing and the other factors that affect health, such as employment and housing.

3.4 The purpose of the Place Based Plan is to:

- Recognise the scale of the challenging triple aim set out in the Five Year Forward View for Barnsley
- Understand how Barnsley will contribute to the South Yorkshire and Bassetlaw STP Priority Areas
- Identify the local priority areas for Barnsley and the actions needed to deliver against these
- Set out how we will work together across Barnsley to deliver the triple aim across all partners
- Form the basis of a system wide action plan that is aligned with the Health and Wellbeing Strategy

3.5 The Barnsley Place Based Plan has been developed through SSDG over a number of months. There have been two dedicated workshops to identify the priority areas specifically for Barnsley which have been identified as;

1 Healthy life expectancy
2 Building stronger communities and being in control of my wellbeing
3 Improving mental health and wellbeing
4 Improving support for older people
5 Changing the way we work together

3.6 Within the Barnsley Place Based Plan, for each Priority Area, the high level detail of what we are going to do and the benefits have been set out. There is now work ongoing through SSDG to convert these actions, alongside those set out in the Health and Wellbeing Strategy, into a meaningful integrated action plan for Barnsley that will be overseen by SSDG.

4. Conclusion/ Next Steps

4.1 It is intended that the Barnsley Place Based Plan will be circulated to all Partner Boards for endorsement following approval at H&WBB.

4.2 SSDG is currently developing an integrated action plan that will set out the key actions for integrated working to deliver the greatest benefits to the Barnsley population. It is expected that this will be monitored through SSDDG with some reporting to the HWBB as appropriate.

5. Financial Implications

5.1 Barnsley health and care services are facing a financial gap in the region of approximately £90 million by 2021 based on indicative modelling from the STP. The purpose of this plan is to address this financial gap whilst driving up care and quality standards and improving the health and wellbeing of the Barnsley population. This is

a hugely challenging agenda. Whilst it is not clear what transformation funding will be available over the full 5 year period, it is imperative to have a robust place based plan to give Barnsley the best chance of securing any additional national transformation monies into our locality.

6. Consultation with stakeholders

6.1 A public engagement event was held in August 2016 where both the Health and Wellbeing Strategy and the priorities within the Place Based Plan were shared with the public. At this point there was broad support for the Priority Areas that had been developed for Barnsley.

6.2 It is acknowledged that as we develop or move towards implementation of some of the specific actions that there may need to be further consultation or co-production with the public.

6.3 The Place Based Plan has also been submitted to the Overview and Scrutiny Committee on the 6th December 2016 alongside the STP.

7. Appendices

7.1 Appendix 1 – The Barnsley Plan

8. Background Papers

8.1 None

Officer: Jade Rose **Contact: jade.rose2@nhs.net** **Date: 23/11/16**

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Barnsley Plan

#BetterBarnsley

PLACE BASED LEADS: LESLEY SMITH (BARNSLEY CCG) | RACHEL DICKINSON (BMBC)

November 2016

Barnsley Plan

Version and distribution:

Version	Date	Board	Comments
V5	6/12/16	Barnsley Health and Wellbeing Board	
V5	6/12/16	Overview and Scrutiny Committee	
V5	8/12/16	Barnsley CCG Governing Body	

#BetterBarnsley

PLACE BASED LEADS: LESLEY SMITH (BARNSLEY CCG) | RACHEL DICKINSON (BMBC)

November 2016

Contents

Foreword

WHAT IS THE BARNSLEY PLAN?

The Barnsley Plan has been developed through partnership across the public sector and voluntary community sector organisations.

It draws on inputs through the engagement and design of our health and care services as well the priorities set out in key documents including the Barnsley Health and Wellbeing Strategy, the Five Year Forward View, GP Forward View, Mental Health Forward View, Facing the Future and National Cancer Strategy.

The development of the plan has been overseen and driven via the Barnsley Senior Strategic Development Group and is one part of the delivery model for the Health and Wellbeing Strategy for Barnsley.

Vision and Principles

OUR VISION FOR BARNSLEY:

That 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, whoever they are and wherever they live.

The principles that will guide us:

Focus on inefficiencies and outcomes
We know that we need to do things differently and we need to be more radical in favour of prevention.

Inspire and empower
We know that we cannot do this alone or in isolation. We must engage as many people as possible to make the greatest difference.

Connect, collaborate & co-produce
We know that the solutions will involve working together with the public, patients, carers and our partners and communities. We will broaden our reach to those who we have not connected to in the past.

Go further, faster
We know that time and resources are precious and therefore we must target our resources and prioritise those actions that will take us further, faster.

Our System

Barnsley is a metropolitan borough in South Yorkshire. We have a strong track record for working in partnership across well established networks.

Collectively we spend approximately £480 million on health and care across a population of approximately 239,000.

Barnsley has consistently lagged behind the England average for health and social care outcomes. We know that Barnsley has not delivered its potential to reduce the substantial gap in healthy life expectancy. There is a marked variation in life expectancy across the borough and average life expectancy in Barnsley is lower than the national average. The percentage of adults diagnosed with depression is higher in Barnsley at 15.8% than the tional average of 11.7%. The proportion of Barnsley residents living with a limiting long term ıess is 24.4%. This is significantly higher than the national average of 16.9%.

We know that a high proportion of current illness in the borough is either preventable or 'delay-able' and the financial benefit of reducing this matches the moral imperative to do so. We also know why; because no one organisation has it in its power to deliver this, it requires whole system solutions where every member understands their role. We also know that to fully address this challenge we need behaviour change in our local population as well as different responses from organisations.

This plan, under the umbrella of a multi agency Senior Strategic Development Group, sets out to address these challenges. By developing our partnerships at the most advanced level and by working with national partners and regulators, as well as communities, patients and carers, we will ensure we deliver real change and close the gaps that we have previously been unable to fully address.

Barnsley Strengths

Co-terminus borough-wide council and clinical commissioning group meaning that services can be more easily commissioned

Track record of strong partnership approach across the system and with our communities

…e combined mental health and community trust

Successfully bid for Prime Minister's Challenge Fund to improve access to GP services

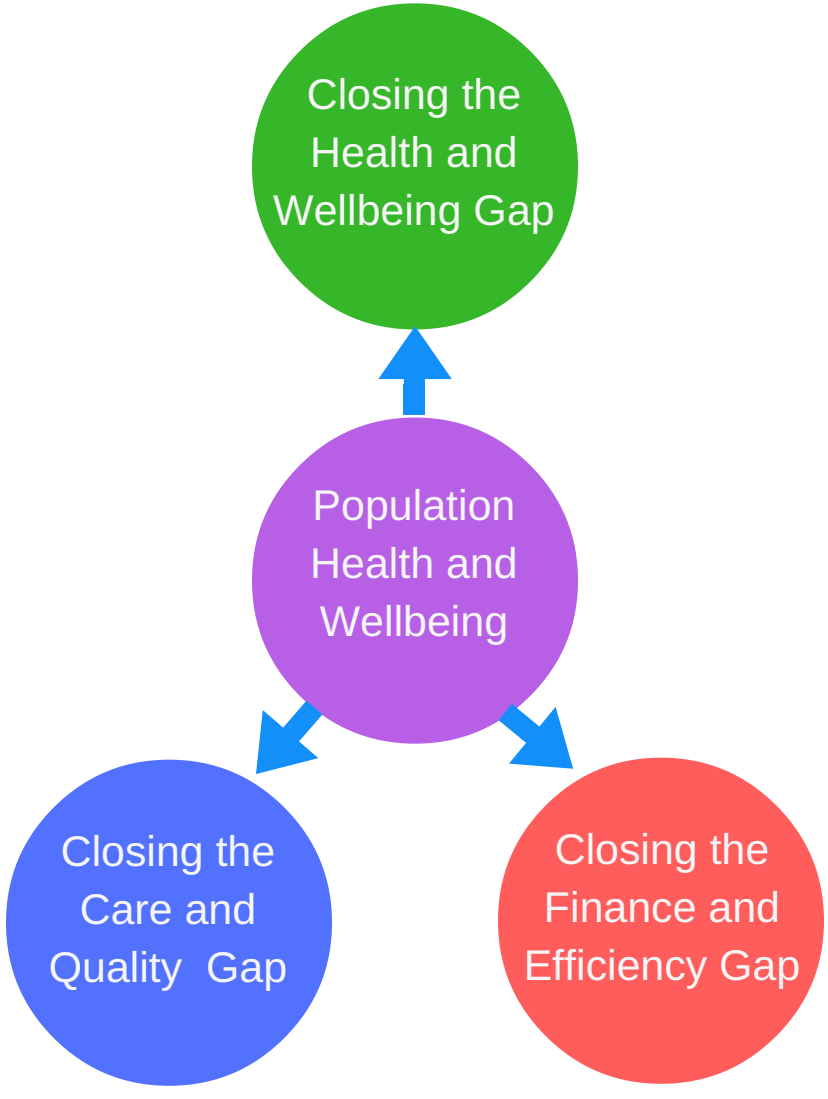
GP federation working on behalf of the majority of GP practices as providers to facilitate changes in approach at practice

One acute hospital trust

Joint commissioning for adult & children's services

Integrated Care Pioneer Site and Integrated Personalised Commissioning Demonstrator Site

The Case for Change



HEALTH AND WELLBEING SYSTEM CHALLENGE

In Barnsley there are three key challenges to improving population health and wellbeing and to providing high quality sustainable services to our population. This plan needs to address each of these three areas. We will specifically set out what each of these challenges mean.

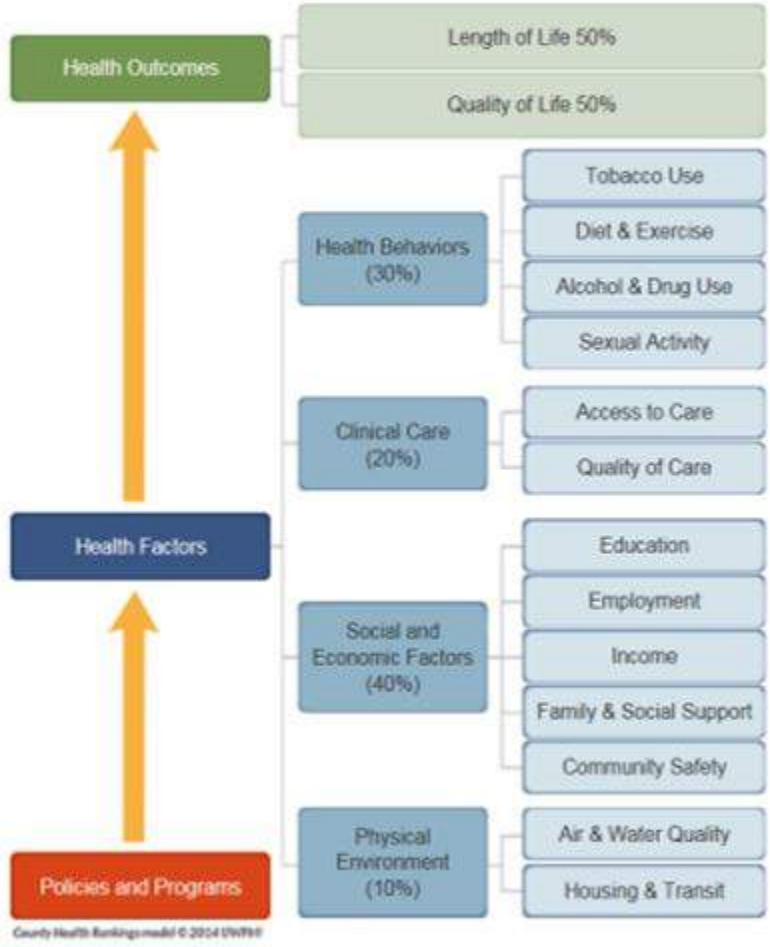
Scale of the challenge

The scale of the challenge health and care services currently face mean tha we need a significant step change in the scale and pace that we transform our services and importantly the way we work in order that we are able to provide affordable and sustainable services.

s means planning for the future through a radical upgrade in prevention streamlining and aligning services that work independently of organisationa boundaries and tackling the broader determinants of health and wellbeing.

Securing behaviour change across the population is also key if we are to succeed in our aims to improve health outcomes for the residents of Barnsley.

This is a significant task and carries a large agenda. The NHS Five Year Forward View reinforces this approach and provides us with an opportunity to genuinely transform the way we work.



Health and Wellbeing Gap

We have high levels of deprivation, poor lifestyles, too many people dying prematurely and from preventable diseases. We also have:

- Lower levels of life expectancy than the national average
- A reduction in healthy life expectancy for both men and women
- Marked inequalities between Barnsley and England and also across Barnsley
- High than expected incidence of long term conditions and resultant admission rates
- High levels of smoking prevalence, obesity and alcohol related hospital admissions
- In 2015, Barnsley ranked the 39th most deprived Borough out of 326 local authorities

Barnsley has significantly worse levels with regard to a range of childhood factors that affect health including:

- Children living in poverty
- School readiness and pupil absence
- Under 16 and under 18 conception

Female life expectancy changes across Barnsley (as at 2013)

Care and Quality Gap

The ageing population, increasing complexity of need and increasing patient expectations are combining to put the health and social care system under unprecedented pressure. Technical advances in treatment have also added to the demand.

Care needs to be more integrated. There are currently too many barriers in how care is provided – between primary care, community health services and hospitals, between physical and mental health and between health and social care, between professional, patient and carer.

In social care there are increasing demands but significantly decreasing resources. Increased demand as a result of a growing and ageing population, increasing prevalence of dementia and frailty, more people with complex physical and learning disabilities living longer and high level of adult mental illness. There have been several years of funding restrictions to social care budgets. Social care spending is protected where possible at the cost of other services but the ability to do this is running out.

After a long period of sustained delivery there is now an increasing pressure to meet referral to treatment targets. We also have:

- High volumes of some procedures of limited clinical priority
- High rates of emergency readmissions within 14 days
- High rates of emergency admissions related to ambulatory care sensitive conditions
- High volumes of out of area mental health placements

Finance Gap

Across South Yorkshire and Bassetlaw we currently invest £3.9 billion on health and social care for the 1.5 million population.

After taking into account the resources that are likely to be available and the likely demand for health and social care services over the next four years, we estimate that there will be a financial shortfall of £571 million by 2020/21. The health service gap is £474 million while £107 million relates to social care and public health.

On a pro rata basis, current modelling indicates the equivalent finance and efficiency gap across Barnsley health and social care is approximately £90 million by 2020/21. It is expected that by working differently we l deliver this through:

ransforming secondary care through productivity improvements of 2%
• Managing activity related demand by a 2% reduction

Our Approach

THE BARNSLEY WAY

The plan supports the delivery of the Barnsley Health and Wellbeing Strategy. Whilst there is a history of partnership working in Barnsley, often programmes, projects and initiatives have been planned and delivered in silos. In order to realise the full benefit and see real improvement in population health and wellbeing outcomes as well as services that give our public the best value for every pound they spend on health and care, we must align our priorities and work together.

We also need to work more effectively in partnership with local people and communities so that people can play their part in taking responsibility for health and well-being. Improving our Barnsley's health and wellbeing must be done in partnership. The Barnsley Plan work will bring together partners to listen and take action in order to achieve our ambitious priorities. The Barnsley Plan describes our shared vision, objectives and future models of care.

What we need to achieve:

Improved health & wellbeing:

Health and wellbeing is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment.

These 'broader determinants of health' are more important than health care services in ensuring a healthy population, and therefore this is where the Board will focus its efforts.

Reduced health inequalities:

There are marked inequalities in health which exist between Barnsley and England as a whole and within Barnsley itself, which is not acceptable.

A gap also exists between people with severe mental illness, learning disabilities and autism, and the general population. Our approach will therefore be to target our resources to achieve equality of outcomes for all.

What this will mean for individuals:

- Children start life healthy and stay healthy
- People live happy, healthier and longer lives
- People have improved mental health and wellbeing
- People live in strong and resilient families and communities
- People contribute to a strong and prosperous economy

HOW WILL THE SYSTEM NEED TO CHANGE?

- By strengthening and broadening partnership working to make the health & care system stronger and more responsive
- By creating joined up approaches that make sense to us all by putting public, patients and carers at the heart of what we do

South Yorkshire & Bassetlaw (SYB) Sustainability & Transformation Plan Priority Areas (STP)

Across SYB, a number of transformational and cross cutting work streams have been identified as shown in the table below. These are all work streams where there is a clear benefit in working across a larger foot print but where there are also local plans being implemented.

Transformational Work Streams

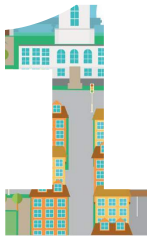
Maternity & Children's	Mental Health & Learning Disabilities	Urgent & Emergency Care	Elective Care & Diagnosis	Cancer

SYB Cross Cutting Work Streams

- Workforce
- Digital/IT
- Carter*, procurement and shared services
- Finance
- Economic Development, Public sector Reform and the City Region

Across Barnsley there is a significant amount of transformation work taking place which will support these South Yorkshire and Bassetlaw transformation work streams. This is detailed in the following slides.

*Refers to the Lord Carter review of 'Productivity in Hospitals' 2016.



Maternity & Children's Services (SYB)

What is the challenge?

- Meeting new standards for maternity care
- Not all children have the best start in life, with high rates of preventable health problems arising
- I ng demand and high use of acute s vices

What are we going to do?

- Improve personalisation and choice in maternity services
- Reduce the rate of smoking in pregnancy
- Increase the rate of breast feeding
- Connect primary and community services more closely and support families to manage common childhood conditions in the community
- Support an increase in levels of physical activity, working with families and schools
- Improve oral health in children
- Implement a perinatal and maternal mental health strategy
- Support all children, young people and families to make healthy lifestyle choices
- Tackle child poverty and improve family life

What are the benefits?

- Women will have maternity services that are safer, more personalised, kinder, professional and more family friendly; every woman will have access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.
- A reduction in preventable health problems
- Improved access to care close to home
- Reduced infant mortality and morbidity rates
- Improved pre-, peri- and post-natal mental health provision
- Reduction in childhood hospital admissions for dental extractions

Mental health & learning disabilities (SYB)

What is the challenge?

- Approximately 25% of the population experiences some kind of mental health problem in any one year
- People with severe mental illness can lose 20 years of life
- Co-morbid mental health problems raise t… health care costs by at least 45% for e… person with an additional long term c…ditions
- These challenges are compounded by a stigma that exists around mental health and learning disabilities and the lack of parity of esteem with physical health services
- Transforming Care Challenge for people with a learning disability

What are we going to do?

- Focus on early intervention and crisis care
- Review of day opportunities for people with a learning disability
- Implement of the all age Mental Health & Wellbeing Strategy, incl. enhanced crisis care, early interventions for people with psychosis, development of hospital liaison services, focus on improving the physical health of people with a serious mental illness
- Implementation of suicide action plan
- Implement integrated personalised commissioning to join up health & social care needs and give people greater say in how they are supported
- Implement Local Transformation Plan for Children and Young People's Mental Health & Emotional Well Being
- Implement a multi-agency public sector hub with South Yorkshire Police & partners
- Deliver large scale mental health awareness work force development across all agencies

What are the benefits?

- Barnsley residents wellbeing and mental health is improved
- Residents with mental illness will receive high quality, response care with a focus on early intervention and recovery and will be better supported to look after their physical health.
- Reduction in mental health related A&E attendances and hospital admissions
- Parity of esteem is delivered
- Equity of access to services for mental health that is similar to those for physical health
- Years lost to life for people with severe mental illness are reduced
- People with learning disabilities are supported to live in the community reducing the need for hospital admissions and long stay placements
- Reduced length of stay for people with learning disabilities

Urgent & emergency care (SYB)

What is the challenge?

- Increasing complexity and acuity of patients and a high volume of A&E Adult Attendances and non-elective adult inpatient admissions
- Data analysis suggests that up to 30% of attendances could be managed in an ernative setting
- orkforce challenges and capacity ues resulting in quality issues, failure to meet NHS Constitutional standards
- Financial sustainability – difficulty in meeting current demand with the current resources

What are we going to do?

- Support the development of RightCare Barnsley
- Increase access to primary care through I HEART Barnsley
- Intermediate Care Review
- Community Nursing Review
- Implementation of integrated clinical pathways for respiratory services

What are the benefits?

- Lower demand enabling improved quality
- Greater cost effectiveness
- Improved patient access and reduced variation in delivery
- Increased support for self care which will enable long term management, improved health and wellbeing and reduce the burden on healthcare services
- Reduction in unnecessary hospital admission and readmission
- Reduction in A&E attendances
- Increased early supported discharge

Elective care (SYB)

What is the challenge?

- Across the system there is increased demand in both elective and diagnostic care across clinical pathways
- There is a need to align elective and urgent care work to ensure that quality is not impeded due to inter dependencies

What are we going to do?

- Develop integrated clinical pathways for Diabetes, Respiratory disease, and Musculoskeletal diseases.
- Implement Map of Medicine
- Develop consultant advice and guidance to GPs
- Continue to enhance direct access to diagnostics and the clinical interpretation and management advice on reports
- Implement Social Prescribing
- Improve oral health in children

What are the benefits?

- Reduce the growth in demand on elective services
- Decrease number of admissions for dental extractions
- Decrease number of new outpatient appointments
- Higher proportion of outpatient clinics held closer to home
- More sustainable delivery of referral to treatment performance
- Improved patient experience and outcomes
- Improved support for self care and within pathways freeing capacity and reduce avoidable spend

Cancer (SYB)

What is the challenge?

- An ageing population and a rise in lifestyle related risk factors mean that cancer incidence is increasing Improvements in cancer survival rates mean that more people are living with and beyond cancer

What are we going to do?

- Radical upgrade in prevention though delivery of the tobacco control strategy
- Work with primary care to increase early diagnosis of cancer
- Increase screening uptake
- Develop shared care pathways across primary and secondary care
- Develop a primary care training programme
- Revitalise the Cancer Care Review Process
- Maximise opportunity to further develop the Survivorship Programme (Living with and Beyond Cancer)
- Implement the End of Life Strategy

What are the benefits?

- Greater ability to address the primary and secondary causes of cancer
- Earlier diagnosis and intervention to achieve a shift in the stage at which a cancer is diagnosed
- Ensure care is delivered in the most appropriate setting
- Improved quality of care and patient experience
- Improved personalisation and choice
- Reduce duplication and drive integration of services
- Greater uptake of choice at the end of someone's life

Barnsley Priority Areas

In addition to the SYB work stream, we recognise that there are a number of priority areas where we can come together as a local system to deliver a greater collective benefit for Barnsley people. These are:

- **Healthy life expectancy**
- **Building stronger communities and being in control of my wellbeing**
- **Improving mental health and wellbeing**
- **Improving support for older people**
- **Changing the way we work together (new models of care)**

Improving healthy life expectancy (Barnsley)

What are we going to do?

- Through Smoke Free Barnsley, work collaboratively to reduce adult smoking prevalence by at least 1% year on year from 24.4% to at least 18% by 2019
- Establish an Alcohol Alliance and a comprehensive programme which creates a culture where sensible drinking is the norm
- Heart of Barnsley – CVD & Diabetes - Decrease the prevalence, morbidly and mortality from Cardiovascular Disease & Diabetes, through a programme of healthy public policies and lifestyle services/interventions, along with enhancement clinical management of CVD risk factors and secondary prevention in primary care and secondary care; implementation of the National Diabetes Prevention Programme.
- Strengthen the relationship between housing and health to enable people to have better living conditions

What are the benefits?

- Healthier population
- Reduction in long term conditions associated with smoking
- Reduction in long term conditions associated with alcohol consumption
- Reduction in alcohol related admissions to hospital
  Improved quality of care
- Greater ability to address the primary and secondary causes of cancer
- Increase in healthy life expectancy
- Reduction in alcohol related harm e.g.. domestic violence, criminal assault, antisocial behaviour
- Reduction in alcohol and smoking related: primary care attendances, A&E attendances, admissions to hospital
- Improved quality of care for patients with CVD and diabetes, leading to increased quality of life, decrease in primary care, A&E and hospital admissions

2 Strengthening relationships with communities and individuals (Barnsley)

What are we going to do?

- Harness the renewable energy represented by patients and communities, maximising the potential health gains from social action and volunteering and maximise the potential of community assets and social capital to support residents to maintain their independence and social participation
- Develop a system wide volunteering strategy
- Develop new impact volunteering to support demand management eg in reach work to hospitals
- Support individuals and communities to improve their health literacy
- Improve access to universal information and advice
- Implement social prescribing
- Map peer support networks, identify gaps and build new networks where required
- Drawing on the strength of local communities, pilot a place based health and wellbeing (including community safety and employment) approach in one locality
- Develop and implement a systematic approach to personalised self management and self care across Barnsley
- Strengthen local voice by securing and responding to feedback about service design and delivery

What are the benefits?

- Strong communities are essential to good health and wellbeing and building individual resilience and independence
- Improved quality of care
- Improved physical, emotional and mental wellbeing
- Improved access to the right service or support
- People will feel enabled to take control of their health
- More residents will get the information and advice that they need to resolve or self-manage a wide range of problems early before they escalate
- Social prescribing will help to link patients with non-medical sources of support within the community
- Patients and carers to be more active participants in their care, supported to understand their choices, truly share decision making, reach self-identified goals and adopt more healthy behaviours. enabling them to live the life they want to their best ability.
- People will understand the system and know what to do and where to go if things change or go wrong. They will be better able to plan ahead and stay in control in emergencies. Patients will have systems in place to get help at an early stage to avoid a crisis
- Decrease demand for primary care, specialist mental health services and social care services

Improving mental health & wellbeing (Barnsley)

What are we going to do?

- Establish a Mental Health Alliance
- Focus on the early recognition of mental ill health and the prevention of escalation of need.
- Implement the Local Transformation Plan for Children and Young People's Mental Health & Emotional Well Being
- Deliver the Mental Health Crisis Care Concordat
- Expand IAPT services and enhanced psychological support for people with LTCs
- Develop shared care pathways across primary and secondary care
- Deliver large scale mental health awareness work force development across all agencies
- Implement a work place health charter across the public sector and other local businesses.
- Enhanced support for people with mental illness to stay in and get into work
- Develop personal health budgets for people with mental health problems
- Implement a multi-agency public sector hub with South Yorkshire Police and partners

What are the benefits?

- Barnsley residents wellbeing and mental health is improved
- Reduction in the gap in life expectancy between people with severe mental illness, learning disabilities and autism and the general population
- Children and adults will receive earlier help, diagnosis and treatment of mental health problems in the most appropriate setting and at the earliest possible time to prevent escalation.
- Increased support available to prevent a crisis occurring and also when a crisis occurs
- Improved co-ordination of interventions for physical and mental health for people with multiple vulnerabilities
- People with long term illnesses and disabilities will have improved psychological health and be better able to cope with their physical health problems

Improving support for older people (Barnsley)

What are we going to do?

- Develop more cohesive ways of working across older people's services to enable an improvement in the coordination of service developments to improve the quality of care for older people.
- Develop integrated care pathways for the prevention and management of falls and osteoporosis that is clinically and cost efficient and has sufficient capacity to have a population impact
- Further develop services for people with dementia in order to deliver an integrated pathway for dementia ensuring high quality care throughout the pathway that reflects the priorities within the Prime Minister's Challenge on Dementia 2020.
- Consider the options for further integration of equipment and adaptation provision across Barnsley
- Early help - strengthen low level supports such as services that support people who are socially isolated
- Integrate our approach to telehealth and telecare
- Redesign homecare support
- Key worker role for Police Community Support Officers

What are the benefits?

- Holistic services for older people and quality of life for older people
- Increased independent living
- Reduction in unnecessary emergency admissions and readmissions
- Increased support for carers and reduction in carer breakdown
- Reduction in avoidable:
- A&E attendances
- Emergency hospital admissions
- Hospital readmissions
- Prevention or delay in need for domiciliary care packages
- Prevention of avoidable Care Home admissions
- Ensure care is delivered in the most appropriate setting
- Reduce duplication and drive integration of services
- Equipment availability is appropriately delaying or reducing the need for support
- More cost efficient equipment provision
- Mobilise faster timely discharge

Changing the way we work together (New Models of Care)

What are we going to do?

- Explore the development of an Accountable Care Organisation in Barnsley
- Develop integrated locality based health and wellbeing teams
- Implement the GP Forward View to strengthen primary care
- Create a single Barnsley health and care digital record

What are the benefits?

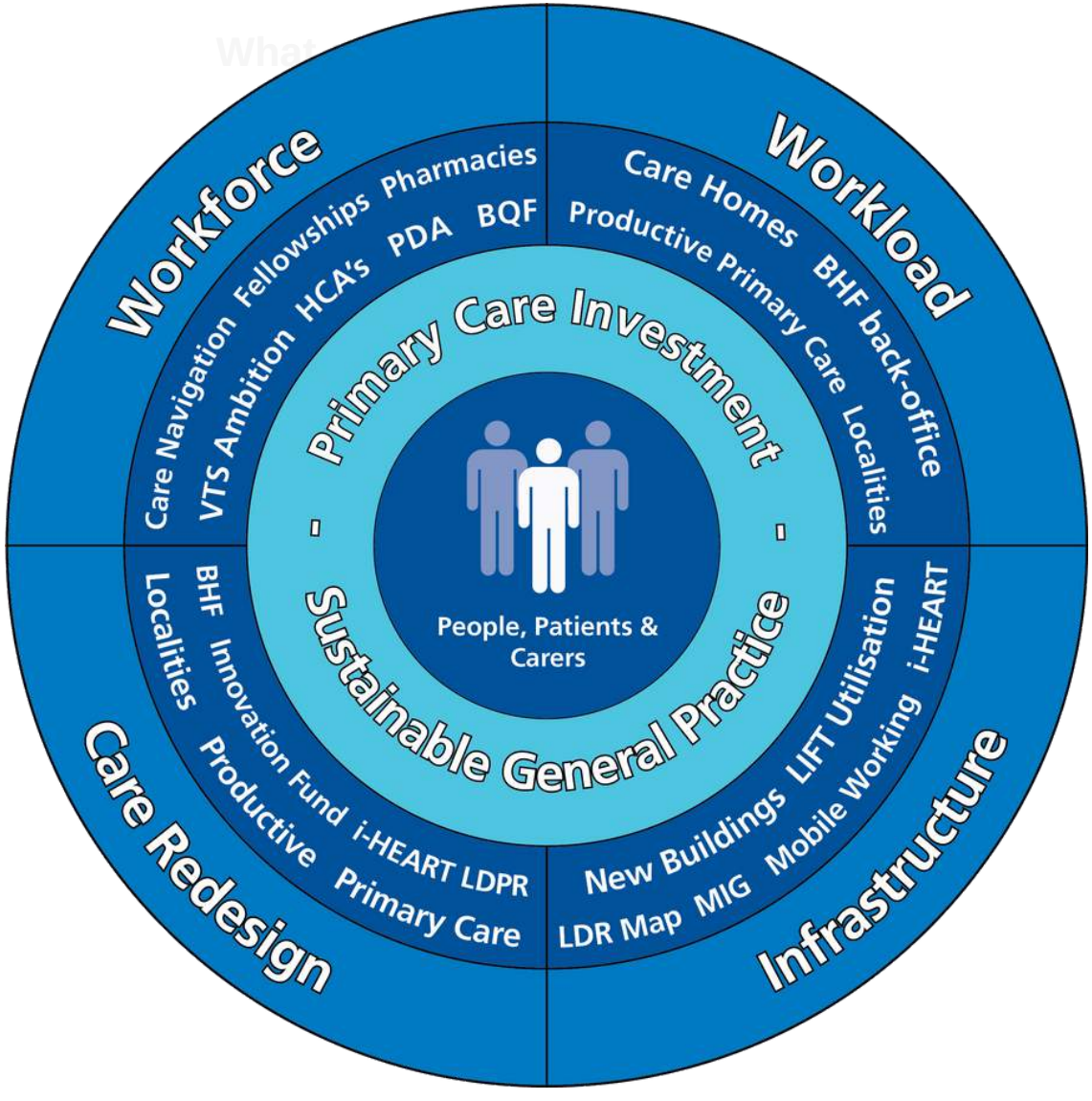
- Holistic services for all
- Joined up, integrated care
- Increased access to primary care
- Improvements brought about through increased digitisation of information that can be accessed by different parts of the health and care service
- Reduction in unnecessary emergency admissions and readmissions
- Ensure care is delivered in the most appropriate setting
- Reduce duplication and drive integration of services

Changing the way we work together - Strengthening Primary Care

Strengthening Primary Care across Barnsley is fundamental in delivery of the Barnsley priority areas.

Our vision is a future in which the current model of primary care is allowed to deliver its full potential. It is for an integrated wider primary and community care offer, which is comprehensive and serving the full range of needs found in the community.

This diagram identifies the work streams that will be delivered to support this in Barnsley.



Changing the way we work together - Accountable Care Organisation Development

- Barnsley CCG has an ambitious strategy to integrate the delivery of health and care for the people of Barnsley. This ambition is supported by our commissioning partners in Barnsley Metropolitan Borough Council and our provider partners in BHNFT and SWYPFT and by the Barnsley Healthcare Federation.

- Our vision for the future of health and care in Barnsley is to create a simpler, more joined up health and care system; one where the people of Barnsley don't see organisational boundaries. Instead, they experience continuity of care; they see familiar faces that are clearly connected to each other regardless of where patients are seen; be that in hospital, in the community or at home. They won't experience gaps in care; they are not isolated but supported and empowered by what feels like "one team", each delivering their part without duplication.

- Our goal is to dismantle boundaries at the point of delivery of care, to create a Barnsley where patient interests come first and resources are focused on improving health outcomes in areas of the borough where inequalities are greatest.

Digital Road Map

Deliver our 'Digital Road Map' to improve services

We recognise that our IT systems are a barrier to people working together, communication between health and care teams needs to improve and we need to take a holistic view of the patient and see them as a whole.

We have therefore developed a 'Digital Road Map' to transform our approaches, develop systems that 'talk' to each other and deliver a better experience for patients and service users.

Digital Road Map

Our vision in Barnsley is to:

- Increase technology enabled care to support people to stay in their homes for longer and help them maintain their
- dependence and wellbeing.
- ransform the way in which we engage with citizens;
- mpowering them to maintain their own health and wellbeing
- rough digital solutions
- Transform the way in which health and care providers, our voluntary and charitable sector organisations engage with patients and their communities
- Accelerate mechanisms that promote record sharing and support access to data for those working within health and care services
- Enable clinicians to provide the best care in all settings by the use of mobile technology.

We will:

- Implement our Local Digital Roadmap
- Work collaboratively to support the development of interoperable IT solutions to enable appropriate record sharing
- Fully roll out the Medical Interoperability Gateway (MIG) to allow appropriate access to primary care records
- Support the development of mobile working for clinical staff across Barnsley
- Deliver the national ambition to be 'Paper Free at the Point of Care' by 2020

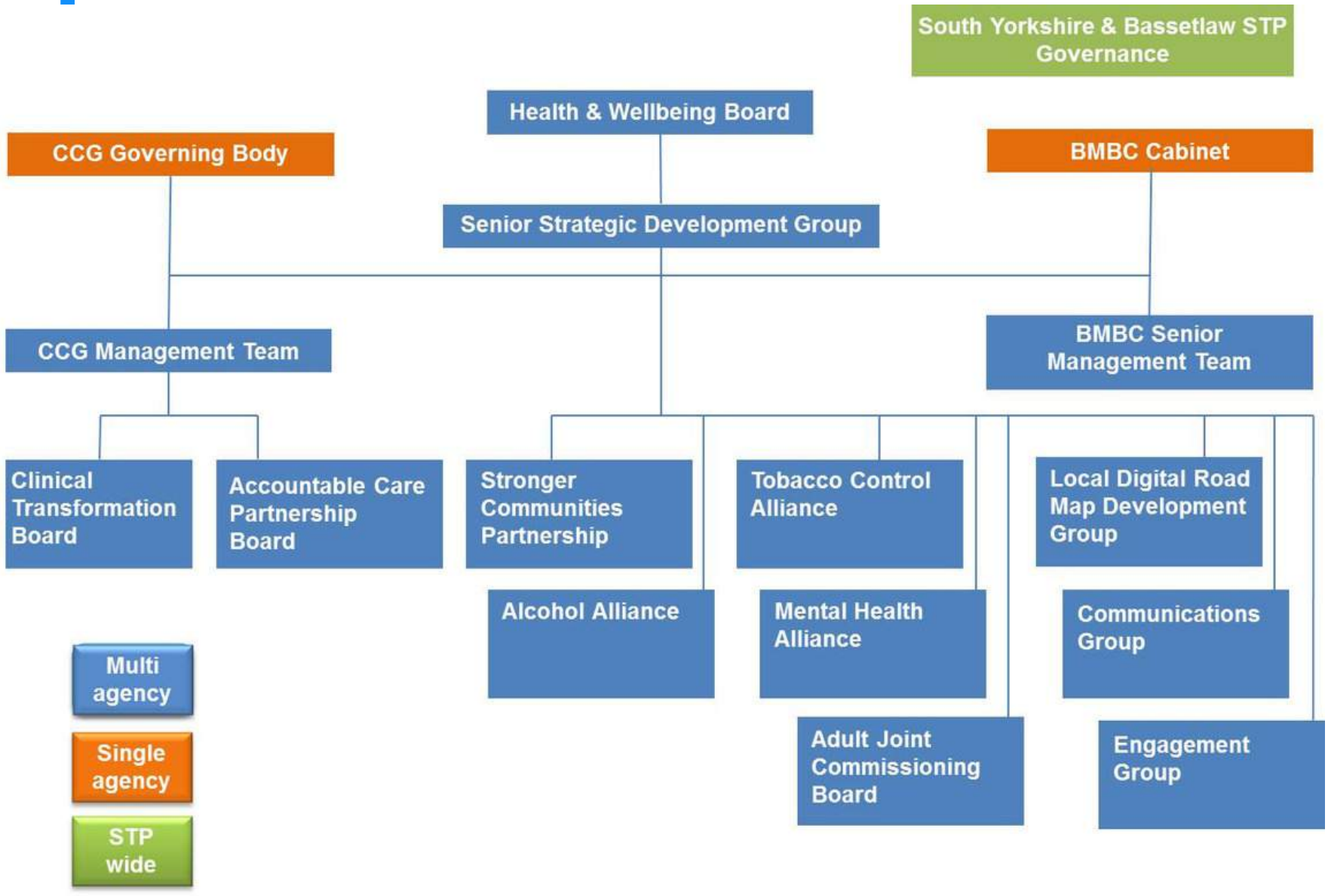
Engagement

Having a strategic framework for communication will allow partners to make greater use of networks, target specific issues and share information through a mixture of channels. This approach will also enable us to pull resource and networks across organisations to allow better joined up working and less duplication.

Partners are committed to putting the voice of Barnsley people at the heart of decisions. In Barnsley we have a strong tradition of service user, carer, patient and community involvement though groups such as Carers and Friends Group, Learning Disabilities Forum, Older Peoples Forum, Patient Forums, Equality Forums, Healthwatch Barnsley and our Ward Alliances . These and other forums play a key role in bringing together people's experience of health and social care in Barnsley to influence and shape local services:

- We intend to develop and build upon the mechanisms to hear the voice of our communities use the community voice to assess our progress against our priorities.
- We are proud to have such an extensive reach in to our communities, where we can have ongoing conversations about what is and what isn't working, and how together we can improve outcomes for our people. Openness and transparency will help bring about continuous improvement.
- We need to engage with communities about behaviour change and personal responsibility effectively.
- This information can then be used by the Area Councils, individuals and voluntary and community groups to achieve creative solutions to improve and shape the health and wellbeing of their communities.
- We intend to develop the mechanisms to hear the voice of our communities and use the community voice to assess our progress against our priorities and co-produce service change with communities, patients and carers.

Governance delivery & implementation



What will be different for Barnsley people?

It's 2015

Mrs Brown is 75 and lives alone at home in Barnsley. She doesn't know many people. She has had high blood pressure and early onset dementia for some time. She is losing her eyesight and is becoming increasingly unsteady on her feet.

Mrs Brown receives some care from the c[illegible]cil, and a few services from the lo[illegible] NHS which help to give her some in[illegible]endence. These include some home c[illegible]nd telecare from the council. She also s[illegible]he specialist nurses at the memory assessment service, the outpatients department for her vision and the district nurse is currently visiting daily to treat an injury from a fall. She has been to hospital three times in the past two months because of a fall or her conditions meaning an ambulance had to be called.

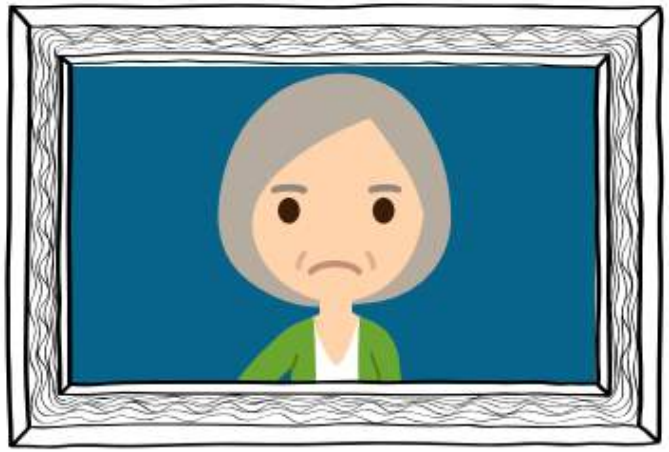
She has had to have a number of assessments, is often referred on from the people she has told her story to, has to do a lot of travelling to different services which are changed at the last minute.

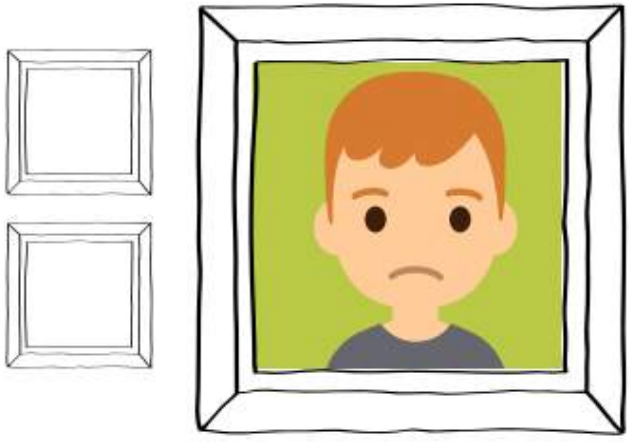
Jack, Mrs Brown's son, who lives on the next street cares for Mrs Brown for about 20 hours per week. He is struggling to pay his bills as he is unable to work and the carers' benefit does not cover these outgoings. He may have to give up caring and try to go back to work. Consequently Jack is suffering with anxiety and mild depression.

Mrs Brown is worried that she will have to go into a home if Jack is unable to continue caring and her health and wellbeing deteriorates further.

This is an expensive situation for two reasons:

- Duplication of resources
- The likelihood that Mrs Brown's situation will escalate and lead to more intensive, more expensive care.





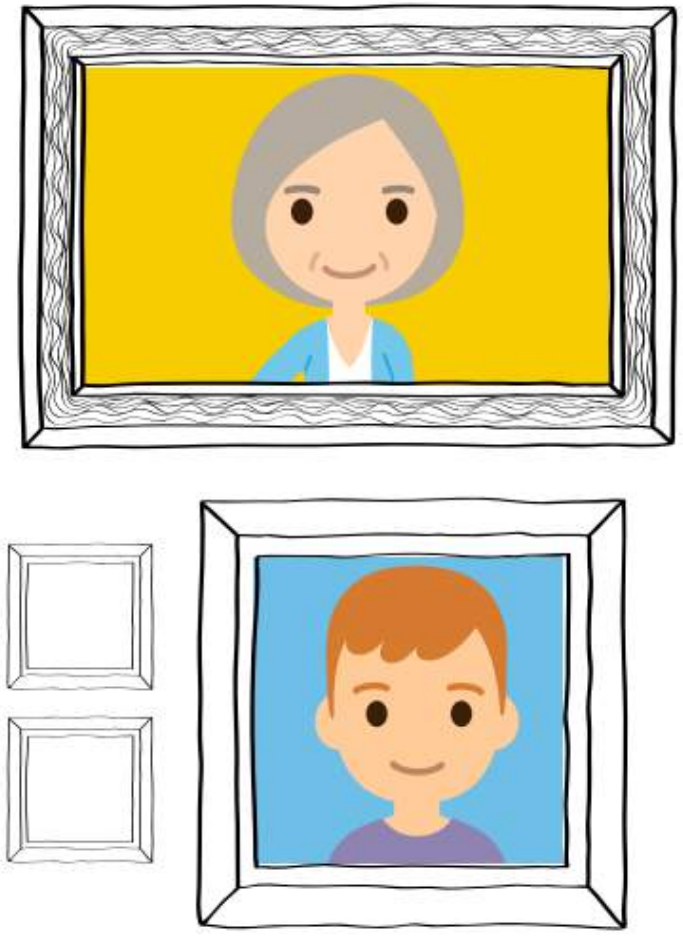
It's 2020

Mrs Brown is now 80. She is still at home despite her fears. Following a discussion with Mrs Brown and Jack, Mrs Brown was given an integrated personal budget to help her manage her health and care needs. As part of this, a single integrated care plan was developed jointly with Mrs Brown and her son Jack. Her care plan involves planned integrated health and care services, the use of assistive technology and the support from local neighbours and the local VCS. For the services Mrs Brown has chosen to buy with h)ersonal budget, there is consistent i mation about quality that has been p ided from regulator's report that helps t ı make informed choices about who p ides the care.

Having a single integrated care plan is a much more cost effective approach as resources are planned more effectively across the system, leading to less emergency visits, and avoiding the need for Mrs Brown to go into a care home.

This has taken some pressure off Jack who is now able to find time to do some training to help him when he is ready to go back to work. Because the system has been integrated and devolved, it is now much clearer how the system works and patients and carers are partners in making decisions. As a result Jack wants to be a part of helping design future services. He has agreed to join a sub group of the Health and Wellbeing Board to help design e-health services for the future so individuals can remain in control of their own health and wellbeing.

Staff in the local health and care economy work together in local multi-disciplinary teams. This helps them to respond more readily to Mrs Brown's needs without having to have multiple appointments and assessments every time something happens. Staff focus on working proactively with Mrs Brown to help her manage her conditions better and therefore avoid a hospital visit due to escalation. Staff have also had training in the use of mobile technology. They can now share and access information to provide the best care for their patients.



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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 of Public Health and Executive Director of People

Joint Strategic Needs Assessment 2016

1. Purpose of report

1.1 The purpose of this report is to notify Cabinet that (a) the Joint Strategic Needs Assessment (JSNA) has been produced for 2016, and (b) draw attention to the 2016 JSNA Executive Summary (Appendix 1), Infographic (Appendix 2) and Report (Appendix 3) and the move to a web-based JSNA.

2. Recommendations

2.1 It is recommended that Cabinet supports the publication of this Joint Strategic Needs Assessment as set out in this report.

3. Introduction

3.1 The purpose of a Joint Strategic Needs Assessment (JSNA) is to use all available data and information to assess the current and future health, social care and wellbeing needs of the local resident population and to guide local strategies and plans.

3.2 The production of a Joint Strategic Needs Assessment (JSNA) is a statutory duty and from 1st April 2013, through the Health and Wellbeing Board, both Barnsley Council and the Barnsley Clinical Commissioning Group (CCG) have an equal and explicit obligation to prepare the JSNA for Barnsley.

3.3 The main audience for the JSNA is health and social care commissioners and service providers who use it to plan services. It can also be used as an evidence base for preparing bids and business cases by the voluntary and community sector to ensure that community needs and views are represented.

3.4 This JSNA has been developed in three parts:

- An Executive Summary report which summaries the main health and wellbeing issues in Barnsley (Appendix 1)
- An 1 page infographic illustrating the main health and wellbeing issues in Barnsley (Appendix 2)

- A Report of the main health and wellbeing issues within Barnsley (Appendix 3)

- The evidence base will be made accessible via Barnsley Council website and will consist of briefings, profiles, infographics and more detailed reports.

3.5 The intention is that our JSNA evidence base is constantly under review and being improved in response to new information and feedback, so decisions can be made on the most accurate and timely data.

4. Proposal and justification

4.1 The proposal is to publish a Joint Strategic Needs Assessment for 2016 as outlined in sections 3.2 to 3.5. The main developments this year have been the move to a web-based resource for the evidence base, increased use of infographics, the use of customer insights data and data about service users' views of the health and social care that they receive.

4.2 The intention is that our JSNA evidence base will be constantly under review and being improved in response to new information and feedback. This will ensure that decisions can be made on the most accurate and timely data available.

5. Consideration of alternative approaches

Not applicable for this report.

6. Implications for local people / service users

Not applicable for this report.

7. Financial implications

Not applicable for this report.

8. Employee implications

Not applicable for this report.

9. Communications implications

9.1 A communication plan has been developed to ensure that the health and wellbeing issues identified are widely communicated including with partners.

10. Consultations

10.1 The Executive summary, infographic and report have been circulated for comment within the Council, with our partners via email circulation and through a number of partnership groups. Comments and amendments have been received and included by:

- Senior Strategic Development Group (18 October and 15 November)
- Barnsley Council SMT (1November)
- Barnsley Strategic Intelligence Group (7 November)
- Barnsley Operational Intelligence Group (13 October)

10.2 Where possible the comments received have been embedded into the report from the following services and partners:

- Senior Strategic Development Group
- Barnsley Council SMT
- Barnsley Strategic Intelligence Group
- Barnsley Operational Intelligence Group
- Equalities and Inclusion Team
- Barnsley Clinical Commissioning Group
- Barnsley Health Watch
- Berneslai Homes
- South West Yorkshire NHS Partnership Foundation Trust
- All Council Services
- South Yorkshire Passenger Transport Executive

11. The Corporate Plan and the Council's Performance Management Framework

11.1 The health and wellbeing issues identified within the JSNA link to the challenges mentioned in the Corporate Plan and appropriate measures will be embedded into the Council's Performance Management Framework.

