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BARNSLEY
Metropolitan Borough Council

MEETING:	Cabinet
DATE:	Monday, 1 April 2019
TIME:	10.00 am
VENUE:	Reception Room, Barnsley Town Hall

AGENDA

1. Declaration of pecuniary and non-pecuniary interests

2. Leader - Call-in of Cabinet decisions

Minutes

3. Minutes of the previous meeting held on 20th March, 2019 (Cab.1.4.2019/3) *(Pages 3 - 10)*

Items for Noting

4. Decisions of Cabinet Spokespersons (Cab.1.4.2019/4) *(Pages 11 - 12)*

Petitions

5. Petitions received under Standing Order 44 (Cab.1.4.2019/5)

Items for Decision/Recommendation to Council

Deputy Leader

6. The 2018 Director of Public Health Annual Report (Cab.1.4.2019/6) *(Pages 13 - 40)*

Communities Spokesperson

7. Stop Smoking Service Business Case (Cab.1.4.2019/7) *(Pages 41 - 84)*

8. Digital First - Enabling Technology (Cab.1.4.2019/8) *(Pages 85 - 96)*

To: Chair and Members of Cabinet:-

Councillors Houghton CBE (Chair), Andrews BEM, Bruff, Cheetham, Gardiner, Howard, Miller and Platts

Cabinet Support Members:

Councillors Franklin, Frost, Daniel Griffin, Pourali, Saunders and Tattersall

Chair of Overview and Scrutiny Committee
Chair of Audit Committee

Diana Terris, Chief Executive
Rachel Dickinson, Executive Director People
Matt Gladstone, Executive Director Place
Wendy Lowder, Executive Director Communities
Julia Burrows, Director Public Health
Andrew Frosdick, Executive Director Core Services
Michael Potter, Service Director Business Improvement and Communications
Neil Copley, Service Director Finance (Section 151 Officer)
Katie Rogers, Head of Communications and Marketing
Anna Marshall, Scrutiny Officer
Martin McCarthy, Service Director Governance, Member and Business Support

Corporate Communications and Marketing

Please contact Martin McCarthy on email governance@barnsley.gov.uk

Friday, 22 March 2019

MEETING:	Cabinet
DATE:	Wednesday, 20 March 2019
TIME:	10.00 am
VENUE:	Reception Room, Barnsley Town Hall

MINUTES

Present Councillors Houghton CBE (Chair), Andrews BEM, Cheetham, Gardiner, Miller and Platts

Members in Attendance: Councillors Franklin, Frost, Daniel Griffin, Pourali, Saunders, Sheard and Tattersall

229. Declaration of pecuniary and non-pecuniary interests

There were no declarations of pecuniary or non-pecuniary interests.

230. Leader - Call-in of Cabinet decisions

The Leader reported that no decisions from the previous meeting held on 6th March, 2019 had been called in.

231. Minutes of the previous meeting held on 6th March, 2019 (Cab.20.3.2019/3)

The minutes of the meeting held on 6th March, 2019 were taken as read and signed by the Chair as a correct record.

232. Decisions of Cabinet Spokespersons (Cab.20.3.2019/4)

The Record of Decisions taken by Cabinet Spokespersons under delegated powers during the weeks ending 1st and 8th March, 2019 were noted.

233. Petitions received under Standing Order 44 (Cab.20.3.2019/5)

It was reported that no petitions had been received under Standing Order 44.

Deputy Leader

234. Alcohol Plan (Cab.20.3.2019/6)

RESOLVED that the strategic direction of the Alcohol Plan including the vision, priorities, outcomes and targets be supported.

Joint Cabinet Spokesperson without Portfolio and Cabinet Spokesperson People (Achieving Potential)

235. Member Representation on the Virtual School Governance Group (Cab.20.3.2019/7)

RECOMMENDED TO FULL COUNCIL ON 4TH APRIL, 2019 that the People (Achieving Potential) and People (Safeguarding) Cabinet Spokespersons and the

respective Cabinet Support Members be appointed to serve on the Virtual School Governance Group, together with six further Elected Members to be appointed at Full Council.

Communities Spokesperson

236. Proposal to Establish a new Public Space Protection Order (PSPO) for Barnsley Town Centre (Cab.20.3.2019/8)

RESOLVED:-

(i) that the conditions of the new Public Space Protection Order (PSPO) as outlined in Section 4.6 of the report now submitted be agreed;

(ii) that agreement be given to the introduction of the begging related condition at Section 4.8 within the report with the understanding that the condition will be utilised as a last resort after other support interventions have been utilised first;

(iii) that the Public Space Protection Order be confined to a new designated area to cover the town centre only, following consideration of the alternative approaches identified in Section 5 of the report; and

(iv) that the intention to further develop the "Help Us Help Them" campaign be noted in relation to begging, building upon the success of this scheme to date and through the campaign continue to raise awareness within the general public.

Core Services Spokesperson

237. Provision of Employee Benefits (Cab.20.3.2019/9)

RESOLVED:-

(i) that the Authority continue to utilise a range of employee benefit schemes through our Just4YOU employee benefits offer including employee discounts, cycle to work scheme, childcare voucher scheme, and technology scheme procured under the ESPO Framework;

(ii) that approval be given to enhance our Just4YOU employee benefits offer with the introduction of a salary sacrifice lease car scheme as outlined at paragraph 4.6 of the report;

(iii) that it be acknowledged that there will be an impact on employee's pensionable pay as outlined at paragraphs 8.2.1/2 should a salary sacrifice lease car scheme be given approval as proposed at paragraph 4.6; and

(iv) that it be acknowledged that a further decision will be required on whether to fund lease car mileage at a rate of 0.45p in line with the current HMRC Approved Mileage Allowance Payments rate (AMAP) as outlined at paragraph 8.2.3 acknowledging the taxable benefit to the employee.

238. Gender Pay Gap 2018 (Cab.20.3.2019/10)

RESOLVED:-

(i) that the results of the Gender Pay Gap Report as of 31st March, 2018 and outlined in Appendix 1 of the report submitted be noted; and

(ii) that endorsement be given to the long term commitment to reducing the Council's Gender Pay Gap and the action plan at Appendix 2 be noted.

239. Implementation of the 2019/20 Pay Policy Statement (Cab.20.3.2019/11)

RECOMMENDED TO FULL COUNCIL ON 4TH APRIL, 2019 that approval be given to implement the 2019/20 Pay Policy Statement, contained at Appendix 1 of the report now submitted, with effect from 1st April, 2019.

Place Spokesperson

240. Adult Skills and Community Learning Service: OFSTED Inspection November 2018 (Cab.20.3.2019/12)

RESOLVED:-

(i) that the outcome of the OFSTED inspection of Adult Skills and Community Learning Service, as detailed in the report now submitted, be noted; and

(ii) that the Service's self-assessment report for the full academic year August 2017 to July 2018 be accepted.