12. Promoting equality, diversity, and social inclusion

12.1 Where possible, the JSNA includes a range of data to enable us to better understand the health inequalities and barriers experienced by diverse communities in Barnsley. However, the availability of this data is limited and, therefore, we have sought national research evidence where available. We have engaged with the network of equality forums at an event on 15th October 2016 with our health partners the CCG, SWYPFT, Barnsley Hospital and Healthwatch. The report from this event is currently being compiled and will be included within the JSNA when it is available. A summary of some of the key health inequalities is also incorporated into the Executive Summary and report.

13. Tackling the Impact of Poverty

Not applicable for this report.

14. Tackling health inequalities

14.1 The JSNA identifies the health and wellbeing issues including health inequalities that are experienced by Barnsley residents and provides evidence for tackling health inequalities.

15. Reduction of crime and disorder

15.1 Issues relating to crime and disorder are included in the JSNA.

16. Risk management issues

16.1 There are two main risks relating to the JSNA. Firstly, there is the risk that the JSNA resources do not accurately describe the health and social care needs of Barnsley in the short and longer term. This risk is mitigated by maintaining an annual JSNA cycle, using the most up to date data, including survey data, and by

using the full expertise of the Council's Research and Business Intelligence Team.

16.2 The second risk relates to the impact the JSNA has on strategy and decision making. This risk is mitigated by making the JSNA resources available online and by providing a more detailed strategic analysis. These actions make the JSNA more usable and more influential. A communication plan has been developed to ensure that the health and wellbeing issues identified are widely communicated.

17. Health, safety, and emergency resilience issues

Not applicable for this report.

18. Compatibility with the European Convention on Human Rights

Not applicable for this report.

19. Conservation of biodiversity

Not applicable for this report.

20. Glossary

JSNA – Joint Strategic Needs Assessment
CCG – Clinical Commissioning Group
SWYPFT – South West Yorkshire Partnership Foundation Trust

21. List of appendices

Appendix 1 Executive Summary
Appendix 2 Infographic
Appendix 3 JSNA Report

22. Background papers

Details of background papers can be obtained through the Research and Business Intelligence team on the contact details below.

Officer Contact Liz Pitt Telephone No 773189 Date 10/11/16

Financial Implications /


Barnsley Joint Strategic Needs Assessment

2016 Report

Introduction

The production of a Joint Strategic Needs Assessment (JSNA) is a statutory duty and from 1st April 2013, through the Health and Wellbeing Board, both Barnsley Council and the Barnsley Clinical Commissioning Group (CCG) have an equal and explicit obligation to prepare the JSNA for Barnsley.

The purpose of a JSNA is to use all available data and information to assess the current and future health, social care and wellbeing needs of the local resident population to guide local strategies and plans.

The main audience for the JSNA are health and social care commissioners and service providers who use it to plan services, as it identifies the health and wellbeing issues of the Barnsley population.

Population

The latest mid-year population estimates from the Office for National Statistics (ONS) show that the population of Barnsley in 2015 was approximately 239,300 which is an increase of 7.5% from 2005.

In 2015 the population consisted of 18.4% aged under 16, 62.9% of working age and 18.7% aged 65 and over. The latest data from the 2011 Census shows that 97.9% of the Barnsley resident population were from a white ethnic background, 0.7% were from mixed/ multiple ethnic groups, 0.7% were Asian or Asian British, 0.5% were Black/African/Caribbean or Black British and 0.2% were from other backgrounds.

The Department for Work and Pensions (DWP) figures regarding non-British nationals that have been issued with a National Insurance Number (NINO), show that there were a total of 1,980 people who moved to Barnsley from other countries during 2015, of these, 58.7% were from Romania, 27.1% were from Poland.

In July 2016 the Gypsy, Roma and Traveller Census that took place showed that there were 130 adults and 89 children (aged under 16 years) who were known to the Council to be currently living within a small group of static and mobile encampments within the Barnsley borough.

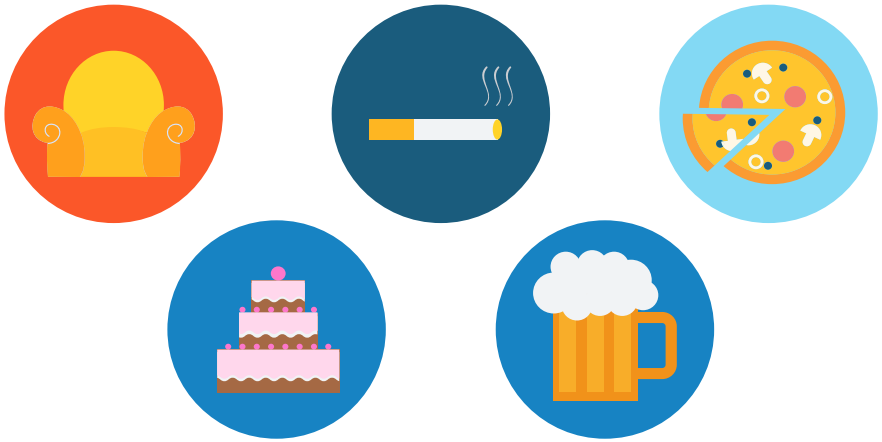
There are groups within the population for whom we do not have accurate and up to date information. One such group is the number of unpaid carers. The 2011 Census indicated that over 7,600 Barnsley residents were providing 50 or more hours of unpaid care a week to a friend, relative or neighbour who has a disability or health problem. Another group are the Lesbian, Gay, Bisexual and Transgender (LGBT) communities. Population estimates for Barnsley show approximately 14,400 LGBT residents living within the borough.

What are the issues that cause poor health and wellbeing within Barnsley?

Determinants of health illustrate the relationship between health and the physical, social and economic environment, many of which are distributed unevenly within the population.

Life expectancy in Barnsley, although lower than the England average, has slowly increased. Life expectancy is 78.4 years for men and 81.8 years for women. Whilst life expectancy has increased for men and women since 1991/93, the proportion of life spent in "good health" for both men and women has decreased. Healthy life expectancy at birth for men in Barnsley during 2009/11 to 2012/14 has increased by 0.2 years. However, due to life expectancy at birth increasing at a greater rate during the period, the proportion of life spent in "good" health has decreased from 74.1% to 73.4%.

Not all communities within Barnsley experience the same health and wellbeing issues. For example those residents from Black and Minority Ethnic communities are reported nationally to experience higher rates of poverty than White British in terms of income, benefits use, worklessness, lacking basic necessities and area deprivation.



Lifestyle factors have contributed to a variety of health problems for Barnsley residents.

These include:

- Smoking
- Excess Weight
- Alcohol Consumption
- Unhealthy Eating
- Inactive Lifestyle

Other factors also contribute to health inequalities. These include:

- Poor Education Attainment
- Lack of Digital Skills
- Unemployment
- Poor Housing Conditions including Fuel Poverty
- Poverty
- Deprivation

What are the health conditions that our residents experience?

The health of Barnsley residents is generally poorer than the national average. There are significant health inequalities across Barnsley. This creates growing pressures on health services, social care, informal care, supported housing and other services.

Some long term conditions are preventable by modifying lifestyles and behaviours and promoting healthy living. Long term conditions impact on quality of life, contribute to inequalities and become more common as people get older. As people are living longer, more of them are expected to be diagnosed with long term conditions over time.

The main health conditions are:

- Cancer
- Coronary Heart Disease
- Respiratory Disease
- Diabetes
- Dementia
- Poor Mental Health

How do service users view the health and social care that they receive?

Barnsley Council and our partners have carried out a number of consultations with service users, the need for improved 'personalisation' of services emerged as a priority:

- Medical professionals need to establish the person's communication needs, record these and make sure that all follow up discussions or correspondence properly meet that individual's personal needs.
- Everyone should be treated with respect and be spoken to directly rather than through a third party.

What are the potential health and wellbeing issues for Barnsley in the future?

The latest population projections based on the mid-2014 population estimates show that the number of Barnsley residents is expected to increase by 6.1% and reach approximately 247,600 by 2020 of which 20% will be aged 65 and over.

To accommodate these extra people the Local Plan has proposed that an extra 14,790 dwellings are to be built across the borough between 2014 and 2033. If left, the current lack of housing options will further impact on resident's wellbeing, including poorer housing conditions, higher housing costs, more people in fuel poverty and higher levels of overcrowding.

The number of older people is expected to rise significantly and the current housing offer may not be able to cope with the demand for suitable or specialist housing to meet the needs despite the additional planned dwellings.

As a result of an ageing population, the number of people experiencing particular illnesses or conditions will also increase. Information suggests that in the next few years more Barnsley residents will:

- Suffer from Dementia
- Suffer from Depression
- Suffer a fall, particularly those aged 75 and over
- Suffer a stroke, particularly those aged 75 and over and particularly males
- Be unable to take care of themselves or move around independently
- Be living with long term illnesses
- Be living alone
- Have obesity issues

What have services already done to help to improve health and/or wellbeing, and what are they developing for the future?

Barnsley Council and our partners are working together to address the health and wellbeing issues within the borough and a variety of projects have already taken place and are starting to have positive outcomes. This partnership working will continue to address the issues outlined in the Joint Strategic Needs Assessment through its strategies and local plans.

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Barnsley Health Needs Assessment 2016

Leading causes of death in Barnsley

29% Cancer

28% Cardiovascular diseases

16% Respiratory diseases

Diabetes

7% prevalence rate

higher than England average rate

6.4%

Dementia

4,600 patients predicted to have dementia by 2030

1/2 adults eat the recommended '5-a-day' the same as the England average

1/2 adults are physically active compared to 57% for the England average

Unemployment

Life Expectancy Years
Healthy Life Expectancy Years

78.4 57.5 Males

81.8 56.3 Females

Barnsley	England
21% of adults smoke	17% of adults smoke
including 32% of those in routine and manual occupations	including 27% of those in routine and manual occupations

1 in 5 drinkers drink at 'increasing risk' levels

1 in 5 young children are overweight or obese (reception pupils) the same as the England average

1 in 3 children are overweight or obese (year six pupils) the same as the England average

7 in 10 adults are overweight or obese

Compared to 6 in 10 for

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Barnsley
Joint Strategic Needs Assessment 2016
Summary Report

Produced on behalf of the Barnsley Health and Wellbeing Board

Prepared jointly by:

Barnsley Council
Barnsley Clinical Commissioning Group

The Research and Business Intelligence Team would like to thank everyone involved in developing this JSNA:

Barnsley Clinical Commissioning Group (CCG)
Barnsley Council Communities, People and Place directorates
Barnsley Hospital NHS Foundation Trust (BHNFT)
South West Yorkshire Partnership Foundation Trust (SWYPFT)
South Yorkshire Fire & Rescue Service (SYFR)
South Yorkshire Passenger Transport Executive (SYPTE)
South Yorkshire Police (SYP)
Voluntary Action Barnsley (VAB) – in particular Health Watch

Contents

Foreword

I am pleased to present this report on the Joint Strategic Needs Assessment (JSNA) for Barnsley. The JSNA uses all available data and information to assess the current and future health, social care and wellbeing issues of the local resident population. Such information is used by public sector partners to identify where best to invest their resources to secure the health and wellbeing outcomes Barnsley people deserve and reduce inequalities.

The JSNA provides the data and intelligence on which the planning, commissioning and delivery of health and social care and other public services should be based. The Barnsley Clinical Commissioning Group (CCG) has a duty to have regard to the JSNA when developing their plans for health services for the local population. Barnsley Metropolitan Borough Council (BMBC) will use the JSNA to shape its plans and strategies to maximise the health and wellbeing of Barnsley people. Together, the partners on the Health and Wellbeing Board will use the JSNA to inform the Barnsley Health and Wellbeing Strategy and our joint planning and commissioning priorities.

It can also be used as an evidence base for preparing bids and business cases by the voluntary and community sector to ensure that community needs and views are represented; by service providers to assist in the future development of their services; and by the public to scrutinise local health and wellbeing information, plans and commissioning recommendations.

This JSNA 2016 has been developed in four parts so it meets the requirements of the different audiences:

- An Executive Summary report containing the main health and wellbeing issues
- A 1 page infographic of the health and wellbeing issues in Barnsley
- A report of the main health and wellbeing issues within Barnsley
- An evidence base that is accessible via BMBC website consisting of briefings, profiles, infographics and reports.

The intention is that our JSNA is regularly reviewed and is constantly under review and being improved in response to new information and feedback, so decisions can be made on the most accurate and timely data.

I would like to thank the officers of the Council, Barnsley CCG, Barnsley Health Watch and voluntary sector colleagues who have worked in partnership to produce this JSNA.

I commend this new JSNA to you.

Councillor Sir Stephen Houghton CBE
Chair of the Barnsley Health and Wellbeing Board

Introduction

What is a Joint Strategic Needs Assessment?

The purpose of a JSNA is to use all available data and information to assess the current and future health, social care and wellbeing needs and issues of the local resident population by guiding local strategies and plans.

Many different factors impact on the health of the resident population of Barnsley. Some of these are due to unhealthy lifestyle choices like smoking and alcohol misuse. Other factors are less straightforward, such as how poor mental wellbeing affects physical health, the impact of poor housing or unemployment and low educational attainment.

In this JSNA we aim to describe what we know about the resident population of Barnsley and the impacts upon their health and quality of life. We attempt to give an overview of a wide range of factors from the economy and worklessness through to disability and diseases that are prevalent.

The JSNA is intended to be a tool for making decisions about the services to be provided, taking into account the need for individuals to take personal responsibility and be in control of their own health and care. Its purpose is to help everyone working with the residents of Barnsley to make the most of limited resources by targeting those who need them most.

We hope you find this document useful whether you are a member of the public or work in the public sector, voluntary sector, third sector, or for a private agency.

Who is responsible for producing the Joint Strategic Needs Assessment (JSNA)?

The production of a Joint Strategic Needs Assessment (JSNA) is a statutory duty and from 1st April 2013, through the Health and Wellbeing Board[1], both Barnsley Council and the Barnsley Clinical Commissioning Group (CCG) have an equal and explicit obligation to prepare the JSNA for Barnsley.

The Health and Wellbeing Board brings together clinical, political, professional and community leaders from the local health and care system. The JSNA enables the board to have a clear and shared understanding of their local community's needs so that they can work together to reduce health inequalities, join up care and improve health and wellbeing.

[1] The Health & Wellbeing Board is a formal committee of the Council established under the Health & Social Care Act 2012, which has a legal duty to produce the JSNA and a Joint Health and Wellbeing Strategy (JHWS).

The Health and Wellbeing Strategy, which has been developed at the same time as this JSNA, will set out how the Health and Wellbeing Board will drive integration in order to support the Barnsley resident population to better help themselves in order to help realise the shared vision:

> *"That the 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 Health and Wellbeing Strategy and related strategies, including the Public Health Strategy, the Local Integrated Place Based Plan and the Clinical Commissioning Strategy, reflect the findings of this JSNA and collectively respond to meet the current and future need of the Barnsley resident population.

Overview

Who is involved in developing the JSNA in Barnsley?

In addition to the Health and Wellbeing Board, there is a Senior Strategic Development Group (SSDG) which oversees the development of the Health and Wellbeing Strategy. The SSDG includes representatives from the NHS, Council, Police and Fire services, SYPTE and the local voluntary and community sector and ensures that the JSNA is fit for purpose and links to the strategy.

Both the Barnsley Strategic Intelligence Group and the Operational Intelligence Group report into the SSDG and both groups have representatives from those organisations which make up the SSDG. The role of the Strategic Intelligence Group is to ensure that the JSNA is delivered on time and is of a high standard. The role of the Operational Intelligence Group is to coordinate information analysis for the JSNA

All of the above groups help to ensure that a broad range of different organisations and communities are involved in the Barnsley JSNA.

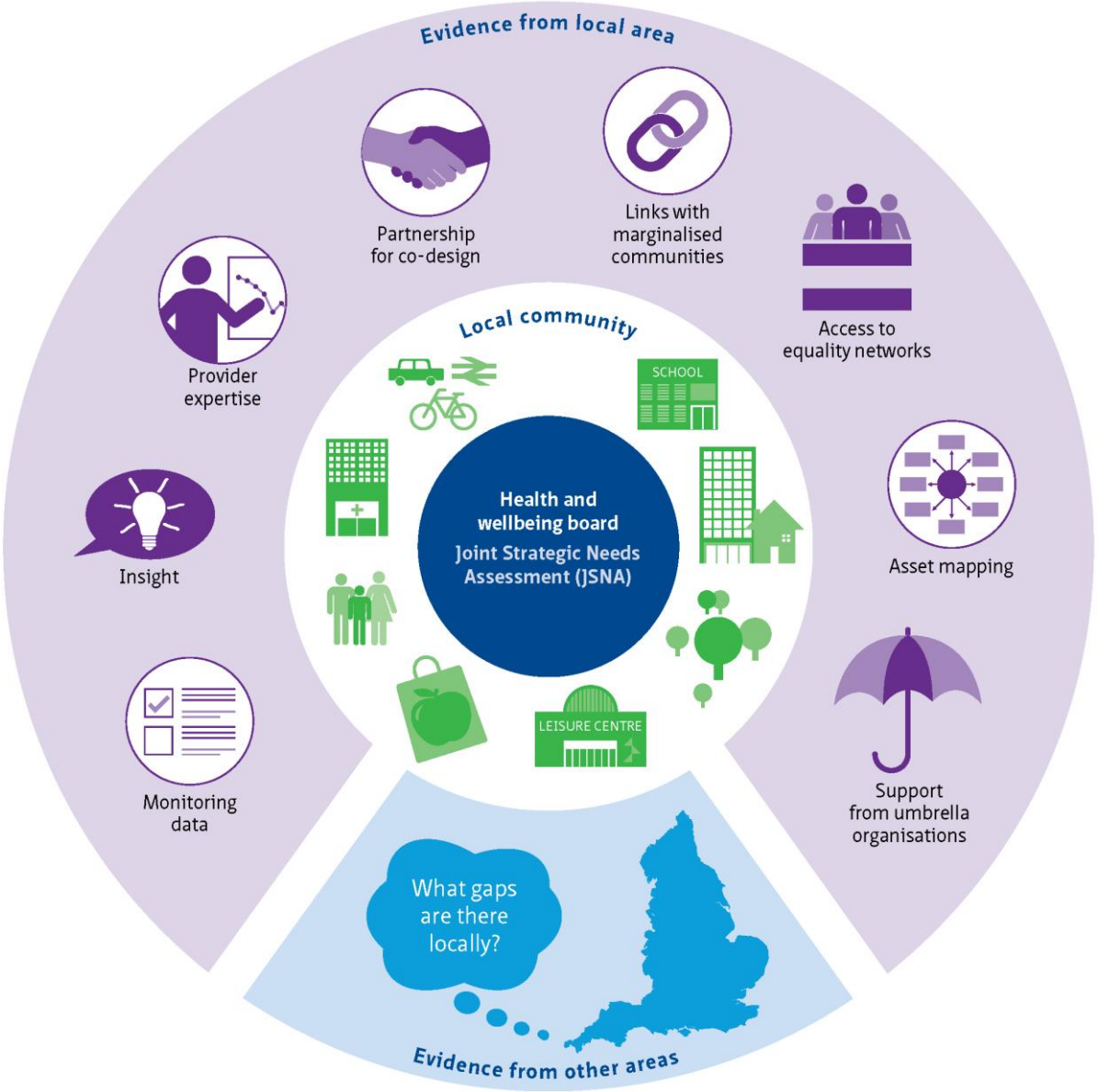
The evidence base for our JSNA is regularly reviewed and improved for the benefit of the health and wellbeing of the Barnsley population. This ensures that we can assist with service planning and reflect the changes in the population and their ever-changing needs.

Data which is of good quality and meets our standards has been used to ensure that decisions are made based on accurate information from a wide range of sources. This includes information about the population, housing, employment, the effects of lifestyle on health, prevalence of diseases, services used and their effectiveness, community perspectives and other useful information.

The data used in this process includes both qualitative and quantitative data, and uses customer insights; collectively these different types of data enhance our knowledge of our population. We have used reports, briefings, infographics, strategies and action plans to provide our evidence base for this JSNA.

As further data and information becomes available, this will be added to the evidence base to give greater insight into the needs of the local population.

Figure 1 – Health and Wellbeing Boards; using voluntary sector evidence



Source: NHS Confederation

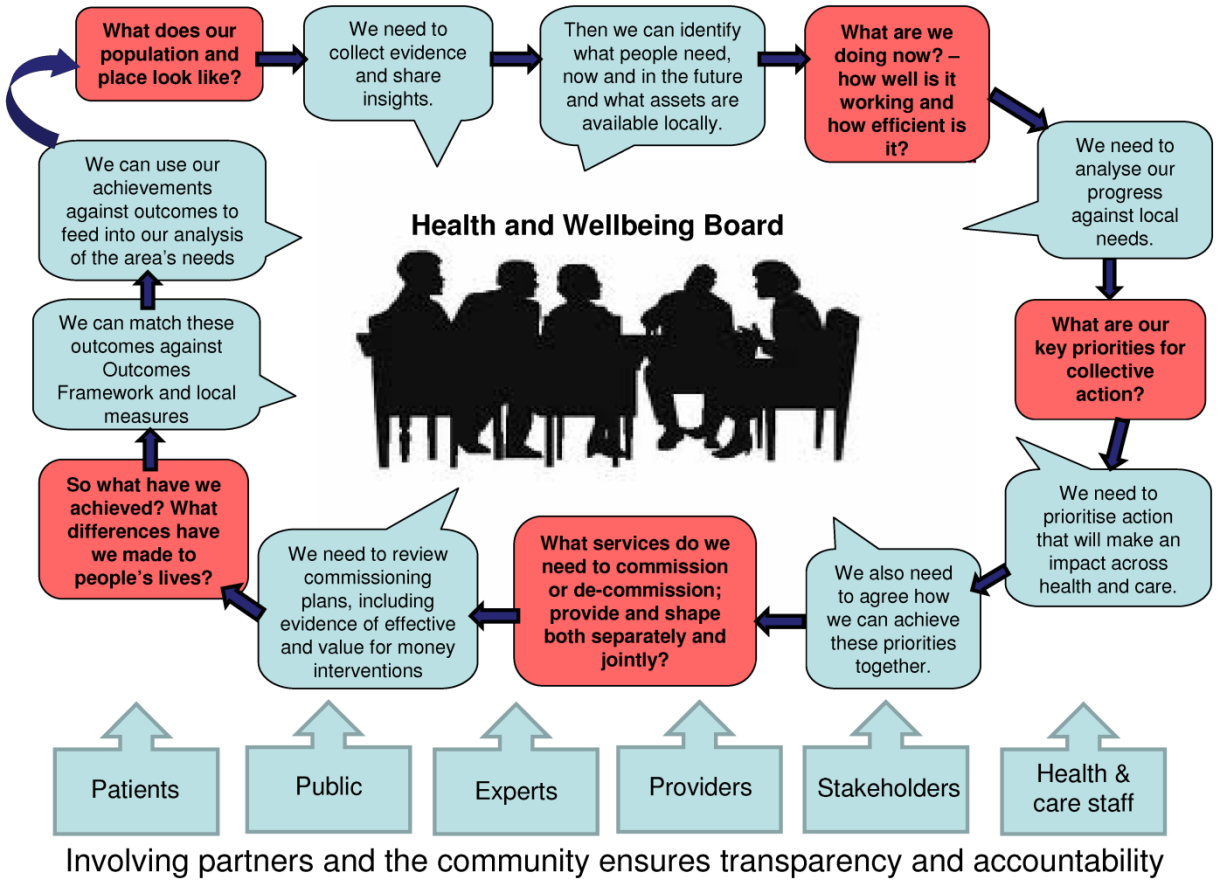
The diagram above shows how this JSNA brings together information about the local community including from schools, GPs, local transport, housing and leisure etc. The evidence about the community comes from monitoring data, customer insights, provider expertise, equality groups and asset mapping etc.

Who is the JSNA for?

The main audience for the JSNA are health and social care commissioners and service providers who use it to plan services, as it identifies the health and wellbeing issues of the Barnsley population.

It can also be used as an evidence base for preparing bids and business cases by the voluntary and community sector to ensure that community needs and views are represented; by service providers to assist in the future development of their services; and by the public to scrutinise local health and wellbeing information, plans and commissioning recommendations.

Figure 2 – Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy: Explicit link from evidence to service planning



Source: Department of Health

What does the JSNA look like in Barnsley?

Following the JSNA feedback in 2015, this JSNA has been developed in four parts:

- An Executive Summary report containing the main health and wellbeing issues
- A 1 page infographic of the health and wellbeing issues in Barnsley
- A report of the main health and wellbeing issues within Barnsley
- An evidence base that is accessible via BMBC website consisting of briefings, profiles, infographics and reports.

The intention is that our JSNA is regularly reviewed and improved in response to new information and feedback, so decisions can be made on the most accurate data.

The contents of a JSNA are flexible, which enables local areas to focus on the priorities and present information in the way that is most relevant to them. This time, we have structured it so we can see clearly what the issues are across Barnsley and the differences across our communities.

The Intelligence

The population of Barnsley

The latest mid-year population estimates from the Office for National Statistics (ONS) show that the population of Barnsley in 2015 was 239,300 which is an increase of 7.5% from 2005. This consists of 50.6% females and 49.4% of males.

Table 1 – Numbers of People Resident in Barnsley, ONS Mid-2015 Population Estimates

	0 to 15	16 to 64	65+	Total
Male	22,500	75,100	20,600	118,200
Female	21,600	75,400	24,200	121,200

(Source: ONS Mid-2015 Population Estimates)
Figures are rounded to nearest hundred.

This consists of 50.6% females and 49.4% of males. The largest proportional increase in age groups is in those aged 65 and over (an increase of 23.2% since 2005).

Table 2 – Percentage of the total population by Region, ONS Mid-2015 Population Estimates

	0-15%	16-64 %	65+%
England	19.0	63.3	17.7
Yorkshire and the Humber	18.9	63.0	18.1
Barnsley	18.4	62.9	18.7

(Source: ONS Mid-2015 Population Estimates)

Barnsley has now a greater proportion of those of aged over 65 years than those aged under 16 years which is different to both the regional and national figures, as shown in Table 2.

The largest proportional increase in age groups is in those aged 65 years and over (an increase of 23.2% since 2005). Barnsley's over 65 years population portion is slightly higher than the regional average of 18.1% and the national average of 17.7%. From mid-2014 to mid-2015, the population increased by 0.62%; this was due to over 2,800 births, 2,400 deaths and a migration net change of approximately 1,100 people.

Part of the net migration can be attributed to the new housing in Barnsley attracting inward migration[2] from more economically active people (Centre for Cities, 2015). Another part will be the number of non-British nationals. The Department for Work and Pensions (DWP) figures regarding non-British nationals that have been issued with a national insurance number (NINO), show that there were a total of 1,980 new arrivals in Barnsley during 2015[3], mainly living in small pockets around the urban centre of Barnsley. Of these, 1,162 (58.7%) were from

[2] Inward migration is all forms of migration which involve an influx of people from a less populated area to a more populated area. Barnsley is in the top 10 for growth in Private Sector jobs (with an 8.4% increase) and for housing growth (with a 8.5% increase); both measures are based on data from 2004 to 2013. Centre for Cities, 2015
[3] There are no figures available for how many 'new arrivals' stay or move on to other areas.

Romania, 536 (27.1%) were from Poland and the remaining 282 (14.2%) were from other countries.

As will be examined later in the report, different populations and communities have different Health and Wellbeing issues.

The latest data from the 2011 Census shows that 97.9% of the Barnsley resident population were from a white ethnic background, 0.7% were from mixed/multiple ethnic groups, 0.7% were Asian or Asian British, 0.5% were Black/ African/Caribbean or Black British and 0.2% were from other backgrounds. Since these figures were collected, the Barnsley population has experienced changes due to international migration but there are no recent data sources available to evidence the changes.

In July 2016 the Gypsy, Roma and Traveller Census that took place showed that there were 130 adults and 89 children (aged under 16 years) who are known to the Council to be currently living within a small group of static and mobile encampments within the Barnsley borough.

There are groups within the population for whom we do not have accurate and up to date information.

The number of Lesbian, Gay, Bisexual and Transgender (LGBT) residents in Barnsley is unknown and very difficult to estimate, not least because there are no agreed definitions or mechanisms for routinely gathering this information. Estimates of the size of the LGBT population vary, but national surveys designed to capture sexual orientation and behaviour show 5% – 7% of the population is LGBT (Department of Trade and Industry (DoTI), 2014), which is the figure the Government uses when undertaking equality impact assessments. Taking 6% as the mid-point, we can reasonably estimate that the LGBT population of Barnsley is approximately 14,400 based on a total population of 239,300.

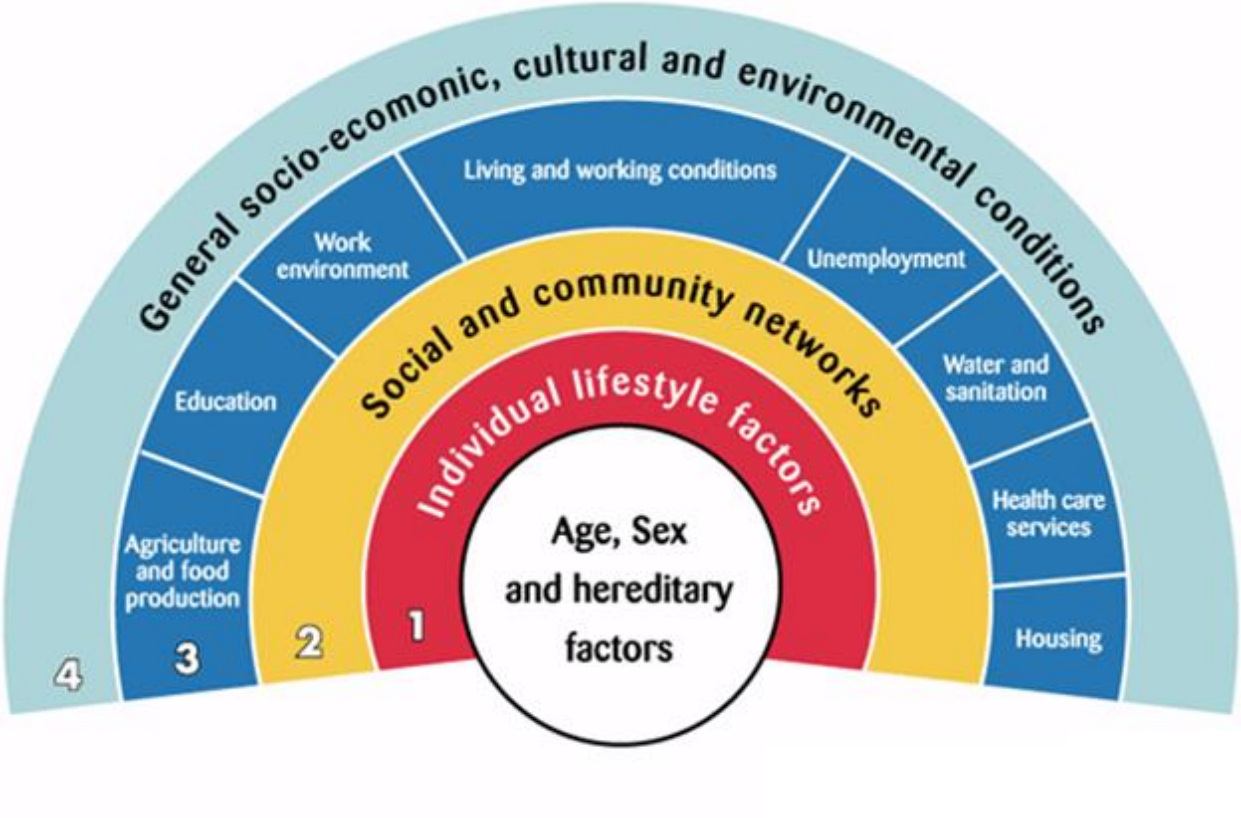
The number of carers is also difficult to estimate. The 2011 Census indicated that over 7,600 Barnsley residents were providing 50 or more hours of unpaid care each week to a friend, relative or neighbour who had a disability or health problem.

What are the issues that cause poor health and wellbeing within Barnsley?

The health and wellbeing of the local population cannot be examined in isolation from other influences that also need to be improved in order to make any sustainable improvements.

Dahlgren (1995) developed a model showing the various determinants of health at different levels. This ranges from general socio-economic, cultural and environmental conditions to age, sex and hereditary factors.

Figure 3 – Dahlgren model



Source: Healthknowledge.org.uk

Research shows that social disadvantage factors create the circumstances in which people's health experience is adversely affected. Such factors are known as determinants of health, many of which are distributed unevenly within the population. The model developed by Dahlgren (1995), summarises determinants of health. It also illustrates the relationship between health and the physical, social and economic environment.

The following section gives an overview of the socio-economic characteristics and make-up of the borough, and an insight into a number of key determinants that shape people's health and wellbeing in Barnsley. We have chosen to not include any information relating to the groups Agriculture and food production, and Water and sanitation. It is recognised that these areas have an impact on the wider determinates of health however there is little or no supporting evidence specific to Barnsley at this time.

Life expectancy

Life expectancy at birth in Barnsley, although lower than the England average, has slowly increased over the period from 1991/993 to 2012/14 Life expectancy at birth is 78.4 years for men and 81.8 years for women. For men, the gap in life expectancy at birth between Barnsley and England has decreased from 1.4 years in 1991/93 to 1.1 years in 2012/14. For women, the gap in life expectancy between Barnsley and England has not changed at 1.4 years.

Life expectancy at birth[4] varies significantly across Barnsley. For men, there is a difference of 7.3 years between the ward with the highest life expectancy, which is Penistone East at 82.3 years and the ward with the lowest life expectancy, which is Dearne North at 75 years. A similar difference in life expectancy exists for women of 7.6 years. Life expectancy for women is highest in Penistone East at 86.7 years and lowest in Wombwell at 79.1 years (see ONS Life Expectancy Briefing 2012/14).

Whilst life expectancy has increased for men and women since 1991/93, the proportion of life spent in “good” health for both men and women has decreased.

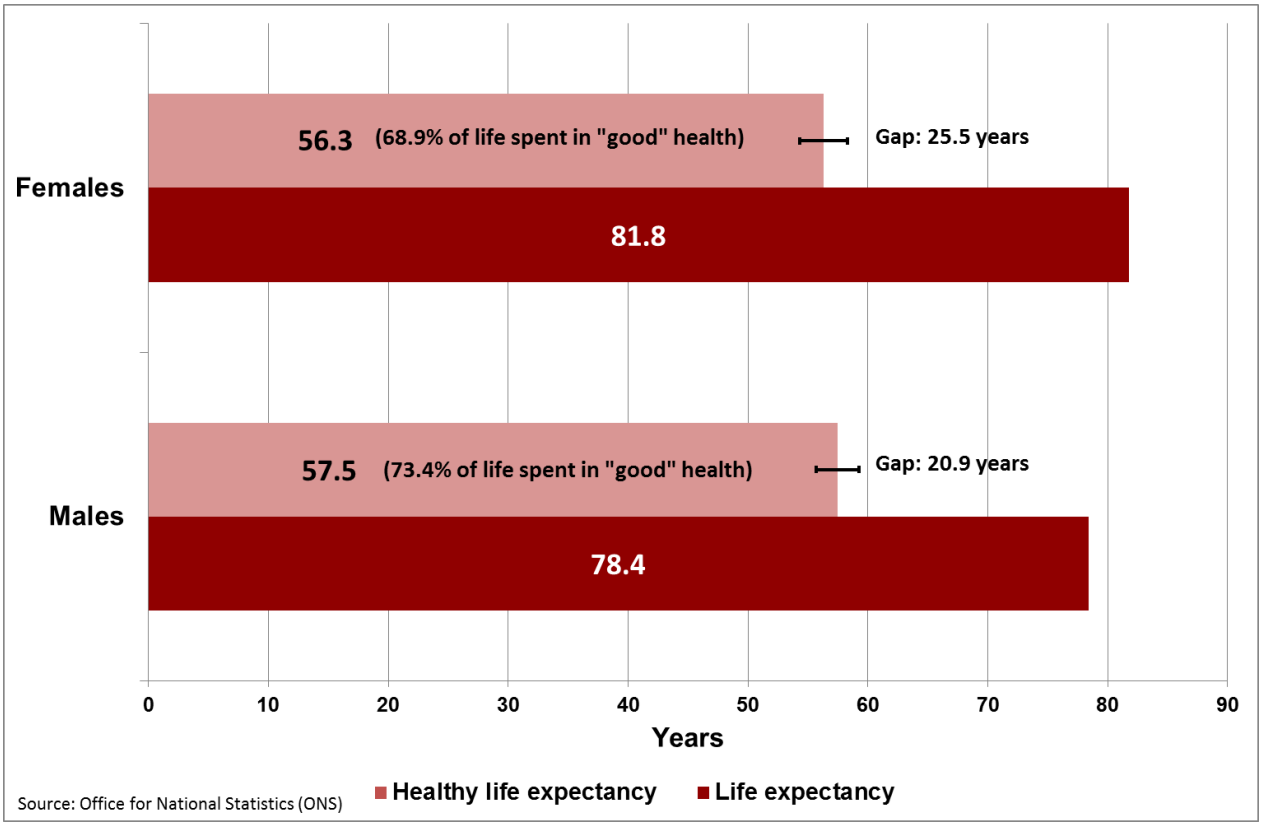
Although healthy life expectancy[5] at birth for men in Barnsley has increased by 0.2 years from 2009/11 to 2012/14, the proportion of life spent in “good” health has decreased from 74.1% to 73.4%; this is due to life expectancy at birth increasing at a greater rate during the period. Healthy life expectancy at birth for women in Barnsley has decreased by 0.8 years from 2009/11 to 2012/14. The proportion of life spent in “good” health has also decreased from 70.6% to 68.9% (see figure 4 overleaf).

Barnsley is ranked 141 out of 150 Local Authorities for men’s healthy life expectancy and is ranked 146 for women’s healthy life expectancy (where 1 is the highest and 150 is the lowest). On average, men in Barnsley live 20.9 years in poor health and women 25.5 years.

[4] Life expectancy reflects mortality among those living in the area in each time period rather than mortality among those born in each area.

[5] Healthy life expectancy estimates are based on survey questions about health. The 2012/14 healthy life expectancy rates represent the expected life years spent in ‘good’ health for an individual assuming 2012/14 mortality and health status rates apply through that individual’s life.

Figure 4 – Life expectancy at birth, healthy life expectancy at birth and the proportion of life spent in 'good' health. Men and women in Barnsley (2012/14).



Lifestyle

The following lifestyle choices have contributed to the increasing health needs in Barnsley.

Smoking

Nationally, smoking is the biggest cause of preventable ill health and causes diseases such as respiratory disease, cancer and circulatory disease. In Barnsley, smoking rates, whilst decreasing remain high. In 2016, a fifth (21.2%) of adults in Barnsley smoke, which is significantly higher than the England average of 16.9%. In Barnsley, for those in routine and manual occupations, nearly a third (31.7%) smoke and this is significantly higher than the England average of 26.5% (Source: Annual Population Survey, 2016).

In December 2015, 46,630 patients registered with a GP in Barnsley smoked. This information is from GP registered patients with a smoking record and it is based on around 95% of the GP registered population. GP record data shows that smoking prevalence is higher for men (25.7%) than women (21.7%) and that there is variation in smoking prevalence across Barnsley. Smoking prevalence is highest in Dearne North at 28.5% and lowest in Penistone West at 12.7% (see Smoking Data 2016).

High rates of smoking in pregnancy are a particular concern in Barnsley. In 2014/15, 20.4% of women were recorded as smoking at the time of delivery compared to 11.4% in England. There are significant inequalities across Barnsley, as ten times more women in Dearne North smoke in pregnancy (38.6%) than in Penistone East (3.9%) (Source: NHS Digital 2014-15).

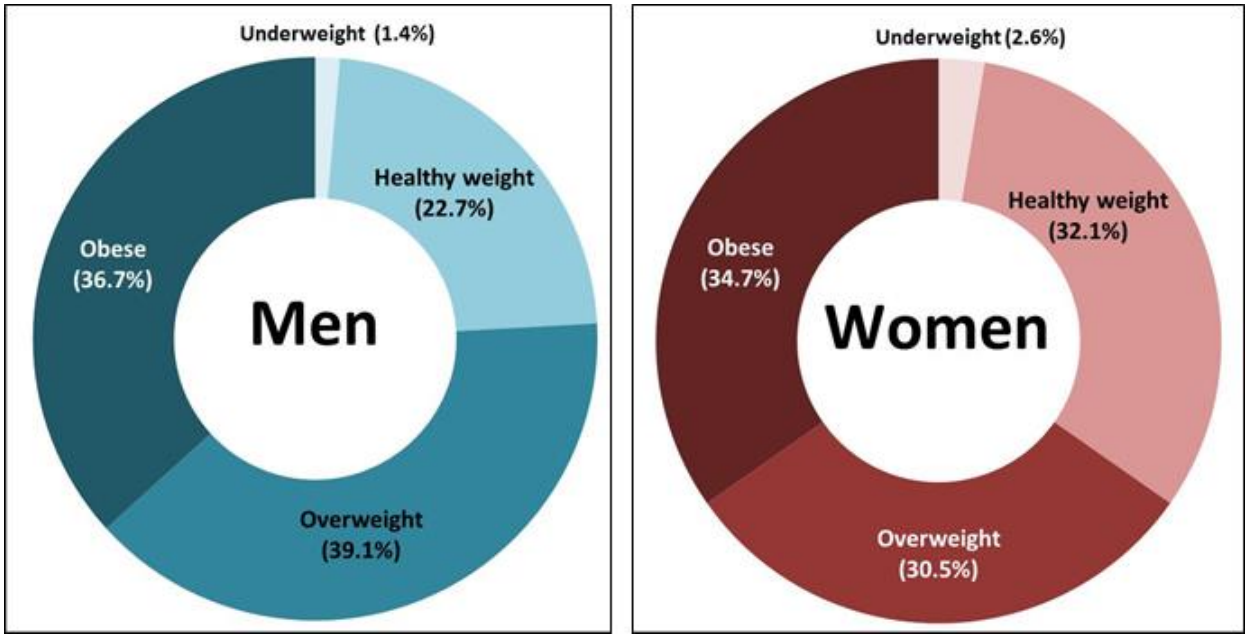
In 2015/16, the proportion of people in Barnsley setting a quit date who successfully quit smoking (38.1%) is slightly higher than the England rate (36.4%). Smoking quit rates have varied over time, but have remained above the England average (Source: NHS Digital 2016). Barnsley's rate for smokers setting a quit date is 6,576.5 per 100,000 which is significantly higher than the England rate of 5,548.9 per 100,000.

Healthy weight

Obesity is associated with an increased risk of developing ill health such as diabetes, some cancers and circulatory disease. It also increases the risk of complications during pregnancy and medical care. There are several sources of data for obesity: the national Active People Survey carried out by Sport England and local registered GP patient data. This information cannot be directly compared.

The Active People Survey (2012/14) estimates that 7 out of 10 adults (71.6%) in Barnsley are overweight or obese, which is significantly higher than the proportion for England (64.6%). In Barnsley, this equates to 36.5% of adults being overweight and 35.1% of adults being obese. For England, 40.6% of adults are overweight and 24.0% are obese.

Figure 5 – Adult BMI status by sex – Barnsley GP registered population (2015)



Source: BMBC Research and Business Intelligence Team, Barnsley GP data (2015)

A second source of data is from local GPs as shown in figure 5. BMI thresholds are: Underweight (BMI less than 18.5), Healthy weight (BMI 18.5 to 24.9), Overweight (BMI 25.0 to 29.9), Obese (BMI 30 and above).

This relates to all patients aged 16 or over, registered with a Barnsley GP, who have a BMI status recorded in the last 15 months. The proportion of patients who have a BMI record is around 48%. This data is available at a ward level and for different age groups. This shows that for men, the prevalence of excess weight[6] increases with age up to 45 – 54 years old (83.6%). For women the prevalence of excess weight increases up to the age 55 – 64 years old (73.9%).

Barnsley's 2014/15 rate for maternal obesity at 10.1% is double the rate for England (5.0%). This is the highest rate during the period 2012/13 to 2014/15. The data is not available at a ward level (Barnsley Hospital NHS Foundation Trust 2014/15).

Active lifestyle

People who have a physically active lifestyle[7] have a 20% – 35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Only half of adults (50.7%) in Barnsley are physically active compared to 57% in England. The rate of physical activity is increasing but a third of the Barnsley population remains inactive (34.6%). The overall proportion of residents who cycle is low but increasing. The proportion of Barnsley residents who cycle at least five times a week in 2014/15 (1.0%) has more than doubled from 2013/14 (0.4%).

Healthy eating

Poor diet increases the risk of some cancers and cardiovascular disease; both of which are major causes of premature death. Just over half of Barnsley residents (52.6%) eat the recommended '5–a–day', which is slightly higher than the England rate (52.3%). There has been no change in the rates since 2014 (Source: Active People Survey 2015).

Alcohol

Drinking excessive quantities of alcohol can lead to liver disease and cancer and is associated with mental health problems. In addition, people who drink excessively are vulnerable and may engage in risky behaviour. In Barnsley, it is estimated that about a fifth (21%) of drinkers aged 16 years and older are drinking at 'increasing risk' levels (North West Public Health Observatory, 2011) and 7% are drinking at 'higher risk' levels.

In Barnsley in 2014/15 the directly standardised rate for hospital admissions for alcohol related conditions (broad definition[8]) is 2,671 per 100,000 population. This is equivalent to 6,212 people. This is significantly higher than the England directly standardised rate of 2,139 per 100,000 population. In Barnsley, the directly standardised rate for hospital admissions for alcohol related conditions has increased from 2,001 per 100,000 in 2008/09 to 2,671 in 2014/15.

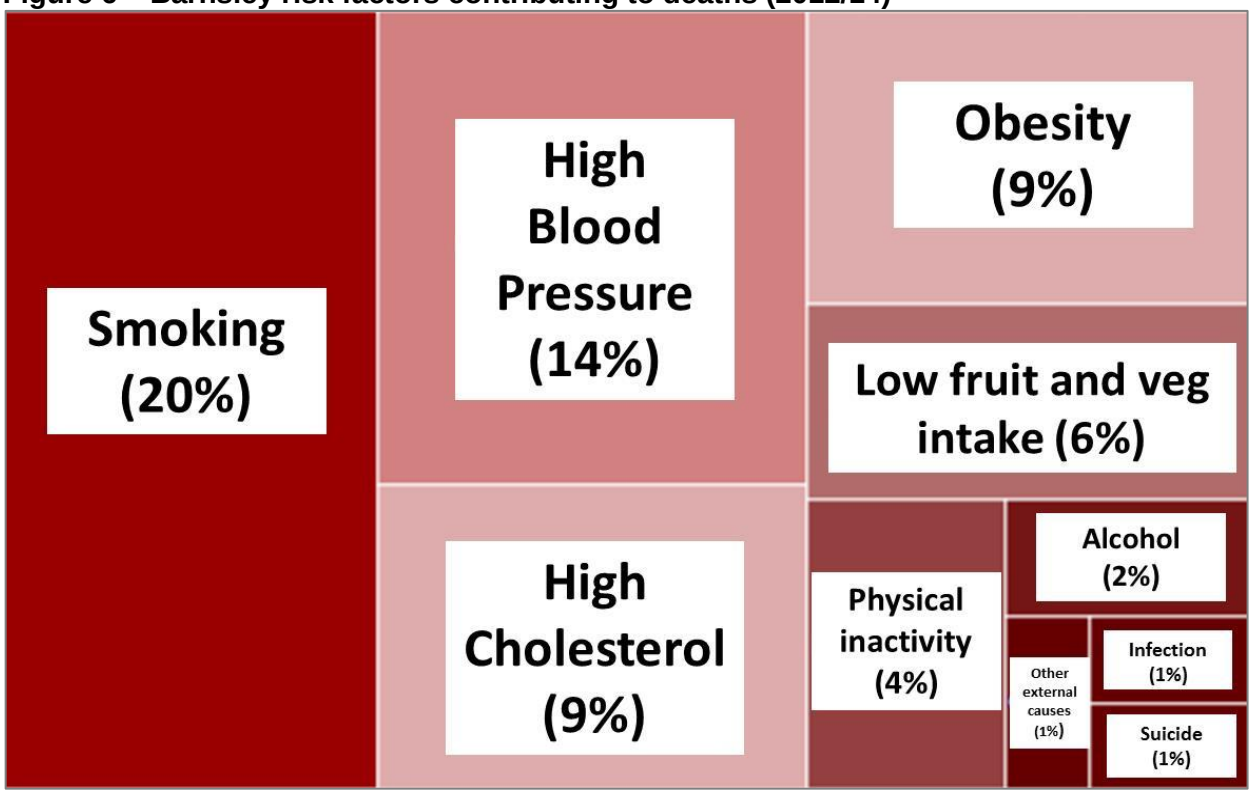
[6] Excess weight is those who have a BMI of 25 or higher.
[7] Active People Survey (Sport England 2015). Active is the percentage of adults achieving at least 150 minutes of physical activity per week. Inactive is the percentage of adults doing less than 30 minutes of physical activity per week. There are some people in between who are nearly active (14.7%).
[8] Hospital admissions for alcohol-related conditions (broad), all ages, directly age standardised rate per 100,000 population European standard population.

The directly standardised rate for hospital admissions for alcohol related conditions (broad definition) is 3,592 for men and 1,884 for women per 100,000 population. This is equivalent to 3,948 men and 2,265 women. Both these rates are significantly higher than the England directly standardised rate for men of 2,947 and for women 1,450 per 100,000 population. In Barnsley, the directly standardised rate for hospital admissions for alcohol related conditions for men has increased from 2,834 per 100,000 in 2008/09 to 3,592 per 100,000 in 2014/15. For women, the directly standardised rate for hospital admissions for alcohol related conditions has increased rapidly from 1,312 per 100,000 in 2008/09 to 1,884 per 100,000 in 2014/15.

Risk factors contributing to deaths in Barnsley

As figure 6 below shows, a large proportion of deaths can be attributed to modifiable lifestyle factors. The leading risk factor is smoking, which contributed to 1 in 5 deaths in 2012/14. This is important when considered with the information on lifestyle factors in Barnsley (see page 16).

Figure 6 – Barnsley risk factors contributing to deaths (2012/14)



Source: Research and Business Intelligence Team, BMBC (ONS Primary Care Mortality Database (2012-14), The World Health Report 2002 (WHO: Geneva, 2003); Statistics in Smoking, The Information Centre, 2004

Health services

The NHS Health Check is for adults in England aged 40 – 74 without a pre-existing medical condition. The Health Check assesses circulatory and vascular health and identifies the risk of getting a disabling vascular disease in future. In Barnsley for 2015/16, 14.4% of the eligible population were invited for a Health Check (9,800 people). Of these, 89.4% (8,758 people) took up the invite and received a Health Check. This has increased from 76.4% in 2011/12.

During the five year period 2011/12 to 2015/16, more than 44,000 people aged 40 – 74 in Barnsley received an NHS Health Check (83.5% of those offered and 67.2% of the average eligible population over the five year period).

Children and young people

There were 2,789 live births in Barnsley in 2014. The infant mortality rate is 4.0 per 1,000 population which is similar to the England average of 4.2.

Breastfeeding

Nearly two thirds (64%) of women in Barnsley initiate breastfeeding, which is lower than the England average of 74% (NHS England 2014/15). This has increased from 62.7% in 2010/11. The rate of breastfeeding initiation varies across Barnsley: Penistone East ward has the highest rate at 89.2%, which is almost double the lowest rate in Dearne North ward of 45.5% (Barnsley Hospital NHS Foundation Trust 2012/13 – 2014/15).

Breastfeeding rates in Barnsley have declined to 29% (861 women) by the time the child is 6 – 8 weeks old (2015/16). This is significantly lower than the England average of 43.2% (NHS England and Public Health England).

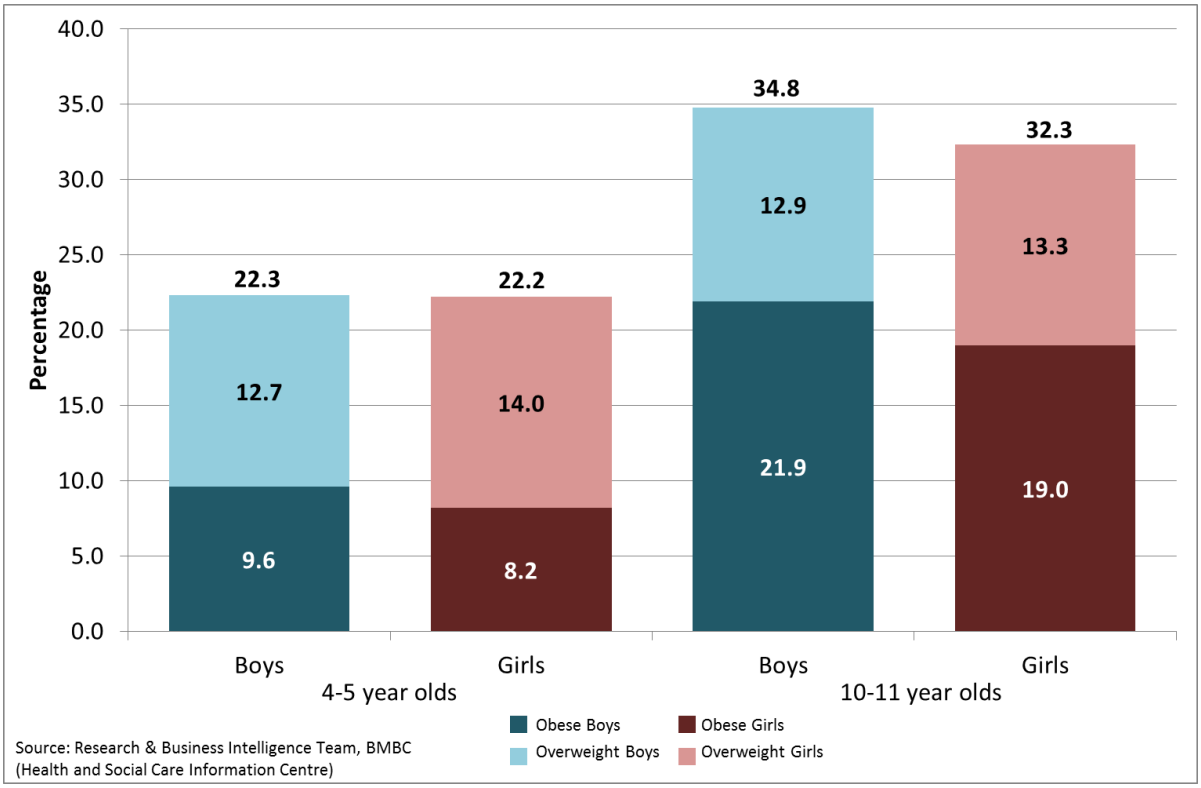
Tooth decay

Tooth decay is predominantly a preventable disease, but significant levels remain in Barnsley. At 69.8%, Barnsley has a significantly lower proportion of five year old children who are free from dental decay compared to England (75.2%) (Source: Dental Health Epidemiology Programme for England 2015). This has improved from 2007/08 when 60.6% of five year olds where free from dental decay.

Healthy weight in children

There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. In Barnsley, almost a quarter (22.1%) of 4 – 5 years old's and just over a third (33.5%) of 10 – 11 year olds are overweight or obese. The prevalence rate of excess weight for 4 – 5 year olds in St Helen's ward at 28.6% is double that of Penistone East ward (14.3%). For 10 – 11 year olds, excess weight rates range from 21.4% in Penistone East ward to 38.2% in Dearne South ward (Source: National Child Measurement Programme 2011/12 – 2013/14) (see figure 7 overleaf).

Figure 7 – Prevalence of excess weight – boys and girls (2013/14)



The following information is from the 2014 What About Youth survey[9]. The survey targets 15 year olds to ask questions relating to general health, wellbeing and behaviour.

Healthy eating

In Barnsley, less than half (44.5%) of 15 year olds eat the recommended '5-a-day' portions of fruit and vegetables and this is significantly lower than the England rate of 52.4%. Boys in Barnsley (50.3%) are more likely to eat the recommended '5-a-day' than girls (38.5%).

Active lifestyle

The proportion of young people (15 year olds) who are physically active for at least one hour every day is 15.8% which is higher than the England rate of 13.9% but not significantly different. There is no difference in the sedentary behaviour of boys and girls.

Smoking

In Barnsley, the proportion of 15 year olds who currently smoke at 10.7% has decreased in recent years; however, it remains significantly higher than the England average of 8.2%. More than a quarter (27.3%) of 15 year olds have used/tried e-cigarettes, which is significantly higher than the England average of 18.4%. More girls (35.2%) than boys (30.7%) have used/tried e-cigarettes.

[9] The What About Youth survey is a newly established survey conducted nationally to collect robust local authority level data on a range of health behaviours amongst 15 year olds.

Alcohol

The proportion of young people in Barnsley who are regular drinkers at 11.3% is almost twice the England average of 6.2%. It is also significantly higher than neighbouring local authorities such as Doncaster (7.5%) and Kirklees (5.5%).

Risky behaviour

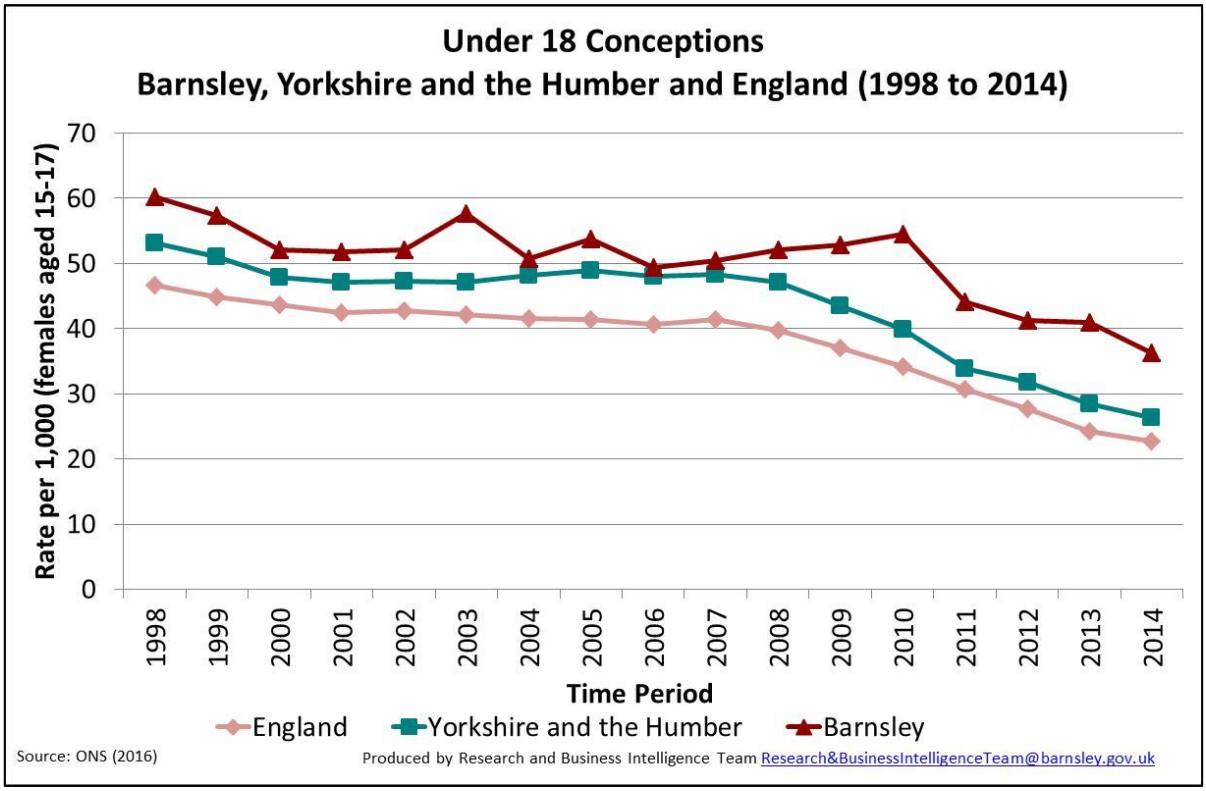
Nearly a quarter (22.5%) of young people in Barnsley undertake three or more risky behaviours (smoking, drinking alcohol, drug use, inactivity, poor diet). This is significantly higher than the England average of 15.9%. Girls (26.7%) are more likely to undertake 3 or more risky behaviours than boys (18.4%).

Teenage conceptions

The 2014 under 18 conceptions rate of 36.3 per 1,000 women aged 15 – 17 (equivalent to 152 women) is a reduction from the 2013 rate of 40.9 per 1,000 women (equivalent to 176 women). However, it remains significantly higher than the England rate of 22.8 per 1,000 women. Kingstone ward has the highest rate of under 18 conceptions at 70.1 per 1,000 women; this is more than six times higher than the rate for Penistone East ward at 11.3 per 1,000 women (Source: Office for National Statistics 2014).

The 2014 under 16 conception rate is 8.5 per 1,000 women, which is equivalent to 32 women. This is significantly higher than the England rate of 4.4 per 1,000 women. (Source: Office for National Statistics, 2014) (see figure 8 below).

Figure 8 – Under 18 conceptions – Barnsley, Yorkshire and the Humber and England (1998 – 2014)



Older people

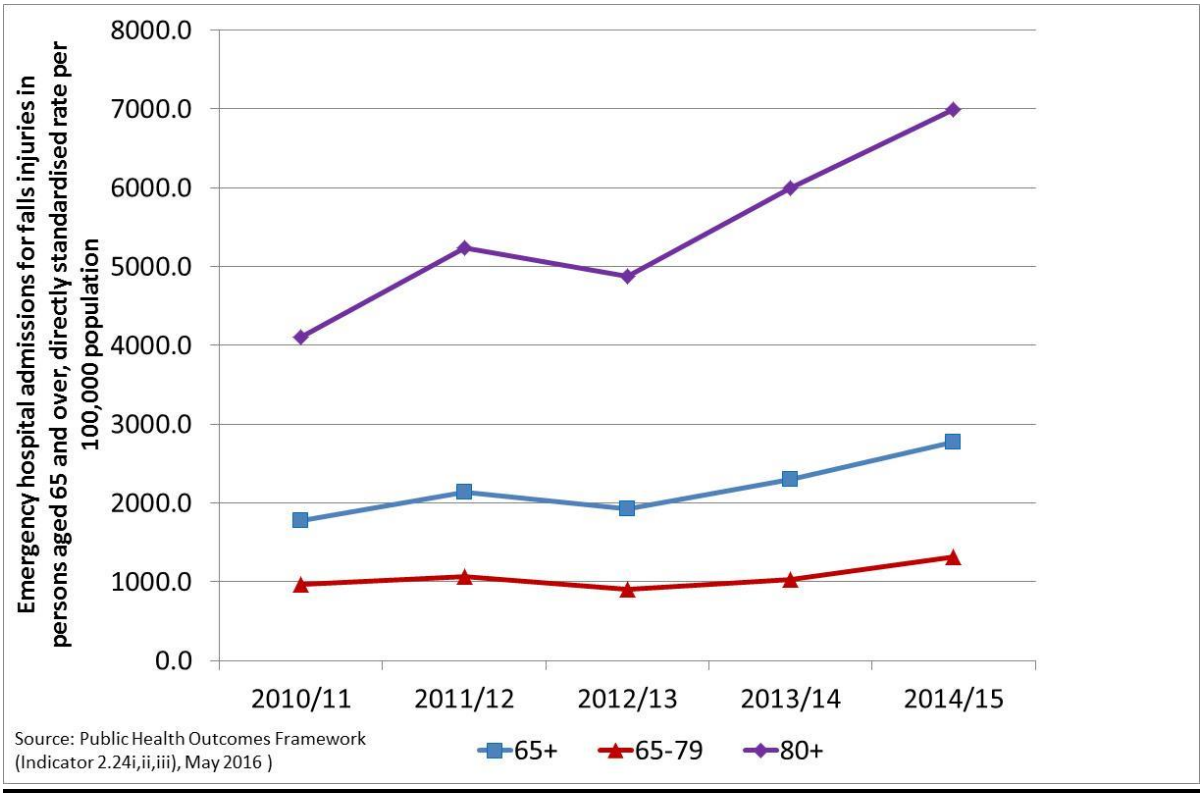
Falls

Falls are the largest cause of emergency hospital admissions for older people and significantly impact on long term outcomes.[10] One in three people over the age of 65 will fall each year, which is 25,500 people in Barnsley. This figure rises to one in two people aged 80 years old and above. The directly standardised rate of emergency admissions for falls injuries in people aged over 65 years old at 2,282.6 per 100,000 population is significantly higher than the England rate of 2,064.3. This is similar to neighbouring local authorities such as Kirklees (2,187.4) and Doncaster (2,357.4).

As figure 9 below shows, in Barnsley the rate of emergency admissions for falls injuries in people aged over 65 years old has increased over time. In the 65+ age group, rates have fluctuated during the period 2010/11 to 2014/15.

The 2014/15 rate is the highest during the period, and is significantly higher than it was in 2010/11. The England rate has increased more slowly from 2,030 per 100,000 population in 2010/11 to 2,125 per 100,000 in 2014/15. In every age group over 65 years old, women have a higher rate of emergency hospital admissions for falls than men.

Figure 9 – Emergency hospital admissions for falls injuries in persons aged 65 and over



[10] Department of Health (2012), Improving outcomes and supporting transparency. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

Dementia

There are currently 570,000 people in England with dementia. Dementia costs the UK economy £17 billion a year and in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.[11]

Dementia mainly affects people over the age of 65 and is caused by a range of conditions that result in symptoms of memory loss, mood changes and problems communicating and reasoning. Early onset dementia affects those under 65 years old; it is estimated that 3,544 people had early onset dementia in England in 2015. In Barnsley this is the equivalent of 64 people. Healthy living may help to reduce the risk of developing vascular dementia and alzheimers disease.

The prevalence of diagnosed dementia is measured through the GP Quality Outcomes Framework (QOF) register, where diagnosed cases of dementia are recorded. Figures for 2014/15 show that 1,904 have a diagnosis of dementia which is a prevalence of diagnosed dementia of 0.8%. This is slightly higher than the England average of 0.7%.

The UK Alzheimer's Society estimates from 2013 show that almost two fifths of patients with dementia are currently undiagnosed in the community. There are also large disparities in diagnosis rates across the country.

Current estimates indicate that there could be 1,057 GP patients in Barnsley with dementia who are undiagnosed (35.9%). The dementia diagnosis rate for Barnsley of 64.1% is higher than the national rate of 60.8% (Source: NHS England Dementia Prevalence Calculator March 2015).

By 2030, it is predicted that 4,612 GP patients will have dementia. This is an additional 1,670 people suffering from dementia in Barnsley (769 men and 901 women)[12]

Flu vaccination

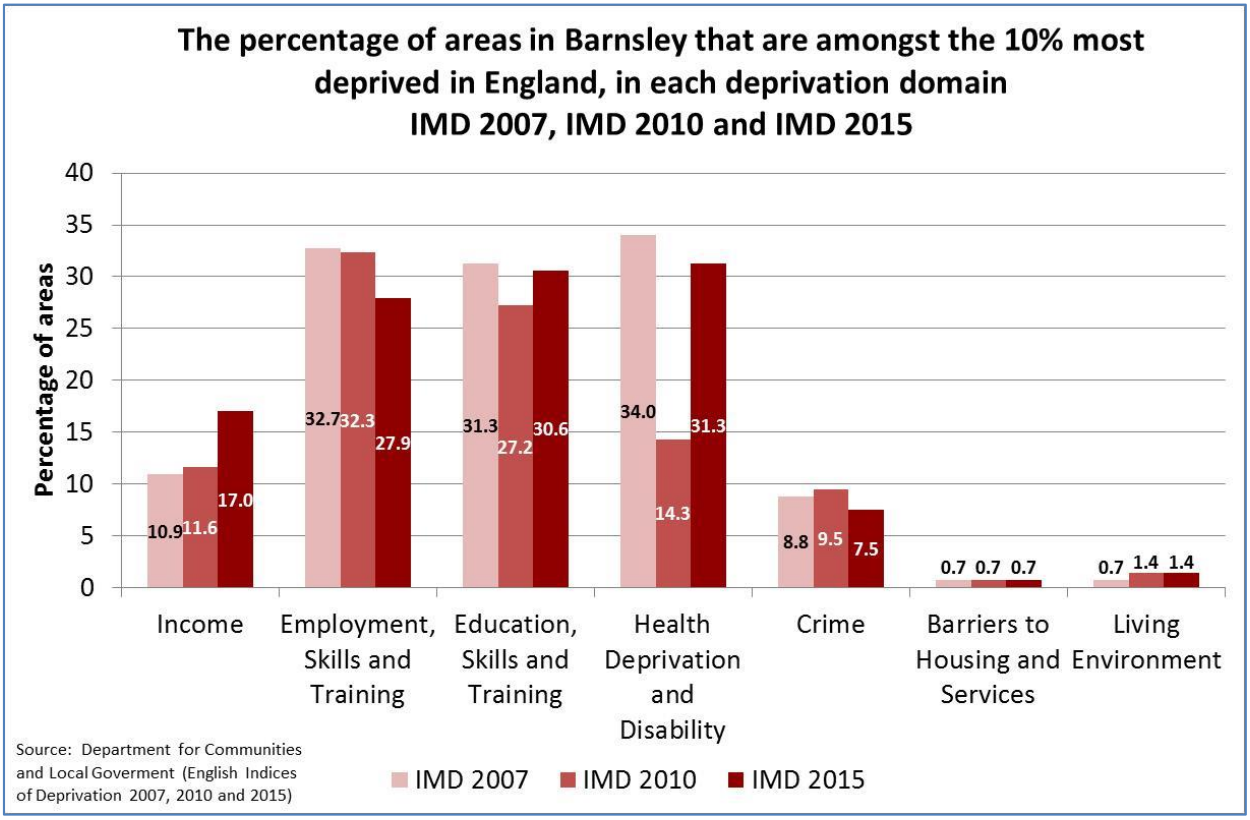
Immunisation is one of the most effective healthcare interventions available. Flu vaccines can prevent flu and flu related hospital admissions among specific groups of people, such as those aged 65 years and older.[13] The number of people in Barnsley aged 65 years and above being vaccinated against flu has increased from 29,903 in 2010/11 to 33,063 in 2015/16**.**
However, due to increases in the population aged over 65 years old, the proportion vaccinated has decreased from 72.5% in 2012/13 to 71% in 2014/15.

[11] NHS England Living well with dementia
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf
[12] Projecting Older People Population Information System 2015 http://www.poppi.org.uk/
[13] Public Health England 2016

Indices of Multiple Deprivation

The Indices of Multiple Deprivation (IMD) 2015 is the official measure of relative deprivation for small areas in England and published by the DCLG; this updates the IMD 2010. For comparability purposes, the methods used in developing the IMD have remained largely consistent during the period 2007 to 2015, to allow change over time to be measured. The data used for this measure is mainly from mid-2012.

Figure 10 – The percentage of areas in Barnsley that are amongst the 10% most deprived in England, by deprivation domain (IMD 2007, IMD 2010 and IMD 2015)



The IMD 2015 data shows the following:

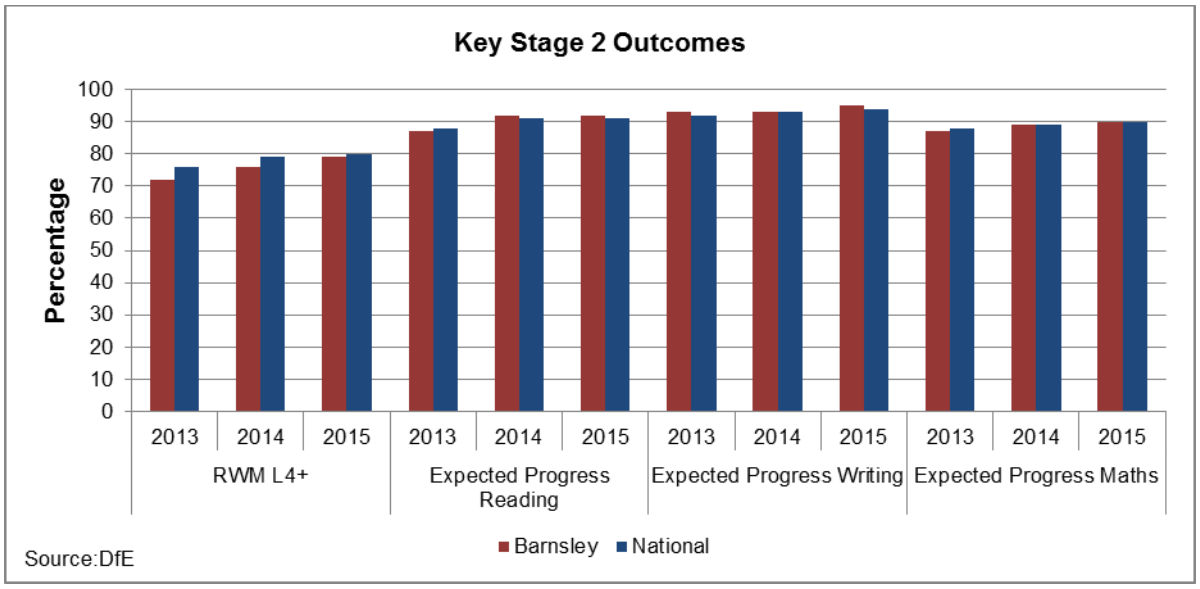
- Overall, Barnsley is ranked the 39th most deprived area in England out of 326 (where 1 is the most deprived), using the IMD 2015 rank of average score measure; a decline from IMD 2010 when it was the 47th most deprived area.
- 21.8% of areas in Barnsley are amongst the 10% most deprived in England.
- The largest change from IMD 2010 to IMD 2015 for Barnsley is in the Health Deprivation and Disability Domain (HD&DD); the shifts in the other domains are much smaller. Within the HD&DD in IMD 2015, Barnsley is ranked 20 out of 326 (where 1 is the most deprived), using the rank of average score measure.
- Within the HD&DD in IMD 2015, 31.3% of areas in Barnsley are amongst the 10% most deprived in England, compared to 14.3% in IMD 2010.
- Within the underlying indicators in the HD&DD, the biggest changes between IMD 2010 and IMD 2015 have taken place in the Acute Morbidity and Mood and Anxiety Disorders indicators. A greater proportion of areas in Barnsley are now within the most deprived in England for these two indicators.

Education

The sustainability of the Borough, together with the health of the local economy is interdependent upon well-educated school leavers entering the job market. It is therefore vital that families have access to quality educational provision that also meets the needs of the most vulnerable children in order to improve social mobility and that all children attend school regularly. National research has demonstrated the strong links between attainment and a wide range of health issues, both physical and mental, including obesity, teenage pregnancy and misuse of alcohol and other substances.

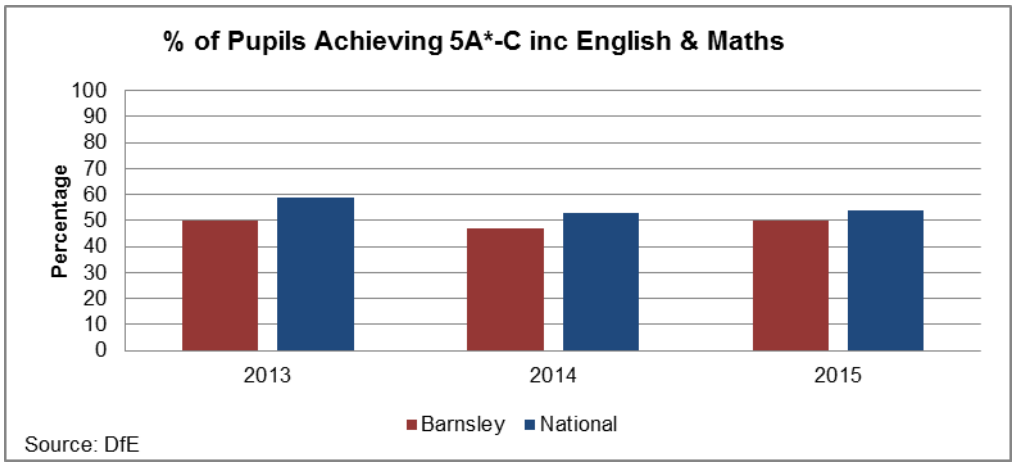
Educational attainment in Barnsley has continued to improve but has remained below the national average at all stages of education in 2015. However, since 2014, pupils between the ages of 7 and 11, made the same or more progress than pupils nationally in the individual subjects of reading, writing and mathematics (RWM).

Figure 11 – Key Stage 2 outcomes in Reading, Writing and Maths (RWM)



Provisional outcomes for 2016 indicate a more positive picture, particularly at Key Stage 4. Barnsley performed above the national average for the first time ever with 55% of 16 year olds achieving 5A* – C including English and Maths in comparison to 53% nationally (see figure 12 overleaf).

Figure 12 – Percentage of pupils achieving 5A* – C including English and Maths



A complex pattern of inequalities still exists between the different pupil groups in Barnsley schools. As in previous years, girls outperform boys. The gender gap that exists at the age of 11 widens by the age of 16 and this pattern has remained unchanged over recent years. However, this pattern is also reflected nationally. Large gaps exist at both age 11 and age 16 between pupils in Barnsley who are in receipt of the government's pupil premium funding and "non-pupil premium" pupils nationally. Whilst it may seem unfair to compare the performance of these two groups, only by closing the gap between them can we address the inequalities that exist in educational attainment. Closing this inequality gap is a key priority for the Local Authority. At the age of 5, the largest gaps are for pupils who have English as an additional language but by the age of 16 these performance gaps have closed significantly. Large gaps also exist for pupils in need of SEN support at ages 5 and 16.

There are variations in attainment outcomes across Barnsley with pupils living in or attending schools in more affluent areas of the borough tending to have better educational outcomes.

Figure 13 – Percentage of pupils achieving Key Stage 2 level 4+ in Reading, Writing and Maths (2015)

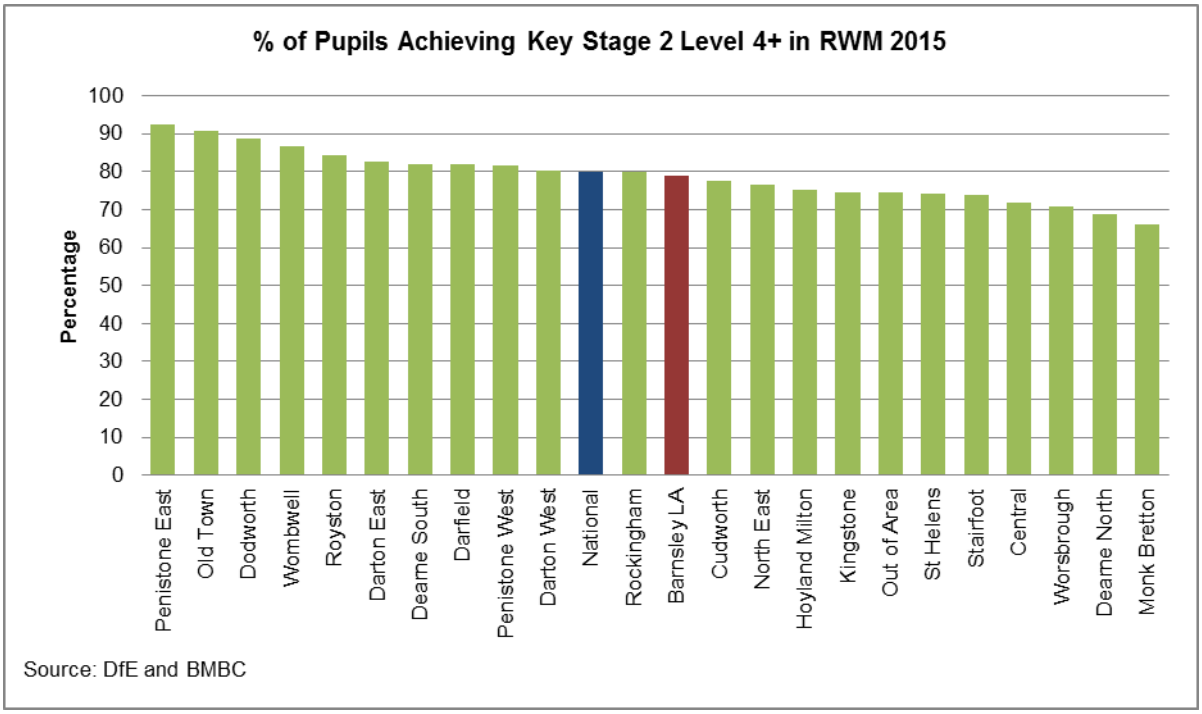
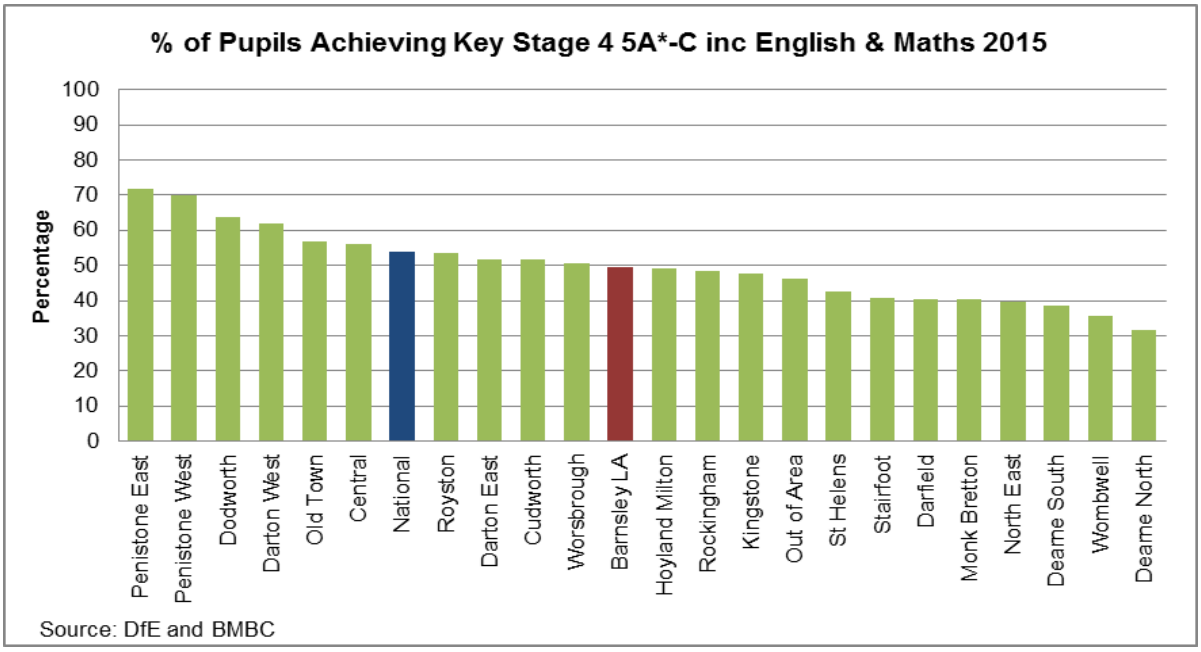


Figure 14 – Percentage of pupils achieving Key Stage 4 5A* – C including English and Maths (2015)



According to the Annual Population Survey (Jan – Dec 2015) the number of people in Barnsley aged 16 and over with no qualifications[14] has increased and is now above the England average. This low level of skills is likely to have an adverse impact on the economic growth of the borough and is a cause for concern.

[14] No Qualifications definition is 'No formal qualifications held' (Source: NOMIS)

The Council's Corporate Plan lays out 3 priorities and 12 outcomes which need to be focused upon to achieve the overall vision for Barnsley. Improving educational outcomes and the health of children in the borough are key areas of the Plan.

Lack of digital skills

A lack of digital skills seems to compound other inequality issues and as the digital divide increases, it gets harder for people to catch up as technology moves so quickly. For individuals, digital skills are linked to boosting productivity in work and helping to improve the chances of unemployed people to find jobs[15]. Digital skills can also assist with success in education and work, reducing social isolation, saving money, claiming benefits and accessing services. On an economic level, digital skills contribute to a vibrant economy and a skilled and confident workforce. Barnsley and other Northern towns and cities seem to suffer an exodus of the technologically skilled, which will in the long term negatively impact on our economy.[16]

The recent Joseph Rowntree Foundation (JRF) report on the causes of poverty adds digital skills to the traditional basic skills of literacy and numeracy (JRF 2016). Recent data from Ofcom (2015) and Go ON UK (2015) suggests:

- 27% of Barnsley residents lack basic digital skills;
- 30% of households do not have a fixed broadband connection, and
- 18% of adult residents have never been online.

The Barnsley Skills and Employment Strategy[17] seeks to address three priority areas that will create more and better jobs in Barnsley in the next 4 years:

- **Getting ready for work**: through increasing school attainment, teaching transferable skills, businesses and education working together, provision of high quality colleges.
- **Getting into work**: through tackling barriers, improving careers advice, providing high quality work experience and apprenticeships, and increasing take up of 25+ Adult Skills provision.
- **Getting on in work**: through working with the businesses to identify their needs, facilitating workplace progression, increasing the amount of high level skills in local businesses.

[15] The economic impact of Basic Digital Skills and inclusion in the UK. A report for Tinder Foundation and GO ON UK. Nov 2015 http://www.tinderfoundation.org/sites/default/files/research-publications/the_economic_impact_of_digital_skills_and_inclusion_in_the_uk_final_v2.pdf
[16] Northern Powerhouse project threatened by 'brain drain': https://www.ft.com/content/7b730442-0196-11e6-ac98-3c15a1aa2e62
[17] Barnsley Skills and Employment Strategy: More and Better Jobs (2016-2020)

Benefits

Please note it has not been possible to calculate how much of the changes in counts of claimants is a result of eligibility or policy changes and how much is a result of changes in the underlying reasons why people claim benefits.

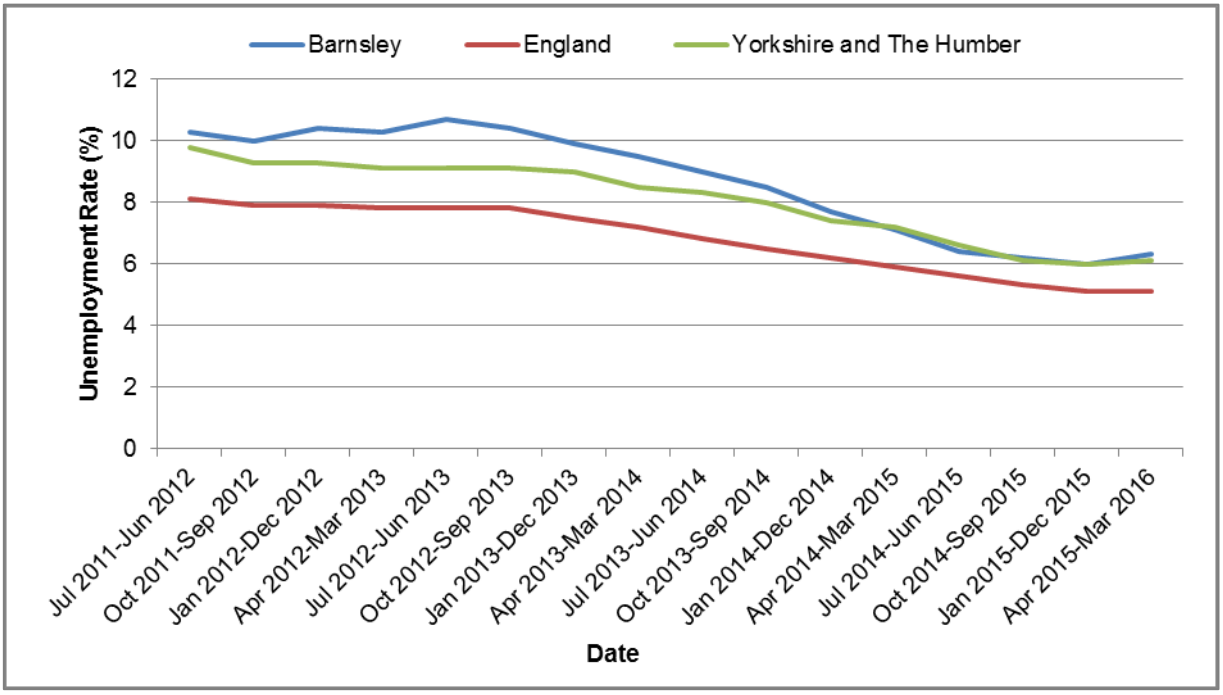
Worklessness

The rate of unemployment[18] has been reducing steadily from the period of July 2012-June 2013, to the latest 12 month period from a high of 10.7% to 6.3%. In actual terms, the 6.3% estimate of unemployment in Barnsley amounts to 7,400 people.

The trend of a decreasing unemployment rate has been mirrored both regionally and nationally, as shown in figure 15 below. Barnsley has, however, closed the gap over the last three years. During the latest period, the unemployment rate in England was 1.2 percentage points lower and Yorkshire and The Humber was 0.2 percentage points lower than that of Barnsley. Although Barnsley performs worse than the national and regional averages, this is an improvement compared to the same period three years earlier when Barnsley had an employment rate 2.5 percentage points higher than the England average and 0.7 percentage points higher than the regional average.

The latest 12 month period (April 2015-March 2016) has recorded the first increase in unemployment rate since the period of July 2012-June 2013.

Figure 15 – Model based estimates of unemployment – rate aged 16 – 64



Source: Annual Population Survey 2016

[18] Unemployed people are those without a job who have been actively seeking work in the past 4 weeks and are available to start work in the next 2 weeks. It also includes those who are out of work but have found a job and are waiting to start it in the next 2 weeks.

During the period April 2015-March 2016, 35,600 people in Barnsley were economically inactive[19]. Of those that are economically inactive, the reason that contributed to the largest proportion was 'long-term sick or disabled' which accounts for 37.4%, followed by those that are 'looking after home or family' which accounts for 22.8%.

The reasons for economic inactivity have stayed fairly steady over the last four years, although it can be observed that 'being retired' has reduced in the period from July 2011-June 2012 to the most recent 12 month period from 18.0% to 10.5%. Temporary sickness on the other hand has increased from 0% in July 2011-June 2012 to 4.1% in the period of April 2015-March 2016.

Of those that are economically inactive, 30.6% of those asked in the period of April 2015-March 2016 wanted a job and the remaining 69.4% did not want a job. This is a higher proportion of those economically inactive in Barnsley that would like a job than both the regional average (26.2%) and national average (24.5%).

The proportion of those that are economically inactive that would like a job differs for males and females in Barnsley. Of all residents who were economically inactive during the period of April 2015-March 2016, 37.2% of males wanted a job, but for females this was lower with 26.3% wanting a job. This split is mirrored both regionally and nationally with a higher proportion of economically inactive males wanting a job than economically inactive females.

There continues to be a mismatch in the local economy between the skills of the local labour supply and the demands of local business[20]. The latest job density rate[21] of 0.58 indicates that the borough is failing to maintain an adequate number of jobs in the local economy to support the indigenous working age population. Whilst the rate is improving (it's at its highest level since 2005) it lags behind the regional rate of 0.77 and the national of 0.82.

National research shows[22] that people's employment conditions have the strongest impact on the risk of poverty and recurrent poverty. Figure 16 overleaf shows the factors that keep people in the low pay/no-pay cycles.

[19] Economic inactivity is people not in employment who have not been seeking work within the last 4 weeks and/or are unable to start work within the next 2 weeks.
[20] Barnsley Skills and Employment Strategy: More and Better Jobs (2016-2020)
[21] Job density is the number of jobs per resident of working age. For example, a job density of 1.0 would mean that there is one job for every resident of working age in the population. Barnsley Labour Market Profile, Jobs Density. ONS. 2014, Nomis, 2016.
[22] Cycles of Poverty, Unemployment and Low Pay. Joseph Rowntree Foundation, 2010. https://www.jrf.org.uk/report/cycles-poverty-unemployment-and-low-pay

Figure 16 – Factors creating the low-pay/no-pay cycles

Source: Joseph Rowntree Foundation, 2010

Factors affecting the cycle include aspects related directly to the labour market, but also include other causal factors including lack of digital skills, available childcare, poor transport and health problems. Job characteristics were found to be very important from the research with low pay, part-time hours and short temporary contracts identified as key determinants of the cycle. These jobs often have little sick pay or pensions compared to more stable positions. They also tend not to provide structured training and promotion opportunities. For those with young children, shift work and anti-social hours tend to be problematic for childcare reasons.

Working Age Client Group (WACG)

People may claim a mix of benefits based on their circumstances. The Working Age Client Group (WACG) is a way of identifying the main reason for their benefit claim. As at February 2016, in Barnsley 17.1% of the working age population are claiming a WACG benefit (England rate was 11.4%). Rates of claimants for this age group have decreased by 3.3% in Barnsley and 3% in England between February 2012 and February 2016. The main driver of this decrease has been the reduction in Jobseeker's Allowance claimants. Other groups have remained static, although one notable exception is the increase in claimants for Carers' Allowance.

Disability and work

Almost half (48%) of people in poverty in the UK are either themselves disabled or living in a household with a disabled person (JRF 2016).

There have been many changes to benefits related to health conditions and disabilities since 2008. This makes it difficult to build a full and accurate picture of changes in counts of claimants and reasons for claims.

Employment Support Allowance/Incapacity Benefit (ESA/IB) data shows that as at February 2016 there were 13,930 people in Barnsley who were claiming these benefits because they were unable to work due to disability or long-term illness.

As at February 2016, Barnsley has 3.1% more working age people claiming Employment Support Allowance (ESA) than for England as a whole, which equates to 4,700 more working age people in Barnsley than if we were at the national average. Over the past three years the rate for ESA/IB combined has remained stable at around 9% of the working age population.

In Barnsley, there has been a 7 percentage point increase in ESA/IB claims which are for Mental and Behavioural disorders (this is an increase of 500 cases). These conditions account for almost half of claimants, which is similar to the regional and England picture. There has been a decrease of 900 cases related to diseases of the musculoskeletal system and connective tissue (a 4.5 percentage point decrease in the proportion of claims). In Barnsley 15.4% of claims are for this condition, which is higher than the England rate of 13.1%.

Jobseeker's Allowance and Tax Credits

The impact of unemployment on mental wellbeing is well documented and while not all people who are unemployed are eligible for Jobseeker's Allowance (JSA), it is a well-used barometer of the labour market. The Claimant Count is the headline indicator of the number of people claiming benefits principally for the reason of being unemployed. From May 2013 the Claimant Count includes people claiming Jobseeker's Allowance plus those who claim Universal Credit who are out of work.

JSA claimant rates have dropped in Barnsley from 5.3% of the working age population in March 2013 (the peak of the unemployment in Barnsley) to 2.3% in July 2016. This reflects the regional and England trends.

The reduction has been seen across Barnsley with reductions in all wards. Those wards with the highest rates have seen the greatest drop between July 2014 and July 2016. However, when including people who are not eligible for JSA, the percentage of working age population who are unemployed stands at 7%, which is above the England average of 5.2% (12 months to March 2016).

A number of policy changes that affect Tax Credits were introduced on 6th April 2012 as part of the Coalition Government's announcements in the June 2010 Budget and the 2010 Spending Review. This changed the eligibility for Working Tax Credits (WTC) and Child Tax Credits (CTC) so comparisons can only be made between April 2013 and April 2016. Between these dates the number of families claiming WTC (or WTC/CTC combined excluding those only getting the childcare element) decreased in Barnsley by 2.7% (about 300 fewer claimant families) from 14,800 to 14,500. This reflects the decrease in the England rate of 2.8%.

Disability Living Allowance & Personal Independence Payments (16 – 64)

Disability Living Allowance (DLA) for 16 – 64 year olds is in the process of being replaced by Personal Independence Payments (PIP) and hence the decrease in DLA for this group from February 2014 onwards is most likely due to this change in policy. Until the transfer of all cases is completed it is not possible to breakdown this information further with any level of accuracy.

Barnsley has a notably higher rate of DLA and PIP claimants at 6.2% than England (3.7%). The decrease in the rate of DLA claimants from February 2014 to February 2016 has been more than off-set by a corresponding increase in the rate of PIP claimants. There may be some double counting in the data but at least the rate of claimants across the two benefits appears to be static.

Disability Living Allowance – children

Disability Living Allowance for children remains in place for claimants for under 16 years of age (0 – 15). The claimant rate for DLA for this age group has increased by 1 percentage point in Barnsley since February 2013 compared with an increase in England of 0.4 percentage point.

Barnsley already has a higher rate at 4.5% than England as a whole (3.4%). In Barnsley this equates to an additional 470 claims since February 2013. The additional claims for the care element have been at the Higher (+300) and Middle (+180) award rates. Again, Barnsley already has a slightly higher proportion of claims at the higher rate than for England as a whole (48.2% and 42.5% respectively).

The pattern of claims by health conditions are similar in Barnsley compared with England as a whole. The largest group of health conditions are related to either Learning Difficulties or Behavioural and Hyperkinetic Syndromes (e.g. attention-deficit hyperactivity disorder)[23]. Between February 2013 and February 2016, these health conditions have accounted for the overall increase in claims (+460 claims for these three conditions).

[23] http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/adhdhyperkineticdisorder.aspx

Carers Allowance

Carers Allowance (CA) is for people who care for another person for 35 or more hours per week. The cared-for person must be in receipt of a benefit for their disability/illness at a rate indicating that they would need additional personal support. Caring for someone can have implications for the carer's physical and mental health. People providing high levels of care are twice as likely to be permanently sick or disabled and 625,000 people in England have health problems because of their caring responsibilities[24].

Barnsley has a higher rate of claimants of this benefit than for England as a whole (which is to be expected given the higher rates of disability/long-term illness). As at February 2016, 2.3% of the 16+ population in Barnsley claimed CA, compared with 1.5% in England. The key point is that this rate is increasing in Barnsley faster than England as a whole. The increase since February 2012 has resulted in an additional 1,320 claims (a 40.6% increase; in England the increase was 30.5%).

Further reading on benefits

Barnsley Skills and Employment Strategy (2016 – 2020)
https://www.barnsley.gov.uk/media/3063/employment-and-skills-strategy.pdf
Labour Market Profiles at ward level
https://www.nomisweb.co.uk/reports/lmp/ward2011/1946157120/report.aspx
Labour Market Profiles at borough level
https://www.nomisweb.co.uk/reports/lmp/la/1946157120/report.aspx

[24] https://www.gov.uk/government/publications/2010-to-2015-government-policy-carers-health/2010-to-2015-government-policy-carers-health#issue

Housing

The quality of housing has a direct impact on health, educational attainment, economic prosperity and community safety; all of which are important to the success and wellbeing of Barnsley communities.