241. Digital Media Centre/The Core Conversion (Cab.20.3.2019/13)

RESOLVED:-

(i) that the Executive Director Place be authorised to undertake the necessary steps to secure delivery of the project;

(ii) that the Executive Director Core Services in consultation with the Executive Director Place be authorised to:

- Negotiate the terms and conditions of any Funding Agreement and that Cabinet delegate the final approval of the terms of the Grant Funding Agreement to the Cabinet Spokesperson Place;

- Conclude the approval and funding process with Sheffield City Region Combined Authority (SCR CA), accept tenders, appoint where necessary a contractor to implement the delivery of the scheme, subject to the costs being contained within the scheme;

(iii) that the Service Director Regeneration and Property be authorised to:

- In compliance with the Council's Contract Procedure Rules, and subject to any procurement requirements specified by the funder, seek tenders where necessary for any aspect of the project and appoint the successful tenders; and/or consider whether the works, services or goods can be provided in-house, subject to value for money considerations; and

(iv) that grant funding from Sheffield City Region Investment Fund (SCRIF) totalling £2.125m towards the total cost of the scheme be accepted.

242. Highways Capital Programme Update (Cab.20.3.2019/14)

RESOLVED:-

(i) that the detailed Highways Capital Programme for 2019/20 as set out in Appendices 1 and 2 of the report be approved, and that the Service Director Environment and Transport be authorised to implement these schemes;

(ii) that the Highways Capital Programme be varied in line with the Council's governance and approval limits (see paragraphs 3.8 – 3.13);

(iii) that the Service Director Environment and Transport be authorised to:

- Obtain tenders for any works, goods and services as necessary, and appoint the successful tenderer on the basis of the most economically advantageous tender;

- Adopt the Highways Maintenance Efficiency Programme (HMEP) principle of collaboration and utilise collaborative procurement to engage external consultants to undertake work which cannot be undertaken in-house or secure the services of contractors or consultants via Regional Alliances where available;

- Appoint other external consultants and contractors as appropriate, within the current procurement rules; and

(iv) that, in the event that the Maintenance, Integrated Transport and Capitalised Highways Maintenance budgets for 2019/20 are not fully expended, the value of any other works be re-phased between financial years, which allows the flexibility to ensure that the available resources are deployed in the most efficient manner possible, whilst maintaining the continuity of the Highways and Engineering Service.

243. Street Lighting Replacement Programme (Cab.20.3.2019/15)

RESOLVED:-

(i) that the Street Lighting Replacement Programme for 2019-21 be approved, and that the Service Director Environment and Transport be authorised to implement this programme of work;

(ii) that the Street Lighting Replacement Programme be varied in line with the Council's governance and approval limits, if required (see paragraphs 3.8 – 3.13);

(iii) that the Service Director Environment and Transport be authorised to:

- Obtain tenders for any works, goods and services as necessary, and appoint the successful tenderer on the basis of the most economically advantageous tender;

- Adopt the Highways Maintenance Efficiency Programme (HMEP) principle of collaboration and utilise collaborative procurement to engage external consultants to undertake work which cannot be undertaken in-house or secure the services of contractors or consultants via Regional Alliances where available;

- Appoint other external consultants and contractors as appropriate, within the current procurement rules; and

(iv) that, in the event that the Street Lighting Replacement Programme budget for 2019/20 are not fully expended, the value of any other works be re-phased into the 2020-21 financial year, which allows the flexibility to ensure that the available resources are deployed in the most efficient manner possible, whilst maintaining the continuity of the Highways and Engineering Service.

244. Launchpad Phase 2 (Cab.20.3.2019/16)

RESOLVED:-

(i) that the Executive Director Place be authorised to approve contracts to enter into a funding agreement with the Ministry of Homes, Communities and Local Government (MHCLG) to implement the Launchpad Phase 2 project;

(ii) that approval be given for the Service Director Finance to amend revenue budgets in accordance with the financial implications and Appendix A of the report submitted;

(iii) that the Executive Director Place be authorised in consultation with the Executive Director Core Services to contract with the programme partners at Sheffield, Rotherham, Doncaster and Bassetlaw Councils plus the Prince's Trust; and

(iv) that approval be given for the Council to act as Accountable Body for Launchpad Phase 2.

245. Strategic Growth Clusters - Update (Cab.20.3.2019/17)

RESOLVED:-

(i) that approval be given to accept grant funding from Sheffield City Region Investment Fund (SCRIF) totalling £1.171m to contribute towards the M1

Junction 37 – Economic Growth Corridor – Phase 1 scheme, previously approved in July 2018 (Cab.25.7.2018/14);

(ii) that approval be given to the acceptance of grant funding from Sheffield City Region Investment Fund (SCRIF) totalling £7.324m and £0.352m from Highways England (total scheme approval of £7.676m) and releases the scheme into the Capital Programme to deliver the approved M1 Junction 36 – A6195 Dearne Valley Economic Growth Corridor (Phase 2 Goldthorpe) Business case, as outlined in Section 3.7 below and detailed in Appendix 2 of the report;

(iii) that the Executive Director Core Services, in conjunction with the Executive Director Place be authorised to:

- Negotiate the terms and conditions of, and final approval of the Combined Authority SCRIF Grant Funding Agreement, for the delivery of the infrastructure improvements set out in the appendices attached to this report;

- Conclude the approval and funding processes with Sheffield City Region Combined Authority (SCR CA), accept tenders, appoint where necessary a contractor to implement the delivery of the scheme, subject to the costs being contained within the Grant Funding Agreement;

- Where necessary, apply for any necessary consents, licence arrangements, prepare details of and publish a Side Roads Order under Sections 14 and 125 of the Highways Act 1980 to deal with any required changes to the existing highway network to accommodate the scheme, to submit the order to the Secretary of State for Transport for confirmation and to take all necessary steps to secure confirmation of the Order including (if necessary) supporting the order at a local public inquiry;

(iv) that the Corporate Asset Manager be authorised to:

- Negotiate the terms and conditions of any development agreements required with relevant private developer(s) in order to minimise the financial risks to the Council;

- Where necessary, that the Corporate Asset Manager be authorised to enter into negotiations with any private land owner(s) to acquire privately owned land or property and enter into agreements to occupy land not in the ownership of the local authority. Also to complete any variation to any existing leases on the occupation of land owned by the local authority and where necessary negotiate compensation payments;

(v) that the Service Director Regeneration and Property be authorised to:

- Develop and submit full business cases for the Strategic Growth Clusters in respect of the schemes detailed in the appendices to the report;

- Submit change variation requests to SCR CA in relation to the schemes where necessary to retain external grant funding secured, whilst ensuring that the overall aims and objectives of the scheme are achieved;