The growing and ageing population of Barnsley not only adds pressure on housing supply in the borough, but also presents new challenges in providing suitable housing options to meet different needs, notably those of older people. As the population ages, the demand for housing will change, moving away from family homes and towards smaller and more specialised homes for people with care needs. The composition of households will also change, with more people living alone. Good housing and support services for vulnerable people can assist them to live healthy, independent lives and reduce the pressure on families and carers.

It is estimated that the demand for housing for vulnerable people[25] will be an additional 3,070 units and 28 bed-spaces by 2030 (Peter Fletcher Associates Ltd, 2015).

People who live in clean, dry, warm, secure and affordable homes are less likely to experience poor health as a consequence of their housing conditions. Also, those living close to areas of green space including parks, woodland and other open spaces tend to experience improved health and a greater sense of wellbeing (Shelter, 2013).

The health effects of poor housing disproportionately affect vulnerable people: older people living isolated lives, the young, those without a support network and adults with disabilities (Kings Fund, 2015).

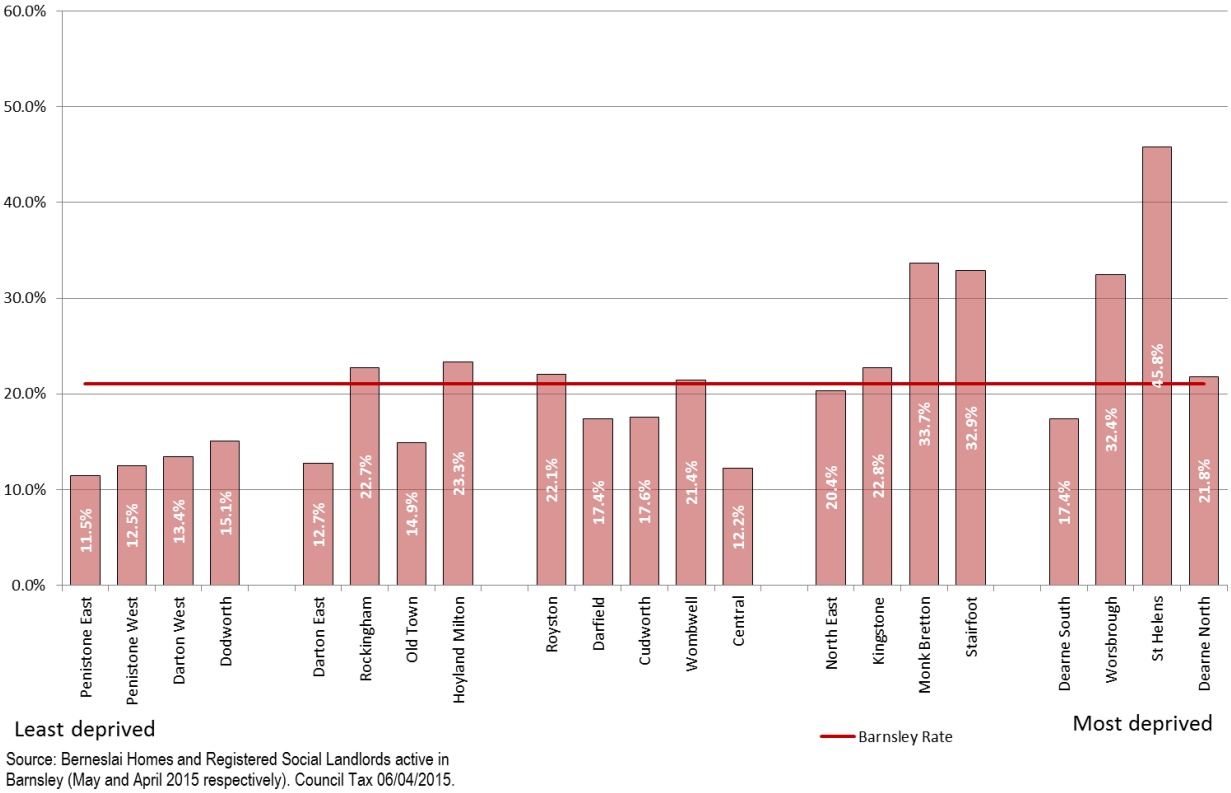
So what does bad housing mean for our children? Evidence from Shelter (2013) states:

- Up to 25% higher risk of severe ill-health and disability during childhood and early adulthood.
- Increased risk of Meningitis, Asthma, and slow growth, which is linked to Coronary Heart Disease.
- A greater chance of suffering mental health problems and problems with behaviour.
- Lower educational attainment, greater likelihood of unemployment, and poverty.
- Bad housing is linked to debilitating (and even fatal) illnesses and accidents.
- There is a direct link between childhood Tuberculosis (TB) and overcrowding. TB can lead to serious medical problems and is sometimes fatal.
- Almost half of all childhood accidents are associated with physical conditions in the home. Families living in properties that are in poor condition are more likely to experience a domestic fire.

[25] Vulnerable people, in relation to housing are: older people; people with dementia; people with mental health issues; people with substance misuse issues; people with sensory or physical disabilities; people with a learning disability; those with an offending history; homeless people; those in need of residential and nursing home provision; refugees/asylum seekers; people affected by domestic violence; ex armed forces personnel; and young people in transition

Berneslai Homes manages 18,719 homes on behalf of Barnsley Council. The waiting list for council homes has remained relatively static recently, with some 6,951 households on the housing register. This is made up of 5,459 general applicants and 1,492 transfer applicants. This is in line with the national average and lower than the South Yorkshire average (Barnsley rate is 56.3, England rate is 54.6 and the South Yorkshire rate is 80.8 per 1,000 households). In total 1,456 households are in the top 3 priority bands for housing (793 general applicants and 663 transfer applicants).

Figure 17 – Social Housing as a percentage of homes in each ward



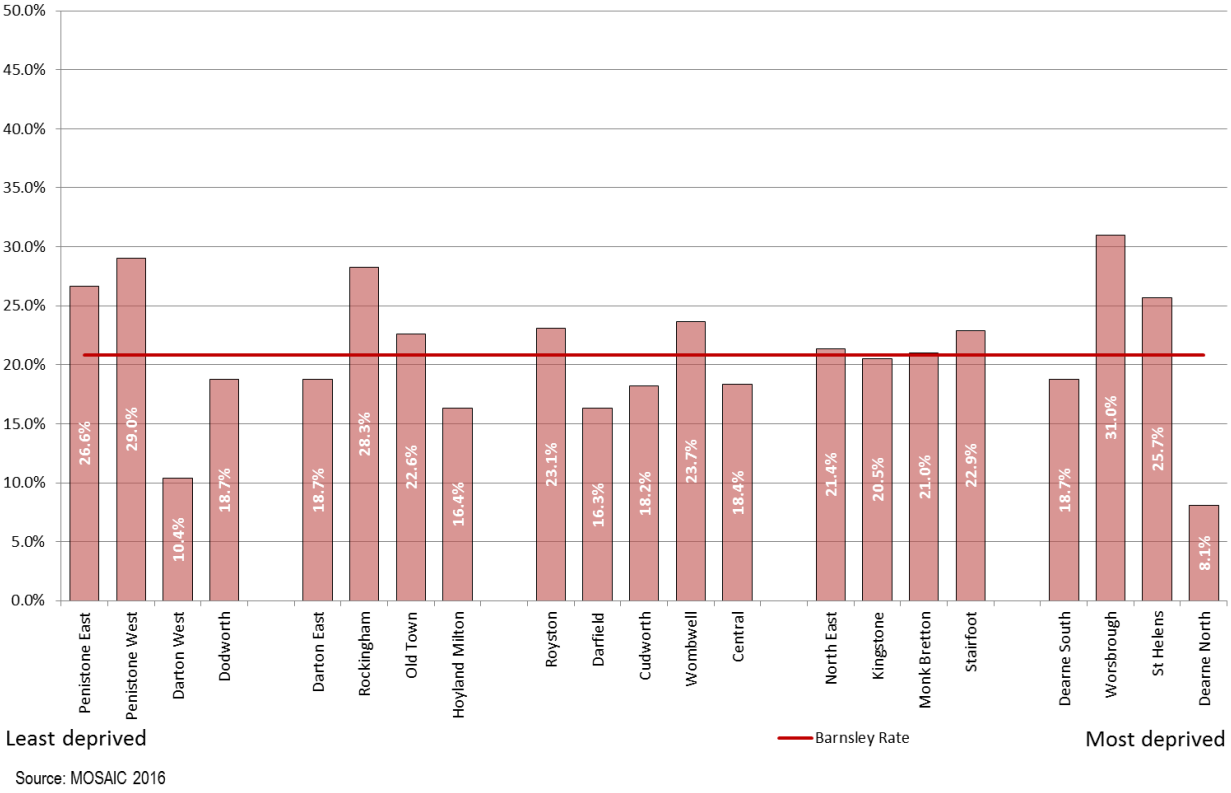
Source: Berneslai Homes and Registered Social Landlords active in Barnsley (May and April 2015 respectively). Council Tax 06/04/2015.

Notes: The accommodation above ranges from a room to a house. Council Tax data excludes Band 'U'.

Figure 17 above shows how the social housing is distributed across the borough, and highlights a concentration in St Helens, Monk Bretton, Stairfoot and Worsbrough wards.

Research undertaken by Peter Fletcher Associates Ltd on behalf of BMBC in 2015 using Department of Health and National Adult Social Care Intelligence Service data for adult social care, shows that Barnsley has a higher than average expenditure on residential care (despite low fee levels) and a much lower than average expenditure on day and domiciliary care than its comparator groups and the England average. Barnsley also has more people aged 65+ receiving residential care and fewer people receiving community based services than its comparator authorities and England averages. This indicates that in both financial and provision terms, the system in Barnsley is still unbalanced and weighted towards institutional care rather than community solutions and prevention.

Figure 18 – Households with older people as a percentage of homes in each ward



Source: MOSAIC 2016

Using Mosaic customer insight data (Experian, 2016) we can estimate the percentage of households where the head of the household is over 65; figure 18 above shows that for Barnsley, the average is 1 in 5 households (21%). This rate varies across wards, with the highest rate being in Worsbrough, with almost 1 in 3 households (31%), and the lowest rate being in Dearne North at 1 in 12 households (8%).

Further reading on housing

DCLG Housing Stats
https://www.gov.uk/government/organisations/department-for-communities-and-local-government/about/statistics
BMBC Housing Strategy 2014-2033
https://www2.barnsley.gov.uk/media/3824981/bmbc_housing_strategy_2014_final.pdf
BMBC Strategic Housing Market Assessment 2014 (Arc4, 2014)
https://www2.barnsley.gov.uk/media/3824978/barnsley_shma_2014_update_final_report.pdf
BMBC Energy Strategy 2015-25
https://www2.barnsley.gov.uk/media/3838552/bmbc_energy_strategy.pdf

Poverty

A recent report examining solutions to UK poverty (JRF 2016) found that people who live in poverty are generally at greater risk of poor mental and physical health; they tend to become sick more often and die younger than people who are better-off. Factors such as an inadequate diet, a higher rate of chronic illness, a lower level of participation in sport and leisure activities, and a generally lower quality of life have all been found to contribute to lower levels of health and wellbeing amongst people who experience poverty.

Poverty is a relative concept which applies to people who are considerably poorer than mainstream society, with resources well below those of the average individual or family which excludes them from ordinary aspects of life which are the norm for the majority. (JRF 2016)

A lack of financial resources severely limits the opportunities available to people and the life outcomes they can expect. Social mobility is difficult and most people born into poverty stay there. (JRF 2016)

Poverty limits the ability of people to participate in society, change their lifestyles and determine their own destiny. This results in fuel poverty, poor diet, unhealthy lifestyles, low aspirations and dependency. (JRF 2016)

A recent report by the Barnsley Anti-Poverty Board (Poverty Needs Assessment 2014) examined why people in poverty are also the ones who pay more for their goods and services. It found that people on low incomes do not use credit more often than affluent people; the rates are pretty similar across all income bands. What people on low incomes borrow money for is to cover the costs of essentials 'to make ends meet' and the limited financial options available result in them paying a much higher fee for their credit than those with higher incomes.

In general, Barnsley residents are making use of services such as the Credit Union, especially in areas with high levels of deprivation (PNA 2014).

There is also evidence that the earnings in Barnsley are failing to keep up with the regional and national levels.

- Incomes in Barnsley at £469 per week (gross) are lower than the regional and England averages of £480 and £530 respectively. The differences between males and females are also wider in Barnsley with men earning an average of £530 and women earning £408 (NOMIS 2016).
- Evidence from the MOSAIC customer insight data suggests that 1 in 3 Barnsley households found it difficult or very difficult to manage their household income (MOSAIC 2016).

There is very little evidence concerning older people affected by poverty in Barnsley, but the data that is available suggests that levels of poverty are not increasing in this age group.

- 1 in 6 of all people aged over 60 years living within Barnsley were claiming Pension Credit and of these, 77% were single. The numbers of Pension Credit claimants has reduced over the past 3 years; in 2014 1 in 5 of all people aged over 60 years living within Barnsley were claiming Pension Credit (NOMIS 2016, ONS 2015).
- The claimant rates for Pension Credit in Barnsley (9,170 or 16%) are higher than the regional and national averages of 15% and 13% respectively (NOMIS 2016, ONS 2015).

People on low incomes, in chronic ill-health or with limited mobility are significantly less able to access and pay for the transport they need to access work, education and services.

- Access to cars and vans is up to 5 times higher in the less deprived wards than in the most deprived (ONS 2011 Census).
- Older people rely most on public transport and those who are in poverty are least likely to have access to alternatives. They also have the highest rates of mobility issues, which make shopping, banking and medical journeys even more difficult (Centre for Social Justice (CSJ), 2010, Department for Transport (DT), 2014).

Fuel poverty

The number of households affected by fuel poverty in Barnsley is roughly in line with the national and regional averages, but there are significant variations across the borough.

- The latest data estimates that 11,505 (11.3%) Barnsley households are in fuel poverty (the figures were 9.2% in 2013, 9.7% in 2012 and 10.9% in 2011) (Department for Energy and Climate Change (DECC), 2014).
- The rate varies substantially across the borough from 5% to 24.3%, with 61 out of the 147 Lower Super Output Areas (LSOAs)[26] being above the borough average.
- There were 340 social rented homes in Barnsley which failed to meet the decent homes standard for 'thermal comfort' which relates to having efficient insulation and heating (Department for Communities and Local Government (DCLG), 2015).
- The average Standard Assessment Procedure (SAP) rating for a Council property in Barnsley is C, which is above the UK average score of D. This indicates that they are more energy efficient than the average home (DCLG, 2015 and DCLG, 2013).

[26] Lower Super Output Area (LSOA) is a small area geography with an average of 1,500 residents and 630 Households.

What are the Health Conditions that our Residents Experience and where do they live?

The health of Barnsley residents is generally poorer than the national average. There are significant health inequalities across Barnsley. This affects the quality of life for Barnsley residents and creates growing pressures on health services, social care, informal care, supported housing and other services.

Long term conditions

Over a quarter of the population in England has a long term condition (LTC).[27] Long-term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension. They can have a significant impact on a person's ability to work and live a full life.

Long-term conditions are more common in older people (58% of people over 60 compared to 14% under 40) and in more deprived groups (people in the poorest social class have a 60% higher prevalence than those in the richest social class and 30% more severity of disease).[28]

The number of people with three or more long-term conditions is predicted to rise nationally from 1.9 million in 2008 to 2.9 million in 2018.[29] Multimorbidity is more common among deprived populations, especially those that include a mental health problem. Some people living in deprived areas will have multiple health problems 10 – 15 years earlier than people living in more affluent areas.

There is an interrelationship between physical and mental health. Mental health problems are much more common in people who have long term physical illnesses. Compared with the general population, people with diabetes, hypertension and coronary artery disease have double the rate of mental health problems, and those with chronic obstructive pulmonary disease, cerebrovascular disease and other chronic conditions have triple the rate. People with severe mental health disorders such as schizophrenia and bipolar disorder, and depression are more likely to develop long term physical conditions such as diabetes or cardio vascular disease.

People with long-term conditions now account nationally for about 50 per cent of all GP appointments, 64 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days.[30] The ageing population and increased prevalence of long-term conditions is having a significant impact on health and social care demand and there is a rising demand for the prevention and management of multi-morbidity rather than of single diseases.

[27] NHS England https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/
[28] Quoted by Kings Fund https://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/long-term-conditions-multi-morbidity
[29] Quoted by Kings Fund https://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/long-term-conditions-multi-morbidity
[30] Quoted by Kings Fund https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

Due to high levels of deprivation and higher levels of risk factors for long term conditions (such as high rates of smoking and obesity and low levels of physical activity) it is likely that the levels of many long term conditions will be higher in Barnsley than nationally.

Table 3 below details the number of people in Barnsley known to General Practices to have a range of long term conditions. There will also be other people with these conditions who have not yet been diagnosed. For some conditions Public Health England has developed models to estimate the predicted prevalence of the condition – that is the expected number of people living with that condition. These models suggest, for example, that there are over 2,500 people with diabetes in Barnsley who have not yet been diagnosed and a further 24,000 people whose blood glucose levels are approaching the diabetic range and are at high risk of developing diabetes (see table 3).

Table 3 – Numbers of People in Barnsley Known to Primary Care to have a Long Term Condition, March 2016

	Number of People known to Primary Care diagnosed with a condition, (Quality Outcomes Framework (QOF) register)			Predicted Prevalence (expected number)			Gap between predicted Prevalence & Barnsley QOF Registers
	Number	% of Population		Number	% of Population		
	Barnsley	Barnsley	England	Barnsley	Barnsley	England	
Obesity (age 18+)	29,806	14.6	9.5				
Diabetes (age 17+)	14,921	7.2	6.5	17,480	8.9	8.6	2,559[31]
Diabetes[32] (age 17+)				21,124	9.8	9.5	
Non-Diabetic Hyperglycaemia				24,093	11.6	11.2	
Cardiovascular Disease:							
Hypertension	40,211	15.7	13.8	65,576	25.8	23.6	25,365[33]
Coronary Heart Disease	11,687	4.6	3.2				
Atrial Fibrillation	4,639	1.8	1.7	6,202	2.5	2.4	1,563[34]
Heart Failure	2,284	0.9	0.8				
Peripheral Arterial Disease	2,598	1.0	0.6				
Stroke and TIA	5,279	2.1	1.7				

[31] Source of prediction model: National Cardiovascular Intelligence Network, Public Health England
[32] Diabetes – predicted prevalence in 2030
[33] Source of prediction model: National Cardiovascular Intelligence Network, Public Health England
[34] Source of prediction model: National Cardiovascular Intelligence Network, Public Health England

	Number of People known to Primary Care diagnosed with a condition, (Quality Outcomes Framework (QOF) register)			Predicted Prevalence (expected number)			Gap between predicted Prevalence & Barnsley QOF Registers
	Number	% of Population		Number	% of Population		
	Barnsley	Barnsley	England	Barnsley	Barnsley	England	
Chronic Kidney Disease (age 18+)	10,386	5.1	4.1	11,733	6.2	6.1	1,347[35]
Respiratory Disease:							
Asthma	14,840	5.8	5.9				
COPD	8,170	3.2	1.9	6,642	3.6	3.4	-1,528[36]
Cancer	6,356	2.5	2.4				
Palliative care	757	0.3	0.3				
Dementia	1,945	0.8	0.8	2,841			896[37]
Epilepsy (18+)	1,811	0.9	0.8				
Mental health:							
Depression (age 18+)	21,035	10.3	8.3				
Severe Mental Illness	1,921	0.7	0.9				
Learning Disabilities	1,359	0.5	0.5				
Rheumatoid Arthritis (age 16+)	1,636	0.8	0.7				

Burden of Disease

Life expectancy in England is increasing mainly because of falls in the death rate from cardiovascular disease, stroke, chronic obstructive pulmonary disease (COPD) and some cancers (with progress partly offset by increased death rates from liver disease). However, the increase in life expectancy hasn't been matched by improvements in levels of ill-health. As a population we're living longer but spending more years in ill-health.

[35] Source of prediction model: Age 16+, National Cardiovascular Intelligence Network, PHE
[36] Source of prediction model: 2011, APHO
[37] Source of prediction model: All ages, CFAS II and AS2014, NHSE

The World Health Organisation (WHO) estimates the overall burden of disease using a combination of the years of life lost due to early death and the years spent living with disability or ill-health. Comparison of the Disability Adjusted Life Years (DALY) for a range of conditions (table x) over time shows that sickness and chronic disability are causing a much greater proportion of the burden of disease as people are living longer with several illnesses.

Nationally for women, low back pain, depression and neck pain all have a greater burden of disease than ischemic heart disease or breast cancer. For men the top three conditions causing the greatest burden of disease are ischaemic heart disease, low back pain and lung cancer, with depression the 7th biggest contributor to overall burden of disease.

Source: Public Health England

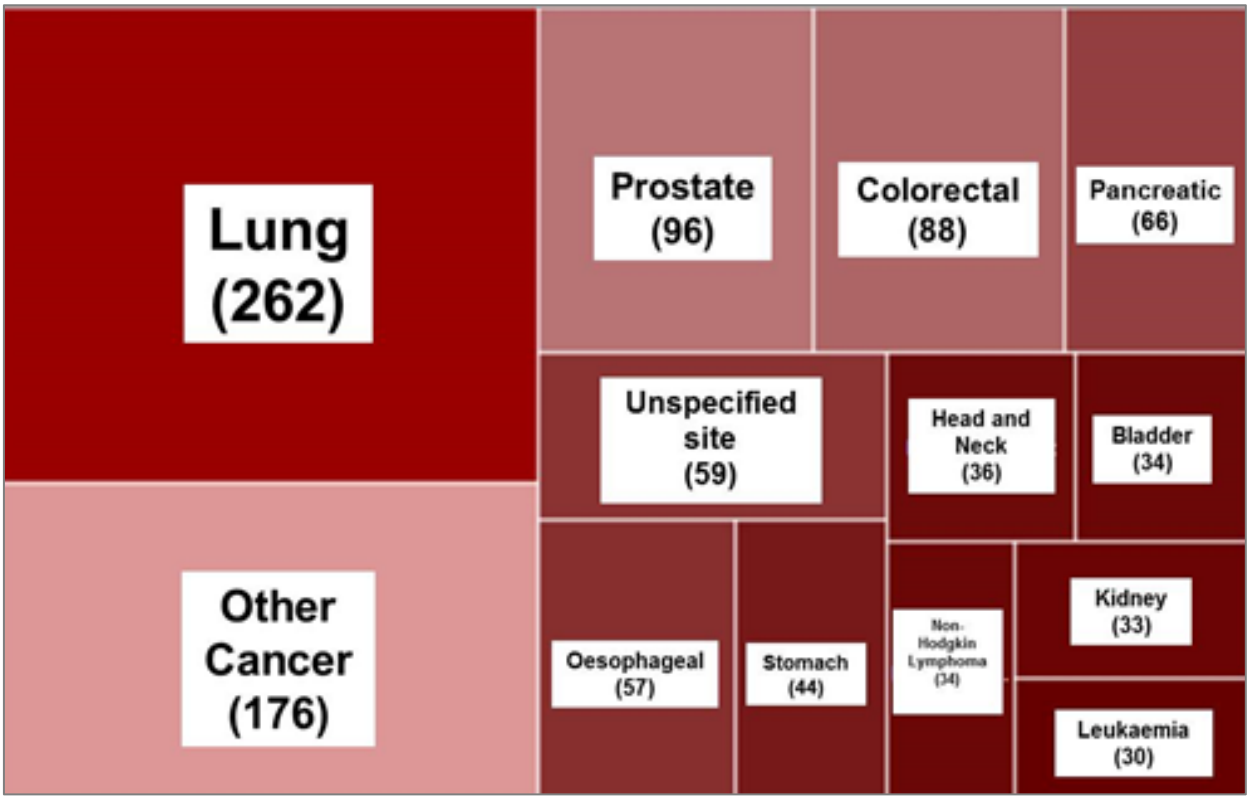
Cancer

Cancer is one of the leading causes of premature death. The cancer incidence rate in Barnsley (551.9 per 100,000) is significantly higher than the England average (507.5 per 100,000). In 2012/13, 1,373 people in Barnsley were diagnosed with cancer. In Barnsley, the highest incident rates are for breast cancer (164.4 per 100,000) and lung cancer (101.6 per 100,000). There are large geographical differences across Barnsley for the incidence of lung cancer, with the rate in Dearne North at 221.5 being almost three times higher than the rate in Penistone West of 73.9.

Cancer screening rates for breast, cervical and bowel cancer are all significantly higher than the England rates. However, the majority of lung cancers (42%) are diagnosed as a result of emergency presentation, which is significantly higher than the England rate of 37%. Nationally, the majority of lung cancer diagnoses are detected via a managed route, such as GP referral. Whilst overall cancer survival rates in Barnsley have steadily increased, the one year cancer survival rate at 67.7% is lower than the England rate of 69.3%.

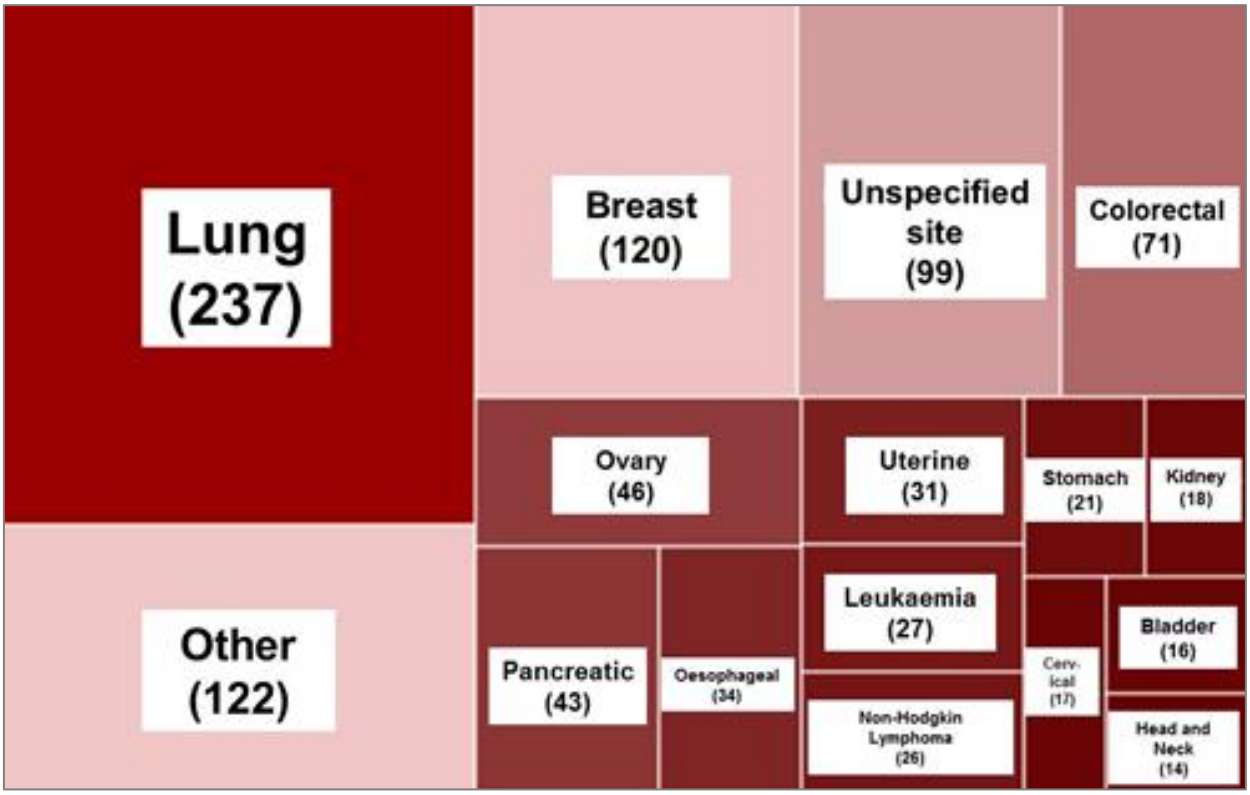
Lung cancer is responsible for the greatest proportion of cancer deaths in Barnsley (25.8% of all men and 25.1% of all women). Figure 19 below and figure 20 overleaf show the number of deaths by type of cancer for Barnsley men and women.

Figure 19 – Number of deaths by Cancer – men (all ages) – by types of Cancer (2012/14)



Source: Primary Care Mortality Database

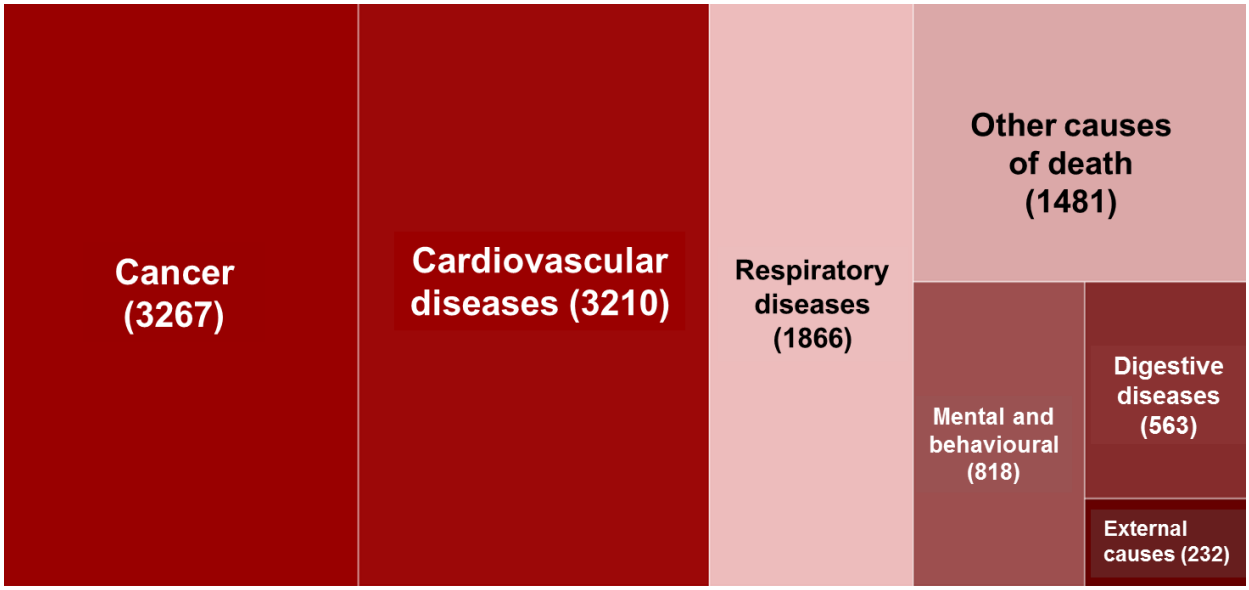
Figure 20 – Number of deaths by Cancer – women (all ages) – by types of Cancer (2012/14)



Source: Primary Care Mortality Database

Mortality

Figure 21 – Causes of death in Barnsley (numbers) 2010 – 2014



Source: ONS Primary Care Mortality Database (2010 – 2014)

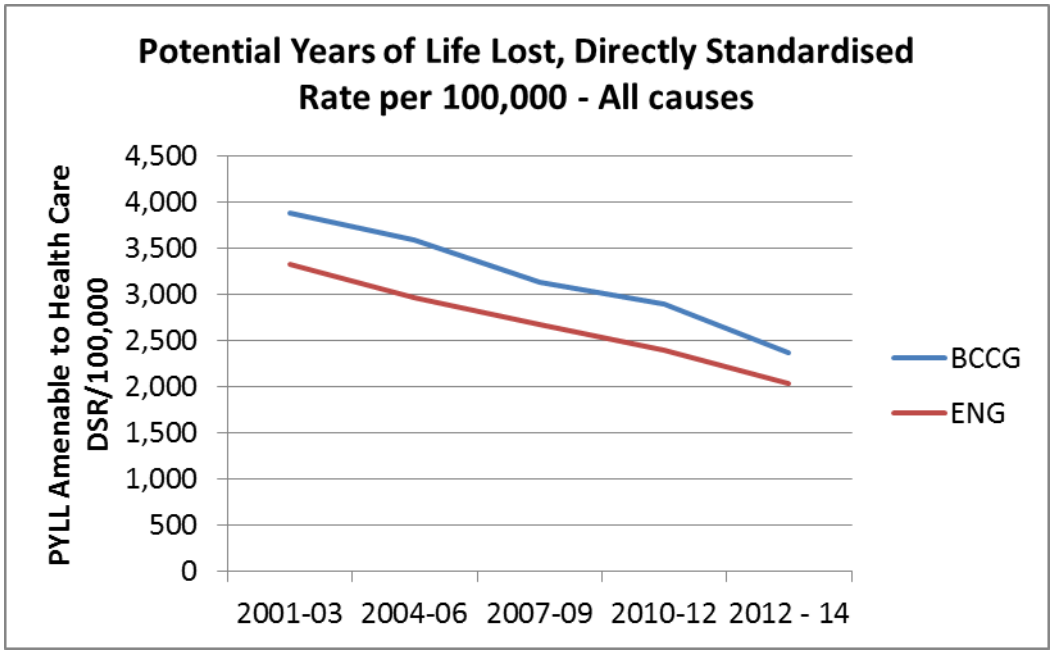
There were 11,437 deaths in Barnsley between 2010 and 2014. As shown in figure 21, the main causes of death were cancer, cardiovascular and respiratory diseases.

Potential Years of Life Lost

As well as the main causes of death in Barnsley, it is also important to consider the Potential Years of Life Lost (PYLL). Potential Years of Life Lost takes into account not only the number of deaths that occur in people aged under 75 but also the age at which the person died.

Over the last decade the potential years of life lost for all conditions considered to be amendable to healthcare has been higher than the national rate, but the gap is beginning to close. In 2012 – 2014 the standardised rate for Barnsley CCG was 2,370.3 per 100,000, 17% higher than the English rate of 2,031.8 per 100,000.

Figure 22 – Potential years of life lost (PYLL) from causes considered amenable to healthcare, Barnsley compared to England (Directly Standardised Rate per 100,000) 2001/03 – 2012/14



Source: Public Health England 2014

Further detailed information can be found in the Potential Years of Life Lost profile (2016).

Cancer mortality aged under 75 years

The 2012/14 under 75 cancer mortality rates (per 100,000 population) for men in Barnsley is 175.6, which is significantly higher than the England rate of 157.7, a difference of 17.9 (per 100,000 population). For women in Barnsley it is 139.7, which is not significantly different to the England rate of 126.6. Overall, cancer mortality in Barnsley is decreasing. The cancer mortality rate has declined from 197.0 in 2001/03 to 157.6 in 2013/15 (persons), a difference of 39.4 (per 100,000 population).

There are differences in cancer mortality within Barnsley. Within the Barnsley wards in 2010/14, Wombwell has the highest cancer mortality rate at 222.4 (persons) and Penistone West the lowest rate at 104.9 (persons).

Cardiovascular disease mortality aged under 75 years

The 2012/14 under 75 cardiovascular disease mortality rates (per 100,000 population) for men in Barnsley is 124.6, which is significantly higher than the England rate of 106.2, a difference of 18.4 (per 100,000 population). For women in Barnsley it is 57.3, which is significantly higher than the England rate of 46.9, a difference of 10.4 (per 100,000 population). Overall, cardiovascular mortality in Barnsley is decreasing. The cardiovascular mortality rate has declined from 178.4 in 2001/03 to 89.7 in 2013/15 (persons), a difference of 88.7 (per 100,000 population).

There are differences in cardiovascular disease mortality within Barnsley. Within the Barnsley wards in 2010/14, Dearne North has the highest cardiovascular mortality rate at 156.6 and Penistone East the lowest rate at 42.4 (persons), a difference of 114.2 (per 100,000 population).

Respiratory disease mortality aged under 75 years

The 2012/14 under 75 respiratory disease mortality rates (per 100,000 population) for men in Barnsley is 48.6, which is significantly higher than the England rate of 38.3, a difference of 10.3 (per 100,000 population). For women in Barnsley it is 37.7, which is significantly higher than the England rate of 27.4, a difference of 10.3 (per 100,000 population). Overall, respiratory disease mortality in Barnsley is decreasing. The respiratory disease mortality rate has declined from 54.9 in 2001/03 to 42.4 in 2013/15 (persons), a difference of 12.5 (per 100,000 population).

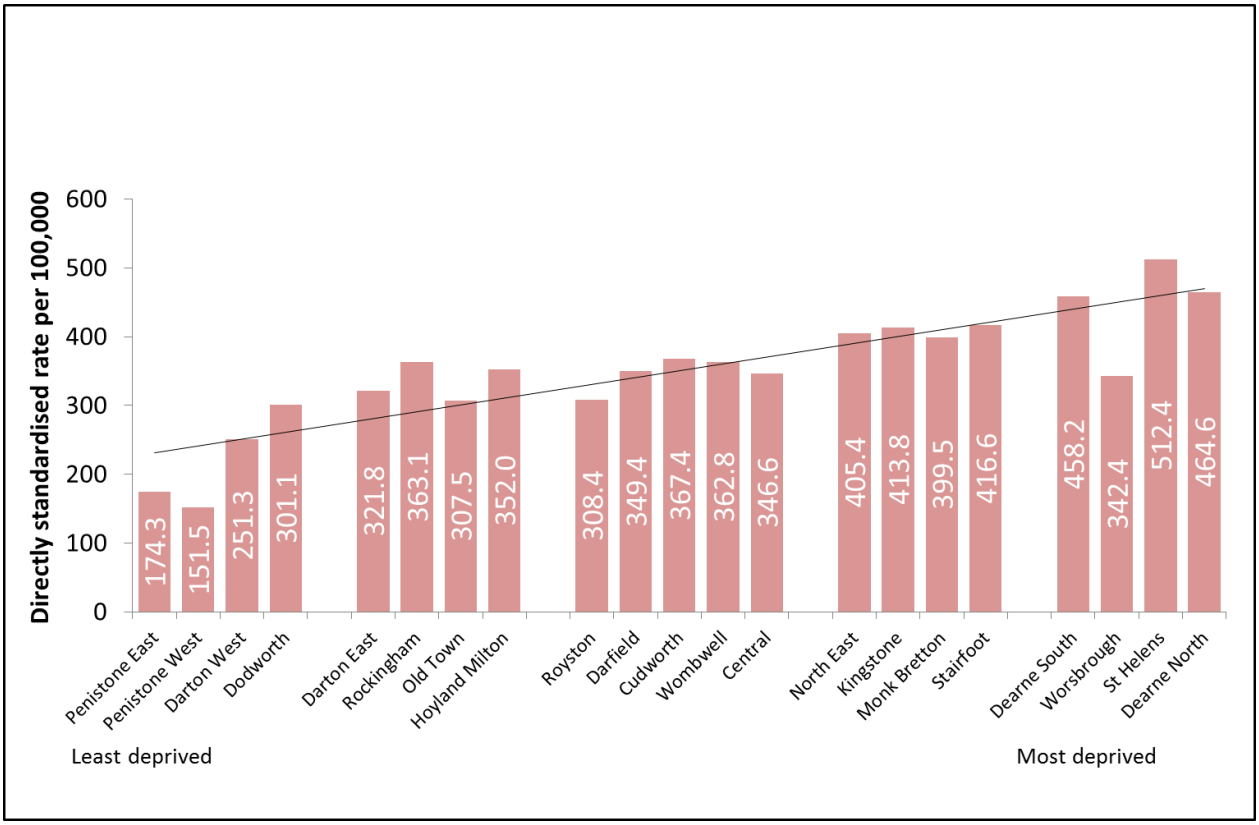
There are differences in respiratory disease mortality within Barnsley. Within the Barnsley wards in 2010/14, St Helens ward has the highest respiratory disease mortality rate at 75.7 and Penistone West the lowest rate at 19.4 (persons), a difference of 56.3(per 100,000 population).

For further details on under 75 mortality in Barnsley, can be found in the profiles.

Smoking attributable mortality

Smoking related deaths in Barnsley at a rate of 345.5 per 100,000 adults are significantly higher than the England rate (274.8). The 2012/14 rate is the lowest during the period 2007/09 – 2012/14. Within Barnsley, smoking attributable deaths are more prevalent in the most deprived areas. The rates range from 151 in Penistone West ward to 512 in St Helens ward (see figure 23 below). The line on the chart shows that as deprivation increases, so too does smoking attributable mortality.

Figure 23 – Smoking attributable deaths: Directly Standardised Rate per 100,000 Aged 35 and over (2010 – 2014) by ward and Index of Multiple Deprivation (IMD) 2015 quintile



Sources: PCMD 2010 – 2014; GP smoking and ex-smoking data (31.12.15), ONS mid-year population estimates 2010 – 2014 and IMD 2015

Alcohol Related Mortality

The 2014 alcohol related mortality in Barnsley rate of 42.5 per 100,000 adults is lower than the England rate 45.5 per 100,000 adults.

Suicide

The suicide rate in Barnsley is 11.6 persons per 100,000 population (2012/14). This is not significantly different to the England rate of 10.0. In Barnsley, this is equivalent to 73 people in a three year period. The rate for men at 19.7 is higher than for women (the numbers for women are too small to report).

Excess winter deaths[38]

The Excess Winter Deaths Index for Barnsley is 18.8% (2011/14) which equates to 402 excess winter deaths over the three year period. This is an average of 133 excess winter deaths per year. The main underlying causes of excess winter deaths (2011/14) were: influenza and pneumonia; chronic lower respiratory diseases; and other respiratory diseases.

It is estimated that 20% of Excess Winter Deaths per year can be directly attributed to excess cold hazards. There is compelling evidence that the drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to living at low temperatures.
The recent Marmot Review Team report showed that low temperatures are strongly linked to a range of negative health outcomes (Fuel Poverty Review 2012, PHO 2015, Marmot Review 'Fair Society, Healthy Lives' 2010).

Wellbeing and mental health

Wellbeing has a major influence over both mental and physical health. The Office for National Statistics National Wellbeing Survey in 2016 found that self-reported wellbeing in Barnsley is lower than England. In summary:

- 81% of residents in Barnsley feel life is worthwhile compared to 84% in England;
- 78% of residents have high life satisfaction compared to 81% in England;
- Almost three quarters of residents feel happy compared to 75% in England; and
- 61% report low anxiety compared to 64% in England.

Mental health problems are widespread, at times disabling, yet often hidden.[39] National figures show:

- One in four adults experiences at least one diagnosable mental health problem in any given year.
- Over half of all mental illness starts before the age of 14 and 75% starts by the age of 18.
- One in ten children aged 5 – 16 years has a diagnosable problem such as a conduct disorder (6%), anxiety disorder (3%), attention deficit hyperactivity disorder (ADHD) (2%) or depression (2%).
- Children from low income families are at the highest risk.
- One in five mothers suffer from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth.
- Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year; roughly the cost of the entire NHS.

[38] Office for National Statistics (ONS) standard method defines the winter period as December to March, and compares the number of deaths that occurred in this winter period with the average number of deaths occurring in the preceding August to November and the following April to July
[39] NHSEngland. The Five Year Forward View For Mental Health, 2016

Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, higher levels of service use and many associated economic costs (Public Health England, 2016).

Barnsley's 2014/15 rate for the number of people known to GPs as having being diagnosed with mental health problems at 9.6% is significantly higher than the England rate of 7.3%. This represents 18,840 adults living in Barnsley who have been diagnosed with depression.

This indicator shows the prevalence of mental health problems as recorded on general practice systems (Public Health England, 2016).

Barnsley's 2014/15 rate of 0.7% (2,942 adults) for the prevalence of severe mental health problems (schizophrenia, bipolar affective disorder and other psychoses) as recorded on GP practice disease profiles is significantly lower than the rate for England of 0.9%. This may represent a under diagnosis or under coding of the conditions, rather than a truly lower rate of severe mental illness in Barnsley.

Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. This is one of the greatest health inequalities in England. Two thirds of these deaths nationally are from avoidable physical illnesses, including heart disease and cancer; many caused by smoking. Nationally, it is also recognised that there is a lack of access to physical healthcare for people with mental health problems.

Barnsley's 2012/13 rate for premature (under75) mortality in adults with serious mental illnesses is 1,329.3 per 100,000. This is slightly higher than the England rate of 1,318.9 per 100,000, but not significantly higher. The rate has increased since 2009/10 from 1,273.5 to 1,329.3 in 2012/13.

Patients with long term conditions such as heart disease, diabetes and Chronic Obstructive Pulmonary Disease (COPD) are more likely to develop mental health problems such as depression than the general population.

For further details, see the mental health in Barnsley profile

Minority Groups

Black and Minority Ethnic Communities

Many Black and Minority Ethnic (BME) groups experience higher rates of poverty than the White British in terms of income, benefits use, worklessness, lacking basic necessities and area deprivation. Much of the variation in self-reported health between and within BME groups can be explained by differences in socio-economic status (Parliamentary Office of Science and Technology, 2007.)

- There are a range of complex factors affecting ethnic health, such as the long-term impact of migration, racism and discrimination, poor delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility (Parliamentary Office of Science and Technology, 2007).
- The health status of Gypsies and Travellers is much poorer than that of the general population, even when taking into account factors such as variable socio-economic status and/or ethnicity (Race Equality Foundation, 2008.)
- BME communities are disproportionately represented in both mental health care and the Criminal Justice System (Centre for Mental Health, 2013).
- BME people are under-represented in substance misuse services. The severe social stigma associated with drug use in some cultural and ethnic groups may lead to under-estimation of problems and inhibit service provision and take up. There may also be a limited awareness among BME groups of the range and value of substance use services (Shelter, 2016).

Lesbian, Gay, Bisexual and Transgender (LGBT)

A number of recent surveys have highlighted some key areas where the health & wellbeing of LGBT people are significantly different from the general population:

- Gay & Bisexual men are less likely to live an active lifestyle, but are more likely to have a normal BMI (Stonewall, 2013).
- LGBT people are less likely to engage with public health initiatives such as HIV testing, STI testing and cervical smear testing than the general population (Stonewall, 2012 b & 2013).
- LGBT people are more likely to self-harm, Gay & Bisexual men are more likely to attempt suicide and Lesbian & Bisexual women are more likely to suffer from eating disorders (Stonewall, 2012 a).
- Gay & Bisexual men are more likely to experience Domestic Abuse and Transgender people are more likely to suffer intimidation, violence and harassment (Stonewall, 2012 b and Scottish Transgender Alliance, 2012).
- Gay & Bisexual men have higher rates of recreational drug use, smoking and alcohol consumption (Stonewall, 2013).
- LGBT people over 55 are more likely to live alone (Stonewall, 2012 b).

Gypsy Travellers

The Health Status of Gypsy Travellers in England report to the Department of Health (Parry et al, 2004) found that:

- Health problems amongst Gypsy Travellers are between two and five times more common than the settled community;
- Gypsy Travellers are more likely to be anxious, have breathing problems (including asthma and bronchitis) and chest pain. They are also more likely to suffer from miscarriages, still births, the death of young babies and older children.

Asylum Seekers

National research shows that asylum seekers can rapidly develop health problems whilst they are in the UK. Reasons for this include:

- A number have faced imprisonment, torture or rape prior to migration and will bear the physical and psychological consequences of this;
- Many have come from refugee camps where nutrition and sanitation has been poor so placing them at risk of malnourishment and communicable diseases;
- The journey to the UK could have affected them through various means such as extremes of temperatures, length of journey, overcrowded transport and the stress of leaving their country of origin.

Sensory Impairment

National research shows that sensory impairment can have a significant impact upon the life of an individual and can place additional strain upon the health, social and economic needs of both individuals and society.

Visual impairment disproportionately affects people within a higher age range. The Royal National Institute of Blind People (RNIB) predict that the incidence of sight loss will increase in line with a growth in ageing population and an increase in underlying causes of sight loss, such as obesity and diabetes.

Being deaf or having hearing loss can be a big issue and often socially disabling. People with significant hearing loss are often very isolated, with social communication becoming increasingly difficult and no externally visible signs of the individual's impairment e.g. Guide dog or white stick. Furthermore, deaf people often have very low literacy and comprehension levels, making reading, writing and understanding the written words very difficult. This can often lead to a rise in frustration and tensions both with the individual as well as society on the whole.

Carers

There are also groups within the population that at times we know very little about, including unpaid carers. These are people who provide care to a friend, relative or neighbour who has a disability or health problem. This care is often provided by an elderly relative and as such, can lead to an increase in health problems for the carer including back problems, anxiety, isolation and low self-esteem.

How do service users view the health and social care that they receive?

A Health and Equality Event took place on the 15th October 2016 where each of the Equality Forums gave a short presentation of their experiences of services and health outcomes. A series of short workshops were then held where the forums could have their say about services and offer suggestions for how these could be improved and how we can work together better in the future.

Feedback highlighted:

- Medical professionals need to establish the person's communication needs, record these and make sure that all follow up discussions or correspondence properly meet that individual's personal needs.
- Everyone should be treated with respect and spoken to directly, rather than through a third party.
- People should simply be treated as you would like to be treated.

Adult Social Care Survey

The Personal Social Services Adult Social Care Survey (ASCS) is an annual survey for England that took place for the sixth time in 2015/16. Service users were sent questionnaires, issued by Councils with Adult Social Services Responsibilities (CASSRs), in the period January to March 2016 to seek their opinions on a range of outcome areas.

The survey covers all service users aged 18 and over in receipt of long-term support services funded or managed by social services following a full assessment of need. The survey is designed to learn more about how effectively services are helping service users to live safely and independently in their own homes, and the impact that these services have on their quality of life.

The key findings are:

- Barnsley has a slightly higher rate of clients who are extremely or very satisfied with their care and support services compared with England as a whole.
- Generally clients reported a better quality of life this year than last year.
- The proportion reporting that they had 'as much control over my daily life as I want' increased significantly from 2014/15 to 2015/16.
- Just under three-quarters of clients felt as safe as they wanted to feel; a slightly higher percentage than last year and England as a whole.
- There were slight improvements in clients reporting that they could socialise and do things that they wanted.
- The vast majority of clients reported that having care and the way they are treated by their carers makes them either feel better or does not negatively change the way they feel.

- There has been a significant increase in clients reporting that they have not tried to access information and advice. There was a corresponding decrease in clients reporting that it was very or fairly easy to find information.
- Clients are reporting better health in 2015/16 compared with 2014/15 generally and more specifically in levels of anxiety and levels of pain.
- With the exception of dealing with finances and clients' ability to wash themselves, there have been increases in clients reporting that they can easily do daily tasks by themselves. There was an increase in the percentage of clients who reported that they could not deal with finances/paperwork themselves.

Health surveys

A range of 16 recent surveys have found some common areas of feedback amongst users of health services in Barnsley.

- Focus needs to be on flexibility and be person centred (based on what the patient wants) rather than organisation led (what the provider wants), i.e. what works for one person might not work for another. Patients with multiple conditions in particular felt that the services didn't work well for them.
- Patient/family inclusion and engagement is important along with being listened to/views taken into account.
- Integration is essential, both between patients, carers and professionals, and between service providers and partners organisations.
- Communication requires improvement. This covers three areas: between partner organisations, keeping patients informed between appointments and between the commissioners, service users and carers.
- Access to the right service at the right time in the right way is important.
- More widespread training and support is essential, especially on issues affecting the Deaf community and those with mental health issues.
- Awareness raising is needed for high quality services such as I-Heart Barnsley, and Pharmacy First. Patients need more information, support and advice about local services.
- Waiting times are too long, especially for mental health services.

What are the potential issues for Barnsley in the future?

Population Projections

The latest population projections (ONS 2014 mid-year projections) showed that the total population of Barnsley was expected to increase to 239,300 in 2015 (which matches the 2015 mid-year estimate). The projections predict that the population will grow further, reaching 247,600 by 2020; an increase of 4.1% from 2014. The projections also show the following increases by age group:

- 0 to 15 years 6.1%
- 16 to 64 years 1.4%
- 65+ years 11.3%

Figure 24 – Population projection – percentage change by age group from mid-2014

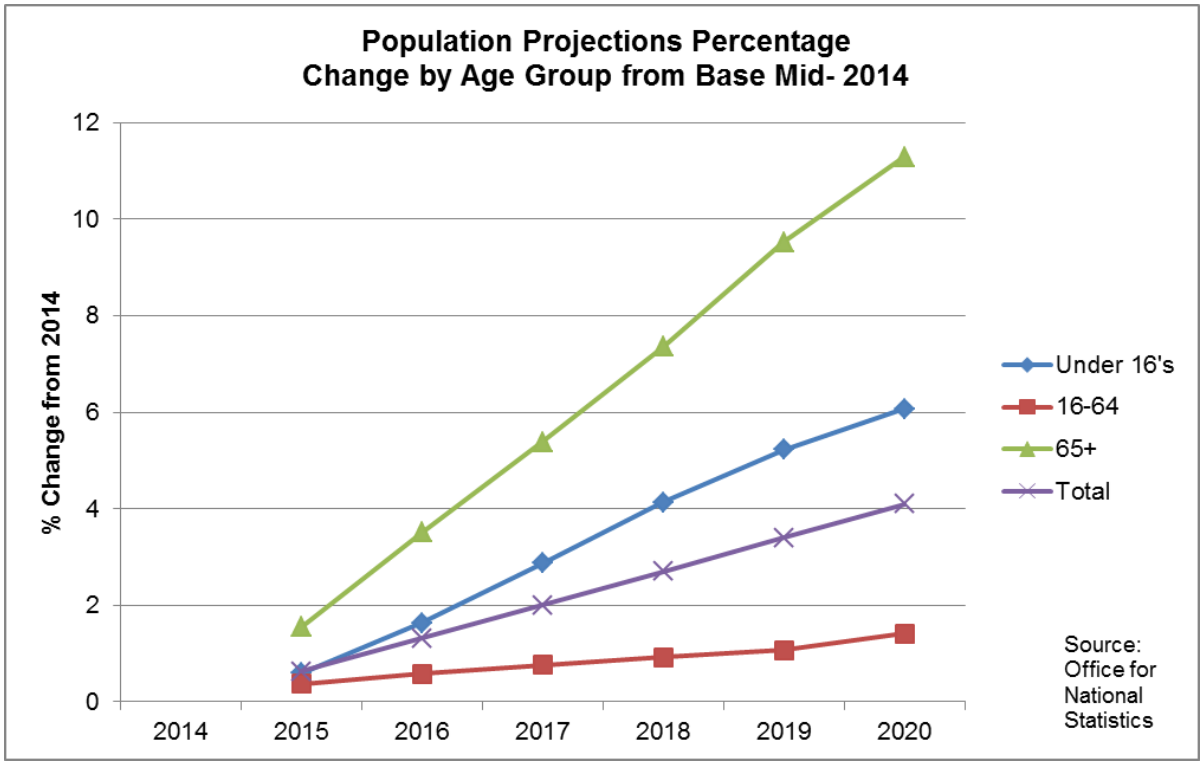


Figure 24 illustrates how the Barnsley population is predicted to grow by age group. The largest and most rapid change is relating to those aged 65 years and over.

Housing Projections

The total number of households in Barnsley is predicted to rise from 106,000 in 2016 to 109,000 in 2020. This will see a small change in the ratio of people to houses, from 2.27 to 2.25, these are slightly lower than for South Yorkshire (2.33 and 2.30), and for England (2.35 and 2.32) (ONS 2016).

New Builds

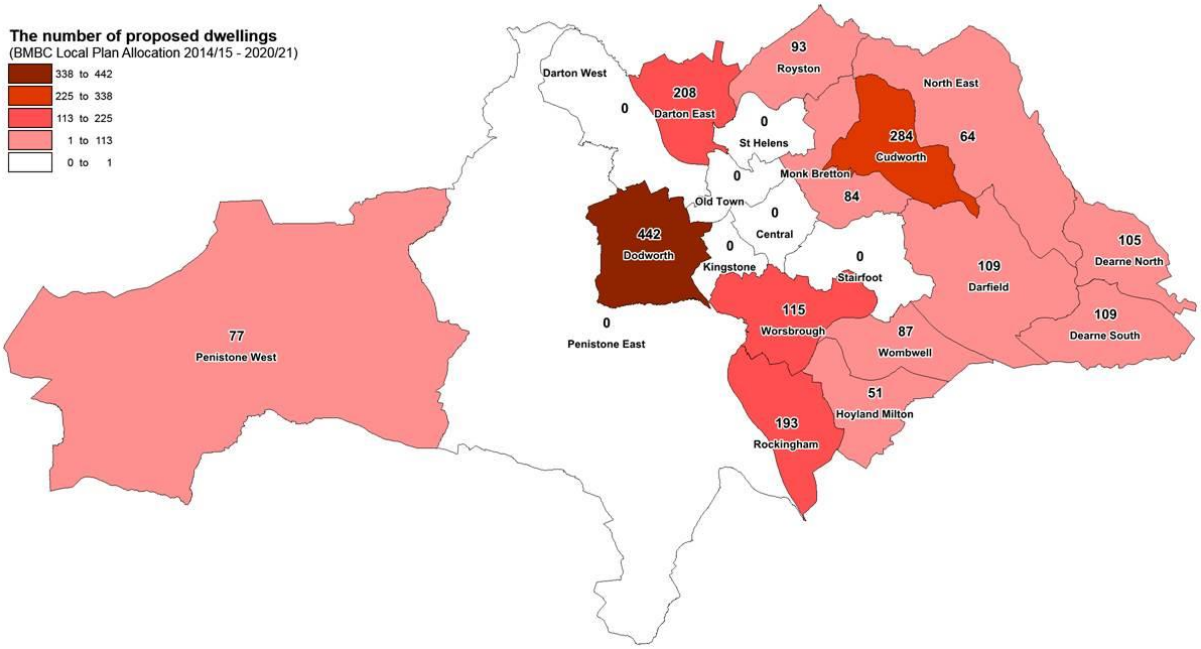
According to the Local Plan allocations, there are 14,790 dwellings proposed for the period of 2014/15 to 2032/33. In addition to this, there are also a number of sites with planning permission which amounts to a further 6,100 potential dwellings.

Based on the ONS Labour Force Survey 2014 the average household size in the UK is 2.4 people. Using this figure to estimate the population that will be housed by these new dwellings, then in the period to 2032/33, there will be an estimated 50,136 people living in new house builds.

For the purposes of this needs assessment, projections have been made for the number of homes and additional population up to the year 2020/21. From the Local Plan it is estimated that 2,021 of the 14,790 dwellings will have been constructed by 2020/21, amounting to an additional 4,850 people.

Figure 25 overleaf shows the number of new dwellings on the Local Plan by 2020/21. The ward with the highest number of additional homes is Dodworth, with a projected 422 new homes followed by Cudworth with 284. Six additional Wards (Darfield, Darton East, Dearne North, Dearne South, Rockingham and Worsbrough) all have an estimate of 100 or more additional homes by 2020/21. Seven Wards (Central, Darton West, Kingstone, Old Town, Penistone East, Stairfoot and St Helens) have no houses on the Local Plan allocation that are projected to be built by 2020/21.

Figure 25 – The number of proposed dwellings in the Local Plan allocation projected to have been built by 2020/21



Source: BMBC Planning 2016/ © Crown copyright and database rights (2016) Ordnance Survey licence number 100022264

In addition to the Local Plan allocation, there are also further sites that have planning consent that will contribute to the number of new dwellings. It is estimated that the majority of these will be built by 2020/21 adding an extra 5,186 new homes (12,446 additional people).

Although these projections are estimates, it is important to have an understanding of the potential effect that these new homes will have on local areas within Barnsley. The additional housing and subsequent change in population will bring with it increased demand on services and it is essential that this is factored in to any forecasts made and service provision planning.

What is the trend and what can we predict will happen over time?

Population and household numbers are projected to grow, so without significant increases in new housing; demand will continue to outstrip supply.

Lack of housing options will impact on residents' ability to have the housing they need and impact on their wellbeing, including poorer conditions, higher housing costs, more people in fuel poverty and higher levels of overcrowding.

The numbers of older people are expected to rise significantly and the current housing offer will be unable to cope with the demand for suitable or specialist housing to meet the needs of an additional 1,400 people aged over 64 by 2020 (POPPI data).

Increases in the private rented sector present challenges in ensuring people can access affordable housing that is free from health and safety hazards and which is managed responsibly.

Welfare reform and the growth in single occupancy households will continue to drive the need for smaller properties.

The 2016 Housing and Planning Act means that council can no longer offer lifetime tenancies, the maximum is now 5 years. It is anticipated that this will create more movement of people within communities, which may further unsettle social housing estates. More frequent turnover of tenants may lead to a greater number of empty properties and higher need for repairs (House of Commons, 2016)

There are two main factors affecting the availability of affordable homes for people on low incomes; the Right to Buy scheme reduces the amount of council homes, and there is a trend to price housing on new developments so that low income families can only afford the small starter homes (JRF, 2015)

Health and Care Projections

Information from Projecting Adult Needs and Service Information System (PANSI) suggests that the number of Barnsley residents aged 18 to 64 years will experience increases from the following health issues over the next few years:

- Learning disabilities.
- Moderate and serious physical disabilities, particularly those aged 55 to 64.
- Common mental health disorders
- Two or more psychiatric disorders.
- Either Type 1 or Type 2 diabetes, particularly those aged 55 to 64.
- Moderate personal care disabilities, particularly those aged 55 to 64 years.
- .

The population for those aged 65 years and over is increasing both nationally and locally; as a result, the number of people experiencing particular illnesses or conditions will also increase. Information from Projecting Older People Information System (POPPI)suggests the following issues will increase and will affect more of our Barnsley residents aged 65 and over within the next few years:

- Dementia.
- Depression.
- Either Type 1 or Type 2 diabetes.
- Living in a care home with or without nursing.
- Falls, particularly those aged 75 and over (this also includes hospital admissions).
- Stroke, particularly those aged 75 years and over and particularly males.
- Unable to manage at least one self-care activity on their own (activities include: bathe, shower, or wash all over, dress and undress, wash their face and hands, cut their toenails and take medicines).
- Unable to manage at least one domestic task on their own. Tasks include: household shopping, wash and dry dishes, clean windows inside, jobs involving climbing, use a vacuum cleaner to clean floors, wash clothing by hand, open screw tops, deal with personal affairs, do practical activities.

- Unable to manage one mobility activity on their own (activities include: going out of doors and walking down the road, getting up and down stairs, getting around the house on the level, getting to the toilet and getting in and out of bed).
- Limited long term illness.
- Living alone.
- Obesity issues.

Which Barnsley residents are potentially at risk of developing health problems?

Mosaic is a Customer Insight tool that describes the social, economic and cultural behaviour of all households. Segmentation is the classification of the population in different groups. It is useful for providing commissioners with an understanding of local populations and neighbourhood contexts.

The proportion of Barnsley households classed as “Transient Renters” and “Modest Traditions” is over double that seen nationally. However, there are significantly lower proportions of households in Barnsley classed as “Urban Cohesion” and “Rental Hubs”.

Customer insight data helps to identify which Barnsley residents are more at risk of behaving in ways which are harmful to their health, and where they live. It also helps us to understand how best to engage with them.

Knowing our population better will allow better targeting and more effective use of our resources to tackle the preventable illnesses and conditions, particularly for residents who:

- Struggle to take care of their health and weight.
- Want to talk about health issues in a way they feel comfortable doing so.
- Do not eat healthily or want to lose weight.
- Have high levels of inactivity.
- Have high levels of alcohol consumption or who smoke.
- Have certain illnesses and health conditions or disabilities.

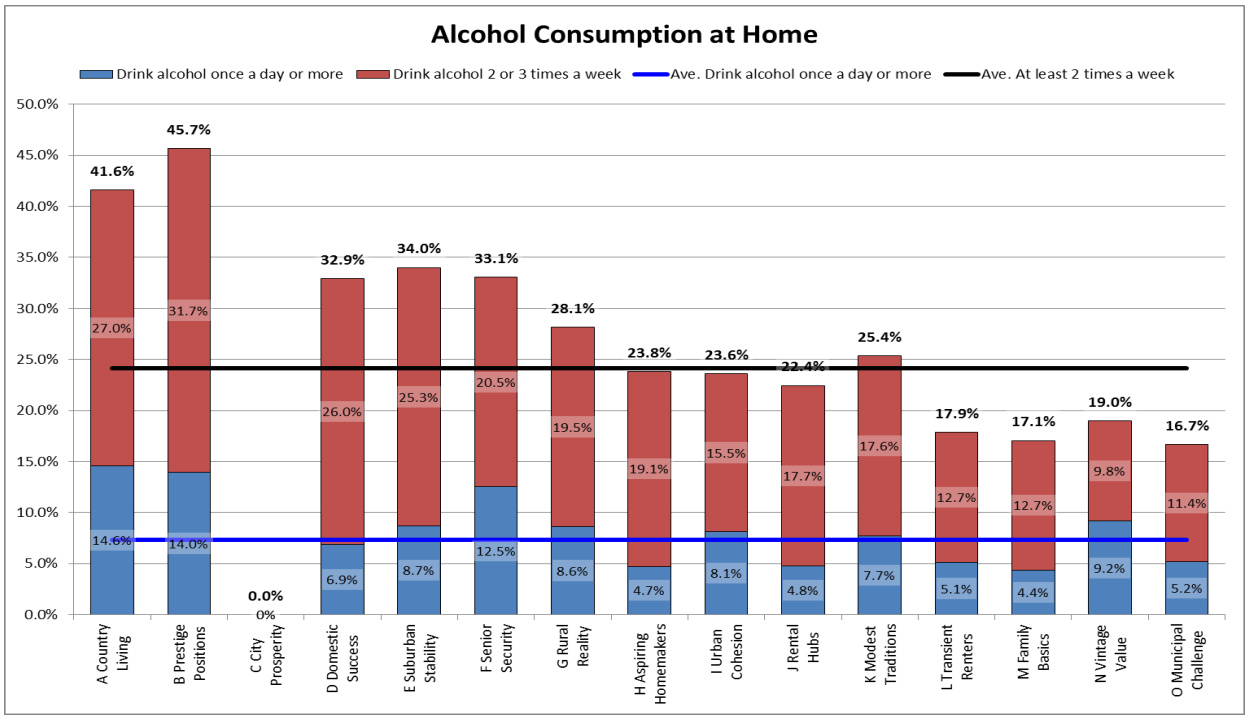
Customer insight data helps to widen the knowledge we already have about the health and wellbeing of Barnsley residents.

There are a number of ways in which Mosaic can be used:

- We can analyse existing customer data to identify characteristics and use this information to create a targeted campaign for similar people within the borough.
- We can analyse the borough geographically and locate residents based on particular characteristics and needs, such as those who are most inactive.

An example of how Mosaic data could be used is a pilot on reducing alcohol consumption at home. Using the underlying Mosaic Grand Index it is possible to identify which Groups most frequently consume alcohol at home. Figure 26 overleaf illustrates that over 40% of households in Groups A and B consume alcohol at home at least twice a week.

Figure 26 – Alcohol Consumption at home, by Customer Insight group



Using Mosaic data at household level we can map where households in Groups A and B are and identify any clusters. By using the Mosaic Grand Index, the preferred channels of communications and the most popular supermarket can be identified for each group to aid targeted communications and in store initiatives.

What have services already done to help to improve health and/or wellbeing, and what are they developing for the future?

The information below provides a few examples of recent projects and schemes which services have tried or delivered to improve health and/or wellbeing during the last few years:

Healthwatch Barnsley

- Address access issues with Children Adolescent Mental Health Services (CAMHS)
- Better access for the Deaf Community
- Consult on issues around Parkinson's Disease
- Awareness raising work with carers
- Increased attendance to dentistry for children and young people
- Better access to health care services for asylum seekers and refugees

Be Well Barnsley

- Over 11,000 people supported to reach their healthy lifestyle goals
- Over 1,000 referrals from GPs each year
- Aiming to see a monthly increase in referrals

Public Health – Wider Determinants of Health

- Developing Housing Local Plan to ensure health and wellbeing are included
- Commissioned Fuel Poverty Service, improve advice on staying warm
- Reduce the Strength (cease sales of high strength, low cost alcohol)
- Purple Flag – improve Barnsley Town Centre in the evening and night-time
- Sustainable Travel – bike projects
- Increased activity levels:
    - Cycling (Sky Ride, Bike Race),
    - Walking (Walk Well)
    - Table Tennis (Ping!)
    - Netball
    - Running (Walk 2 Run)
    - Men 35+ (Fit Reds)
- Support people with health conditions into employment
- Training:
    - Workplace Health Champions – to improve health and wellbeing of staff, impacting positively on sickness absence and productivity in the workplace
    - Mental Health First Aid resources for businesses
    - Healthy Hearts
- Develop better routes to employment for vulnerable people
- Develop workplace health programmes
- Excess Winter Deaths and Fuel Poverty Action Plans
- Licensing and Enforcement Partnership and an Alcohol Prevention Alliance
- Active Travel plans

- Support in acquiring funding for current and new physical activity initiatives

Police

- Substantial amount of work around early identification of vulnerable people, especially those with mental health and substance misuse issues, to ensure that they get the help and assistance they need
- High Intensity User, Intensive Home Based Treatment, Dementia and Single Point of Access projects
- Training for Officers around Autism, risk assessments of vulnerable people
- Continue to work with Health on Alcohol screening, Places of Safety, Joint Home Visits, people Absconded from Health
- Better data collection, especially around mental health incidents.

Communities

- Isolation pilot projects – Area Councils
- Implementation of Care Act, Making Safeguarding more personal
- Focus on maximizing independence – support to manage own health, short term targeted interventions, falls strategy, stimulate development of innovative services, improved reablement and access to information and advice
- Re-design and re-procurement of community accommodation (primarily those with a learning disability)
- Domiciliary Care retendered in the hope of better outcomes, quality and value for money
- Pilots: Eye Clinic Liaison
- Crisis Care Concordat aimed at improving crisis care arrangements for the people of Barnsley
- Implement a sustainable Adult Autism and ADHD service that has a better match of capacity and demand
- Proactively manage the performance of providers leading to more consistent and better quality care and support
- Work continues with partners on the Anti-Poverty Delivery Group on delivering the Anti-Poverty Action Plan
- Secured additional funding to employ a full complement of 4 Independent Domestic Violence Advisors (IDVA) and established a single pathway into domestic violence services
- Enhancing substance misuse services to better target the multiple needs and multiple layers of disadvantage, such as poverty and social exclusion (i.e. substance misuse plus one or more of the following: offending history/Criminal Justice System involvement; domestic violence (victim/perpetrator); vulnerably housed/no fixed abode; mental health; disability/learning disability; poor educational attainment/employability prospects; safeguarding concerns/parenting capacity)
- High rates of successful completions from substance misuse treatments
- Recommission the Substance Misuse Service

- Further develop:
    - Adult Social Care Strategy
    - Mobile working
    - Carers services
    - Early Help information and advice
    - Extra Care housing
    - Intermediate Care
    - Assistive Technology and Telecare
    - Outcome-focussed performance monitoring
    - Transformation of learning disability services
    - How to measure the impact of anti-poverty activities
    - A client focused Domestic Abuse and Sexual Violence Service
    - Personalised, integrated Substance Misuse Service supporting sustainable change

Housing

- Improved the thermal performance of housing stock (by installing insulation), reduced fuel poverty (653 properties fitted with solar panels, 560 air sourced heat pumps, energy switching scheme),
- Invested £1.2m in a remodelled Independent Living Service for older people to promote healthy eating, exercise, maintaining independence and social integration
- Training: Dementia, mental health, hoarding, vulnerability, Child Sexual Exploitation (CSE)
- Participation in: safeguarding boards, Troubled Families, Anti-Poverty Group, Multi Agency Risk Assessment Conference (MARAC), the Community Safety Partnership, Early Help Adults and Children Delivery Groups
- Digital Inclusion: increased internet access (26 schemes/centres added), deliver digital skills training to residents, outreach activities with carers and people with Dementia, learning disabilities, mental health problems and, sensory impairment
- Support Navigator (Housing Options team) – helps with health and wellbeing (GPs, Dentists, mental health services, substance misuse services and hospital appointments etc.)
- Further develop:
    - Thermal performance of stock, reduce fuel poverty (air source heat pumps)
    - Build/acquire more homes
    - Engage with harder to reach customers to better understand their digital needs and how we can help assist online access
    - Work with asylum seekers, refugee and Gypsy & Traveller families

Fire Service

- Numerous schemes around fire safety, home safety checks and education:
    - Home Safety Checks
    - Barnsley Babies – with midwives and maternity units
    - Age UK – work with vulnerable old people and the organisations which support them

    - Dementia Care – work with people with dementia and the organisations which support them
    - Fire Safety for Professionals – training staff in over 70 partner organisations
    - Crucial Crew – for Year 6 pupils, covers issues such as arson, hoax calls, road safety, fire safety, travel safety, internet safety, anti-social behaviour and lifesaving CPR training.
    - Befriender Schemes
- Further develop:
    - Links with Groundworks (improving private rented housing in deprived communities)
    - Safe & Well Programme
    - Yorkshire Ambulance Partnership
    - Use of technology in fire prevention

NHS Barnsley Clinical Commissioning Group (BCCG)

BCCG has responsibility for commissioning healthcare for the population of Barnsley. Commissioning is a process of planning and buying services to ensure that the people who live in the borough have the right healthcare. Some examples of work that we have undertaken to help improve the health and care for people living in Barnsley in the last couple of years includes:

- RightCare Barnsley service – helping to arrange support for people when they become unwell, preventing the need to be admitted to hospital.
- Review of community nursing services, moving to a locality based model.
- Development of primary care services including:
    - The iHEART Barnsley service which is providing extensive and speedy access to nurse and GP advice during the day and appointments in the evening and on Saturdays.
    - Recruitment of clinical pharmacists and health care assistant apprentices to work within general practice.
    - A Practice Delivery Agreement and local quality framework was introduced in 2014 to increase the investment in staff at practice level on a recurrent basis in order to target key activities that will really make a difference to people's health and wellbeing.
    - This year the CCG has developed this further to increase interventions in practice to reduce heart disease, diagnose dementia earlier, increase alcohol interventions and coordinate care around patients with long term conditions.
    - 'Year of Care' model, which aims to provide personalised care planning for people with long term conditions, by working in partnership with patients and care professionals.
    - Commitment to develop dementia friendly surgeries and dementia advisors running clinics in local GP surgeries.
- Developed a very comprehensive mental health and wellbeing strategy.
- Commissioned a borough wide social prescribing service to help put patients in touch with voluntary and community sources of support.

Digital

The Device Doctor project has contributed to improved health and wellbeing this year by doing the following:

- Carrying out 1 to 1's with a wide range of groups (e.g. Wednesdays Voice, the carers group, residential mental health group) using various technologies (including online).
- Working with Cloverleaf and Wednesday voice to create a guide to using Facebook targeted at people living with Learning disabilities.
- Working with the RNIB Online Today project to deliver workshops on sensory impairment and publicly available technology.
- Delivered a training day to front line staff with South West Yorkshire Partnership Foundation Trust (SWYPFT) and Online today to raise awareness of sensory impairment and the benefits digital technology can bring to aiding independence. This has led to the development of YouTube films to be used in the training and in home visits (under development). Free Wi-Fi in our communal living schemes and community centres.

Work is underway to explore ways that technology and the internet can enhance front line service delivery and the lives of Barnsley residents.

What are we intending to do in the future?

Following the review of the previous JSNA, we are developing a new State of the Borough Portal. This will become the focal point for intelligence gathering for the council and its partners, so all the information is accessible and in one place for everyone to share and use. All profiles that make up the evidence base for this JSNA can be accessed via this site.

Information quickly becomes out of date. We will therefore be constantly updating the profiles and data within the portal, ensuring that commissioners and service planners have the latest available information at their fingertips. All data and information will be of good quality.

As the portal grows, we will look to improve the information available about forecasts and projections to inform future business and service planning.

The portal will also contain information for the Joint Strategic Intelligence Assessment (JSIA) and the Child Poverty Needs Assessment, as it brings data together and reduces the duplication of effort in the production of the evidence bases.

As part of the portal development plan, data will be available to be mapped or downloaded if required and partners will also have the facility to upload information themselves.

We have received positive feedback relating to the format of the Health Inequality Profiles, stating that the information is clear and understandable. We have therefore continued to apply this approach to make other information and data accessible.

Key priorities for the JSNA over the coming year are:

- Embedding the issues identified within the JSNA to inform the priorities of the Health and Wellbeing Strategy 2016 – 2020, the development of joint commissioning plans and ongoing evaluation of outcomes.
- Consulting with the Health and Wellbeing Board and key partners on gaps in the JSNA.
- Explore options to reduce the gaps in our data and information so we have better information for future service planning.
- Use the Communication Plan to improve the awareness of the State of the Borough Portal and the JSNA findings.
- Use the key findings from the JSNA to inform future strategies and plans developed by the Council and our partners.

Appendices

NAME/TITLE OF PROFILE
Barnsley General Facts and Figures
Country of Birth and English as a main language
Income Deprivation Domain Briefing
Employment Deprivation Domain Briefing
Education, Skills & Training Domain Briefing Paper
Health Deprivation & Disability Domain Briefing Paper
Crime Domain Briefing Paper
Barriers to Housing & Services Domain Briefing Paper
Living Environment Deprivation Domain Briefing
Barnsley Index of Multiple Deprivation 2015 Briefing Paper
Barnsley Index of Multiple Deprivation 2015 infographic
Cancer in Barnsley (2016)
Dementia (2015)
Falls (2016)
Musculoskeletal Diseases Briefing (2016)
TB Briefing (2016)
Barnsley Health Inequalities Profile
Women In Barnsley Profile
Barnsley Life Expectancy Briefing at Area Council & Ward Levels
Healthy Life Expectancy Briefing 2016
ONS Life Expectancy Briefing 2015
Alcohol Data Guide (2016)
Healthy Weight (2016)
Smoking Data Guide (2016)
Cancer Mortality Rates 2010-2014 Briefing
Cardiovascular Disease (CVD) Mortality Rates 2010-2014 Briefing
Respiratory Disease Mortality Rates 2010-2014 Briefing
National Health Profile for Barnsley Borough (PHE)
National Child Health Profile for Barnsley 2016 (PHE)
National Child Measurement Results for the Barnsley Borough 15/16
Oral Health of Children in Barnsley (2015)
WAY Survey Briefing
ONS Wellbeing Survey (2016)
Barnsley Borough Population
Barnsley Ethnicity Infographic
Poverty Needs Assessment 2014 Key Findings
Central Area Council Profile
Central Ward Profile
Dodworth Ward Profile
Kingstone Ward Profile
Stairfoot Ward Profile

NAME/TITLE OF PROFILE
Worsborough Ward Profile
Central Area Council Index of Multiple Deprivation 2015 Infographic
Dearne Area Council Profile
Dearne North Ward Profile
Dearne South Ward Profile
Dearne Area Council Index of Multiple Deprivation 2015 Infographic
North Area Council Profile
Darton East Ward Profile
Darton West Ward Profile
Old Town Ward Profile
St Helens Ward Profile
North Area Council Index of Multiple Deprivation 2015 Infographic
North East Area Council Profile
Cudworth Ward Profile
Monk Bretton Ward Profile
North East Ward Profile
Royston Ward Profile
North East Area Council Index of Multiple Deprivation 2015 Infographic
Penistone Area Council Profile
Penistone East Ward Profile
Penistone West Ward Profile
Penistone Area Council Index of Multiple Deprivation 2015 Infographic
South Area Council Profile
Darfield Ward Profile
Hoyland Milton Ward Profile
Rockingham Ward Profile
Wombwell Ward Profile
South Area Council Index of Multiple Deprivation 2015 Infographic
JSNA - Housing Profile (not yet finalised)
JSNA - Poverty Profile (not yet finalised)
Profiles of Pupils Attending Schools in Dearne Area Council 2016
Profiles of Pupils Living in Dearne Area Council 2016
Profiles of Pupils Attending Schools in Central Area Council 2016
Profiles of Pupils Living in Central Area Council 2016
Profiles of Pupils Attending Schools in North Barnsley Area Council 2016
Profiles of Pupils Living in North Barnsley Area Council 2016
Profiles of Pupils Attending Schools in North East Barnsley Area Council 2016
Profiles of Pupils Living in North East Barnsley Area Council 2016
Profiles of Pupils Attending Schools in Penistone Area Council 2016
Profiles of Pupils Living in Penistone Area Council 2016
Profiles of Pupils Attending Schools in South Barnsley Area Council 2016
Profiles of Pupils Living in South Barnsley Area Council 2016

NAME/TITLE OF PROFILE
Key Stage Analysis by Pupil Group v Nat and YH (2013-15 protected)
2015 Area Council Education Overview (protected)
Mental Health in Barnsley (not yet finalised)
Potential Years of Life Lost in Barnsley (not yet finalised)

Glossary

TERM	DEFINITION
APB	Anti-poverty Board.
Asset Mapping	A list of assets (land and buildings) owned or managed by community organisations. These assets can cover a wide spectrum and include community centres, sports facilities, affordable housing and libraries. (Not all land and buildings are community assets). Community assets in the context of this document can also include community organisations/groups and volunteers who may be able to provide a service within their local community.
Clinical Senate	Clinical Senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent.
CSJ	Centre for Social Justice.
DCLG	Department for Communities and Local Government
DEFRA	Department for Environment Food and Rural Affairs
Determinants (of health)	The range of personal, social, economic, and environmental factors that influence health status are known as determinants of health. Determinants of health fall under several broad categories (e.g. education, housing).
DFE	Department for Education
DWP	Department for Work and Pensions
Economically Inactive	*"People not in employment who have not been seeking work within the last four weeks and/or are unable to start work within the next two weeks"*. (Source: ONS). This includes students, disabled people, the long-term sick, unpaid carers and those who retire early.
EPC/SAP rating	An Energy Performance Certificate (EPC) shows the energy current and potential energy rating of a property, known as a 'SAP rating'. A **'SAP'** rating stands for **S**tandard **A**ssessment **P**rocedure and is the governments recommended system for producing a home energy rating.
FCT	Family and Childcare Trust.
Fuel Poverty	In the UK, fuel poverty is defined by the Warm Homes and Energy Conservation Act as: "a person is to be regarded as living "in fuel poverty" if he/she is a member of a household living on a lower income in a home which cannot be kept warm at reasonable cost". The UK Government definition of 'Low Income High Costs' is "*a household is considered to be fuel poor if:* • *they have required fuel costs that are above average (the national median level)* • *were they to spend that amount, they would be left with a*

	residual income below the official poverty line."
Health Inequalities	Health inequalities are preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged.
HMRC	Her Majesty's Revenue and Customs
HPA	Health Protection Agency
JRF	Joseph Rowntree Foundation.
LSOA	Lower Super Output Area (LSOA) is a small area geography with an average of 1,500 residents and 630 Households.
Multimorbidity	Multimorbidity is commonly defined as the presence of two or more chronic medical conditions in an individual
NASCIS	National Adult Social Care Intelligence Service
ONS	Office for National Statistics.
PANSI	Projecting Adult Needs and Service Information
PCMD	Primary Care Mortality Database
PHO	Public Health Observatory
PNA	Poverty Needs Assessment
POPPI	Projecting Older People Population Information
Prevalent/prevalence	Existing very commonly or happening often.
Qualitative data	Data that shows people's opinions and feelings rather than information that can easily be shown in numbers (e.g. information from surveys).
Quantitative data	Data that is shown as numbers (e.g. population, number of births).
Repository	A central location in which data is stored and managed.
RNIB	Royal National Institute of Blind people
SAP/EPC rating	An Energy Performance Certificate (EPC) shows the current and potential energy rating of a property, known as a 'SAP rating'. A **'**SAP' rating stands for Standard Assessment Procedure and is the governments recommended system for producing a home energy rating.
WHO	World Health Organisation
Worklessness	*"Worklessness is difficult to define, but is often researched in terms of the unemployed and economically inactive***.** The unemployed population 'are people who are without a job, want a job, have actively sought work in the last four weeks and are available to start work in the next two weeks or are out of work, have found a job and are waiting to start it in the next two weeks'. The economically inactive***** population are 'those without a job who have not actively sought work in the last four weeks, and/or are not available to start work in the next two weeks'."* (Publication Hub 2009a; 2009b). (Source: ONS) *(****** See Economically Inactive).

References

Document	Link
Active People Survey (Sport England 2015)	https://www.sportengland.org/research/about-our-research/what-is-the-active-people-survey/
Age UK Risk of Loneliness index 2016	http://data.ageuk.org.uk/loneliness-maps/england-2016/barnsley/
Annual Population Survey 2016	
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healthwatch

Healthwatch Barnsley Annual Report 2015/16

Presented to the Health and Wellbeing Board

Working together as a network

Healthwatch Barnsley

We have 2323 Healthwatch Members

This year we have reached 237 likes on Facebook and 1,408 followers on Twitter

Our volunteers help us with everything from public engagement, conducting Enter and View visits to writing reports and providing direction. Our reports have tackled issues ranging from access to Child and Adolescent Mental Health Services (CAMHS) and experiences of Crisis Care Mental Health Services.

We have met and engaged with over 3,000 Barnsley people through our outreach and engagement events.

27 Active Volunteers

We've visited 18 local services

SO WHAT???

GP help for hard of hearing

PERSONAL hearing amplifiers are being introduced in to GP surgeries across Barnsley to help those who are hard of hearing.

The small, simple bit of kit have been put in place by Barnsley Clinical Commissioning Group – which commissions the town's health services – after working with Healthwatch Barnsley and local people who are deaf to identify some of the challenges they face when going for a GP appointment.

In addition, the Barnsley sensory impairment services team, run by South West Yorkshire Partnership NHS Foundation Trust, has provided training to GP practice staff across the borough on how to safely support people with sight and hearing impairments.

Dr Nick Balac, of the CCG, said: "GP surgeries are busy environments and can be quite noisy, with telephones and conversations from multiple directions."

★★★★★

Rated by Anonymous
15th April 2016

BSL interpreting

I go between Sheffield and Barnsley Hospital, Sheffield Hospital ENT
do not use a good interpreter. Sheffield sent me back to Barnsley Hospital, I talked to them and got a clear explanation, now I would prefer all of my appointments to be at Barnsley because of the quality of interpreting. The only thing I would ask for them to consider is letting the interpreter stay if I need to pick up my prescription, so I understand their explanation when they hand it over. They also shout you to collect at the pharmacy which means I'm just sat there waiting as I can't hear. But apart from that. Good
less ▲

Leave a provider response ?

Hospital Guidelines

Probably the most important improvement has been the success of our commissioning of Healthwatch (an organisation which advocates for NHS users) to review the treatment of people with Parkinson's on being admitted to hospital either in an emergency or for a planned admission.

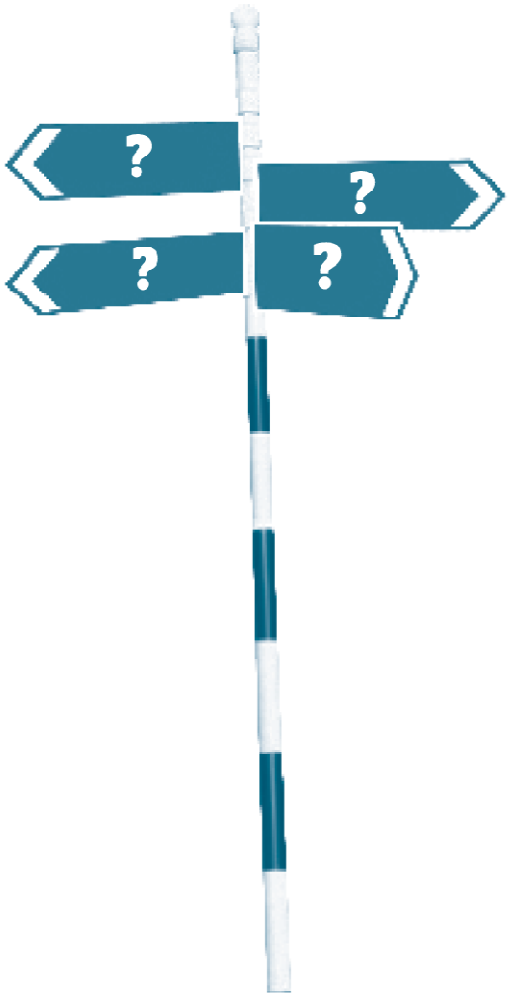
The result of Healthwatch's investigation, which included interviews with our own members, has resulted in the publication of a practice note for the treatment of people with Parkinson's in hospital by Barnsley District Hospital NHS Trust.

Healthwatch Barnsley
Published by Carrianne Stones [?] · April 15 ·

Healthwatch in partnership with Leeds Involving People have just been to the Deaf Social club to report on actions so far after the Deaf Access to Assessment and Care Management Services event on the 5th of March 2016. We have received a thumbs up on work done to date, and have booked to attend again to report back in September 2016 once we have spoken to service providers.

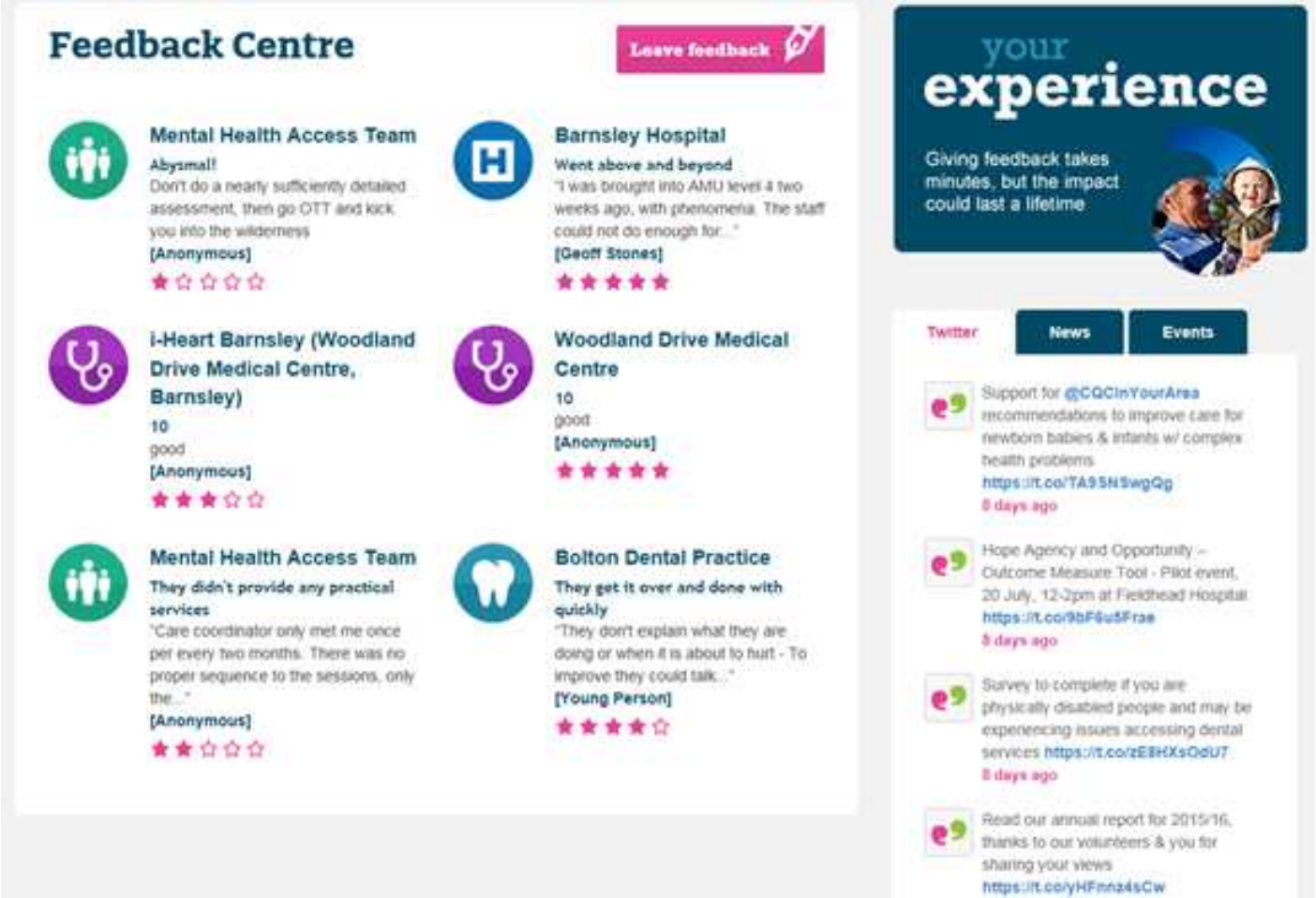
As an added bonus we also received some excellent feedback at this meeting from members of the Deaf Club on their experience of interpreters at Barnsley Hospital and one-to-one counselling services with a Deaf counsellor, a service which was commissioned earlier this year, after Healthwatch raised issues around access.

Signposting and information



Many of us don't know where to go if we have a problem or concern to raise

Collecting and Sharing Your Views



Next Steps

Activity

Continue to promote Healthwatch Barnsley to members of the general public and raise our profile locally.

Expand our programme of outreach and promotion with front line staff within health and social care services.

Continue to train and develop our Healthwatch Champions, and ensure they have plenty of opportunities to meet with and talk to members of the public.

Embed the feedback centre monitoring reports into our work improving our communications with the general public.

Continue to look at opportunities in line with our remit and bid for local/regional contracts.

Recruit to the Healthwatch Strategic Advisory Board and Champions.

Next Steps

Priorities

Healthwatch has chosen its priorities for 2016/17 based on the information we received as part of the reflective audit and the comments collected over the last 12 months. Next year we will focus on:

Complete our work looking at access to general practice.
Complete our work on C.A.M.H.S by undertaking an Enter and View in 2017
Continue to work with the Deaf Forum looking at access to Assessment and Care Management Services.
Continue to work with the Mental Health Crisis Care Concordat

We will also continue to remain responsive to the trends data that we receive.

Any Questions?

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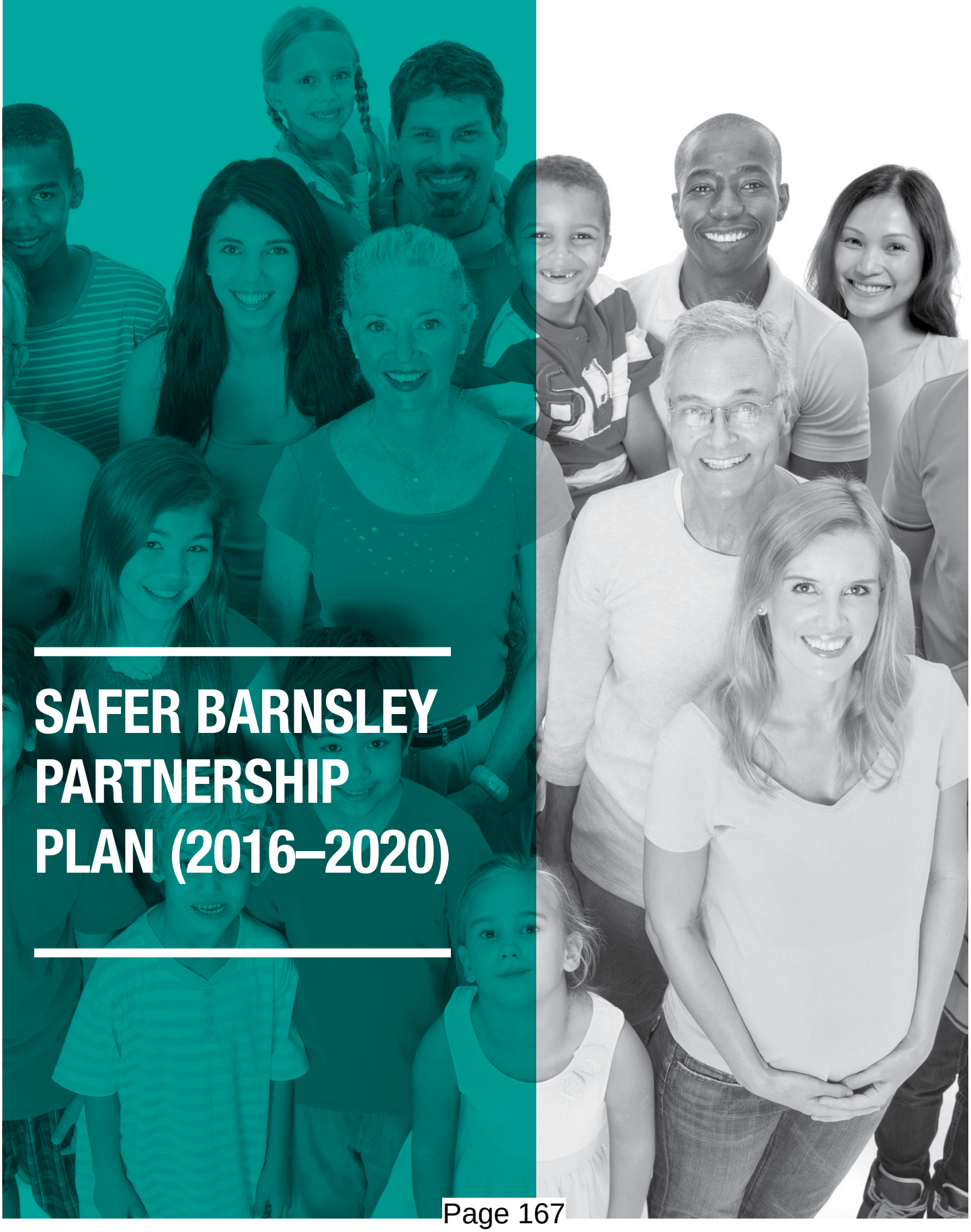
SAFER BARNSLEY PARTNERSHIP



SAFER BARNSLEY PARTNERSHIP PLAN (2016–2020)

CONTENTS

FOREWORD

Community safety is a key priority for Barnsley. We have made a significant amount of progress in a number of key areas around crime and community safety over recent years, working closely for and in partnership with our local residents and communities.

The Safer Barnsley Partnership Plan (2016–2020) identifies a series of priorities where we feel collectively, that we can make the most difference to achieve the best outcomes for individuals, families and communities. It is important that in such times where resources are reducing we are able to share and pool all our resources to address the key community safety priorities facing the borough.

Working collaboratively with our communities to build on our previous successes, will be an essential ingredient to help us to continue to evolve and make further improvements to ensure people are safe and feel safe in their homes, neighbourhoods and communities.

The Partnership Plan will remain a live document and will be used as a means to track and where required challenge our performance and delivery.

We will review the plan on an annual basis to ensure it is consistent with local needs and circumstances and able to influence how community safety resources are used within the Borough.

We look forward to working with you to continue to make Barnsley a safe place to live, work and socialise for all members of our communities.