- Under the terms of the Barnsley Contract Procedure Rules, if necessary, seek tenders for any aspect of the project and appoint the successful tender on the basis of most economically advantageous bid; and to consider whether the works, services or goods can be provided in-house, subject to value for money considerations;

- In accordance with paragraph 2.3 (b)(i) of the Council's Contract Procedure Rules (In-House Providers), the Business Park service contract be awarded to NPS Barnsley, under the Joint Venture Service Level Agreement to provide check and challenge on any private sector work packages involved in delivering the Strategic Business Parks;

- Make use of the Council's Land Solve Framework (managed by NPS Barnsley) to appoint if necessary land brokers or land advisors to support the delivery of the projects outlined in Appendices 1, 2, 3 and 4;

(vi) that the progress made delivering the M1 Junction 36 – A6195 Dearne Valley Economic Growth Corridor (Phase 1 Hoyland), as outlined in Section 3.8 below and detailed in Appendix 3 be noted, and authorisation be given to continue development and progression of the scheme to ensure all external grant funding be secured, whilst ensuring that the overall aims and objectives of the scheme are achieved;

(vii) that the continued development and progression, and submission of the M1 Junction 37 – Phase 2 (Claycliffe) full business case be authorised to Sheffield City Region for appraisal, as outlined in Section 3.9 and detailed be Appendix 4;

(viii) that the Executive Director Place be authorised to undertake all necessary steps to secure delivery of the projects outlined in Appendices 1, 2, 3 and 4; and

(ix) that the Service Director Environment and Transport in consultation with the Service Director Regeneration and Property be authorised to seek any necessary planning permission, (outline or full) for the proposed schemes in relation to the projects detailed in Appendices 1, 2, 3 and 4.

246. Exclusion of Public and Press

RESOLVED that the public and press be excluded from the meeting during consideration of the following items, because of the likely disclosure of exempt information as described by the specific paragraphs of Part I, of Schedule 12A of the Local Government Act 1972, as amended, as follows:-

Item Number	Type of Information Likely to be Disclosed
247	Paragraph 3

People (Safeguarding) Spokesperson

247. Older People's Residential and Nursing Care Fees (Agreed Cost of Care) (Cab.20.3.2019/19)

RESOLVED:-

(i) that the current position regarding the state of the Residential and Nursing care market for Older People across Barnsley, as detailed in Appendix B to the report, be noted;

(ii) that the exercise/consultation undertaken to determine the 'cost of care' and considered the concerns/representations made by care providers be noted;

(iii) that approval be given to the uplift in fees to the determined cost of care or fair fee level and for this to be implemented over 3 years (2018/19, 2019/20 and 2020/21) in accordance with the recommended option indicated in paragraphs 7.9 and 7.10 of the report; and

(iv) that the benefits of ongoing partnership work with Barnsley CCG in developing a fee setting and uplift agreement for Older People's Residential and Nursing Care Homes be recognised.

(Note: In view of the need to conclude all necessary agreements in the above matter by 1st April 2019, the Chair of the Overview and Scrutiny Committee has agreed to waive the delay in implementation associated with the Call-In procedures.)

CHAIR'S COMMENT

The Leader informed Members this would be Ian Turner's last Cabinet meeting and thanked him for his many years of service and dedication to the Council, the Councillors and the people of Barnsley.

On behalf of the Council, the Leader wished Ian well in all his future endeavours.

…………………………….
Chair

BARNSLEY METROPOLITAN BOROUGH COUNCIL

CABINET SPOKESPERSONS' DECISIONS

Schedule of Decisions taken for week ending 22nd March, 2019

Cabinet Spokesperson	Item	Decisions
1. Place	Kenworthy Road, Worsbrough Common Re-Development	(i) that approval be granted for the building of 2 x 2 bed houses and 1 x 3 bed detached house on a site which previously accommodated low demand bed sit bungalows. The homes will be Housing Revenue Account (HRA) properties, managed by Berneslai Homes and let to applicants on the Council's Housing Waiting List; (ii) that approval be granted to appoint Berneslai Homes Construction Services, under the PRIP contract, to directly deliver the scheme as principal contractor subject to a GMP within the approved funding envelope; and (iii) that approval be granted for the reprioritisation of the current approved capital investment programme (as set out in Section 7 of the report).

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BARNSLEY METROPOLITAN BOROUGH COUNCIL

This matter is a Key Decision within the Council's definition and has been included in the relevant Forward Plan

REPORT OF THE
DIRECTOR OF PUBLIC HEALTH
TO CABINET ON 20th MARCH

The 2018 Director of Public Health Annual Report

'Are You Contactless? Changing the Way we Connect in a Digital World'

1. PURPOSE OF REPORT

1.1 The aim of this report is to provide Cabinet members with information about the Director of Public Health 2018 Annual Report.

2. RECOMMENDATIONS

2.1 That the contents of the Director of Public Health 2018 Annual Report be noted.

3. INTRODUCTION

3.1 National context

The Director of Public Health (DPH) is as independent advocate for the health of the population and system leadership for its improvement and protection. The independence is expressed through the DPH Annual Report – an important vehicle for providing advice and recommendations on population health to both professionals and public – providing added value over and above intelligence and information routinely available.

The Annual Report is the DPH's professional statement about the health of local communities, based on epidemiological evidence, and interpreted objectively. However, it is not just the annual review of public health outcomes and activity. The annual report is an important vehicle by which the DPH can identify key issues, flag up problems, report progress and thereby serve their local populations.

It is a valuable process for internal reflection and team prioritisation as well as external engagement and awareness raising.

3.2 Local context
The 2017 Director of Public Health report in Barnsley, *A Day in the Life of*' captured a snapshot in time to illustrate the health and wellbeing of Barnsley's residents. Through the completion of a diary, residents told us about their physical and mental health on 7 November 2017 and what might have made it better or worse.

More residents wrote about loneliness, social isolation and the importance of connections with others than any other subject. An eighty-four year old female resident wrote: “I’m going out today – looking forward to this, even if it is to a hospital appointment.” This diary entry was a stark reminder of the importance of our connections with other people, no matter how brief they may be.

Loneliness is one of the greatest public health challenges of our time and so public health welcomes the Government strategy for tackling loneliness, ‘*A Connected Society’,* which was published in October 2018. The strategy suggests how we must all lay the foundations for change which are described in the recommendations of ‘*Are You Contactless?’*

4. PROPOSAL AND JUSTIFICATION

4.1 The report will be used to communicate the work of the public health team within BMBC to the public, BMBC staff and partners. The public health team will work with partners, both internal and external, to coordinate delivery of the recommendations throughout 2019 which will be reported in the next DPH Annual Report.