Wendy Lowder, Barnsley Council,
Acting Executive Director, Communities
Co-Chair of Safer Barnsley Partnership

Tim Innes, South Yorkshire Police
District Commander, Co-Chair
of Safer Barnsley Partnership

BACKGROUND AND CONTEXT

The Safer Barnsley Partnership is the statutory partnership responsible for tackling crime and disorder, combating substance misuse and reducing reoffending.

The Crime and Disorder Act 1998 and subsequent legislation places statutory duties on community safety partnerships to:

- Produce an annual Joint Strategic Intelligence Assessment;
- Prepare and implement a community safety plan;
- Establish information sharing agreements;
- Establish domestic homicide reviews.

Our partnership is known as the Safer Barnsley Partnership and comprises of representatives from the following agencies:

- Barnsley Council;
- South Yorkshire Police;
- South Yorkshire Fire and Rescue;
- National Probation Trust;
- Community Rehabilitation Company;
- Barnsley Clinical Commissioning Group;
- Neighbourhood Watch;
- Berneslai Homes;
- South Yorkshire Criminal Justice Board; and
- Office of the Police and Crime Commissioner.

The Safer Barnsley Partnership reports to the Health and Wellbeing Board, representing the links between crime, community safety and overall health and wellbeing.

We work closely with other strategic groups such as the Children's Trust, the Youth Offending Board and both Adult and Children Safeguarding Boards. This ensures that where joint priorities are identified, work is undertaken collaboratively to ensure the best possible outcomes for and with local people and communities.

This plan aligns with the priorities outlined in the South Yorkshire Police and Crime Plan (2013–2017) which ensures a collective approach to achieving the best possible outcomes for and in partnership with our communities.

1 THE PARTNERSHIP AND OUR COMMITMENT

Partnership approaches to tackling crime and disorder are largely built on the principle that no single agency can deal with, or be responsible for dealing with, complex community safety and crime problems.

We have developed the following principles to guide us all, as partners, to achieve our collective vision.

A new relationship with residents

We will provide better connected services, putting residents at the heart of what we do. In return, we expect that residents will do what they can, for themselves, their families and their communities, helping us all to be safer.

One public sector – one borough

Residents want efficient and effective services no matter who provides them. We will work with partners to create joined up approaches that make sense to us all.

A relentless drive for efficiencies and outcomes

We will make sure every pound is spent effectively, delivering the outcome we all want to see – a safer Barnsley.

Our vision for community safety in Barnsley is…

"Barnsley people and communities are safe and feel safe, able to contribute to community life and take responsibility for their actions and how they affect others."

2 PROGRESS SINCE THE LAST PLAN

PRIORITY 1 – PROTECTING VULNERABLE PEOPLE

OUTCOME – VULNERABLE PEOPLE ARE PROTECTED AND HAVE ACCESS TO QUALITY, SPECIALIST SUPPORT SERVICES WHICH MEET THEIR INDIVIDUAL NEEDS, IMPROVE THEIR SAFETY, REDUCE RISK OF REPEAT VICTIMISATION AND ENABLE THEM TO IMPROVE THEIR HEALTH AND WELLBEING.

CASE STUDY 1

During a routine visit to her GP, L was identified as a victim of domestic abuse from her husband and a referral was made to the right agencies for support. L was immediately appointed an Independent Domestic Violence Advisor (IDVA) and due to her husband's coercive and controlling behaviour, she was quickly identified as high risk of further abuse.

L decided she wanted to escape from the abuse and flee her marriage. Therefore, she was supported throughout the process allowing her to leave the family home and relocate elsewhere with her children, without the knowledge of her husband. She continued to receive support and counselling at her new location. Here is what L said 11 weeks after the initial referral; "I would never have left my abusive marriage without the support from my GP and Pathways, I didn't think there were any options available to me."

A PICTURE OF OUR ACHIEVEMENTS…

Domestic abuse

- The number of Independent Domestic Violence Advisors (IDVA) has doubled to make sure we provide effective support for high-risk victims.
- 366 frontline professionals have received training in how to identify and support victims of domestic violence.

Hate and harassment

- We now have a new hate and harassment strategic plan, which has helped to improve community and stakeholder involvement.
- 550 people across the public, private, voluntary and community sector have received hate and harassment awareness training. This has led to an increase in reports of incidents of hate and harassment in the central areas of Barnsley.

Safeguarding

- The Safeguarding Children's Board have established a multi-agency safeguarding hub to tackle safeguarding issues within the borough.
- Additional funding of £100,000 has been secured to support the delivery of therapeutic support for victims.

Fire prevention

- South Yorkshire Fire and Rescue (SYFR) carried out 3,863 home fire safety checks in Barnsley in 2015.
- SYFR have launched the Safe and Well scheme, which focuses on working together to improve identification and access to those most at risk in our communities.

PRIORITY 2 – REDUCING DRUG AND ALCOHOL RELATED HARM

OUTCOME: THE HARM CAUSED BY DRUGS AND ALCOHOL MISUSE IS REDUCED FOR INDIVIDUALS, FAMILIES AND COMMUNITIES THROUGH THE DELIVERY OF INTEGRATED CARE PATHWAYS.

A PICTURE OF OUR ACHIEVEMENTS…

61.9%

Of people in Barnsley who are dependent on opiates and/or crack cocaine are accessing treatment services which is well above the national average of 52 per cent.

Increased opportunities

The rate of successful completions from the treatment system means that those in treatment are accessing increased opportunities for education, employment and training skills.

Within the top **25%**

of the best performing areas in the country.

Successful completion rates for those in treatment remain above national averages for all substance categories. Barnsley is currently ranked in the top two within Yorkshire and the Humber for all categories of treatment and remains within the top 25 per cent of the best performing areas in the country.

CASE STUDY 2

NB was arrested in the summer of 2015 and he tested positive for cocaine at the police station. Although NB reported only using cocaine occasionally, he identified that he required further support to ensure that this did not escalate and he continued to engage with the treatment offered to him. For several months, NB engaged in regular sessions with his recovery navigator and these focused heavily on identifying high risk situations, justifying substance use and relapse prevention techniques.

During the sessions, NB was also identified as a victim of domestic violence and therefore, his recovery navigator referred him to pathways for support. The interventions resulted in a sustained abstinence from illicit substances and no further arrests. NB was later discharged successfully from treatment.

PRIORITY 3 – PREVENTING AND REDUCING RE-OFFENDING

OUTCOME: THE PUBLIC IS PROTECTED AND OUR COMMUNITIES ARE SAFER THROUGH THE REDUCTION OF RE-OFFENDING IN BARNSLEY.

A PICTURE OF OUR ACHIEVEMENTS…

A significant reduction in Youth Justice Re-offending, which is, along with the overall offences committed by repeat offenders better than the national, regional and comparative areas.

A higher percentage of adult offenders leaving prison with suitable accommodation.

Ex-offenders are supporting others to achieve their goals through a newly established mentoring scheme.

A women offender strategy has been developed and championed by local staff, providing women only services for women offenders.

CASE STUDY 3

JD is currently on licence and voluntarily attends the Women's Programme weekly. She feels the group has given her purpose and increased her confidence greatly. She has attended a meeting and spoke about her experiences of being a female in the Criminal Justice and Prison System.

In company with the Giving Real Opportunities to Women' (GROW) project and her offender manager, JD has recently attended Northern College for an insight on what they offer. She now plans to sign up for a Volunteer Mentoring Course with a view to working as a volunteer with Women in the Criminal Justice System.

PRIORITY 4 – REDUCING ANTISOCIAL BEHAVIOUR

OUTCOME: BARNSLEY IS A SAFE AND PLEASANT PLACE FOR PEOPLE TO LIVE, WORK AND VISIT. VICTIMS AND WITNESSES ARE EFFECTIVELY SUPPORTED TO MINIMISE THE DETRIMENTAL IMPACT ON ANTISOCIAL BEHAVIOUR.

A PICTURE OF OUR ACHIEVEMENTS…

40%

reduction in intensive intervention

The community intervention team conducts intensive intervention with Barnsley's highest risk antisocial behaviour families, resulting in an overall reduction of over 40 per cent in demand from these families.

The integration of South Yorkshire Police and the Barnsley Council antisocial behaviour teams now provide resilience, shared accountability and reduced duplication.

80 DIRECT INTERVENTIONS

The introduction of a Public Spaces Protection Order to address antisocial behaviour in the town centre has resulted in more than 80 direct interventions since March 2016.

60% reduction in repeat demand cases

The neighbourhood resolutions team received a national citation for good practice, increased the number of volunteers, and is now an accredited trainer for the Restorative Justice Council. There is an ongoing reduction of repeat demand of around 60 per cent for cases that have been through neighbourhood resolutions.

CASE STUDY 4

Levels of antisocial behaviour and hate related incidents on a particular street in the borough were escalating with one house being the focus of attention. The antisocial behaviour team conducted a three-day long operation in partnership with a number of agencies where both police and civil powers were used. The operation was a success with acceptable behaviour contracts, community protection notices and a harassment warning being issued. In addition, 30 tonnes of waste was removed from the communal areas and residents' gardens.

Following the operation, the number of reported incidents on the street dropped by 65 per cent which helped achieve a better life for the residents.

3 SETTING OUR PRIORITIES FOR 2016 – 2020

UNDERSTANDING HOW SAFE BARNSLEY IS – RESULTS OF THE JSIA.

SHARED PRIORITIES FOR 2016 – 2020

THE SAFER BARNSLEY PARTNERSHIP HAS AGREED A NUMBER OF PRIORITIES TO DELIVER THE VISION FOR 2020.

These priorities are based on information from the JSIA coupled with consultation with representatives from agencies across the partnership and the public in order to focus activity on what safety issues matter most to communities in the borough. Therefore, the shared priorities for the coming period will be:

Protecting vulnerable people;

Tackling crime and anti-social behaviour; and,

Promoting community tolerance and respect.

To achieve our priorities we need to be ambitious, innovative and continue to work together so that we produce better outcomes for our community. The issues within these priorities are interlinked and therefore it is expected that work to tackle the priorities will not occur in isolation, but will support a holistic strategy to improve community safety within Barnsley.

EMERGING ISSUES

The Joint Strategic Intelligence Assessment (JSIA) is a statutory requirement which is carried out annually with a view to providing an evidence base on which to inform the CSP's strategic plan and priorities.

The emerging issues from the JSIA 2015 are:

ANTI-SOCIAL BEHAVIOUR

Increase in anti-social behaviour specifically in the town centre. Begging vagrancy and street drinking incidents have also seen an increase.

The number of domestic abuse repeat victims has increased, along with the number of domestic crimes reported.

Recorded sexual offences have increased, including child sexual exploitation offences.

Levels of Arson and Deliberate Fires are low, however could be linked to other areas of ASB such as fly-tipping.

There are known links between Accidental Fires and vulnerability. This is a priority area for the Fire Service.

Barnsley has seen the highest increase in hate crime when compared to other areas in South Yorkshire but still has the lowest levels in the county.

Cyber crime is recognised as a national and emerging threat.

Both adult and youth re-offending rates have remained fairly stable within the borough.

Drug and alcohol treatment has seen an increase in successful completions.

International migration has increased locally, leading to the potential for underreporting of issues or tensions amongst new arrivals and vulnerable communities.

The use of Novel Psychoactive Substances (NPS), known as legal highs is a growing threat.

Increases in line with the national trend have been seen in violence offences.

Serious acquisitive crime such as robbery, burglary and some vehicle crime has continued to reduce since 2012, however, this crime type still represents 25% of all crimes reported.

There is a clear link between mental health and strands of vulnerability. There has been an increase in child admissions for mental health issues.

Hospital admissions for alcohol related conditions has increased, however, alcohol mortality rates have decreased to lower than the national average.

Modern Slavery is naturally 'hidden' due to its nature, resulting in limited data. The Modern Slavery Act 2015 which recently came into force allows for better identification of modern slavery crimes.

SHARED PRIORITY – PROTECTING VULNERABLE PEOPLE

OUTCOME – THE THREAT, HARM AND RISK TO VULNERABLE PEOPLE, FAMILIES AND COMMUNITIES IS MINIMISED.

OUR FOCUS

We will:

- Work collaboratively to ensure that domestic abuse becomes socially unacceptable and that the harm caused to victims and their families is reduced.
- Take effective preventative and enforcement action to protect children from sexual exploitation.
- Acknowledge that vulnerable people are at an increased risk of the occurrence of accidental dwelling fires and ensure they are prioritised for home safety and health and wellbeing checks via the Safe and Well scheme.
- Re-commission holistic drug and alcohol services to encourage, support and empower individuals to take control of their lives and minimise the harm caused by drug and alcohol misuse.
- Provide a multi-agency approach to support and reduce the vulnerability of people with multiple and complex needs by coordinating and tailoring interventions across agencies to ensure individual, family and community needs are effectively addressed.

SHARED PRIORITY – PROMOTING COMMUNITY TOLERANCE AND RESPECT

OUTCOME – COMMUNITIES ARE SAFER, COHESIVE AND MORE RESILIENT.

OUR FOCUS

We will:

- Help to reduce ignorance and prejudice by helping people to get to know each other and challenging myths and racism.
- Defuse community tensions when they arise by recognising the signs early and having the right tools and skills available to reduce them.
- Work proactively to prevent people from being drawn into terrorism and reduce the likelihood of extremism.
- Ensure engagement processes are effective with our local communities.
- Utilise Area Councils and Ward Alliances to work in partnership with local communities to understand problems and create shared solutions.

SHARED PRIORITY – TACKLING CRIME AND ANTISOCIAL BEHAVIOUR

OUTCOME – PEOPLE AND COMMUNITIES ARE PROTECTED THROUGH THE TARGETING OF CRIME AND RE-OFFENDING.

OUR FOCUS

We will:

- Prevent antisocial behaviour and reduce the impact that it has on people's lives and the community through using our collective resources to support victims, target offenders and address issues in high demand areas based on threat, harm and risk.
- Prevent people becoming engaged in criminal activity and break cycles of re-offending through the continued focus on pathways out of crime including support, education, diversion, housing and employment.
- Work with the Town Centre Board and the business community to address issues of conduct in the town centre.
- Continue to develop and enhance our partnership working practices to reduce the level of violent crime including alcohol-related violence, domestic abuse and sexual offences ensuring root causes are effectively tackled – not just the symptoms.
- Protect and reduce the risk to individuals, communities and businesses from becoming victims of cybercrime through increased awareness and making the best use of all multi-agency resources to bring offenders to justice.

4 MONITORING THE DELIVERY OF OUR PLAN

Delivering our priorities

The Safer Barnsley Partnership has overall responsibility for the delivery of the plan. To ensure delivery of the partnership priorities, a series of task and finish sub-groups will be established. These will translate the strategic intentions of the partnership into operational delivery and will report on an exception basis into the strategy and performance group and Safer Barnsley Partnership Board.

All actions will have lead officers and be time bound to ensure impact can be monitored and measured. This will be accompanied by a performance and delivery dashboard, where performance against outcomes and key metrics will be assessed; in line with key actions from the delivery plans, to provide a holistic assessment of impact and drive continuous improvement. The focus of performance assessments will be against the delivery of high-level outcomes to demonstrate the impact on local people and communities and their quality of life.

Resources

Public services are going through an unprecedented time of austerity measures coupled with rising expectations of local residents and communities which means that now more so than ever, the partnership will hold individual agencies to account for the collective delivery of the shared vision, outcomes and priorities. At a time when resources are and will continue to shrink, it is essential that all resources are applied in the most efficient and effective manner to achieve the best outcomes for and with local people and communities. This challenge cannot be under estimated due to the organisational pressures the public sector faces over the coming period and the need to continue to further embed a culture of stronger and more resilient communities.

Communications and engagement

Communication and engagement are essential components of a successful partnership. A visioning conference was held with representatives from across the partnership, including the voluntary and community sector, to inform the development of the partnership plan.

As a product of this work, a communication and engagement plan will be produced to describe how stakeholders from across the partnership and wider general public will be engaged in the delivery of the community safety vision and priorities over the period to 2020. The intention is that a series of stakeholders from the visioning conference held in January 2016 will become part of a reference group and will be consulted regarding specific elements of work as the plan progresses over 2016-2020.

Review

The partnership plan covers the 2016-2020 period and it will be reviewed annually to ensure any emerging trends from the JSIA are factored into future years' delivery.

CONTACT US

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REPORT TO THE HEALTH AND WELLBEING BOARD

Date: 6th December 2016

BARNSLEY SPECIAL EDUCATIONAL NEEDS AND DISABILITY STRATEGY (2016-18)

Report Sponsor:	Rachel Dickinson (Executive Director: People) Barnsley MBC
Report Author:	Margaret Libreri (Service Director: Education, Early Start and Prevention) Barnsley MBC
Received by SSDG:	11th July 2016
Date of Report:	22nd November 2016

1.0 Purpose of Report

1.1 To inform the Board of the aims and strategic priorities of the Borough's Special Educational Needs and Disability Strategy (2016-18)

2.0 Recommendations

2.1Health and Wellbeing Board members are asked to:-

- Note the recent publication of the Strategy and for partners on the Board to adopt its broad aims and strategic priorities.

- The Board notes the future developments indicated in Paragraphs 5.2 – 5.3 of this report.

3.0 Background

3.1 The Barnsley Special Educational Needs and Disability or SEN(D) Strategy (2016-18) was recently submitted for approval and adoption by the Council's Cabinet, at its meeting held on 16th November 2016. The development of the Strategy was informed through extensive consultation with the Council's partners and a copy is attached as Appendix 1 to this report.

3.2 The purpose of the SEN(D) Strategy is to support Barnsley MBC and its partners in meeting their statutory duty under Part 3 of the Children and Families Act (2014) including the following:

- To work with health and social care organisations in jointly commissioning services that will provide integrated support for children and young people with SEN aged 0 – 25 years.

- To consult children and young people, together with their parents and carers and to co-operate with a range of local providers across education (including post 16 education and training providers) health, social care and voluntary sectors in order to plan and commission quality services.

- To co-produce and publish a local 'offer' of SEN(D) services and provision, including assisting young people with SEN(D) to access skills and employment opportunities and obtain decent accommodation.

- Provide a co-ordinated education, health and care assessment for children and young people aged 0-25 years with SEN(D) and provide education, health and care plans (EHCPs) in order to improve their education and health outcomes, including through the option of direct payments and personal budgets.

- Consider the transition from children's to adults services for young people with SEN(D).

3.3 The Strategy's vision is to create a well planned continuum of provision from birth to age 25 that meets the range of complex needs of such young people. This includes a strong commitment to early help and intervention in order to ensure a child or young person's needs are identified early in order to promote independence.

3.4 The three broad aims of the Strategy closely adhere to this statutory duty and are outlined below:

1. To improve education outcomes, supported by the Schools Higher Needs Funding Block, together with the health and emotional wellbeing for all children and young people with SEN(D) in Barnsley and that the Strategy is owned and supported by all statutory and non statutory partners.

2. To ensure Barnsley delivers the necessary changes to the assessment of needs and joint commissioning of integrated provision, as set out in Part 3 of the Children and Families Act.

3. To address any gaps in provision and to improve the quality of integrated services across the full spectrum of provision.

3.5 These broad aims are underpinned by the following strategic priorities and objectives:

<u>Priority 1: Improving Lifelong Outcomes For Children And Young People With SEN(D) And Their Families</u>

Objective 1: To continue to raise the attainment of children and young people with SEN(D).

Objective 2: Improve and strengthen the early identification of SEN(D) and improve the efficiency of production of EHCPs to ensure children's needs are met promptly.

Objective 3: To develop a co-ordinated, planned, approach to multi agency working.

Objective 4: Support young people in making a fulfilling transition to adult life.

Priority 2: Involve, Engage And Enable Children And Young People With SEN(D) And Their Families

Objective 5: Enable children and young people with SEN(D) and their parents and carers to obtain full participation in the planning and delivery of services.

Objective 6: To work towards ensuring the right support is available to parents and carers.

Objective 7: Ensure all relevant information on the local SEN(D) offer and on local services is clear and accessible.

Priority 3: Ensure The Highest Quality Of Provision And Services Through Effective Procurement And Commissioning Arrangements

Objective 8: Delivering the right provision and the right support at the right time.

Objective 9: To develop a skilled professional SEN(D) workforce which is knowledgeable and confident.

3.6 The broad aims and strategic priorities of the SEN(D) Strategy will be progressed through an action plan which will be managed and monitored by a Multi Agency SEN(D) Strategy Group. This main group will be supported by a set of task and finish groups who will be responsible for the implementation of developments to a range of services and systems.

3.7 Membership of this Strategy Group will include the following organisations:

Barnsley Alliance for School Improvement, Barnsley CCG, Barnsley MBC and the South and West Yorkshire Partnership NHS Trust.

3.8 The action plan, together with the emergence of any risks and resulting remedial action, will be reported on a regular basis to the Children and Young People's Trust Executive Group.

4.0 Resource Implications

4.1 The financial implications of meeting the education, health and wellbeing needs

of children and young people with SEN, together with future demand and available resources, during 2016-18, were reported to the Cabinet on 16th November. There are no resource implications or risks arising for the Board through consideration of this report.

5.0 Conclusion And Next Steps

5.1 The Board is recommended to note the publication of the new Strategy with partners encouraged to adopt its broad aims, strategic priorities and objectives as part of a Borough wide, place based approach for improving education, health and wellbeing outcomes for children with SEN(D).

5.2 Barnsley MBC and its statutory partners are anticipating a forthcoming Ofsted inspection of SEN(D) provision in the Borough during 2016/17 and the outcomes of the inspection will be reported to a future meeting of the Board.

5.3 In the Education White Paper, published in March 2016, SEN(D) provision was identified as being a continuing role of local authorities in conjunction with their partners. Therefore, the Board is, also, recommended to note that a central government consultation on the future role of the local authority in education, to include SEN(D) provision, is expected to be launched early next year.

6.0 Appendices And Background Papers

6.1 Appendix 1: Barnsley Children and Young People's Services SEND Strategy (2016-18)

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Barnsley Children and Young People's Services

BARNSLEY SEND STRATEGY 2016-18

a BRIGHTER future for EVERY CHILD make EVERY DAY count
365
children young people families
BARNSLEY CYP TRUST

Introduction and Context

Vision	Strong families, strong Barnsley
	Every child in a good school
	Success in learning and work
	Strong and Resilient Adults
Core Purpose	To work together to improve children, young people and adults outcomes

This is a 2-year strategy to fundamentally review and re-configure services and partnerships in Barnsley to deliver the Special Educational Needs and Disability (SEND) reforms effectively and improve outcomes for children and young people with Special Educational Needs and Disabilities. 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. A child or young person may have special educational needs or disability or both. The Code of Practice and the Equality Act respectively define SEN and Disability.

Who is the strategic plan for?

The strategy is primarily for all children and young people with SEND and their families, as well as those children and young people who have a Statement of Special Educational Needs or an Education, Health and Care Plan.

It is also for all other stakeholders and organisations who contribute to working together to secure high quality provision for SEND children and young people that is efficient, sustainable and effective.

This strategy has been produced in response to the significant government reforms to education, health and social care requirements for services working with children and young people who are disabled and those with SEN, aged between 0-25, and their families and carers. Under the Children and Families Act 2014 legislative Framework local authorities have to:

- Work with health and social care colleagues jointly to commission services to deliver integrated support for children and young people with SEN aged 0-25.
- Consult children, young people and their parents, and co-operate with a range of local providers across education, health, social care and voluntary sector partners to deliver the new system, including post-16 education providers such as further education colleges and training providers.
- Work with local partners, parents and young people to co-produce and publish a local offer of SEN services and provision to assist young people in finding employment, obtaining accommodation and participating in society.
- Provide a co-ordinated education, health and care assessment for children and young people aged 0-25 and new Education, Health and Care (EHC) plans that will replace the two existing systems of SEN statements (in schools) and Learning Difficulty Assessments (in further education and training).
- Offer those with EHC plans the option of a personal budget.
- Consider the transition from children to adult services and whether to use a new power to provide children's services to young people over 18 to smooth their transition

In addition to local authority responsibilities, NHS England are mandated by government to work in partnership across different services in supporting children and young people with special educational needs or disabilities. NHS England's objective is to ensure that children and young people have access to the services identified in their agreed care plan, and that parents of children who could benefit have the option of a personal budget based on a single assessment across health, social care and education.

The vision is for a well-planned continuum of provision from birth to age 25 in Barnsley that **meets the needs** of children and young people with SEND and their families. These means **integrated services** across education, health and social care which work closely with children, young people, parents and carers and where individual needs are met without unnecessary bureaucracy or delay. It also means a strong commitment to **early intervention and prevention** so that children's and young people's needs do not increase because early help is provided in a timely way.

We believe that every Barnsley child and young person should have their needs met, as far as possible, in their local community, in local early years settings and schools, in further education colleges and work places. They should be offered high quality provision which ensures good health and care and good educational progress and achievement and preparation for adulthood.

We expect every early years provider, mainstream school and post 16 setting to make effective provision for disabled children and those with SEN so that they make good progress in their learning and can move on easily to the next stage of their education and later into **employment and independent adult life**.

We also expect education, care and health services to be delivered in an integrated way so that the **experience of families** accessing services is positive and that children's and young people's safety, wellbeing and health outcomes are well promoted alongside their educational progress and achievement.

The aim is to have effective services in place for young people with additional needs up to the age of 25. They should be recognised as full citizens with their own contributions to make to their local communities and society. Barnsley wants transition to adulthood to be a good experience for young people and wants them to be **talking to the right people in the right places at the right time**, to inform their choices and support independence. Successful transition support between schools and FE Colleges, and adult services where appropriate is key.

Every Barnsley child and young person who is disabled has the right to live as ordinary a life as possible in the local community, with easy access to local schools and leisure facilities, and to the support services they and their families need. Some young people with the most complex needs require significant levels of help and we aim to ensure they and their **families can work with us to shape the services** that will best **ensure good outcomes** for them, supporting their inclusion in society, ensuring resilience and independence in adulthood.

Our vision is for all early years' settings, schools, colleges and health and care support services to have the capacity and confidence to deliver high quality provision for children and young people with special educational needs and who are disabled (SEND), to improve their educational and health outcomes and their access to social opportunities. Barnsley wants to **improve provision and parental choice** by working in partnership with providers in the voluntary and independent sectors who share the same vision and values. This will be achieved by using the best expertise and knowledge in schools and other services, to increase capacity throughout the local area, and by **promoting a model of collaborative working and shared responsibility**.

Barnsley's Strategic Priorities for SEND

The **over-arching aim** of this strategy is **to improve educational, health and emotional wellbeing outcomes** for all Barnsley's children and young people with SEN and who are disabled. It is recognised that parents, carers and young people are central to the successful delivery of the SEND Reforms and this strategy. It will be necessary to ensure that the **views of children and young people with SEND, and their families**, are fully represented in the strategic design and delivery of this SEND Strategy across Barnsley.

The **second key aim** is to ensure Barnsley delivers **the necessary changes to the assessment of needs and joint commissioning of provision** as set out in the Children and Families Act, so that our services are joined up, professionals have good up to date knowledge of each other's practice, and children and young people have better integrated support across education, health and social care. The aim is to improve the quality of communication between different agencies to ensure that needs are identified swiftly and appropriate action taken to provide early help and prevention; targeted support and intervention which supports choice and independence for children, young people and their families.

The **third key aim** is to **address the gaps in provision**, and improve the quality of provision, for children and young people with special educational needs and those who are disabled. This will mean challenging universal services to be inclusive of children and young people with special educational needs or who are disabled; developing a range of social care, health and education providers; and encouraging a mixed economy of provision across mainstream and special schools in Barnsley, as well as high quality, cost effective independent and non-maintained specialist provision necessary for some children and young people. Barnsley will develop and implement a strategic approach to the deployment of resources to ensure effective provision by engaging with schools and settings to support the development of a diverse range of provision to meet emerging needs.

Key partnerships:

- Barnsley Alliance Board
- Early Years settings, schools and post-16 education providers
- Public Health
- Commissioners and providers of targeted and specialist services

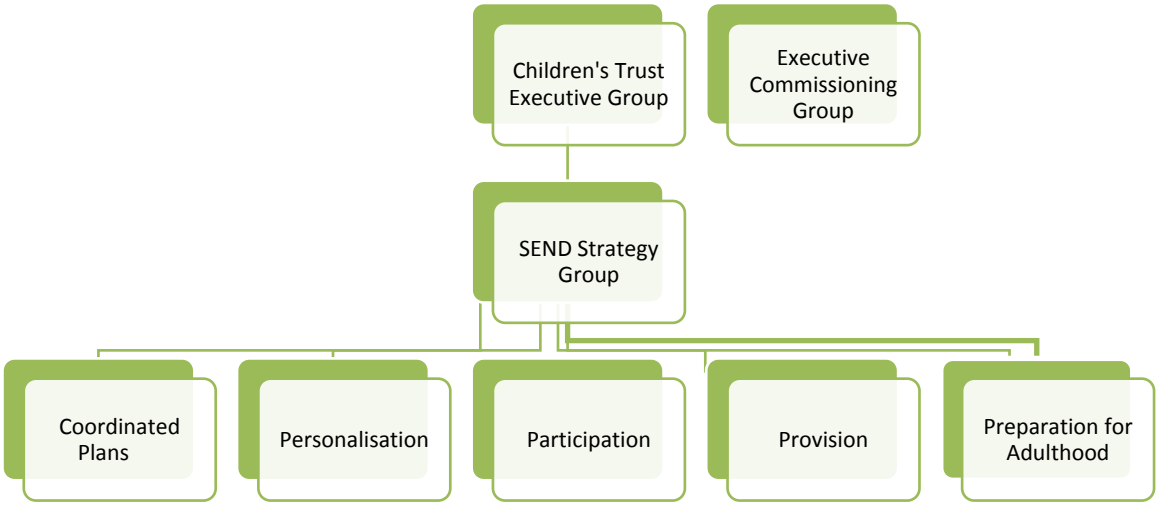
Key Plans and Strategies:

- Barnsley CYP Plan 2016 -19
- Barnsley Alliance Strategy
- Early Help Strategy
- Barnsley Future in Mind Transformation Plan

Governance Arrangements

A multi-agency SEND Strategy Group has been established to implement the reforms to the SEND arrangements. The SEND Strategy Group is supported by a number of Task & Finish Groups which are working on the detailed reforms to services and systems. Once the reforms have all been implemented the work of these groups will cease but the SEND Strategy Group will continue to monitor the impact of the reforms and will report, at least annually, to the Children's Trust Executive Group on outcomes for children and young people with SEND.

To ensure democratic accountability the SEND Strategy Group will also periodically report on improvement plans, progress and outcomes to Council Overview and Scrutiny and Cabinet committees.



SEND Code of Practice

A revised 'SEN and disability code of practice 0 to 25 years' came into effect on 1st April 2015 and can be found at:

https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

The code of practice sets out guidance on policies and procedures aimed at enabling children and young people with SEND to reach their full potential and support families to do the best for their children. It reflects the provisions of Part 3 of the Children and Families Act 2014 and associated regulations and explains and provides guidance on carrying out the duties in the legislation.

The Code of Practice is statutory guidance for organisations who work with and support children and young people with SEND and their parents, such as:

- head teachers and principals
- governing bodies
- school and college staff
- special educational needs (SEN) coordinators
- early education providers
- local authorities
- health and social services staff

The Task & Finish Groups are using the detailed guidance in the revised code of practice to ensure that organisations in Barnsley are fulfilling their statutory duties.

The Strategic Priorities: what we want to achieve

PRIORITY ONE:
Improve Lifelong Outcomes for children and young people with SEND and their families

This is important because:

Where schools and other education settings offer good or outstanding provision, children and young people with SEND can be supported to achieve their ambitions and make good progress. Barnsley and national data shows us that a significant number of children and young people with SEND do not always make good progress or reach their potential, and are not always well prepared for the next stages of their lives. Barnsley families would like to work closely with their schools to achieve the best outcomes for children and young people and feel strongly that increased awareness and joint training around SEND issues would make a significant positive difference.

Objective One:
Continue to raise attainment of children and young people with SEND and their families

We will support schools and educational settings to continue in leading on the raising of attainment of children and young people with SEND. This will include working with schools to further develop training programmes and further develop information, advice, support and guidance. We'll increase opportunities for school to school support and work in partnership with special schools and local authority outreach and support services to build greater skills and confidence on the more complex aspects of SEND in mainstream schools.

Objective Two:
Improve and strengthen early identification of SEND and improve efficiency of production of EHC Plans to ensure children's needs are met promptly

We will target support in the Early Years so that we can identify children with SEND as early as possible. We will work with Early Years settings and other partners to put in place early intervention mechanisms so that children's learning and development is maximised at this crucial time. We will introduce new ways of doing things by looking for best practice across the Barnsley to improve our services.

Objective Three:
Develop a single coordinated plan approach to integrated multi agency working

We will review how our multi-agency 'team around the child' and early support processes work to reduce bureaucracy and avoid duplication wherever possible. We will pilot a 'Single Plan' approach for young people with exceptionally high levels of need and work in partnership with education, NHS and care providers and try to meet their needs locally.

Objective Four:
Support young people to make a fulfilling transition to adult life

We will support every child and young person with SEND to help them make a successful transition in this period of significant change. We will start early, be flexible and try to tailor our support to the individual young person and their family. We'll make sure parents and carers can access advice and guidance on what options are available. We'll work in partnership with parents and carers to enable them to take part in the decisions about their child's needs and support arrangements.

PRIORITY TWO:
Involve, engage and enable children and young people with SEND and their families

This is important because:

A focus on a smooth transition through life stages and particularly into adulthood can support the achievement of the best possible outcomes for each child and young person and maximise their independence, choice and control as they enter adulthood. Barnsley Council and its partners are committed to work together to overcome obstacles and join up services in order to achieve this aim.

Objective Five:
Ensure parents and carers, children and young people are able to participate more in decision-making

We will ensure that parents, carers and young people have increased opportunities to participate in decision making about their provision and care. We will also encourage their involvement in changes to strategies and the on-going evaluation of our services. We will look at how best we can get feedback from children and young people with SEND about their educational experiences.

Objective Six:
Work towards making ensuring that parents and carers receive the right support

We will support our local Parent Carer Forum and use this as one of the ways we can improve parent consultation. We will fully review all our services for parents and carers using the feedback they have given us and we will involve them in this review, helping parents and carers access support and advice at the right time. We will work with parents and carers in experimenting with the development of personal budgets.

Objective Seven:
Ensure that all information that goes to parents and carers is clear and accessible

We will continue to develop SEND web pages on the Barnsley website. These will provide information about local services and guidance for parents, carers and professionals about the range of services, the full range of educational provision available and how transitions between children and adult services are coordinated. We will make sure this and all information- is clear and accessible and written in everyday language. We'll promote the availability of this information through children's family centres, libraries, schools and other places that are regularly visited by members of the public.

PRIORITY THREE:
Ensure the highest possible quality of provision and services through effective procurement and commissioning arrangements

This is important because:

Individuals should be able to access a range of high quality services when required to meet a wide and varied range of needs. BMBC Partners will seek to develop SEND Provision in consultation with, and in collaboration with, its customers, recognising the challenges imposed by financial constraints in times of austerity and the need to be opportunistic and flexible in their approach.

Objective Eight:
Deliver the right provision and the right support arrangements at the right time

We'll review our existing specialist provision to match our current need more closely. We'll also re-designate current places to get the best from what we already have and

work with our neighbouring boroughs in partnership to achieve economies of scale. We will improve our commissioning and procurement arrangements to ensure that we get best value for money in all places that we commission outside the borough.

We'll work in partnership with mainstream schools to develop increased curriculum options for young people with learning difficulties to improve their qualifications and post 16 pathways. We will work with the Colleges and other providers of further education (FE) to help develop provision to accommodate more high needs learners from 16-25 years old. We will develop the transition planning information in young people's Education, Health and Care plans to help FE providers to tailor programmes that meet the educational needs of the learners and support their progression once they leave formal education

Objective Nine:
Develop a skilled professional workforce who is knowledgeable and confident about SEND

We will support the leadership and management in schools and all other educational settings in their development of inclusive practice and specialist training in specific areas of SEND. We will work with our partners to make sure that all those who work with children and young people with SEND have the necessary skills and confidence (appropriate to their role) to support children and young people and their families.

Over the next two years we will review and redesign how we work to implement the Special Educational Needs and Disability Arrangements for 0 to 25 year olds, so that by April 2018:

Parental Engagement

- A wide range of parents will be communicated with regarding the SEND reforms and will have the opportunity to be involved and have their voice heard.
- Parents will be engaged in commissioning decisions and views of local communities will be gathered so that services for those with SEND can be shaped by users' experiences, ambitions and expectations.
- Parents/carers will be involved in the development of and the review of the Local Offer.

Education Health & Care Plans

- All SEN Statements/LDAs will have been transferred to EHC Plans.
- EHC planning process will be well embedded both within the Local Authority and schools.
- Workforce, parents and young people will be familiar with the EHC needs assessment process, the plan, will be able to contribute to and write outcome focussed reports and will be familiar with the review process.

Local Offer

- There will be a comprehensive Local Offer website and an alternative means of accessing this information for those who do not have internet access.
- There will be an established mechanism for the Local Offer highlighting gaps in provision which the LA will respond to so that the needs of all children and young people with SEND can be met locally.

Joint Commissioning

- There will be a single joint commissioning process which will inform the commissioning and decommissioning of services to meet the needs of SEN children and young people in Barnsley.
- The Barnsley JSNA will evidence the SEN needs of children and young people in Barnsley.

Personal Budgets

- All professionals, parents and young people will have a good understanding of personal budgets and direct payments and the take up of direct payments/3rd party arrangements will increase thus reflecting increasing choice and control for families.
- An all age brokerage service will be in place.
- Smooth mechanisms for the set up and review of direct payments/third party arrangements will be in place across the LA and CCG.
- A move towards pooled budgets will be planned so that families can have just one payment and review process.

How we work

In implementing the strategy our work will be underpinned by the following principles

- In all our services, from universal to targeted, we are transparent in our communication and engagement with families; we listen actively to what they say, so that we can understand their perspective, their needs and their desired outcome

- Our starting point is identifying and building on strengths, our approach is non-judgemental and inclusive

- Our approach is family centred, recognising that the context individuals live in, and their important relationships, have an impact on actions and outcomes
- We involve families, children and young people in the decisions that affect their lives
- Our focus is on improving outcomes; making a difference that can be sustained
- We build capacity, resilience and independence, so that families can make choices that enhance their quality of life
- Services, pathways and processes are sensibly integrated, and families experience coherence and consistency in their engagement with services
- We provide continuity of support, communication and relationships at points of transition in families' lives
- We make it easy to get the right support at the right time, so problems don't escalate

What do we mean by Special Educational Needs and Disability (SEND)?

The Special Educational Needs and Disability Code of Practice: 0 to 25 years (the Statutory Guidance that all organisations working with children and young people with SEND must have regard to) offers the following definitions that Barnsley subscribe to:

Special Educational Needs (SEN)

A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her.

A child of compulsory school age or a young person has a learning difficulty or disability if he or she:

- has a significantly greater difficulty in learning than the majority of others of the same age, or
- has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions

For children aged two or more, special educational provision is educational or training provision that is additional to or different from that made generally for other

children or young people of the same age by mainstream schools, maintained nursery schools, mainstream post-16 institutions or by relevant early years providers. For a child under two years of age, special educational provision means educational provision of any kind.

Post-16 institutions often use the term learning difficulties and disabilities (LDD). The term SEN is used in this Code across the 0-25 age range but includes LDD.

Disabled Children and Young People

Many children and young people who have SEN may have a disability under the Equality Act 2010 – that is '…a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities'. This definition provides a relatively low threshold and includes more children than many realise: 'long-term' is defined as 'a year or more' and 'substantial' is defined as 'more than minor or trivial'. This definition includes sensory impairments such as those affecting sight or hearing, and long-term health conditions such as asthma, diabetes, epilepsy, and cancer. Children and young people with such conditions do not necessarily have SEN, but there is a significant overlap between disabled children and young people and those with SEN. Where a disabled child or young person requires special educational provision they will also be covered by the SEN definition.

Areas of Special Educational Need

There are 4 main areas of special need:

Cognition and Learning Needs

This includes children who have difficulty with learning, thinking and understanding or who have developmental delay. They may have features of moderate, severe or profound learning difficulties or specific learning difficulties (dyslexia and dyspraxia).

Social, Emotional and Mental Health Needs

Pupils with social, emotional and mental health needs cover the full range of ability and severity. Their needs can present a barrier to learning and persist despite the implementation of an effective school policies and a robust personal/social curriculum.

Communication and Interaction Needs

This includes children with speech and language difficulties and disorders and autistic spectrum disorders including Asperger's Syndrome.

Sensory and/or Physical Needs

This includes children with a range of significant visual or hearing difficulties and children with physical disabilities which impede their learning in school and their ability to take part in the curriculum.

We recognise that some children will have needs in more than one area. When a child has very significant difficulties falling into a number of these areas, then this child may be described as having complex needs.

The Local Picture

Children and Young People with SEND in Barnsley

This section aims to give a sense of the numbers and the characteristics of the children and young people that this strategy is aimed at.

Analysis of Need within Barnsley

- In January 2015, Barnsley's SEN population was 16.1% compared with 15.4% nationally.
- The current school population in Barnsley is 33,093 (January 2016).
- Of the current school population, 4,836 have an identified Special Educational Need. This represents 14.6% of the school population in January 2016.
- The current (May 2016) SEN population (including post-16) is 5,039 and is profiled across stages as follows:
    - Early Years 421
    - Primary 2,843
    - Secondary 1,560
    - Post-16 215
- Barnsley generally has higher numbers of children subject to a statement of SEN or an Education, Health & Care Plan (EHCP) than is the case regionally, 1.3% higher and nationally, 1% higher.
- Statements / EHCPs as a % of school population (January 2015) *:
    - England 2.8%
    - Yorkshire & Humber 2.4%
    - Barnsley 3.8%
- There are currently 1412 children and young people with a statement of special needs/or a EHCP. The category of primary need as stipulated on Capita is as follows:

    - Autistic Spectrum Disorder 250
    - Social Emotional Mental Health 294

- Hearing Impaired 31
- Moderate Learning Disability 212
- Multi-Sensory 3
- Non specified Primary Need 26
- Physical Disability 113
- Profound Multiple Learning Disability 44
- Speech Language Communication Need 324
- Severe Learning Disability 76
- Specific Learning Difficulties 18
- Visual Impairment 21

As of May 2016 there are 92 children placed out of borough in independent special schools.

**all comparator data is drawn from January 2015 School Census*

Educational Provision for Children and Young People with SEND

Special Schools in Barnsley

All admissions to special schools and resourced provisions are agreed through provision panel meetings.

An EHC Plan or a Statement of SEN is required for all children and young people who are enrolled to a special school or resourced provision.

Springwell Special Academy (96 places) for pupils 3 – 19 years with social, emotional and mental health needs.

Greenacre Special School (320 places) for pupils aged 3- 19years with severe and complex needs

Satellite Provision:

Kexborough Primary School KS1

Kexborough Primary School KS2

Hoyland Springwood Primary School KS2

Darton College KS3

Resourced provisions in Barnsley

Some of the mainstream schools in Barnsley mainstream have resourced provisions (91 places) for specific types of need.

- **Horizon Community College** - resourced provision for pupils with a hearing or visual impairment
- **Joseph Locke Primary School** - resourced provision for pupils with a hearing or visual impairment
- **Carlton Community College** - resources provision for pupils with communication and interaction difficulties
- **Meadstead Primary Academy** - resourced provision for pupils with communication and interaction difficulties
- **Hoyland Springwood Primary** - resourced provision for pupils with communication and interaction difficulties
- **Worsbrough Common Primary** - resources provision for pupils with communication and interaction difficulties
- **Oakhill Primary Academy** - resourced provision for pupils with communication and interaction difficulties
- **Greenacre Special School** - resourced provision for pupils with communication and interaction difficulties
- **Darton College** – a resource provision for pupils with moderate learning needs

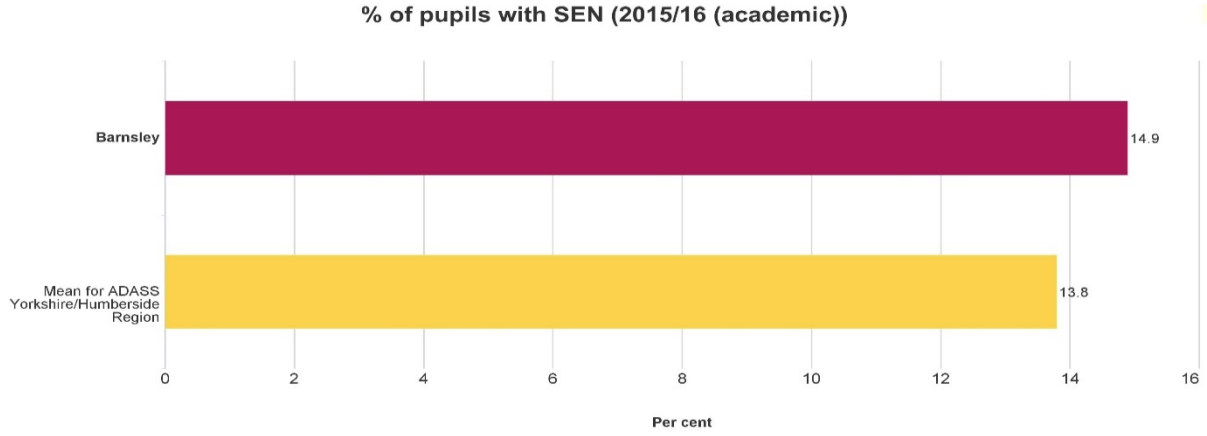
Other specialist educational provision outside of Barnsley

In addition to the special schools and resourced provisions listed above, there are other specialist provisions outside of Barnsley. A list of the independent special schools and post-16 institutions approved by the Secretary of State (Section 41) can be found on the GOV.UK website.

Barnsley will always try, wherever possible, to meet the educational needs of children and young people within Barnsley but, in rare circumstances, will arrange for children to be placed in schools outside of the Borough to ensure that very specific needs are met.

Profile of pupils with SEND in Barnsley

In Barnsley 14.9% of pupils have some type of special educational need (SEN), compared to 13.8% in the Yorkshire/Humberside Region. These figures, and those in the first three charts below, are for pupils attending schools in Barnsley. They do not include children and young people for whom Barnsley is responsible but has placed out of borough.



Source:
Metric ID: 2212, Department for Education, Special Educational Needs in England

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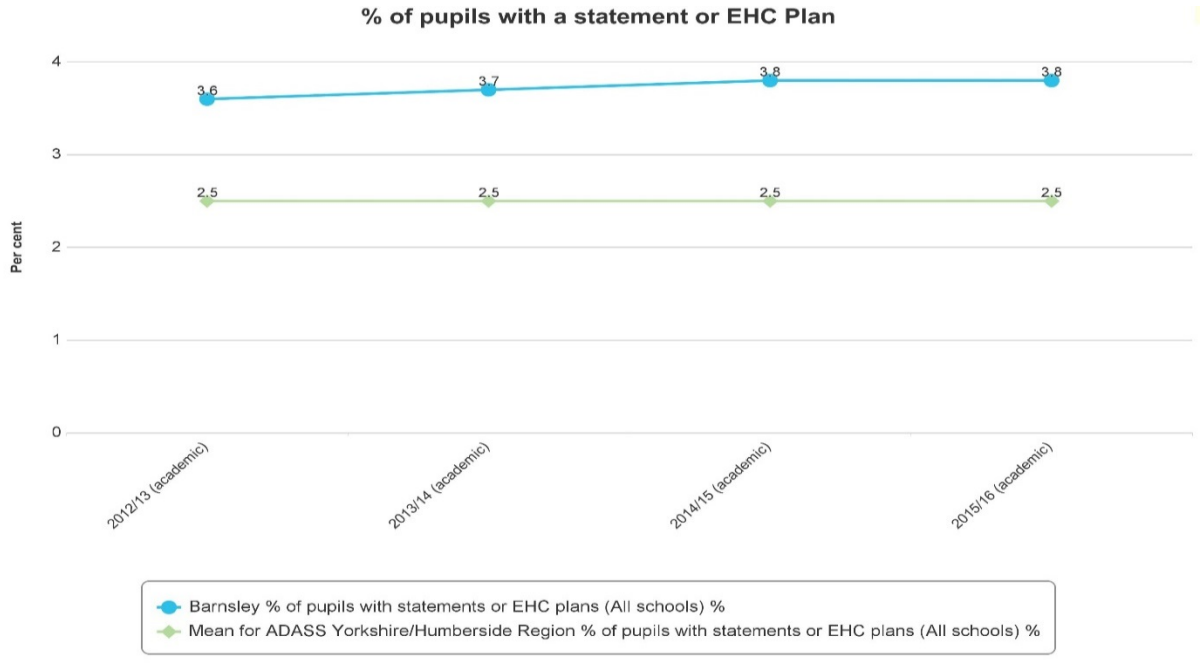
Pupils with statements of special educational needs or education health and care plans:

Across the Yorkshire/Humberside Region, the proportion of pupils with statements or education, health and care (EHC) plans ranges from 1.8% to 3.8%. Barnsley has a value of 3.8%, compared to an average of 2.5% in the Yorkshire/Humberside Region.