5. CONSIDERATION OF ALTERNATIVE APPROACHES

5.1 The report is easily understandable for members of the public and those professionals who are not public health specialists. The report will take a Digital First approach and will be web based. A small number of hard copies will be made available to community groups.

6. IMPLICATIONS FOR LOCAL PEOPLE/SERVICE USERS

6.1 The report provides a unique insight into the impact of loneliness and connections on residents’ lives. This will enable us to have a better understanding and will help inform the Council’s decision making with regards to health and wellbeing; both physical and mental.

7. FINANCIAL IMPLICATIONS

7.1 There are no resource implications. The ‘call to action’ includes signposting to Live Well Barnsley and Town Spirit.

The allocated budget for the design, print and photography of the annual report was £1,500 and it is not expected to exceed this amount.

8. EMPLOYEE IMPLICATIONS

8.1 There are no employee implications.

9. LEGAL IMPLICATIONS

9.1 None

10. CUSTOMER AND DIGITAL IMPLICATIONS

10.1 The report will take a Digital First approach and will be web based. A small number of hard copies will be made available to community groups. The 'call to action' includes signposting to Live Well Barnsley and Town Spirit.

11. COMMUNICATIONS IMPLICATIONS

11.1 The Director of Public Health's 2018 report will be publicly launched following presentation to the Health and Wellbeing Board (date to be confirmed).

12. CONSULTATIONS

12.1 The report has been shared with People, Place and Communities Directorates.

13. THE CORPORATE PLAN AND THE COUNCIL'S PERFORMANCE MANAGEMENT FRAMEWORK

13.1 The report and subsequent actions to be taken will contribute to the 3 priorities within the Corporate Plan:

- thriving and vibrant economy
- people achieving their potential
- strong and resilient communities

14. PROMOTING EQUALITY, DIVERSITY AND SOCIAL INCLUSION

14.1 Extensive public engagement took place to develop this year's annual report and was promoted through many routes to ensure a diverse response. Groups consulted included Refugee Council, Barnsley Together Forum, Race Equality, Barnsley Advocacy Service, Disability Forum, Deaf Forum, LGBT Forum, Age UK, Dementia Support and service user networks.

15. TACKLING THE IMPACT OF POVERTY

15.1 There are no issues relating to tackling the impact of poverty.

16. TACKLING HEALTH INEQUALITIES

16.1 The report and subsequent actions will ensure that commissioned services and programmes of work continue to tackle health inequalities.

17. LIST OF APPENDICES

Appendix 1: *Are You Contactless? Changing the Way we Connect in a Digital World.*

Report author: Diane Lee, Head of Public Health

Financial Implications/Consultation
 …………………………………………………….. *(To be signed by senior Financial Serv[obscured] where no financial implications)*

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"WHEN THE CULTURE AND THE COMMUNITIES THAT ONCE CONNECTED US TO ONE ANOTHER DISAPPEAR, WE CAN BE LEFT FEELING ABANDONED AND CUT OFF FROM SOCIETY. IN THE LAST FEW DECADES, LONELINESS HAS ESCALATED FROM PERSONAL MISFORTUNE INTO A SOCIAL EPIDEMIC. MORE AND MORE OF US LIVE ALONE. WE WORK AT HOME MORE. WE SPEND A GREATER PART OF OUR DAY ALONE THAN WE DID 10 YEARS AGO. IT SOMETIMES FEELS LIKE OUR BEST FRIEND IS THE SMARTPHONE."

Rachel Reeves MP, Co-chair,
Jo Cox Commission on Loneliness

ARE YOU CONTACTLESS?

Changing the way we connect in a digital world

BARNSLEY
Metropolitan Borough Council

an Borough Council

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FOREWORD

I am the Director of Public Health in Barnsley and every year I am required by law to produce a report about the health of people who live in our town. This report helps me, my team and our wider partners to identify any key issues, flag up any problems, make new recommendations and describe how we are helping residents, their families and their friends to live healthier, happier lives.

In our 2017 annual report, we captured a snapshot in time to illustrate the health and wellbeing of Barnsley's residents. Through the completion of a short diary, residents told us about their physical and mental health on 7 November 2017 and what might have made it better or worse. The response from residents was overwhelming and details of how we have responded to the issues raised can be found in chapter 1 of this report.

More residents wrote about loneliness, social isolation and the importance of connections with others than any other subject in the diary entries we received. I remember in particular one diary entry from an eighty-four year old female resident who wrote:

"I'M GOING OUT TODAY – LOOKING FORWARD TO THIS, EVEN IF IT IS TO A HOSPITAL APPOINTMENT."

"JO ALWAYS LOOKED FORWARDS, NOT BACK: SHE WOULD HAVE SAID THAT WHAT MATTERS MOST NOW ARE THE ACTIONS, BIG AND SMALL... THAT'S A RESPONSIBILITY FOR ALL OF US."

Seema Kennedy MP and Rachel Reeves MP, Co-chairs of the Jo Cox commission on Loneliness

This diary entry was a stark reminder of the importance of our connections with other people, no matter how brief they may be. A ten minute conversation during a hospital appointment might be the only human contact someone has that day or sadly, that week.

During a conversation about social isolation last year, a local resident told us how it was great that her bus pass was now contactless but it meant she did not even need to speak to the driver anymore. This example illustrates how the world is changing and it is important we continue to embrace digital and technological advances. Our report will provide examples of how this can improve our connections with others but it will also discuss how we need to change in the way we connect with other people in our communities.

Loneliness is one of the greatest public health challenges of our time. No-one should live unknown or feel alone. Everyone should have the social contact they need. We welcome the Government strategy for tackling loneliness, 'A Connected Society', which was published in October 2018. The strategy suggests how we must all lay the foundations for change and you can read how this plan will be implemented locally in the recommendations included in chapter 6.

We are the most digitally connected generation in history but if our society is to address the growing loneliness epidemic, we need to rethink how we connect with others in this new world.

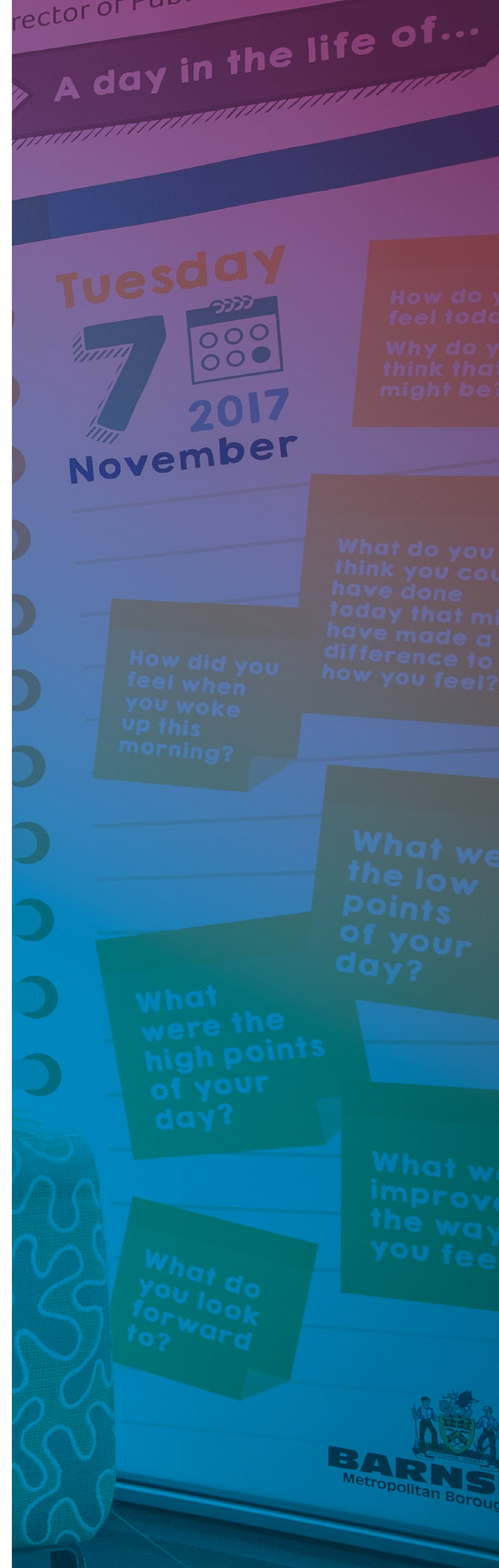
Julia Burrows

Director of Public Health, Barnsley Metropolitan Borough Council

1. OUR PROGRESS SINCE MY 2017 ANNUAL REPORT

I would like to thank the residents of Barnsley who took part in 'A day in the life of'. Along with colleagues across the council, I was overwhelmed by the response we received and I am incredibly grateful to all those who took the time to share their thoughts, feelings, worries and aspirations with us. This chapter summarises what we have done since November 2017 and describes the programmes of work we will continue to deliver in response to what you told us.

From all the diaries we received, in addition to our connections with others, four other key themes were identified where we have focussed our efforts over the past 12 months.



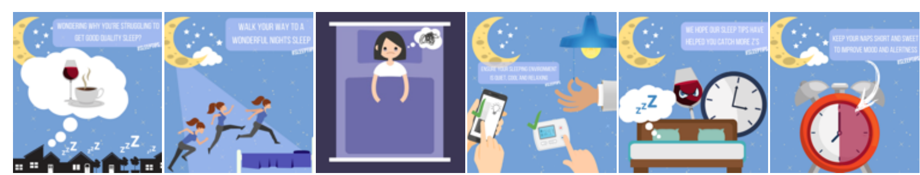
1. RESILIENCE

Put simply, resilience is the ability to cope with and rise to the inevitable challenges, problems and set-backs you meet in the course of your life, and to come back stronger from them. It is having the ability to bounce back in the event of adversity. Building personal resilience is one of three public health priorities in the refreshed public health strategy for Barnsley www.barnsley.gov.uk/services/health-and-wellbeing/barnsley-public-health-strategy. Over the next three years, we will examine what tests our own resilience and what major moments in life have the most impact, for example, separation, retirement, bereavement and illness. We will support residents to grow their own resilience through focussing on what can be done now, tomorrow, next week; next month and beyond. We are working with our primary schools to improve the resilience of future generations. The Thrive Programme is currently delivered in 32 schools, with 113 staff trained to date and aims to improve the social and emotional mental health and resilience of young people.

2. SLEEP

Sleep is crucial to our health and wellbeing. An occasional night without sleep makes you feel tired and miserable the following day, but prolonged nights with poor sleep can lead to more serious issues and undoubtedly makes us feel down and our mood low. Unfortunately, too many people in Barnsley are suffering from a lack of, or poor sleep. Therefore, using an evidence-based toolkit we have launched a local campaign to help people understand the importance of sleep, sharing hints and tips on how to improve both the quantity and quality of our sleep. Key messages include cutting down on caffeine, less technology use before bed and having a regular bedtime routine. We will continue to evaluate this campaign to identify the difference it has made to residents' sleep.

Smoking, alcohol and a poor diet can also affect how we sleep and significant progress has been made in tackling these other public health priorities. We are continuing to work with residents to 'make smoking invisible' and thereby protecting children and young people from the harms of tobacco in addition to helping smokers to stop. Through programmes such as Best Bar None, Reducing the Strength and Purple Flag, we are working to tackle the affordability, availability and acceptability of alcohol; and a food plan which aims to nourish our town with good food for all, was launched in October 2018.



3. WORK

We are working with Barnsley employers across the borough as part of our Healthy Workplace Awards scheme and our first awards ceremony was held in September 2018 recognising the excellent contribution organisations are making to the health and wellbeing of their employees.

Our workplace health offer to businesses includes signposting to services; provision of training; support with health needs assessments; and advice on how small changes can make a big difference to an employer's bottom line. There are over 50 businesses in Barnsley that are actively engaged with workplace health reaching in excess of 18,000 employees. We will continue to encourage businesses to further improve their employment offer by implementing additional measures that will improve the health and wellbeing of their employees and to help keep them in work.

Best Workplace Health and Wellbeing Intervention Award - Amalgamated Construction Ltd

Workplace Health Champion Award - Paul Hewkin, Distinction Doors

Healthiest Barnsley Business Award - XPO LOGISTICS

4. FIVE WAYS TO WELLBEING

In our last report, we recommended that we continue to build the Five Ways to Wellbeing (connect, be active, take notice, learn and give) into our daily lives as a way of improving our overall wellbeing and growing our resilience.

There are many examples we could share to illustrate this further but we have chosen to focus on the programmes which have been implemented over the past twelve months to provide opportunities to increase activity levels for everyone.

We have published a new Active Travel strategy which is committed to improving cycling and walking across the borough. Following the Tour de Yorkshire in May 2018, we have worked with a number of cycle clubs and community groups to maximise the legacy of this fantastic event. We have continued to support schools to join the growing Daily Mile movement and now have over 30 schools in the borough delivering this or a similar scheme. Walk Well Barnsley has gone from strength to strength delivering 12 regular walks with over 1,827 attendances throughout the year.

2. INTRODUCTION: WHAT'S OUR PROBLEM?

Loneliness and social isolation are damaging our health, both mentally and physically. There are links between health and social inequality and social isolation; many factors associated with social isolation are unequally distributed in society. Social disadvantage is linked to many of the life experiences that increase risk of social isolation, including poor maternal health, teenage pregnancy, unemployment, and illness in later life. In addition, deprived areas often lack adequate provision of good quality green and public spaces, creating barriers to social engagement.