Source:
Metric ID: 2213, Department for Education, Special Educational Needs in England

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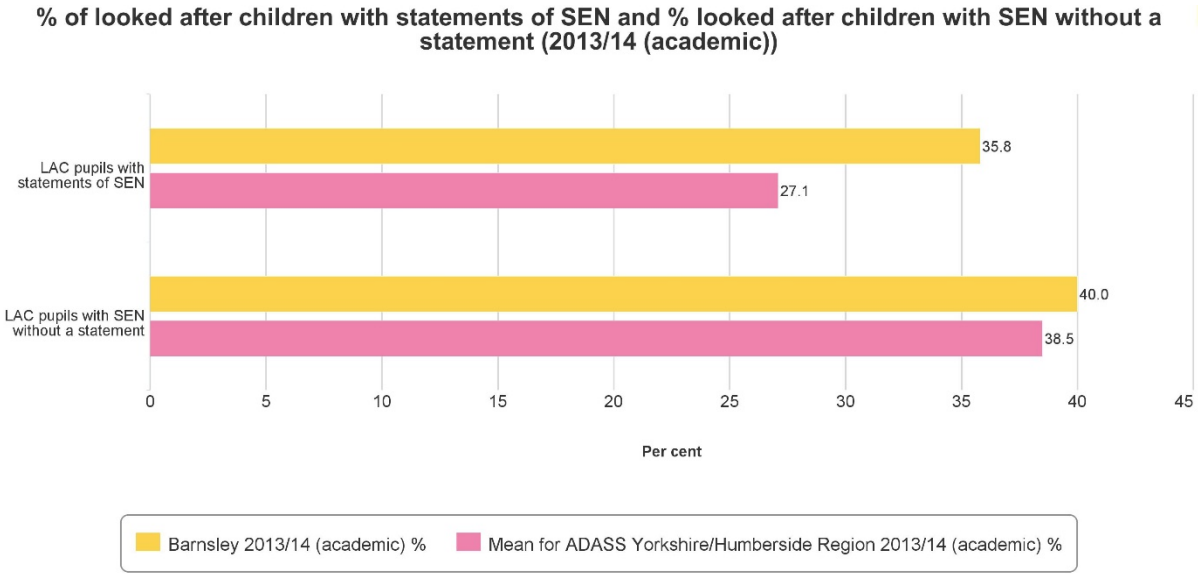
Looked after children and children in need

Looked after children are defined as those looked after by the local authority for one day or more. In Barnsley, 40.0% of looked after children are on SEN support, compared to 38.5% in the Yorkshire/Humberside Region. 35.8% of looked after children in Barnsley have a statement of SEN or EHCP, compared to 27.1% in ADASS Yorkshire/Humberside Region.



Source:
Metric ID: 2133, Department for Education, Outcomes for Children Looked After by Local Authorities in England
Metric ID: 2134, Department for Education, Outcomes for Children Looked After by Local Authorities in England

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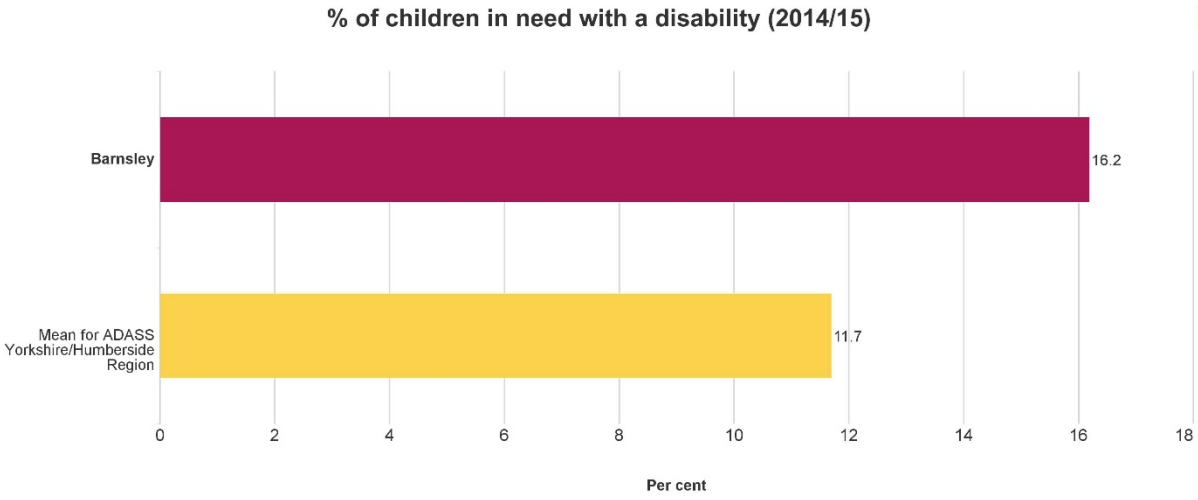
In Barnsley, 16.2% of school-age children in need have a disability, compared to 11.7% in the Yorkshire/Humberside Region



Source:
Metric ID: 2246, Department for Education, Characteristics of Children in Need in England

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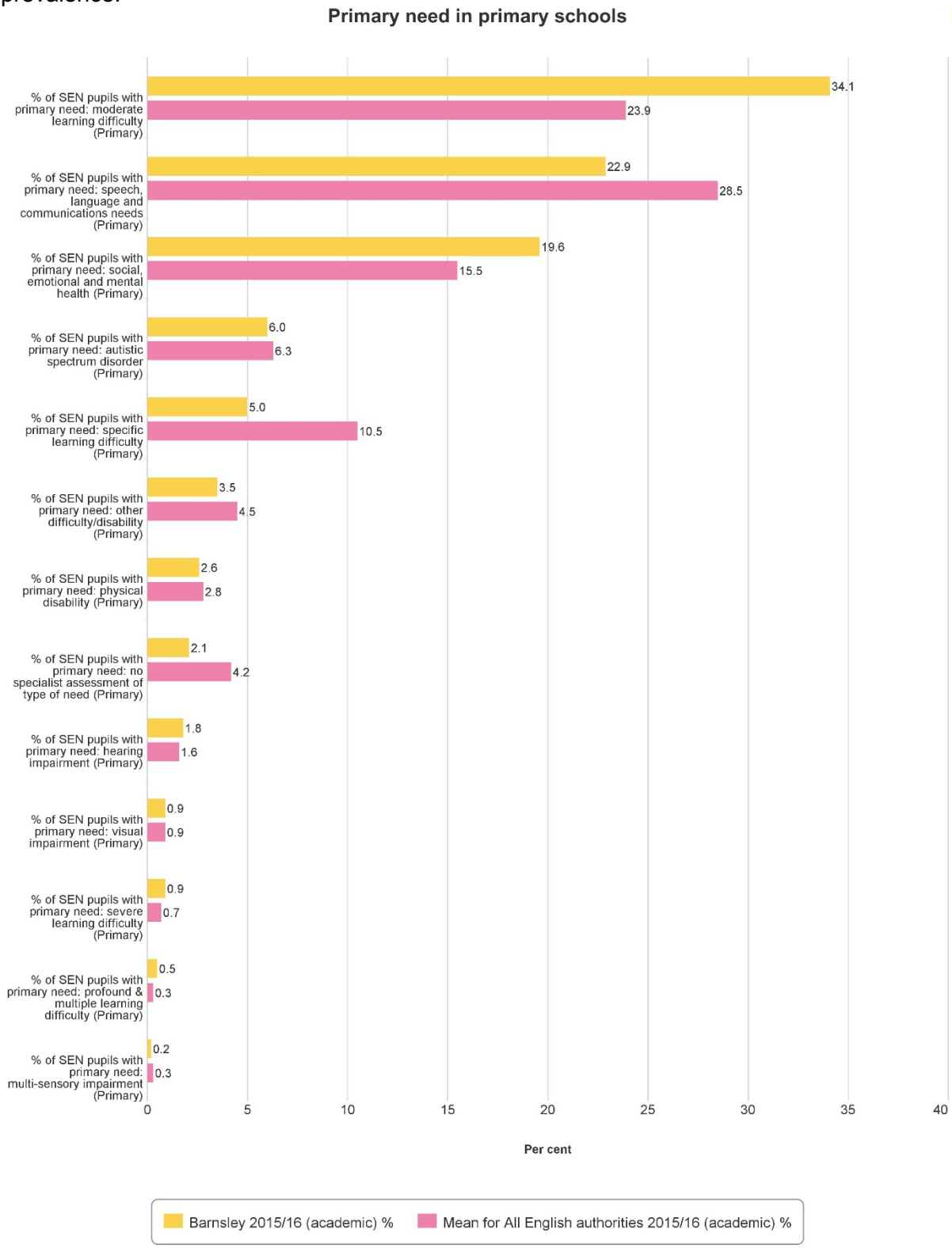
Primary Need

A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for them. All pupils with SEN have an assessment of their primary need. The following charts show the breakdown of need in Barnsley by primary, secondary and special school, compared to the national averages and ranked by prevalence.



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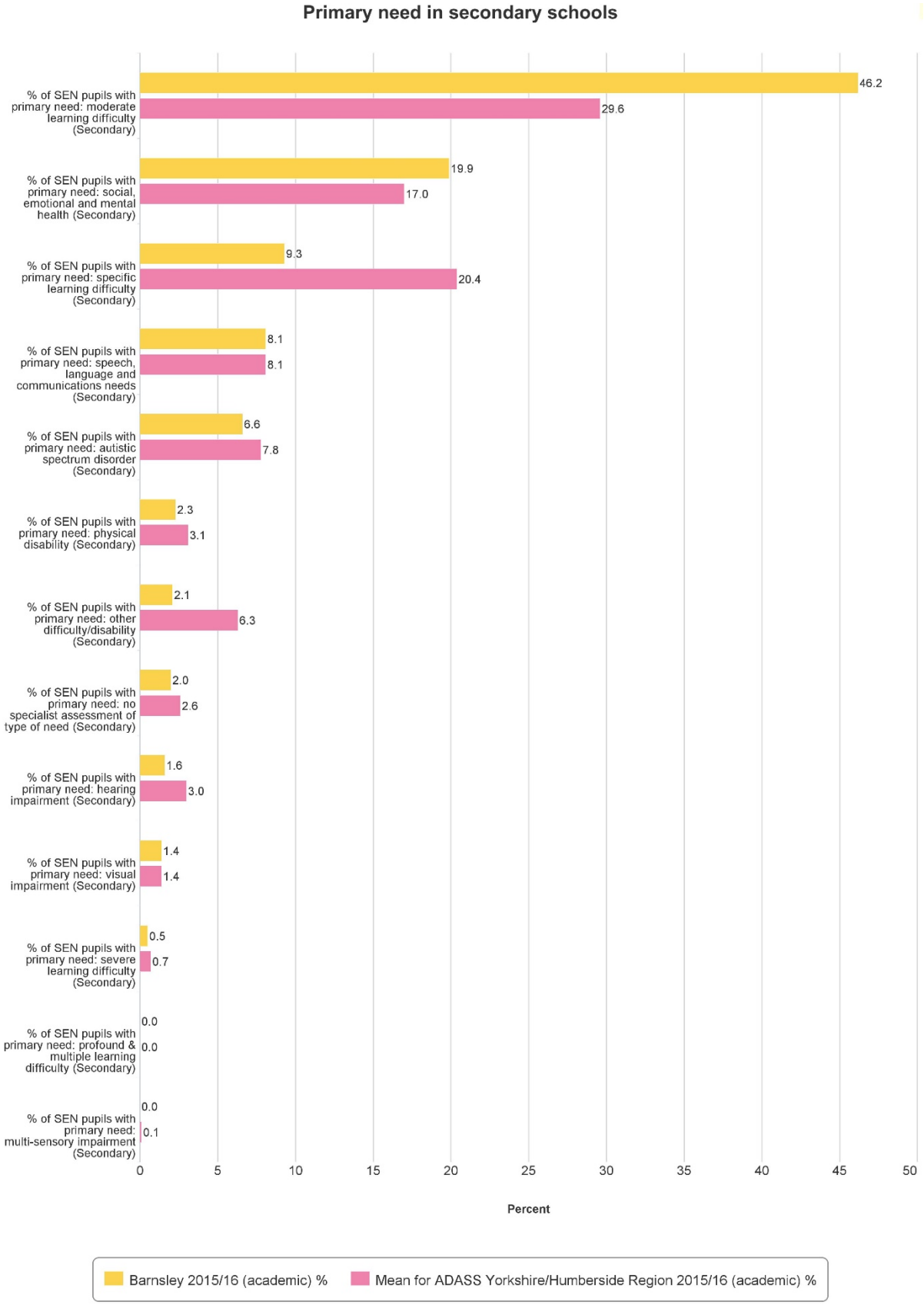
Primary need in secondary schools
% of SEN pupils with primary need: moderate learning difficulty (Secondary)
46.2
29.6
% of SEN pupils with primary need: social, emotional and mental health (Secondary)
19.9
17.0
% of SEN pupils with primary need: specific learning difficulty (Secondary)
9.3
20.4
% of SEN pupils with primary need: speech, language and communications needs (Secondary)
8.1
8.1
% of SEN pupils with primary need: autistic spectrum disorder (Secondary)
6.6
7.8
% of SEN pupils with primary need: physical disability (Secondary)
2.3
3.1
% of SEN pupils with primary need: other difficulty/disability (Secondary)
2.1
6.3
% of SEN pupils with primary need: no specialist assessment of type of need (Secondary)
2.0
2.6
% of SEN pupils with primary need: hearing impairment (Secondary)
1.6
3.0
% of SEN pupils with primary need: visual impairment (Secondary)
1.4
1.4
% of SEN pupils with primary need: severe learning difficulty (Secondary)
0.5
0.7
% of SEN pupils with primary need: profound & multiple learning difficulty (Secondary)
0.0
0.0
% of SEN pupils with primary need: multi-sensory impairment (Secondary)
0.0
0.1
0
5
10
15
20
25
30
35
40
45
50
Percent
Barnsley 2015/16 (academic) %
Mean for ADASS Yorkshire/Humberside Region 2015/16 (academic) %
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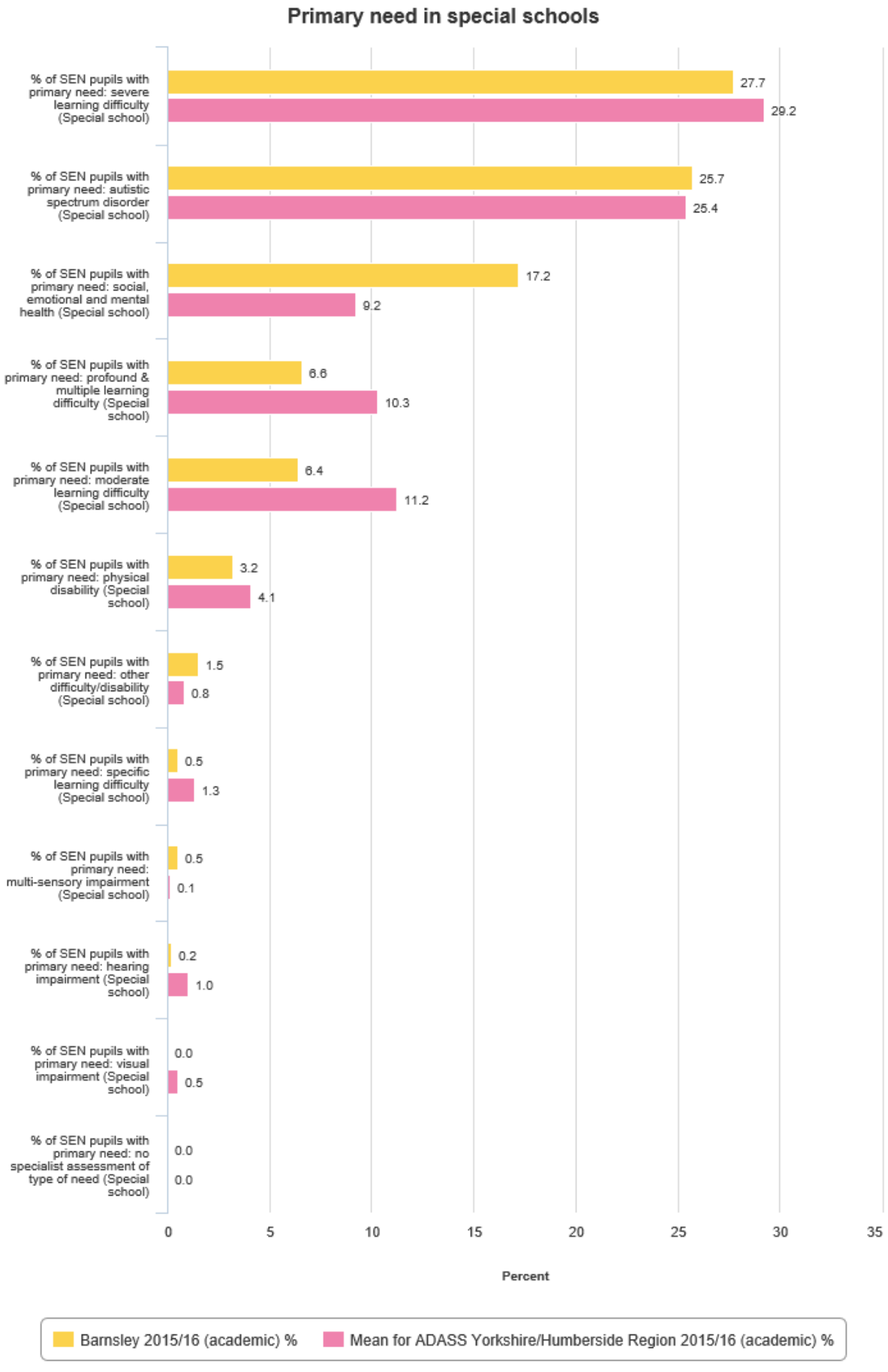

Primary need in special schools
% of SEN pupils with primary need: severe learning difficulty (Special school)
27.7
29.2
% of SEN pupils with primary need: autistic spectrum disorder (Special school)
25.7
25.4
% of SEN pupils with primary need: social, emotional and mental health (Special school)
17.2
9.2
% of SEN pupils with primary need: profound & multiple learning difficulty (Special school)
6.6
10.3
% of SEN pupils with primary need: moderate learning difficulty (Special school)
6.4
11.2
% of SEN pupils with primary need: physical disability (Special school)
3.2
4.1
% of SEN pupils with primary need: other difficulty/disability (Special school)
1.5
0.8
% of SEN pupils with primary need: specific learning difficulty (Special school)
0.5
1.3
% of SEN pupils with primary need: multi-sensory impairment (Special school)
0.5
0.1
% of SEN pupils with primary need: hearing impairment (Special school)
0.2
1.0
% of SEN pupils with primary need: visual impairment (Special school)
0.0
0.5
% of SEN pupils with primary need: no specialist assessment of type of need (Special school)
0.0
0.0
0
5
10
15
20
25
30
35
Percent
Barnsley 2015/16 (academic) %
Mean for ADASS Yorkshire/Humberside Region 2015/16 (academic) %

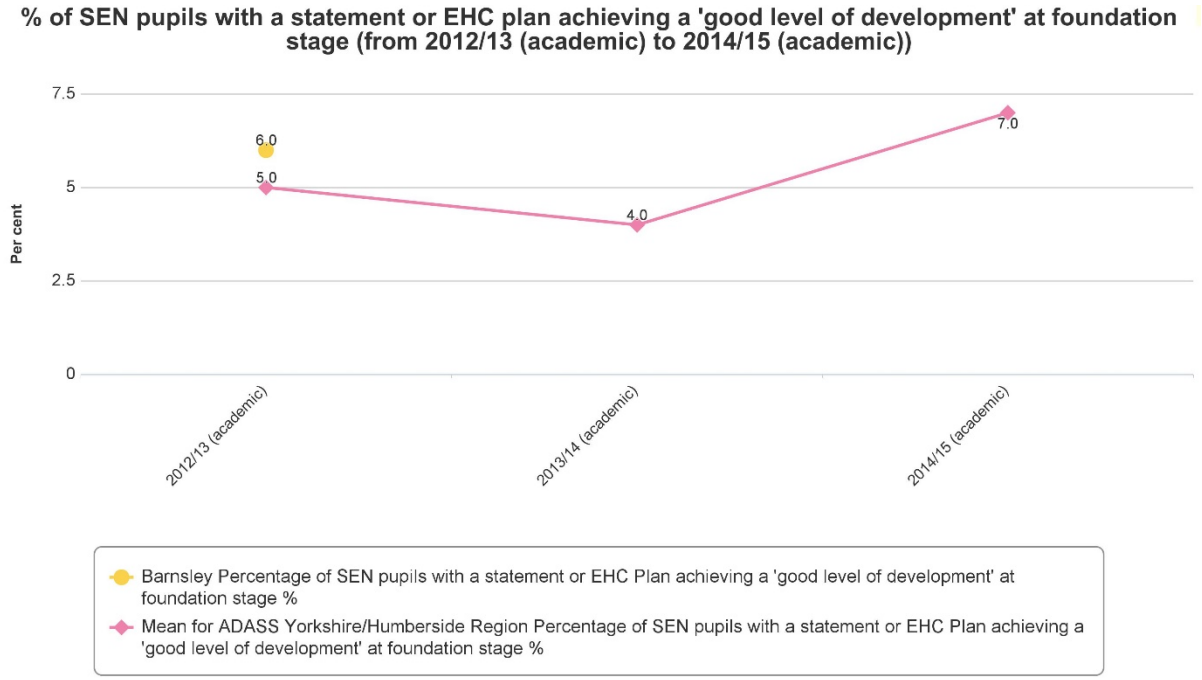
Attainment of pupils with SEN

Pupils with SEND have learning difficulties or disabilities that make it harder for them to learn than most pupils of the same age. Our aim is that with support, and using differentiated learning, the attainment gap between pupils with SEN and those without is reduced

Early Years

The Early Years Foundation Stage Profile (EYFSP) is a teacher assessment of a child's development at the end of the academic year in which they turn five. Suppressed of children with statements of SEN or EHC plans and 15.0% of children on SEN support in Barnsley achieve a good level of development, defined as achieving in 7 areas of learning covering 17 early learning goals. This compares to a Yorkshire/Humberside Region average of 7.0% for children with statements of SEN or EHC plans and 21.7% for children on SEN support.

Please note that where values are not displayed, this is a result of them being suppressed, which means that the number of pupils is too low to be published.



Source:
Metric ID: 4685, Department for Education, Early years foundation stage profile attainment by pupil characteristics

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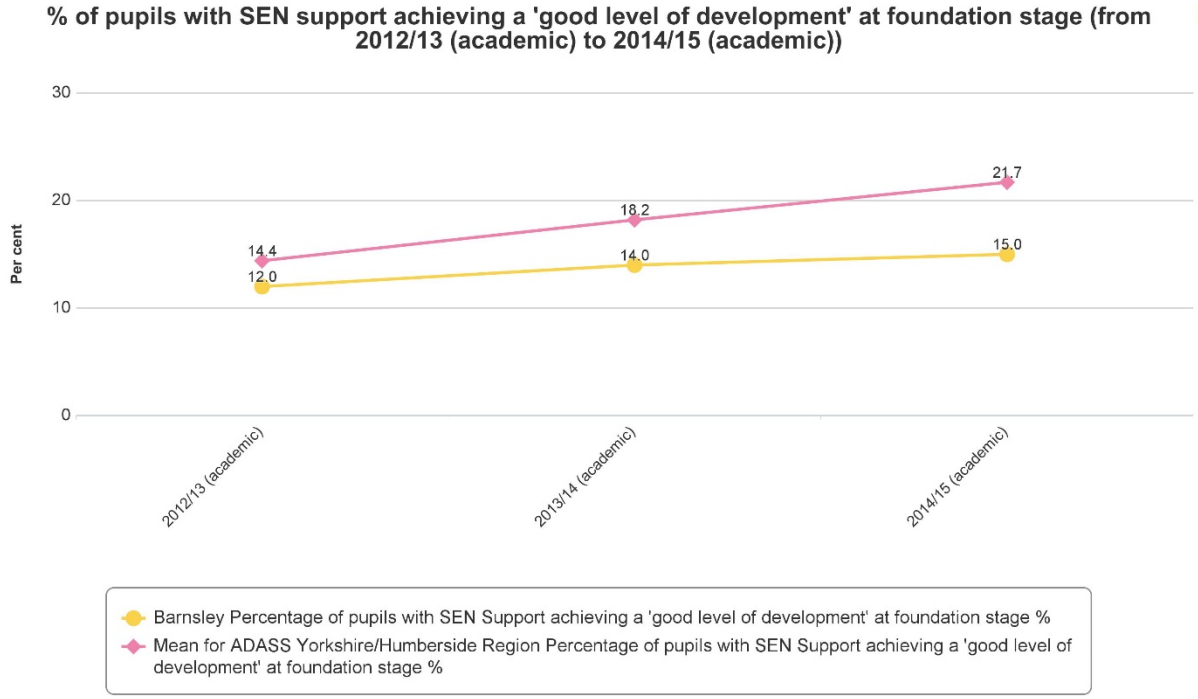

Source:
Metric ID: 4684, Department for Education, Early years foundation stage profile attainment by pupil characteristics

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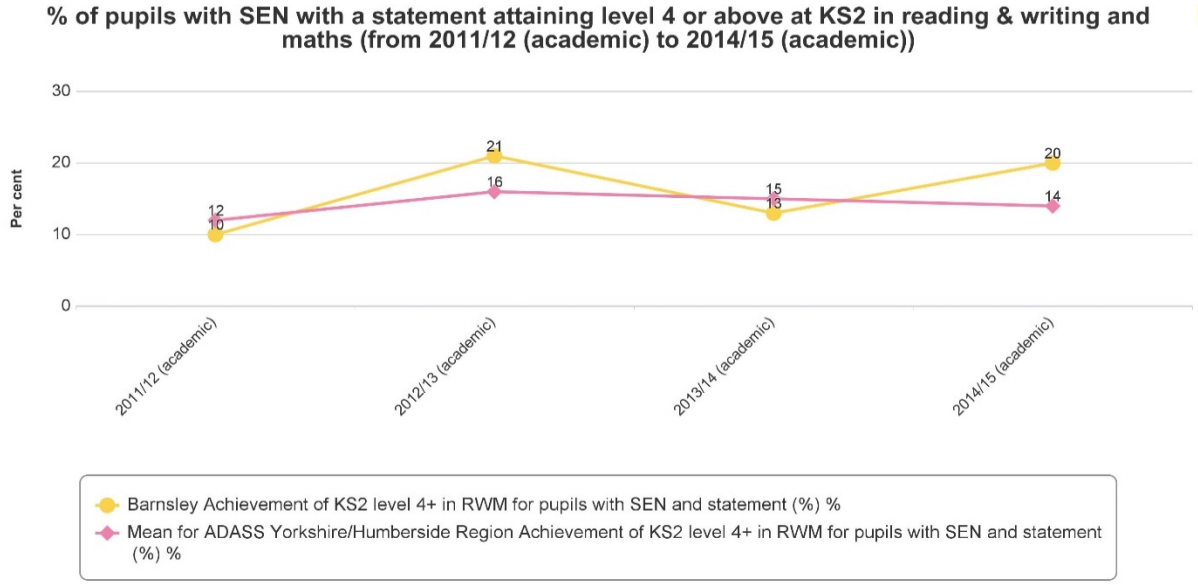
Key Stage 2

All children in state funded primary schools are required to take part in key stage 2 national curriculum assessments before they move to secondary school. Pupils are expected to achieve level 4 by the end of key stage 2, and to make at least two levels of progress between key stage 1 and key stage 2. The tests are designed to show what pupils have achieved in selected parts of a subject at the end of each key stage.

20% of pupils with statements of SEN or EHC plans and 39% of pupils on SEN support in Barnsley achieve a level 4 or above in reading, writing and mathematics at KS2. For pupils with statements, this is an improvement on the previous period (13%) and for pupils with SEN support this is an improvement on the previous period (38%). This compares with a Yorkshire/Humberside Region average of 14% for pupils with statements of SEN or EHC plans, and 37% for pupils on SEN support.



Source:
Metric ID: 4307, Department for Education, National curriculum assessments at Key Stage 2 (KS2)

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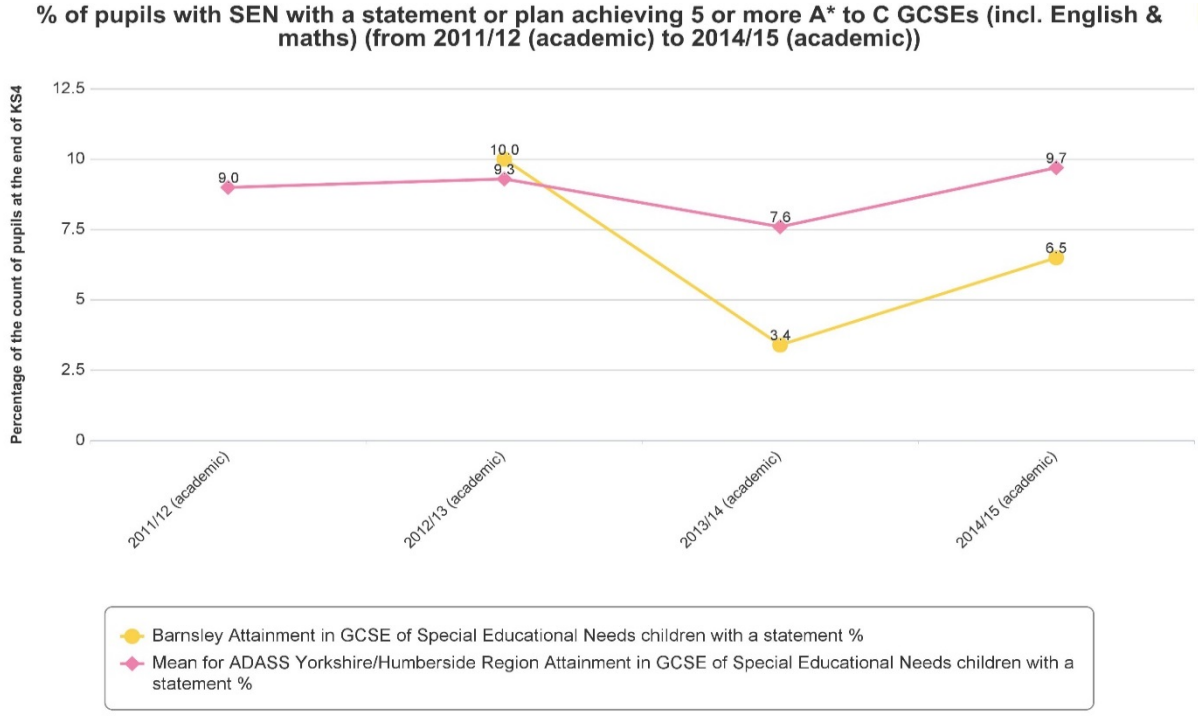
Key Stage 4 (GCSE)

6.5% of pupils with statements of SEN or EHC plans and 13.8% of pupils on SEN support in Barnsley achieve 5A*-C inc. English and maths at KS4. This compares to the Yorkshire/Humberside Region average of 9.7% for pupils with statements of SEN or EHC plans, and 22.2% for pupils on SEN support. For comparison, of pupils with no SEN, 55.5% in Barnsley and 62.0% in the Yorkshire/Humberside Region achieve 5A*-C inc. English and maths at KS4.



Source:
Metric ID: 921, Department for Education, GCSE and equivalent attainment by pupil characteristics

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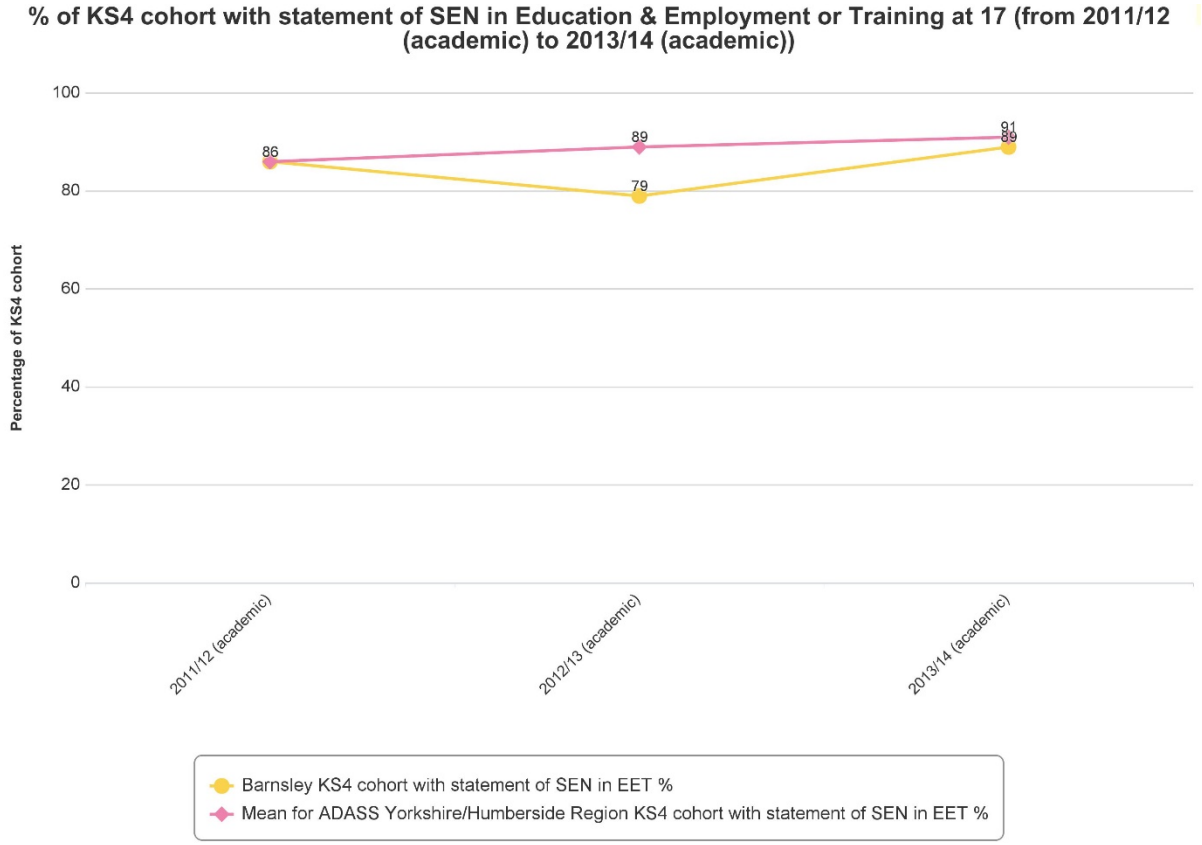
Preparation for adulthood

The reforms placed increased emphasis on supporting children and young people with SEND to make a positive transition to adulthood, including paths to employment, good adult health, independent living and participating in society. For more information, visit **http://www.preparingforadulthood.org.uk/.**

This chart below shows the percentage of the Key Stage 4 SEN cohort in a sustained education, employment or training destination at 17. To be included in the measure, young people have to show sustained participation in education, training or employment destinations in all of the first two terms of the year after they completed key stage 4. In Barnsley, 89% of the KS4 cohort with a statement were in education, employment or training at 17, this compares to the previous period of 79% and the Yorkshire/Humberside Region average of 91%. Of those without a statement 83% were in education, employment or training at 17, 84% were in education, employment or training at 17 in the Yorkshire/Humberside Region.



Source:
Metric ID: 4689, Department for Education, Destinations of key stage 4 and key stage 5 pupils

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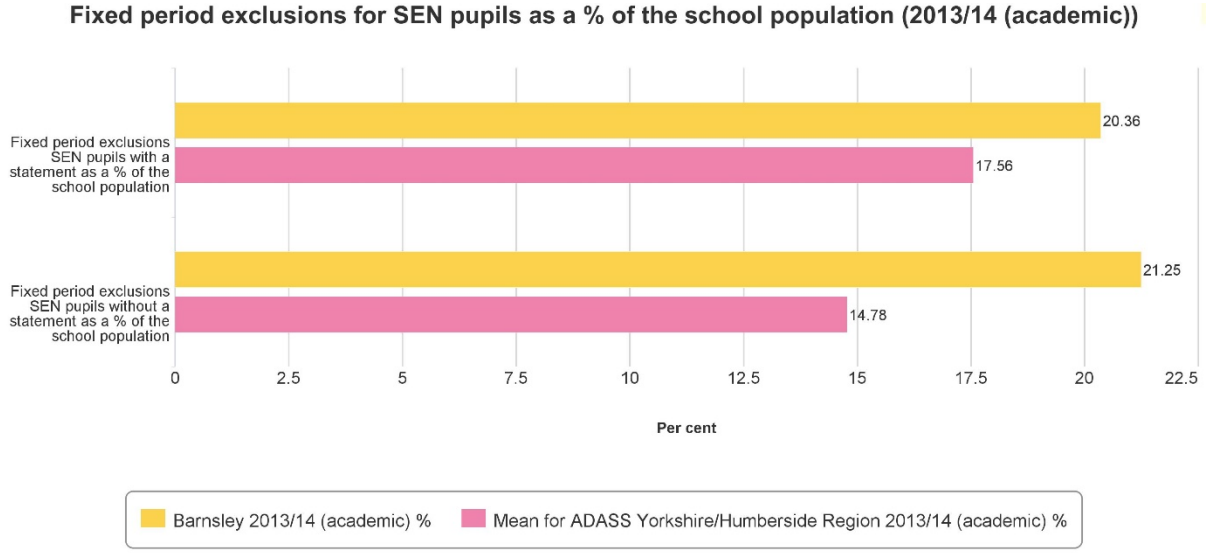
Exclusion

Fixed period exclusion refers to a pupil who is excluded from a school for a set period of time. A fixed period exclusion can involve a part of the school day and it does not have to be for a continuous period. A pupil may be excluded for one or more fixed periods up to a maximum of 45 school days in a single academic year.

In Barnsley, the rate of fixed term exclusions for SEN pupils - calculated by taking the number of fixed term exclusions for SEN pupils and dividing it by the total number of SEN pupils in the LA - was 20.36%. The compares to an average of 17.56% in the Yorkshire/Humberside Region.



Source:
Metric ID: 4732, Department for Education, Permanent and Fixed Period Exclusions from Schools in England
Metric ID: 4729, Department for Education, Permanent and Fixed Period Exclusions from Schools in England

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The Graduated Response to Supporting Children, Families and Practitioners:

To ensure that this strategy is sustainable and that positive outcomes are a natural part of life for children and young people with SEN or Disability and their families significant work is required around the development of a model of support across the continuum. There is both a national and local drive to build a Sector Led Model of support and it is therefore essential that this strategy builds positive foundations for this. Across Barnsley there is a breadth of knowledge and skills which will be required to support effective sustainable models, a skilled workforce and confident families.

The model intended is a “Hub and Spoke” approach which will look to develop alliances and partnerships across community level and borough wide multi agency support. It is intended that this model will ensure that the right support is put in place at the right time for both the child and their family.

SEN Support/Local Offer

1. Early intervention and Prevention
   - work with provision to assess needs of school related to individual and local need
   - work with providers to create and implement a clear pathway for progression for children academically, emotionally and socially

- create Communication Hubs to enable planned and proactive interventions to take place

2. Support the development of a Physical Health and Well Being Curriculum

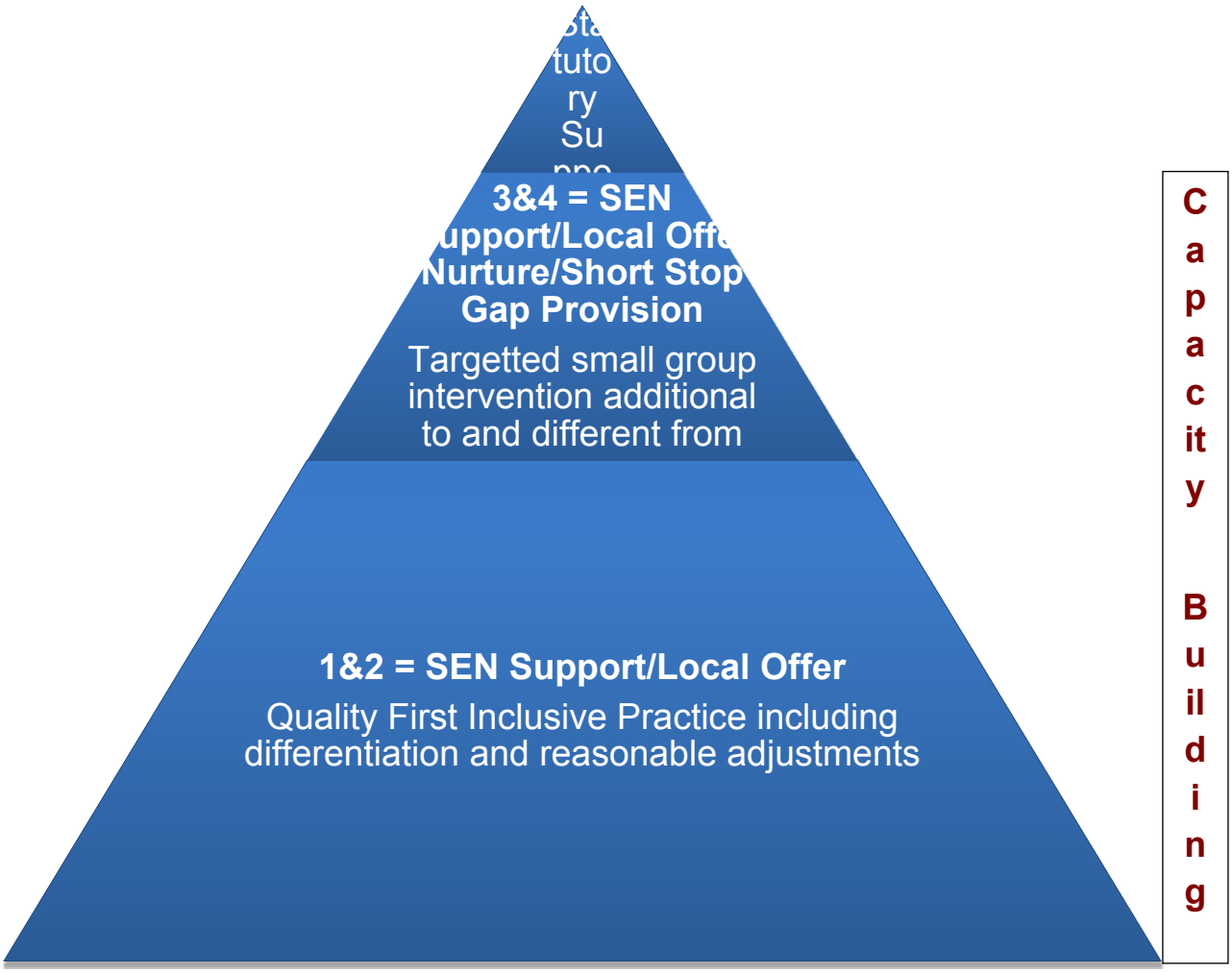
SEN Support/Local Offer next step

Nurture/Short Stop Gap Provision

3. Work with provision and the community to develop personal development, behaviour and welfare support
   - "step in" support to provide interventions to reintegrate and minimize disruption and learning
4. Alternative Provision and inclusion to be developed across schools, communities and multi-agency staff through the Hub and Spoke Approach

What are we aiming to do?

1. Improve provision for, and access to, local services in education, care and health, which means families can access appropriate health, care and social opportunities locally and fewer children will need to be educated out of their local area and out of the borough.
2. Develop the quality and capacity of early years' providers, schools and colleges, in order to meet the needs of local families and their children with SEN and disability. We want to provide the training and support they need.
3. Develop the broadest range of providers to increase parental choice and offer provision which offers a flexible match to the needs of children and young people. We want a continuum of provision across mainstream and special education so that providers can develop and maintain specialist skills.
4. Improve progress rates and outcomes for all children and young people with SEN and those who are disabled so that we close the gap between them and other children and achieve outcomes which are above national expectations.
5. Build parents' confidence in the support provided and improve the engagement of parents by providing them with timely information, advice and support.
6. Develop and improve services for children, young people and families with their active participation and make available personal budgets where it will improve independence and choice.
7. Deliver greater local integration and coordination of education, health and care services and plans for children and families in Barnsley ensuring this is extended to young people aged 25 and promote positive and seamless transitions at all stages between the ages of 0-25.
8. Develop innovative approaches to addressing gaps in services through joint commissioning and using evidence-based practice and research to improve the quality and availability of provision 0-25, with good transition to adult services.
9. Ensure we improve the effective and efficient use of our resources to meet increasing demand and remove perverse incentives so that costs do not continue to escalate.



Personalisation in Barnsley

What are we are trying to address?

1. High concentration of resource at the highest level of intervention rather than a graduated response including early help for children and young people with a specialist educational need and disability.
2. Defining the Core Offer of Service in relation to Personal Health Budgets (expansion beyond continuing care)
3. A mechanism for allocating indicative budgets and forecasting costs.
4. Issues around block contracts and the facilitation of personal budgets.
5. Capacity to be able to facilitate personal budgets through the existing infrastructure/resource within children's services.
6. Issues in relation to workforce development which will focus on a different way of providing services both strategically and operationally.
7. To meet the requirements of the new Ofsted Inspection Framework/NHS England expectations/SEND Code of Practice.
8. How to fully integrate services to ensure effective and coordinated decision making processes, joint commissioning and service delivery.

What do we want to focus on/develop/do differently?

1. Adopt an asset focused, person-centred thinking and planning approach to understand families' skills and knowledge, resilience, finances, social networks and involvement in community activities. A cultural change in the way that we listen to and engage with parents, carers, children and young people resulting in coproduction of policy, services and individual plans.
2. Analyse needs and strengths; be clear about what works to improve outcomes in order to inform decisions about how to organise, re-organise or decommission services. This will include focusing on the real cost of in-house and externally provided services, the outcomes they achieve and the contractual costs.
3. Share learning between adult and children's service.
4. Continue to develop established joint commissioning arrangements through the Children and Young People's Trust.
5. Provide the leadership capacity and strategic drive required for whole system change.
6. Support practitioners through training and development to change the way they work with children, young people and families so they can address outcomes differently.

What is already in place to support development?

1. Aligned budget arrangement with the CCG and a delegated commissioning function in relation to children's services and securing joint care packages.
2. Strong Children's Trust and Governance Arrangements
3. Established Panel arrangements for joint commissioning/allocation including Education, Health and Care Plans.
4. Parents starting to engage with strategy development.

Next steps:

1. Develop an action plan for the development of the core offer, strategy, promotion and implementation of personal budgets in conjunction with the CCG and adult services.
2. Ensure personal budgets are embedded within the work programme for the Disabled Children's Programme Board and regular progress is reported to TEG and ECG.
3. Implement learning from the NHS England Personal Budgets Development Programme alongside colleagues from adult social care and the CCG.

What do we think success will look like?

1. Single or coordinated strategy for the development and implementation of personal budgets across education, health and social care services (0 to 25+).
2. Improved attainment and progression of pupils with SEND.
3. Well planned continuum of provision from 0 to 25 which meets local need and reduces levels of specialist provision and increases levels of inclusive practice and reasonable adjustment.
4. Improved early identification of SEND and efficient production of EHC plans.
5. Young people with SEND will make a fulfilling transition to adult life.
6. Coproduction of services at an individual and strategic level with children, young people and families.
7. A clear core offer, robust service pathways and transparent decision making processes.
8. Integrated and effective financial arrangements between the local authority and CCG

9. A skilled professional workforce which understands SEND and works hard to achieve the best possible outcomes for children young people and families which will help to foster support for personal Budgets and further develop the personalisation agenda through a cultural change and developed joint commissioning and procurement arrangements.
10. A confident and competent workforce to support children, young people and families who want a personal budget.
11. A developed infrastructure within children's services to support direct payments.

Proposed Core Offer for Personal Budgets:

- Child Care for Children with SEND
- Children's Continuing Health Care
- SEN range 4 and above
- Short breaks for children with a disability and complex health need
- Specialist Equipment

High Level Action Plan

Objective	High Level Actions	Measurement of success
1. **Continue to raise attainment of children and young people with SEND and their families**	Support schools and educational settings to raise the attainment of children and young people with SEND. a) Increase opportunities for school to school support through the Barnsley Alliance and building a stronger Inclusion network. b) Work in partnership with specialist provision and local authority outreach and support services to build greater skills and confidence on SEN in mainstream schools.	Improvement in Pupil Performance data. Increase in the number of schools supported by special schools.
2. Strengthen early identification of SEND and improve efficiency of production of EHC Plans to ensure children's needs are met promptly	Target support in the Early Years so that we can identify children with SEND as early as possible. a) Work with all our Early Years settings, including Family Centres and other partners, to put in place early intervention mechanisms so that children's learning and development is maximised at this crucial time.	Improvement In Early Years progress data. Improvement in the production of EHC Plans within 20 weeks.

Objective	High Level Actions	Measurement of success
	b) Improve the efficiency of producing EHC Plans.	
3. Develop a single plan approach to integrated multi agency working	Review how our multi-agency 'team around the child' and early support processes: a) Can work to reduce bureaucracy and avoid duplication wherever possible. b) Pilot a 'Single Plan' approach for eight young people with exceptionally high levels of need. c) Work in partnership with education, NHS and care providers and try and meet their needs locally.	Increased number of plans with a team around the child approach. Plan in place for the continued production of Education, Health and Care Plans.
4. Support young people to make a fulfilling transition to adult life	Support every child and young person with SEND to help them make a successful transition in this period of significant change. a) Start early, be flexible and try and tailor our support to the individual young person and their family. b) Make sure parents and carers have advice and guidance on what options are available. c) Work in partnership with parents and carers to enable them to take part in the decisions about their child's needs and support arrangements.	Improved clarity in IAG for parents and carers. More options/places available to young people for post 16 education and training. More parents/carers involved in transition planning.
5. Ensure parents and carers, children and young people are able to participate more in decision making	Provide opportunities for more parents, carers and young people to have increased opportunities to participate in changes to strategies and on-going evaluation of our services. a) Determine how best we can get feedback from children and young people with SEND about their educational experiences.	Increased number of person centred reviews. More plans informed by children and young people's views. Improved outcomes and satisfaction levels reported by children, young people, and parents/carers.
6. Work towards making sure that parents and carers receive the right support	Support Barnsley Parent Carer Forum to	Views informing service delivery.