Being cut off from social interaction is not only a problem for the elderly but also younger people, and the impact it has on our bodies is thought to be equivalent to smoking over a dozen cigarettes a day. Recent studies have shown that social isolation and loneliness are associated with a 50% excess risk of heart disease (Public Health England, 2015).

Social Isolation is the inadequate quality and quantity of social relations with other people at an individual, group, community and larger social environment, whereas loneliness is an emotional perception that can be experienced by individuals regardless of the breadth of their social networks (Public Health England, 2015).

> "I GO OUT TO WORK WHICH I ENJOY BUT I SOMETIMES FEEL LONELY. I COULD IMPROVE THIS BY GOING OUT MORE BUT I FIND THIS DIFFICULT ON MY OWN."
>
> Barnsley resident aged 57
> (A Day in the Life of, 2017)

Other national studies have found that adequate social relationships increase the likelihood of living longer. Although the true cost of social isolation is difficult to determine, studies have found that interventions to improve someone's social contact can provide a substantial return on investment up to the value of £5.96 for every £1 invested (PHE, 2015).

The Campaign to End Loneliness (2018) has described how loneliness places individuals at greater risk of cognitive decline. Lonely individuals are more prone to depression and loneliness and low social interaction are predictive of suicide in older age.

Lonely individuals are more likely to visit their GP, have a higher use of medication, higher incidence of falls and increased risk factors for long term care and chronic illness.

The Campaign to End Loneliness wants loneliness to be a public health priority at a local and national level and we hope our report goes some way to addressing this issue across Barnsley. Over the next 12 months we will work with colleagues, partners and local communities to ensure that:

- people most at risk of loneliness are reached and supported;
- services and activities are more effective at addressing loneliness; and
- a wider range of loneliness services and activities are developed.

The Jo Cox Foundation was established so Jo's friends, family and colleagues could continue her work and and highlight the issues she cared about so deeply, including the despair caused by loneliness in the UK. The Foundation has supported the continuation of the work of the Loneliness Commission that Jo established before her death in summer 2016. This advocated for a UK wide strategy to tackle loneliness and social isolation across the lifecycle and across all society. Therefore, it was welcomed when the government published 'A Connected Society': a strategy for tackling loneliness in October 2018.

Whilst successfully campaigning for national action, the Loneliness Commission has been running their "Happy to Chat" campaign which aims to strengthen relationships by encouraging people and businesses to start a conversation. The objective is to connect people, and by wearing the "Happy to Chat" badge as a visual indicator so people would feel comfortable to stop and chat. The campaign is part of a bigger movement which is being led by national charities and organisations and one that we will work hard to promote across Barnsley throughout 2019.

Sadly, loneliness can happen to anyone, at any time and too many residents are lonely or isolated, suffering ill health as a result. How many times during one day do we ask "are you contactless?" when buying goods or services and have we ever really thought what that means? It is now possible to spend a day working, shopping or travelling without speaking to another human being and for some people this can be repeated day after day (HM Government, 2018).

We want to ensure that nobody living, working or studying in Barnsley feels lonely and we all have a role to play. Small things can make a big difference and we would ask everyone to think about their neighbours, their friends and their family.

Our society is changing and we are experiencing a digital revolution which brings innovation, opportunities and possibilities to communicate and connect with others in ways that we have never seen before. However, too many residents in Barnsley do not have the social connections they need or want.

"MY TIP FOR A HAPPY LIFE IS TO VOLUNTEER AND HELP ONE ANOTHER. IT GIVES YOU A GOOD FEELING AND MAKES YOUR DAYS HAPPY."

Barnsley resident aged 44
(A Day in the Life of, 2017)

"MY TIP FOR BEING HEALTHY IS KEEPING REGULARLY ACTIVE AND CONNECTING WITH COMMUNITIES AND GROUPS, REMAINING SOCIAL."

Barnsley resident aged 53
(A Day in the Life of, 2017)

3. THE EVIDENCE: WHAT DO WE KNOW?

We are the most digitally connected generation in history and technology has changed the way we communicate and connect with other people...

We can communicate faster and more cost-effectively than ever before. If you're in the same room with someone, there's certainly nothing faster than just opening your mouth and talking. But in our global economy, many of the people we need to communicate with are in different locations.

Technology has created limitless opportunities for us to connect with our friends and family across the world. It allows us to keep in touch with those who live far away and makes it easy to arrange social events through group chat and discussion. It can also help those with caring responsibilities in providing a quick and simple communication method.

Most people may have experienced more efficient services as a result of technology. From booking a holiday to ordering a bus ticket, there is little that can't be done via technology.

...but not always in a good way...

We make less telephone conversations, instead relying on text messaging and other smart phone applications. There is no doubt that these can make life easier by being able to communicate with large groups of family or friends at the same time, but when was the last time you called a friend or family member purely for a chat?

Messaging technology has created pressure to reply as quickly as possible which can often create anxiety. Those sending a message can not only identify if their message has been delivered but also at what time it was read.

Technology has reduced the number of conversations we now have on the high street as part of our day to day life. For example: self-serve check outs in supermarkets (which at times can be the only pay point available); self-service in banks and building societies; and contactless bus passes which remove the need to even speak to the driver.

It is now commonplace to see people of all ages wearing head phones in public spaces which could give a signal to other people of "do not talk to me". This is a particularly familiar sight on public transport which traditionally might have been a place for people to start a conversation.

Tablets, screens and other electronic devices are contributing to a loss in the art of conversation and commonly used to pacify children. Many fast food restaurants now feature these as a way of encouraging families and young people to visit.

We should continue to embrace technology and the many benefits and advantages this brings. But alongside this, reconsider how we connect with each other and never forget the importance of human warmth.

It is difficult, if not impossible to know how many residents feel lonely or how many are socially isolated. That's why it is so important that we all take the time to look out for our friends, families and neighbours and that we work hard to keep our own social relationships strong, so that we are better protected at vulnerable points in our lives which might include separation, illness or bereavement.

FEELING LONELY IS OFTEN LINKED TO EARLY DEATHS

on a par with smoking or obesity. It is also linked to increased risk of coronary heart disease and stroke, depression, cognitive decline and an increased risk of Alzheimer's.

It is estimated that between 5% and 18% of UK adults feel lonely often or always. This could mean that approximately, between...

10,000 AND 35,000 ADULTS IN BARNSLEY FEEL LONELY OFTEN OR ALWAYS

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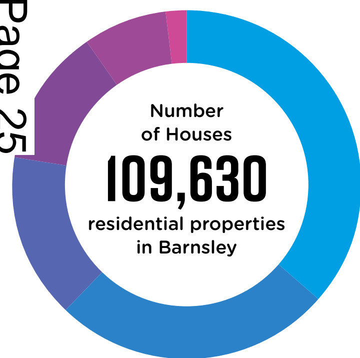
One focus of the Government's strategy for tackling loneliness is to improve the evidence base so we better understand what causes loneliness, its impact and what works to tackle it.

National data available to us locally provides an indication as to the extent of loneliness and social isolation experienced in Barnsley.

- In 2017, there were 109,630 residential properties in Barnsley. Although the percentage of people living alone in Barnsley is currently lower than the regional and national averages, projections suggest that this will change and that by 2039, 32.3% of the adult population in Barnsley will live alone.
- Approximately 13% of residents aged over 65 years in Barnsley live alone and could be at risk of social isolation.
- Many people in Barnsley depend on work for their social contact and feelings of wellbeing; residents told us this in the diaries they shared as part of A Day in the Life of. Although trends are declining over time, 1 in 5 households were workless in 2016 and are, therefore, at risk of loneliness and social isolation.

In December 2018, the Office for National Statistics published some worrying statistics about children's and young people's experiences of loneliness. Although these are national figures, we can make some assumptions about their relevance locally.

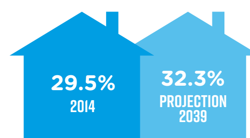


TYPES OF HOUSES

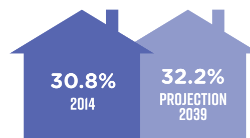
Semi-detached 36.4%
Terraced 25.8%
Bungalow 15.3%
Detached 12.9%
Flats 7.6%
Other 3.9%

MID-2014 BASED HOUSEHOLD PROJECTIONS – RESIDENTS LIVING ALONE

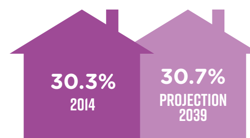
From the 2014 base year, Barnsley has slightly fewer one person households compared to both the regional and national rates. If recent trends continue, the number of one person households will increase to a high 32.3% by 2039.



Barnsley

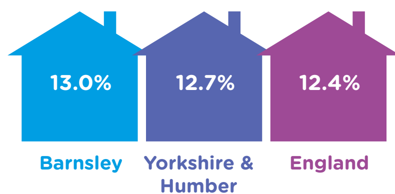


Yorkshire & Humber



England

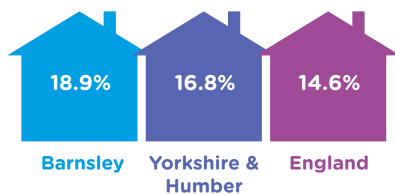
RESIDENTS LIVING ALONE AND AGED 65+ YEARS



Barnsley **Yorkshire & Humber** **England**

The 2011 Census showed that 13.0% of households in Barnsley contained residents aged 65+ years that were living alone and could be at risk of social isolation.

% OF HOUSEHOLDS THAT ARE WORKLESS



Barnsley **Yorkshire & Humber** **England**

Trends show that the numbers of workless households are declining over time; however, in 2016 almost 1 in 5 households in Barnsley were workless.

CHILDREN (AGED 10 TO 15 YEARS)

- 11.3% of children said that they were "often" lonely; this was more common among younger children aged 10 to 12 years (14.0%) than among those aged 13 to 15 years (8.6%).
- 27.5% of children who received free school meals said they were "often" lonely, compared with 5.5% of those who did not.

YOUNG PEOPLE (AGED 16 TO 24 YEARS)

- 9.8% of young people said that they were "often" lonely.
- Nearly half of young men reported that they "hardly ever or never" felt lonely, compared with 32.4% of young women.

QUALITATIVE RESEARCH WITH CHILDREN AND YOUNG PEOPLE FOUND THAT:

- A range of predictable transitions linked to schooling and the move on from secondary education can trigger loneliness in children and young people.
- Children and young people described embarrassment about admitting to feeling lonely, seeing it as a possible "failing".
- Practical, social and emotional or mental barriers to participating fully in social life and activities can also contribute to loneliness.
- The intersection of multiple issues and triggers to loneliness, or more extreme and enduring life events such as bereavement, disability, being bullied or mental health challenges, may make it more difficult for children and young people to move out of loneliness without help.
- Their suggestions for tackling loneliness included: making it more acceptable to discuss loneliness at school and in society; preparing young people better to understand and address loneliness in themselves and others; creating opportunities for social connection; and encouraging positive uses of social media.

SOCIAL ISOLATION

Only 45% of adult social care users have as much social contact as they would like; less than both the regional and national averages (meaning 55% of adult social care users in Barnsley feel lonely).

Only 33.5% of adult carers have as much social contact as they would like, less than both the regional and national averages (this means that over two thirds of carers in Barnsley feel lonely).

There are many other contributing factors which impact on our connections with other people:

- The 2011 Census reported that 26.9% of households in Barnsley do not own a car or a van and are therefore dependent on public transport to access wider community neighbourhoods.

People's access to woodland within 500 metres of where they live

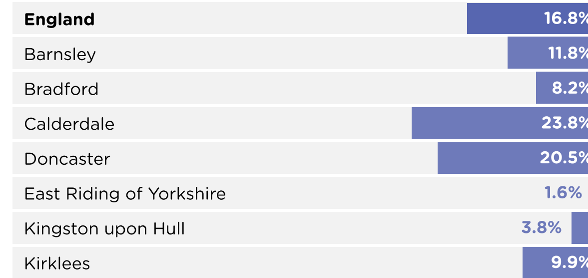
- Access to green space such as woodland, supports wellbeing and allows people to engage in physical activity and to connect with other people. Both the presence of a woodland and the number of people who can readily access the space represents a significant asset to that community. Woodlands provide spaces for community activities, social connectedness, volunteering as well as employment. Woodlands provide spaces for community activities, social connectedness, volunteering as well as employment.

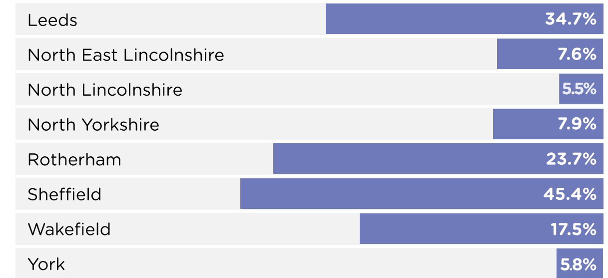
  The positive impact our pets can have on the way we feel – both physically and mentally – was made clear in the diary entries we received for a day in the life of:

  "Get a dog and go out for a walk (borrow one if you don't want one permanently). Strangers will talk to you and become your friend." Female, 57