Objective	High Level Actions	Measurement of success
	a) Improve parent consultation. b) Fully review all our services for parents and carers annually, using the feedback they have given us. c) Involve them in this review to help parents and carers access support and advice at the right time.	
7. Ensure that all information that goes to parents and carers is clear and accessible	Improve communication pathways to parents and carers. a) Develop further the local authority SEND web pages to provide information about local services and guidance for parents and carers and professionals and the range of services, the full range of educational provision available and how transitions between children and adult services are coordinated. b) Ensure this and all information is clear and accessible and written in everyday language.	Positive feedback from parents and carers via parent carer forum group and survey about access to information.
8. Deliver the right provision and the right support arrangements at the right time	a) Work in partnership with mainstream schools to develop increased curriculum options for young people with learning difficulties to improve their qualifications and post 16 pathways. b) Work with the Colleges to help develop its provision to accommodate more high needs learners at age 16 and age 19. c) Develop a clear commissioning strategy which will set out a newly defined commissioning cycle that includes effective SEN resource planning, and new audited commissioning processes. d) Ensure best value for money out of borough places from special school places commissioned from independent providers. e) Explore collaborative commissioning arrangements with other boroughs	Improve post 16 opportunities available to students with SEND. Implement a commissioning strategy. Reduction in costs of out of borough placements via local negotiations with providers.

Objective	High Level Actions	Measurement of success
9. Develop a skilled professional workforce who are knowledgeable and confident about SEND	Offer an extensive SEND training programme for schools and educational settings to include leadership and management. a) Work with our partners to make sure that all those who work with children and young people with SEND have the necessary skills and confidence.	Training programme in place in response to workforce skills audit. SEN support services reviewed and strengthened in line with demand. More empowered and confident workforce as determined by survey feedback. More pupils and young people with SEND effectively supported
10. Develop personalization and personal budgets	Develop an Action Plan for the development of personal budgets in conjunction with the CCG and Adult Services Ensure personal budgets are embedded across the workflow of the DCYPP Board Implement the learning from the NHS England Personal Budgets Development Programme	Coordinated Strategy for the development and implementation of personal budgets A clear core offer, robust service pathways

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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 Executive Director, Place Directorate

TRAVEL ASSISTANCE POLICY – CONSULTATION RECOMMENDATIONS ON UPDATED POLICY

1. Purpose of report

1.1 The purpose of this report is to present the draft updated Travel assistance Policy. This is an updated document of the authorities' last Home to School Transport Policy 2015-16. This report conveys and highlights the main planned changes that the authority would like to see incorporated into the updated policy. This report seeks to gain support to consult with the residents and relevant stakeholders of the borough prior to an implementation of the updated policy planned for 1st April 2017.

2. Recommendation

2.1 That Cabinet supports the draft Travel Assistance Policy.

2.2 That Cabinet supports the decision to undertake a nine-week consultation period commencing in November on this updated policy.

3. Introduction

3.0 As part of Future Council, transportation for eligible children, young people and adults have been brought together under BU 6 Environment & Transport, within the Place Directorate. The current Travel Policy expires at the end of 2016. A 'One Council' joint task & finish group from different business units have worked together to update the policy in line with our corporate strategy; that is to support eligible children and adults with the provision of statutorily required services that encourage and support independence.

As part of this group's work it built upon the review of transport services undertaken in 2014. This work benchmarked our services against many other local authorities in the region. This draft policy has been centred on Doncaster's recent update of the policy to bring service convergence and consistency across south Yorkshire.

3.1 This draft updated policy has been developed around the following key aims:

- To meet our corporate strategy to create and support independence;
- To provide a more sustainable, efficient and effect service offer;

- To update our policy in line with best practices recommended by Department for Education;

- To align our updated policy more closely with our adjacent south Yorkshire authorities and those services that South Yorkshire Passenger Transport support; and

- To support and compliment the Barnsley SEND Strategy 2016-18.

3.2 This is part of a wider series of changes being introduced to improve the service offer to eligible children and adults across the borough. The four key themes of this work are:

1. To improve the daily operations of the transport service to eligible children, young people and adults;

2. To improve the provision of services through better use of third party providers;

3. To update and improve the provision of services through a refocussed Travel Assistance Policy; and

4. To work with other authorities and the SYPTE to bring about improved collaborative working and better use of resources.

3.3 This Policy is prepared in response to the duties of Barnsley Metropolitan Borough Council (BMBC), under section 508B of the Education Act 1996, (amended by Education and Inspections Act 2006) which deals with the duty of Local Authorities in England to ensure that suitable travel assistance as it considers necessary are made to facilitate attendance at school for eligible children or students. The Council's policy is to provide free school transport (referred to in the Act and in this document as "Travel Assistance") to these categories of eligible children in accordance with its legal obligations, but not otherwise unless there are exceptional circumstances. This travel assistance policy has been designed to and compliments the school curriculum in providing the skills to create independence. It will provide support to eligible children to encourage independent travel.

The policy summarises the categories of eligible children set out in the Act who are entitled to travel assistance. It also sets out how parents or carers must apply for travel assistance, how decisions are made and how parents and carers may appeal against decisions that they are unhappy with.

3.4 Key changes to the policy include:-

3.4.1 Introduction of a hierarchy of options: To encourage and support the strategy of creating independence. Unless otherwise specified, travel assistance will normally comprise of one of the following options for pupils:

- A Zero Fare Pass (ZFP) Passes are purchased by the LA from South Yorkshire Passenger Transport Executive (SYPTE);
- Personal Budgets – In Particular for pupils having SEN or EHCP, provision of payment through personal budget;
- Mileage Reimbursement – Paid half termly or termly retrospectively, based on the Families choice;
- Independent Travel Training – Provision of training as part of a pupils curriculum to encourage independence; and
- Travel Assistance - Via a coach, mini-bus, people carrier or taxi/private hire or similar vehicle.

3.4.2 The introduction of annual reviews: As part of the LA's corporate strategy to develop people to their full potential aligned with the Key Stages of the educational curriculum, the Travel Assistance provision will be reviewed to assist in the development of independence for any qualifying pupil who is in receipt of services through this policy. At the present moment this is not a formal part of the process and will place a demand on both People and Place directorates.

3.4.3 Greater dependency and use of Travel Training as an option: Historically this has been a reactive and passive-based service. The updated policy will consider this as a clear option within the hierarchy. The benefits of travel training are proven to show greater access to education and employment opportunities. In addition the outcomes from this included greater accessibility, road safety awareness, improved health and a reduction of dependency of social services and the like. This will place a resource demand on the Communities directorate's Travel Training team.

3.4.4 The introduction and use of the Personal Budget: Represents a change in the provision of services within this policy. It seeks to place the choice of provision with the parents and carers. This process will place a resource demand on People and Place directorates with respect to the administration and management.

3.4.5 Review of the appeals process: The present appeals process was not in keeping with the best practice advised by the Department for Education. Therefore this has been amended.

3.4.6 Following the consultation in 2015 with respect to removing non-statutory transport for post 16 with an SEN statement; this element of the policy has been retained. This was an approved KLOEs to save £40k.

4. Consideration of alternative approaches

N/A

5. Proposal and justification

5.1 Presently there are a number of significant changes in national policy for health, special educational needs and disability, which will impact upon the delivery of this service, by increasing demand on limited resources.

5.2 In January 2015, Barnsley's SEN population was 16.1% compared with 15.4% nationally.

5.3 Barnsley generally has higher numbers of children subject to a statement of SEN or an Education, Health & Care Plan (EHCP) than is the case regionally, 1.3% higher and nationally 1% higher.

5.4 Statements / EHCP as a % of school population (Jan 2015)

- England 2.85%
- Yorkshire & Humber 2.4%
- Barnsley 3.8%

5.5 Barnsley has good provision of specialist educational establishments within the borough, albeit as of May 2016 there are 92 children placed in out of borough independent special schools. This number is increasing each year.

5.6 The following table indicates the recent change in demand since April 2014.

Objective Measure	Apr 14	Apr 15	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Comments
Number of Children Statutory (Mainstream) Zero Fare Passes (ZFP)	566	511	478	478	478	478	478	378	448**	
Number of Children Statutory Special Educational Needs (SEN)	392	448	495	492	501	501	501	508	519	
Average Cost per Child – SEN	-	-	14.68	14.63	14.91	14.91	14.91	Not yet confirmed	Not Yet confirmed	Purchased Orders are Still being raised
Number of vehicles used	85	96	100	100	100	100	100	96	105	
Number of Escorts used	60	65	71	71	71	71	71	81	83*	

*This figure includes some parents who are acting as escorts for their own children.
** Number of ZFP on issue as at 07/10/16. This is ongoing. As expected, sporadic applications are still being received.

5.7 The following table identifies the number of children we are providing services to:

Category of Pupil/Student	As at 07.10.2016	Remarks
Mainstream - Zero Fare Passes (ZFP)	448	Daily requests still being made for service

Statutory Pupils aged 5 to 16 - SEN	429	Transport provided to Special Schools both in and out of the Borough.
Pre 5 - SEN	5	4 to Greenacre & 1 to Royston Meadstead Primary
Post 16 - Mainstream	0	Nil
Post 16 - SEN	84	71 to Greenacre & 13 to other Schools
Post 19	1	to Portland College, Notts. This placement ceases at the end of this academic year.
TOTAL	**967**	

5.8 To deliver the key aims of section 3.1 this policy represents a conscious change strategically from a policy based upon provision of transport services to one that provides assistance with transport services. This aligns with one of our Future Council Priorities - 'People achieving their potential' and is centred upon providing assistance where appropriate to help people help themselves; it is about being an enabling organisation.

5.9 The key changes to the new draft Travel Assistance Policy and those that we need to consult over are:

- Greater promotion and planned use of the Travel Training service;
- Introduction of payments for transportation alternatives within a Personal Budget; and
- Deletion of travel assistance for pupils' attending denominational schools.

5.10 In 2015, a seven-week consultation period ran from 23rd February, to 17th April. It sought the view of parents, carers and guardians of children who received free home to school transport services, in particular for the following proposed changes:-

Pre-School Children:

Either
- Withdraw or phase out free, non-statutory home to school transport for pre-school children, or
- Introduce a charge for this service.

Young People Aged Over 16:

Either
- Withdraw or phase out free, non-statutory home to school transport for young people aged over 16 with SEN or
- Introduce a charge for this service

5.11 The outcome from this consultation for pre-school children was to make the changes to this updated policy for non-statutory home to school. For 16/17 there are not any pre-school children that this service is provided to.

5.12 The outcome for young people aged over 16 with SEN for non-statutory home to school was overwhelmingly in favour to retain the service. As part of the

consultation there was concerns raised by equality forums, local MPs and those that used the Engage system.

6. Implications for local people / service users

No immediate changes as a result of this updated policy. Eligible children and young people in receipt of services through this policy will continue to receive services, albeit this will change and evolve over time as the reviews of services becomes more embedded into the process and as we seek to provide services that help people help themselves.

7. Financial implications

7.1 The Travel Assistance function continues to face significant financial pressures. Whilst the additional cost as a result of the increase in users of the service has been recently recognised within the Council Medium Term Financial Strategy, the service still shows a forecast overspend as reported in the recent Quarterly Monitoring Report.

7.2 Future delivery of a balance budget for the service is heavily predicated on the adoption, strict control and adherence of this new policy. This will be monitored carefully form 1st April 2017 with any variations reported through the normal financial performance monitoring route

8. Employee implications

N/A

9. Consultations

Internal consultation has been undertaken. External consultation has been undertaken with other local authorities. Previous consultations on Home to School have also been considered in the development of this report and appendix. This report seeking support to consult with service users and key stakeholders.

10. List of Appendices

10.1 Appendix one – draft Transport Assistance Policy

11. Background Papers

None

Office Contact: Paul Castle Telephone No: 01126 772057 Date: 24/10/2016

BARNSLEY
Metropolitan Borough Council

Barnsley Metropolitan Borough Council

Draft Travel Assistance Policy

Date: DD/10/2016 **APPENDIX 1**

CONTENTS

Information can be made available in other languages, on other formats such as Braille or Audio Tape, on request. Please contact xxxxxxxx.

1. GENERAL

This Policy is prepared in response to the duties of Barnsley Metropolitan Borough Council (BMBC), hereafter known as the Local Authority (LA) (See note 1), under section 508B of the Education Act 1996, (amended by Education and Inspections Act 2006) which deals with the duty of Local Authorities in England to ensure that suitable travel assistance as it considers necessary are made to facilitate attendance at school for eligible children or students. The Council's policy is to provide free school transport (referred to in the Act and in this document as "Travel Assistance") to these categories of eligible children in accordance with its legal obligations, but not otherwise unless there are exceptional circumstances. This travel assistance policy has been designed to compliment the school curriculum in providing the skills to create independence. It will provide support to eligible children to encourage independent travel.

This policy summarises the categories of eligible children set out in the Act who are entitled to travel assistance. It also sets out how parents or carers must apply for travel assistance, how decisions are made and how parents and carers may appeal against decisions that they are unhappy with.

The policy is intended to provide clarity for parents or carers facing a wide range of circumstances, and to ensure that children and young people with particular and significant needs according to the eligibility criteria are appropriately supported. However, it is the legal responsibility of parents or carers of each child or young person to ensure they attend school regularly.

1.1 The primary responsibility for ensuring pupils and students attend school or college is that of the parent or carer (see note 2). However, section 444(3B) provides a parent with a defence if he or she proves that:

- The LA has a duty to make travel arrangements in relation to the child under section 508B and has failed to discharge that duty.

Schedule 35B of the 1996 Act (amended by the Education and Inspections Act 2006) defines "eligible children" as those categories of children in an authority's area for whom travel arrangements will always be required. A condition of each category is that they are of compulsory school age. Under section 508B, these arrangements must be provided free of charge.

1.2 Unless otherwise specified, travel assistance will normally comprise of one of the following options for pupils:

- A Zero Fare Pass (ZFP) Passes are purchased by the LA from South Yorkshire Passenger Transport Executive (SYPTE). This allows pupils to travel free of charge between the bus stop nearest to their home address, and the school/college or the nearest bus stop to the school/college they attend, on commercial or tendered bus services. A full explanation of the criteria and how to apply is available at www.barnsley.gov.uk and search for ZFP.

  The criteria and provision of a ZFP apply to both Mainstream and SEN (Special Educational needs) pupils.

- Personal Budgets – In Particular for pupils having SEN or EHCP, provision of payment through personal budget will be considered as an eligible way of the LA fulfilling its requirement under this policy for the provision of Travel Assistance.

- Mileage Reimbursement – Paid half termly or termly retrospectively, based on the Families choice and correct submission to the Home to School Transport Office of mileage claim forms. Reimbursement is calculated on 2 journeys per day and the actual mileage multiplied by the number of days the pupil has attended. (See Section 14)

- Independent Travel Training – Provision of training as part of a pupils curriculum to encourage independence. This will require plans to encourage independent travel to be put in place by the Travel Training team, school/college and parents/carers working in partnership. Progress should be evidenced at each annual review. There is a specific duty on schools and LAs to begin planning for the transition to adulthood formally from Y9. (See Section 9)

- Travel Assistance - Via a coach, mini-bus, people carrier or taxi/private hire or similar vehicle for pupils identified as having Special Educational Needs (SEN) or for children who are disabled. (See section 9/10) As determined by the LA as appropriate to meet the child's individual needs.

1.3 As part of the LA's corporate strategy to develop people to their full potential aligned with the Key Stages of the educational curriculum Travel Assistance provision will be reviewed to assist in the development of independence for any qualifying pupil who is in receipt of services through this policy.

1.4 The LA is not able to provide free Travel Assistance to pupils who are In transition between schools, or attending 'taster sessions' at new schools. Travel can only be provided to the School where a Pupil/Student is on roll.

1.5 Assessments of Travel Assistance managed through this policy will be awarded on the basis of hierarchy of travel Assistance detailed in 1.2.

2 PUPILS UNDER THE AGE OF 4 YEARS

2.1 Other than for a child with a statement of SEN or Education Health Care Plan (ECHP) who has had transport approved in accordance with Section 9, no assistance with transport shall be given to a nursery aged child.

3 PUPILS AGED 4-7 ATTENDING THEIR CLOSEST SCHOOL

3.1 For pupils less than 8 years of age (on 1 September), free transport will be provided where the distance between their home and allocated school is 2 or more miles, measured by the nearest available walking route (hereafter referred to as statutory qualifying distance – see note 4). Free transport will

normally be facilitated through the provision of a zero fare bus pass for the child.

3.2 Pupils living less than the statutory qualifying distance may be eligible for free travel if the LA determines that they qualify under section 7.

3.3 Parents/carers should ensure their child's safety by making appropriate arrangements for their child to be accompanied to and from the nearest bus stop and during the journey if required.

4 PUPILS AGED 8-16 ATTENDING THEIR CLOSEST SCHOOL

4.1 For pupils who are aged 8 years or older (on 1 September) and still of compulsory school age, free transport will be provided where the distance between their home and allocated school is 3 or more miles measured by the nearest available walking route (hereafter referred to as the statutory qualifying distance – see note 4). Free transport will normally be facilitated through the provision of a zero fare bus pass.

4.2 For pupils who move home within the Barnsley Metropolitan Borough Area whilst in Years 10 or 11, and who wish to remain at the school they have been attending to complete their examination course, free transport will be provided where the distance between their new home and their school is more than the statutory qualifying distance. Free transport will normally be facilitated through the provision of a zero fare bus pass.

4.3 For pupils from low income families please refer to section 7.

4.4 Parents/carers should ensure their child's safety by making appropriate arrangements for their child to be accompanied to and from the nearest bus stop and during the journey if required.

5. PUPILS ATTENDING DENOMINATIONAL SCHOOLS

5.1 From September 2016, the LA is no longer able to provide transport on denominational grounds. Pupils who were previously entitled to free transport on denominational grounds and who qualified under the low income category (See Section D on previous Home To school Policy) prior to September 2016, will continue to receive a free Zero Fare pass until they reach the end of their particular phase of education, i.e. until the end of primary education in Y6 or until the end of statutory secondary education in Y11.

6 PUPILS NOT ATTENDING THEIR CLOSEST SCHOOL

6.1 The LA recognises the rights of parents given under the Education Act, 1996 to express a preference for their choice of school and the duties on the LA under the same Act in respect of those preferences expressed. However, in order to ensure the efficient use of its resources, the LA will normally only provide free travel to pupils meeting the relevant eligibility conditions attending:

- The school designated as the closest school for the area in which the LA has determined the pupil is ordinarily resident for the purposes of

admissions to schools. An exception to this policy is made, and assistance in the form of a ZFP will be offered for pupils in the following circumstances:

a) Where the parents/carers have chosen for their child not to attend the allocated school and have accepted a place for him/her at an alternative school, which is the statutory qualifying distance appropriate to the age of the pupil from where the pupil is ordinarily resident but is nearer than the allocated school.

b) Where the LA is unable to make a place available at the pupil's allocated school, and makes a place available at the next nearest school which is the statutory qualifying distance appropriate to the age of the pupil from where the pupil is ordinarily resident.

c) Where the parents/carers have chosen for their child not to attend his/her allocated school and have accepted a place for their child at an alternative school, which is the statutory qualifying distance appropriate to the age of the pupil from where the pupil is ordinarily resident, providing the LA does not incur additional expenditure. A ZFP to enable the pupil to attend the alternative school will be provided equivalent to that which the pupil would have received had s/he attended either the, allocated, school as the case may be.

6.2 Where a pupil qualifies for travel assistance under these exceptions, the parents/carers should ensure their child's safety by making appropriate arrangements for their child to be accompanied to and from the nearest bus stop if required.

6.3 The LA is not in a position to guarantee travelling arrangements to any school; such arrangements are entirely in the hands of the providers of bus services and/or SYPTE.

6.4 When selecting alternative schools, parents/carers must do so in the knowledge that, unless they qualify under the above exceptions, free transport, or assistance with transport costs, will not be available, regardless of the distance involved. They should also consider, as a factor in making their decision, the consequences of possible future alterations to bus services.

7 PUPILS FROM LOW INCOME FAMILIES

7.1 The Education and Inspections Act 2006 introduced free transport assistance for pupils from low income families. Pupils who qualify under this legislation are pupils in receipt of Free School Meals (FSM) or whose families are in receipt of Maximum Working Tax Credit (MWTC). Pupils meeting the following criteria will receive transport usually in the form of a zero fare bus pass.

7.2 Primary Pupils

Pupils aged 8 to 10 who are attending their allocated school* and the distance between home and school is more than 2 miles

7.3 Secondary School Pupils

Pupils aged 11 to 16 attending any 1 of their 3 allocated school * where the distance between home and school is more than 2 miles but not more than 6 miles from their home address

7.4 Pupils attending School on grounds of Religion or Belief

Pupils up to 16 years of age attending their nearest appropriate denominational school on grounds of religion or belief, where the distance between home and school is more than 2 miles but not more than 15 miles.

7.5 Distances referred to in this section are measured as follows:

- Up to 2 miles – as per the statutory walking distance, along the nearest available walking route.

- The 6 miles upper limit or the 15 miles upper limit – along road routes passable by suitable motorised transport.

*The nearest allocated school is one with places available that provides education appropriate to the age, ability and aptitude of the child.

7.6 Once eligibility has been determined and confirmed, the pupil will remain eligible until the end of the school year for which the assessment has been made. This particular section does not cover the provision of Mi. cards, Student passes or any other concessionary travel passes.

8 POST 16 – SIXTH FORM/FURTHER EDUCATION STUDENTS

8.1 The Council does not provide free transport for Post 16 students entering into further education at Sixth form or College for the first time or undertaking new courses.

9 SPECIAL EDUCATIONAL NEEDS: PUPILS AND STUDENTS (UP TO THE AGE OF 19)

9.1 General

Each pupil or student identified by the LA as having (SEN) (under the four overarching types of need: Communication and Interaction, Cognition and Learning, Sensory and/or Physical or Social, Emotional and Mental Health), will have their individual transport needs assessed against set agreed criteria, taking into account their age, mobility and the effect of their special educational needs on their ability to travel. If it is concluded that a pupil or student does not require Transport Assistance under this section, then consideration will be given under the other sections of this policy as appropriate.

9.2 Pupils and Students with a Statement of Special Educational Needs or Education Health Care Plan

For pupils and students being considered for an Education Health Care Plan or with an existing statement of SEN, an assessment of travel assistance need will be undertaken at the draft EHCP or amended EHCP or amended

statement of SEN stage. This will be shared with parents/carers who are encouraged to express their views about all aspects of their child's SEN provision, including transport. Travel Assistance is not included in a Statement of SEN but may be included in an EHCP Plan exceptionally, for example if Travel Assistance provision is agreed as part of a Personal Budget. Statements of SEN will cease by April 2018 and children will either have their needs met at the SEN Support Stage or with an EHCP.

9.3 The provision of Travel Assistance to meet a pupil or student's need will be in accordance with the provisions of this section and will be reviewed and, if necessary, reassessed at each annual review of the statement or EHCP. Where it is decided that:

- A Travel Assistance need is now required; or
- A Travel Assistance need previously identified should be modified to encourage independence or
- Travel Assistance is no longer required

9.4 Independent Travel Training

Our aim is for all secondary age pupils, and students over compulsory school age, with SEN who have previously been assessed as requiring Travel Assistance under this section, will receive support for independence and mobility training as part of their school/college curriculum with the aim of reducing their reliance on individual transport in preparation for adult life. This will require plans to encourage independent travel to be put in place by the Travel Training team, school/college and parents/carers working in partnership, to mutually agreed targets. Progress should be evidenced at each annual review.

9.5 Pupils and Students with Special Educational Needs but no Statement

For pupils and students with SEN but without a statement or EHCP, an assessment of Travel Assistance need will be undertaken by the appropriate Officer(s) at the time a decision on the provision to be made for the pupil or student to meet their need is taken. Where it is determined that the provision of a zero fare bus pass would not be appropriate to meet the needs of the pupil or student, the provision of Travel Assistance will be in accordance with the provisions of this section and will be reviewed and, if necessary, reassessed annually by the appropriate Officer(s).

Schools and parents/carers will encourage their children to take up public/community transport options at the earliest opportunity – this will be regarded as a positive achievement towards the pupil or student's attainment in becoming an independent traveller. Where transport is ceased under this section, pupils and students may be eligible for support under other sections of this policy as appropriate. For more details on the service and its benefits please see www.barnsley.gov.uk and search for the 'Free to go service'.

9.6 Provision of Transport for pupils and students with SEN

The type of transport assistance provided will be the most appropriate, taking into account the child's age, safety and needs as assessed in accordance with the approved assessment criteria. A pupil or student will be expected to share a vehicle with other pupils and/or students. Individual transport will only be provided in exceptional circumstances and where the need for individual transport has been clearly identified from the assessment under the approved assessment criteria.

9.7 Social reasons such as out of hours activities or parents/carers work commitments will not be regarded as valid reasons for determining the type of transport assistance for their child.

9.8 A ZFP will operate from the bus stop nearest to the pupil's home. Parents/carers should ensure their child's safety by making appropriate arrangements for their child to be accompanied to and from the nearest bus stop if required.

9.9 Pupils and students who are assessed as requiring travel on a coach, mini-bus, taxi/private hire or similar vehicle, will be picked up and dropped off at the most convenient designated point nearest to their home address, having due regard to their needs and safety this may be a designated bus stop. Pupils will only be guaranteed collection and drop-off from outside their home address if their needs exceptionally require this arrangement. It is the responsibility of parents/carers to ensure their child's safety by making appropriate arrangements to accompany their child to and from the designated pick-up point, or see them safely onto and off the vehicle.

9.10 Approval will not be given for ad-hoc or occasional variations to the arrangements determined by the LA. If parents/carers request a variation to the arrangements for example, for their child to be collected from, or dropped off at, a relative/neighbour/child-minder's address, consideration to an amendment to the agreed travel arrangements will only be given where:

- The request is for a permanent change on each school day; and
- No change to the transport provider will be required; and
- No additional cost will be incurred by the LA; and
- The request would not add unreasonable additional travelling time for other pupils in the vehicle.

9.11 Arrangements will be made to transport pupils with SEN as follows:

a)	day pupils/students	- at the start and end of each school/college day;
b)	pupils/students who board for 5 days	at the start and end of each - school/college week;
c)	pupils/students who board for 7 days	at the start and end of each - school/college term and half term.

In addition pupils who are in the National Curriculum Year Group 7 or below i.e. who have not yet had their twelfth birthday, and who board for 7 days, will be provided with additional return journeys for two weekends per half-term.

9.12 Any special equipment or supervision arrangements required because of the child's needs will normally be arranged by the LA.

9.13 No Travel Assistance will be provided under this section where the LA has identified an institution or provider to meet a pupil or student's need but the parents/carers preference is to send their child to a more distant institution, independent school or provider of the same type. For pupils and students with a statement of SEN or EHCP, this will apply irrespective of whether the institution or provider is named in the statement or EHCP, which will make clear there will be no support with transport.

10 SPECIAL EDUCATIONAL NEEDS STUDENTS OVER THE AGE OF 19

10.1 Individual Travel Assistance needs will be assessed against set agreed criteria, by the appropriate Officers of the Special Educational Needs (SEN) Transport Panel, for students who are;

- Over the age of 19 and under 25 years of age on 1 September each year; and
- Ordinarily resident in the LA area; and have, or have had previously, a statement of SEN, an EHCP and a Social Services Assessment of Need which includes, or included, in order to meet the needs of the student, a requirement for transport.
- Be registered or registerable as disabled under the Chronically Sick and Disabled Persons' Act 1970; and
- Attending a course funded by the Education Funding Agency, at an FE College which has been agreed as appropriate and that the course is a graduation/progression of a previous subject and that this meets the needs of the student. Unless attendance on a course at another institution has been agreed as more appropriate, to meet a specific educational and/or social need of the student.
- Progression in learning must be evidenced against outcomes in the EHCP. Lack of progression will mean that Travel Assistance will no longer be approved. Funding will not normally be provided where a student repeats a course or studies at the same academic level as one previously studied.

10.2 Assessment may include undertaking a transport assessment with trained travel trainers, and failure to attend this assessment could mean Travel Assistance is not provided. Where assistance with transport is deemed necessary it will be provided in accordance with the provisions of this section until the completion of the course for which it was approved or the end of the academic year in which the student attains the age of 25 years whichever is the earlier. Assistance with transport will, if necessary, be subject to an annual review and/or reassessment.

10.3 Provision of Transport

10.4 Students could be offered a ZFP to enable them travel free of charge between the student's place of ordinary residence and the college. Where a college has several sites at which the student is required to attend, free travel will be provided to one designated site only which is agreed between the LA, the student and the college authorities. Any inter site transfer will be the responsibility of the college to provide.

10.5 Social reasons such as out of hours activities or parents/carers work commitments will not be regarded as valid reasons for such an arrangement. It is the responsibility of parents/carers to ensure the student's safety by making appropriate arrangements to accompany them to and from the designated pick-up point, or see them safely onto and off the vehicle.

10.6 Where the LA has determined that transport using a ZFP is not appropriate, the type of Travel Assistance provided will be the most appropriate taking into account the student's age, safety and needs as assessed in accordance with the approved assessment criteria. A student will normally be expected to share a vehicle with other students. Individual transport will only be provided in exceptional circumstances and where the need for individual transport has been clearly identified from the assessment under the approved assessment criteria. Social reasons such as out of hours activities or parents/carers work commitments will not be regarded as valid reasons for determining the type of transport assistance.

10.7 Students who are assessed as requiring travel on a coach, mini-bus, taxi/private hire or similar vehicle, will be picked up and dropped off at the most convenient designated point nearest to their home address, having due regard to their needs and safety this may be a designated bus stop. Students will only be guaranteed collection and drop-off from outside their home address if their needs exceptionally require this arrangement.

10.8 Approval will not be given for ad hoc or occasional variations to the arrangements determined by the LA. If the student/parents/ carers request a variation to the arrangements for example, for their child to be collected from, or dropped off at, a relative/neighbour's address, consideration to an amendment to the agreed travel arrangements will only be given where:

- The request is for a permanent change on each college day; and
- No change to the transport provider will be required; and
- No additional cost will be incurred by the LA; and
- The request would not add unreasonable additional travelling time for other students in the vehicle.

10.9 Any special equipment or supervision arrangements required because of the student's needs will normally be arranged by the LA.

10.10 Arrangements will be made to transport students as follows:

a) Day students - At the start and end of each college day;

b) Students who board for 5 days
- At the start and end of each college week;

c) Students who board for 7 days
- At the start and end of each college term and half term.

11 PUPILS AND STUDENTS IN PUBLIC CARE (UP TO THE AGE OF 19)

The LA recognises its duties and responsibilities in respect of pupils and students in Public Care. For the purposes of determining any assistance with Travel Assistance pupils and students in public care will be considered under the appropriate section of this policy.

12 EXCLUDED PUPILS AND STUDENTS

12.1 Pupils of Compulsory School Age Attending Schools:
Where a pupil has been excluded from their school and the LA allocates an alternative school which is within the statutory qualifying distance appropriate to the age of the pupil from where the pupil is ordinarily resident, a ZFP will be provided, to enable the pupil to attend the allocated school.

12.2 Where the parents/carers of the pupil choose for him/her not to attend the allocated school and accept a place at an alternative school, which is the statutory qualifying distance appropriate to the age of the pupil from where the pupil is ordinarily resident, to the extent that the LA does not incur additional expenditure, a ZFP to enable the pupil to attend the alternative school will be provided equivalent to that the pupil would have received had s/he attended either the allocated, school.

12.3 Where a pupil qualifies for assistance with transport under this section, the parents/carers should ensure their child's safety by making appropriate arrangements for their child to be accompanied to and from the nearest bus stop if required.

12.4 The LA is not in a position to guarantee travelling arrangements to any school – such arrangements are entirely in the hands of the providers of bus services and/or SYPTE.

12.5 When selecting alternative schools, parents/carers do so in the knowledge that, unless they qualify under the above exceptions, free transport, or assistance with transport costs, may not be available, regardless of the distance involved. They should also consider, as a factor in making their decision, the consequences of possible future alterations to bus services.

12.6 Pupils of Compulsory School Age attending other Provision:
Where a pupil has been excluded from their school and the LA arranges provision for the pupil at institutions other than a school, assistance with travel will be considered under Section 12.1/12.2 of this policy.

13 REQUESTS FOR MILEAGE REIMBURSEMENTS

13.1 **Eligibility**

In order to qualify for Mileage Reimbursement a pupil must satisfy the following criteria:

- The pupil must have an EHC Plan or SEN; and
- Must fall into one of the four categories of 'eligible child' (please see Note 7 for definition of 'eligible child').

13.2 **Reimbursement of Mileage Expenses**

Mileage Reimbursement will be paid termly or half termly calculated on the actual mileage allowance multiplied by the number of days the pupil is expected to attend. Payment is based on 2 journeys per day will be paid by BACS transfer; parents will need to supply bank account details to enable this to take place.

Mileage Reimbursement will be paid at the following rates in accordance with the rates outlined below:

	Circumstances	Suggested Rate Per Mile
1	Parents offer to undertake transport but pupil can fit on existing transport at nil cost.	Nil – Request refused
2	Parent offers to transport their own child no other run in place.	23p (taken from AA motoring costs mid-point) **NB:** Rate based as at August 2016 will need to be reviewed on an annual basis as rates change.
3	Local Authority requests parents to transport own child as LA is unable for whatever reason to provide safe transport (e.g. Health and Safety).	40p This is the current BMBC car mileage rate

The payment will be calculated using the mileage between home and school E.g. 10 miles between home and school. The mileage will be determined by the shortest route using the Council's Geographical Information System.

E.g. 10 miles home to school – 1 journey home to school & 1 journey school to home – 20 miles @ 23p x number of days = £

NB: Please note that this payment is based on the assumption that the pupil will attend school regularly in order for this payment to continue. Any long term absence will result in a corresponding deduction in any future termly payments and/or a request for repayment to the Council, as deemed appropriate in the circumstances.

14 APPEALS

14.1 Parents/carers will have the right to appeal against any decision to refuse requests for assistance with travel made by Officers of the LA under this policy.

This will be a 2-stage process as follows:

14.2 **Stage One Review**

This Review will be undertaken by a Senior Officer of the Council.

- Parents/carers will have 20 working days from receipt of the local authority's decision to refuse their application to complete and return a Notice of Appeal Form requesting a review of the decision. This form should be completed by the parent/carer and give details of any personal or family circumstances that the parent/carer believes should be taken into account when the decision is reviewed.

- Within 20 days of receipt of this form, the Senior Officer will review the case and send out a letter notifying the parent/carer of the decision.

- The letter should explain how the review was conducted, information about other Departments or Agencies that have been consulted as part of the process, the rationale for the decision reached and information about how the parent can escalate their case to stage 2.

14.3 **Stage Two Review**

This Review will be undertaken by an independent appeal panel facilitated by the Council Governance Unit

- A parent/carer will have 20 working days from receipt of the Stage 1 decision to make a written request to escalate the matter to Stage 2.

- The Council Governance Unit will be informed that an appeal has been received, they will arrange a date for the Hearing and will send out Agendas and invites to the meeting.

- Within 40 working days of receipt of the parent/carer's request the Council Governance Unit will consider written and verbal representations from both the parent and Officers of the council involved in the case.

- The Council Governance Unit will send out notification of the outcome of the appeal within 5 working days which will set out:

    - The nature of the decision reached.

    - How the review was conducted, information from other agencies or departments consulted, what factors were considered, the rationale for the decision reached and information about the parent's right to put the matter to the Local Government Ombudsman.

- It will be made clear that a referral of a complaint to the Local Government Ombudsman should only be made if the complainant considers that there was a failure to comply with the procedural rules or if they consider that there have been any irregularities in the handling of the appeal.

14.4 All hearings of the Panel will be conducted in accordance with the approved LA protocols.

15 CEASING ASSISTANCE WITH TRANSPORT

15.1 The LA has adopted a Code of Practice for the safety and behaviour of pupils where Travel Assistance is provided. If any pupil persistently endangers their own safety or that of others by not adhering to the Code of Practice, consideration will be given to ceasing their Transport Assistance and parents/carers will then be expected to make alternative arrangements to ensure their child attends school.

15.2 In addition to the Code of Practice the LA has, in conjunction with the other 3 South Yorkshire Authorities and SYPTE, produced a policy for managing criminal and unacceptable behaviour on public transport. Any breach of this policy may result in the withdrawal of the zero fare bus pass and/or further measures being taken as appropriate.

15.3 As part of the provision of services provided by the LA through this policy we would ask that the following points are met with regards to acceptable behaviour of students and families. More information on this can be found in the parents hand book. Failure to adequately meet these criteria could result in the Travel Assistance provision from being removed on a temporary or permanent basis. As follows:

- To behave
- Be polite
- To be timely
- The parents or carer notify the LA if the child is not attending school as soon as possible.
- Do not keep the vehicle waiting – Transport can only wait for a maximum of 5 minutes

15.4 In cases where individual transport is provided by taxi or minibus, parents are requested to cancel transport when not required i.e. in case of holidays or illness. Repeated failure to cancel transport when not required may lead to a recharge of the cost or ultimately cancellation of the transport.

15.5 The LA shall consider withdrawal of the provision of free Travel Assistance, where a child has demonstrated such poor behaviour whilst using that transport as to put at risk themselves or other persons on the vehicle, as follows:

(a) The driver of the vehicle and/or the Home to School Transport Escort.
(b) Themselves.
(c) Other passengers.
(d) Using threatening, violent and/or abusive language
(e) Damage caused to the vehicle.

15.6 The withdrawal of free Travel Assistance transport will be:

(a) Temporary.
(b) Permanent at the discretion of the LA having regard to the circumstances of the pupil's behaviour where this has been serious or in persistent cases of misbehaviour.

15.7 The LA shall suspend the provision of Travel Assistance in cases of persistent absence or where the pupil/student has been absent for a week or more without good reason until the pupil is able to return to school.

15.8 Each case will be considered on its own merits. Where free travel is withdrawn it will be the responsibility of the parent(s) to pay for travel costs between home and school. 'Temporary' shall be for a specified number of weeks and 'permanent' shall be for the remainder of the school year or longer if justified by the circumstances.

15.9 The withdrawal of Travel Assistance (either temporary or permanent) for a particular child shall not imply that travel arrangements were not necessary and should not be provided. The withdrawal would be because the child's behaviour was such that they could no longer take advantage of it.

15.10 Where a Head teacher or Principal of a school, under the provisions of Section 89(5), considers that a child's conduct whilst using the transport is such that free home to school transport should be withdrawn, the Head teacher or Principal will notify the LA who will consider whether to withdraw transport provision. In these cases the parent shall have the right for a review of the decision in accordance with Part 6 of the Policy

16 Travel for Pupils and Students with Medical Needs

16.1 Pupils with a medical condition are those who require:

(a) Prescribed medicines;
(b) May require emergency medical treatment;
(c) Continuous medical support.

16.2 Administering medicines to pupils
School Escorts are not trained to administer medication or to pupils, be it prescribed or that purchased from a pharmacy without a prescription.

16.3 Emergency medical treatment
In the event of emergency medical treatment being required, the Escort shall contact the emergency medical service by telephoning 999; and inform the Local Authority and the Parents of the child concerned.

16.4 Escorts accompanying children with a medical condition or those who require emergency medical treatment shall carry a mobile telephone.

16.5 Continuous medical support -Escorts are not trained to, or expected to deliver medical procedures or interventions to pupils whilst travelling on home to school transport. Where the normal travel arrangements provided under the Travel Assistance policy cannot facilitate the travel of the pupil, the Relevant Officer shall convene a case conference.

16.6 The case conference shall be chaired by an appropriate Senior Officer of the Service and other relevant professionals shall be invited to attend.

The case conference shall:

(a) Discuss the issues associated with transporting the pupil to school; and
(b) Make a recommendation for the future transport arrangements.

16.7 General provisions -In any circumstances that should arise which are not provided for in this policy, the Relevant Officer shall, at their discretion, convene a meeting to discuss the travel arrangements of a pupil.

16.8 Escorts will not normally transport a pupil's medication from home to school. The parents are responsible for ensuring, where relevant, that the school has a sufficient supply of medication for the child.

16.9 In individual cases, subject to the agreement of the parent, Escort and School, a pupil's medication may be transported in the vehicle with the pupil. Where this arrangement is agreed the medication shall be in a sealed envelope or container with the pupil's name clearly displayed. The storage of the envelope/container or the vehicle will be determined in each individual case.

17 Status

17.1 This information represents the Travel Assistance Policy of Barnsley Metropolitan Borough Council (BMBC) at the time of publication. However, BMBC reserves the right to amend the policy to reflect either changes in policy or legislation.

17.2 Any personal data/information held by the Home to School Transport Team in relation to Travel Assistance, will be securely stored and maintained in line with the Data Protection Act 1998.

17.3 Personal data collected will only be processed for the purpose of the education of the young person.

NOTES

1 The LA

References in this policy to the 'LA' are a reference to Barnsley Metropolitan Borough Council (BMBC) and references to the 'LA's area' is to the administrative area of the Borough.

2 Parent/Carer

Reference to parent and/or carer in this policy means any person having parental responsibility for the child (for whom assistance with transport is being sought) within the meaning of the Children Act 1989.

It is the responsibility of those applying for assistance with transport to satisfy the LA that they have parental responsibility for the child for whom assistance is being sought.

3 Ordinarily Resident

Reference in this policy to 'ordinarily resident' means where a pupil or student is habitually and normally resident at their address other than for occasional absences and for a settled purpose, which is not solely to receive education i.e. the residence at which the child resides during the normal school week at the closing date for receiving applications for admission to school during the normal admission round.

Any reference to the pupil or student's 'home', or to where they 'live' or 'reside' shall refer to where they are ordinarily resident.

It is the responsibility of those applying for assistance with transport to provide such information as the LA requires in order to be satisfied as to where the pupil or student is ordinarily resident.

4 Statutory Qualifying Distance

The walking distances are:

a) For pupils of less than 8 years of age (on 1 September) 2 miles; and

b) For pupils aged 8 years or older and still of compulsory school age (on 1 September) 3 or more miles.

Each case is measured by the nearest available walking route.

For the purposes of this policy, the walking distance will be measured from the front gate of the address where the LA has accepted the pupil or student is ordinarily resident, to the nearest designated entrance of the school or college to which assistance is being considered under the relevant clause of the policy.

The route measured will be the nearest direct available walking route, having had regard to the age of the child, the walking route, or alternative routes, to the school the pupil could reasonably be expected to take. The LA has established criteria for the assessment of the safety of a walking route to school and will determine the availability or otherwise of a route in accordance with the approved criteria. The assessment of the availability or otherwise of a route will

be based on a child being accompanied by an adult. It will be irrelevant for the purposes of that assessment whether or not the child would or would not be so accompanied when attending the school or college.

In the case of a pupil qualifying for free travel on the grounds of 'low income' i.e. they are in receipt of FSM or their family receives MWTC the distances will be measured as follows:

- Up to 2 miles – as per the statutory walking distance along the nearest available walking route.

- The 6 mile or 15 mile upper limit – along road routes passable by suitable motorised transport.

The route will be measured using a computerised Geographical Information System. The LA considers this as an exact measure and cannot be considered marginal. If the LA considers it necessary a route may be measured by calibrated pedometer.

5 Full-Time Course

References in this policy to a 'full-time course' is a reference to a course of which the student is required to study for at least 12 guided learning hours per week.

6 Closing date for applications for Bus Passes

No refunds will be made for travel expenses incurred as a result of a late application for transport. The closing date for new bus pass applications is 30 June. Whilst we will process bus pass applications at any time we will not guarantee that they will be available at the start of term unless received by the closing date.

7 Definition of Eligible Child

The following are examples of an Eligible Child

i Children who attend schools beyond the statutory walking distance

These children are eligible for free school transport, provided that the LA has made no "suitable arrangements" for boarding accommodation or attendance at a nearer school and the children live beyond walking distance and attend their nearest suitable school. The statutory walking distance is 2 miles for children under 8 years old and 3 miles for children of 8 or over.

ii Children with SEN, disabilities or mobility problems

These children may live within the statutory walking distance and have special educational needs, a disability or mobility problem which means that they cannot reasonably be expected to walk to their school and no suitable arrangements have been made by the LA to enable them to attend a nearer school.

iii Children whose route to school is unsafe

These children may live within the statutory walking distance but they cannot reasonably be expected to walk to their nearest suitable school

because the route they could reasonably be expected to take is not deemed an available walking route, accompanied as necessary.

iv Children from low income families

Secondary school age children who attend schools over 2 and up to 6 miles from their home, even if the school they attend is not their nearest suitable school, providing there are not three or more suitable schools which are nearer to their home, or

Secondary age children from low income families who attend a school over 2 miles but under 15 miles away from home, if their parent has expressed a wish for them to be educated at that particular school based on the parent's religion or belief and, having regard to that religion or belief, there is no nearer suitable school. This applies to parents with a particular religious or philosophical belief, including those with a lack of religion or lack of belief.

Junior age children (aged 8 – 10) from low income families who live more than 2 miles (rather than 3) from their nearest suitable school.

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TO:
Chairs of Health and Wellbeing Boards
Chief Constables
Police and Crime Commissioners

15 November 2016

Dear All

Police and Crime Commissioners and Health and Wellbeing Boards

We are writing to highlight and support some of the important benefits that can be realised through closer collaboration between policing and health partners.

The interface between crime and public health is well-documented – in the Department of Health's public health outcomes framework, for example, which contains a number of indicators that recognise the links, including: entry to the youth justice system, people in prison with a mental illness, domestic abuse, violent crime, re-offending, drug treatment outcomes and perception of community safety.

In many areas of the country, police and health and care partners, in both the NHS and Local Government, are working collaboratively to deliver better outcomes for individuals, including the most vulnerable and local communities and there is potential for further joint working. For example, local authorities, the NHS and the police are required members of Safeguarding Adult Boards which help ensure a collaborative, inter-agency approach to the responses and prevention of abuse or neglect.

In addition, many health and wellbeing boards already include amongst their membership either their Police and Crime Commissioner (PCC) or representatives from their local police force or criminal justice agencies. This has enabled boards to take a broader strategic view of their area beyond health and social care, and through Joint Strategic Needs Assessments (JSNAs) provides boards with the opportunity to better understand the nature of public needs and demands on local services – which can in turn influence local commissioning strategies.

There are already a number of areas where greater collaboration has had positive outcomes including:

- Every area in England is now working to implement their local Mental Health Crisis Care Concordat action plans, involving NHS services, police forces and local authorities, and many of these local partnerships are using their Boards to ratify their plans and support progress. Local action plans and other helpful information on the Concordat can be found here: http://www.crisiscareconcordat.org.uk/

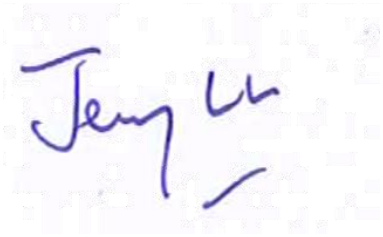
- In addition, around 30 police forces now have some form of street triage in operation. These models, often jointly commissioned by the PCC and Clinical Commissioning Groups, ensure mental health nurses staff support and advise police officers in their responses to people in mental health crisis. In some forces mental health workers and police officers provide joint responses in the community; in others mental health professionals work in emergency call centres in order to provide real time advice and support to frontline officers. The evaluation of nine initial pilot sites evidenced that the schemes contributed towards large reductions in the use of police custody as a place of safety for those vulnerable people detained under section 136 of the Mental Health Act.

- Around 25 police forces operate a drug intervention initiative which involves policing and health partners working together to identify, assess and refer users into appropriate treatment pathways. Investment in treatment is proven to reduce reoffending, with every £1 spent saving £2.50 for the Criminal Justice System, and with access to treatment reducing the impact of wider health harms including the spread of blood borne viruses and drug related mortality.

- A recent Home Office and Public Health England initiative in Middlesbrough brought together senior partners in policing, health and probation to consider the impact of heroin misusing offenders in their area and the wider implications this was having on individuals and the community. This has galvanised further collaborative working, including the development of a joint strategy to address their local needs and consider opportunities for developing a multi-agency commissioning approach for treatment services.

- The first phase of the local alcohol action areas programme, which ran until March 2015, saw police and health partners work closely together to reduce a range of alcohol-related harms. For example, Gravesham began a one-year pilot of a Make Every Adult Matter approach to street drinkers. An operational group is led by the area's alcohol and drug treatment provider with members including the police, third sector organisations, primary care providers, Jobcentre Plus and the Prison Service. Early indications are that the project is working well and that links between partner agencies are much improved and that better coordinated services for individuals with multiple needs are emerging. Invitations to apply to take part in the second phase of the programme were sent to PCCs, chief constables and all local authorities in England and Wales last month. The programme will begin in January and will again encourage active partnerships between local agencies to reduce alcohol harms.

Given the benefits outlined above, and the pressures on health and care services and police forces, we would like to ask Health and Wellbeing Boards and PCCs to consider how they can better work together by ensuring appropriate representation from both sectors on Health and Wellbeing Boards.



The Rt Hon Amber Rudd MP

The Rt Hon Jeremy Hunt MP

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