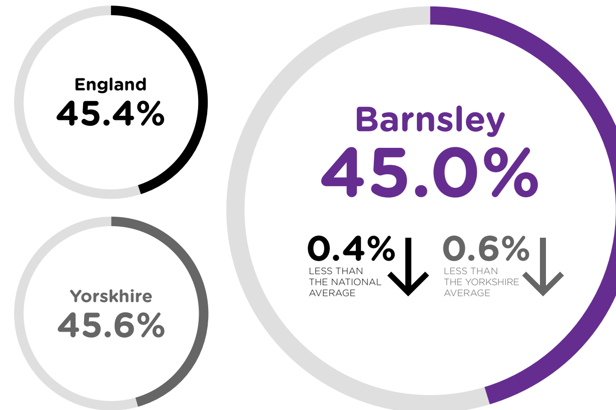
  A dog walk in the fields. This is the best part of the day, so peaceful, just listening to the birds and enjoying the countryside." Male, 64

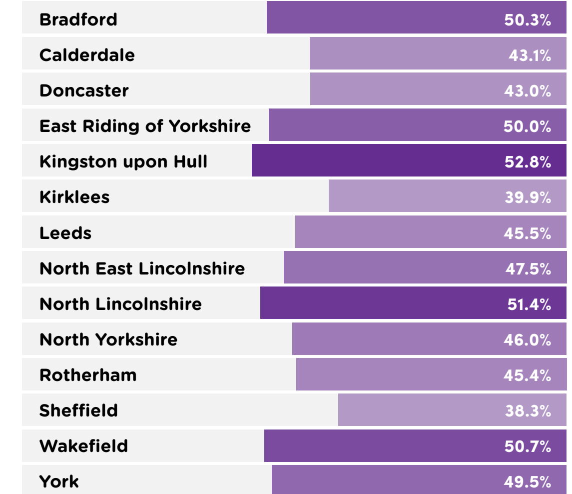
People's access to woodland within 500 metres of where they live



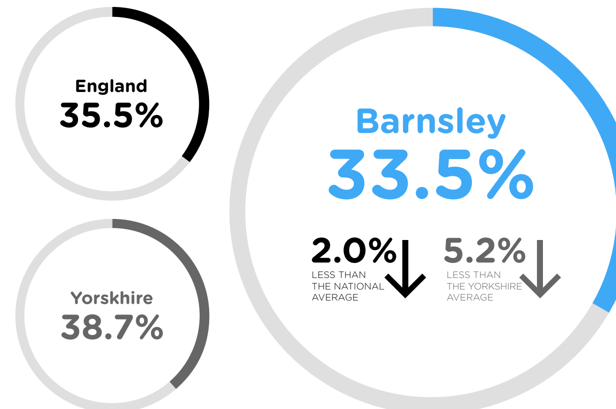


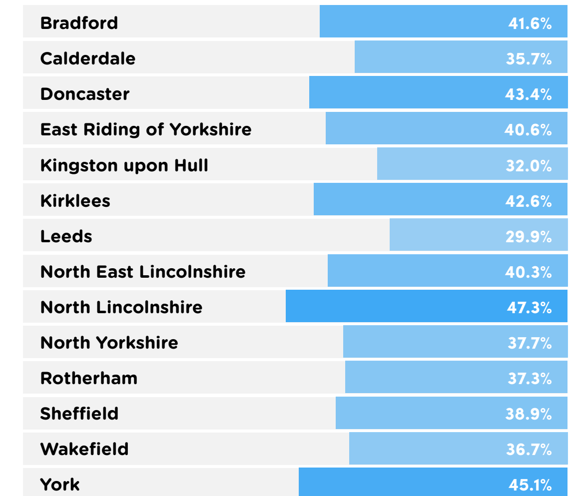
Percentage of **adult social care users** who have as much social contact as they would like





Percentage of **adult carers** who have as much social contact as they would like (18+ years)





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4. WHAT YOU TOLD US...

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Our 2016 annual report was a short film which aimed to find out what being healthy means to those living and working in Barnsley and how our approach to promoting good health might need to change, from the decisions we make, to the services we provide. Making this video taught us that if we want to succeed in raising health and wellbeing to be the best it can be, we need to get out more and listen and engage with what matters to people who live, work and learn in Barnsley.

The public health team spent October and November of 2018 talking with local residents, young people and community groups about their connections with other people and how this might impact on their feelings of loneliness and social isolation. In particular, we asked residents to think about how technology has improved their communication and where it might have had a postive or negative impact.

Here is a summary of the community groups who participated in the production of this report and we would like to express our sincere gratitude to each person who shared their thoughts and feelings with us and helped to shape our future response.

We have included some of the comments we received over the next few pages.

CHITTY CHATTY BUS

'Hattie' is a retired bus from the original Skegness Seasiders which was transformed into a community bus, kitted out with seating areas, tea and coffee making facilities, games and activities. 'Hattie' is supporting Stagecoach in their efforts to bring communities together and promote health and wellbeing around the area. As part of 2018 National Inclusion Week, members of the public were encouraged to stop by and have a chat with light refreshments and to have a look onboard the child friendly bus. In partnership with Age UK Barnsley, 'Hattie' was on tour in Barnsley to bring people together to promote social inclusion to show that no one needs to be alone.

KIDDY WINX PLAY CAFÉ

Kiddy Winx Play Café is a learn and play facility in Thurnscoe and is dedicated for parents and carers with children under 5. There is a cafe and activity room that hosts classes and regular activities suitable for babies and toddlers. The café is one of ten locations for the breastfeeding drop-in groups offered by Barnsley infant feeding team.

KEYRING

KeyRing is a supported living network made up of a number of ordinary homes. People who need support live in all but one of them. These people are KeyRing members who help each other out and meet up regularly, gaining greater independence, improvements in their wellbeing and stronger social connections.

HUMANKIND

Recovery Steps Barnsley is an integrated drug and alcohol recovery service for Barnsley. Their aim is to help as many people as possible to recover from and be free from drug and alcohol dependency and to reduce the harm that is caused to individuals, families and communities. Many of HumanKind's clients are vulnerable adults, many of whom are detached from communication in the tech era we currently live in.

CENTREPOINT

Young people in Barnsley become homeless for lots of reasons, including relationship breakdown and mental health problems. Centrepoint works with Barnsley Council and our partners to provide support and accommodation. Along with a safe place to stay, their services include technical and practical support to help young people to live independently.

SOCIAL CARE FORUM

A professional forum made up of Barnsley Council's social workers who work on a daily basis with the borough's most vulnerable families and young people and those that don't often access or connect with other services.

DIAL

Established in 1985, DIAL is an information, advice and support organisation for disabled people and carers in Barnsley. The charity is an independent user-led organisation which works with local people to coproduce and design services, raise awareness amongst the community of the abilities and rights of disabled people and represent their views with local service planners and providers.

OUR RELATIONSHIP WITH SOCIAL MEDIA

> My best friend emigrated but I don't do Skype or Facebook. We send written letters which I find very therapeutic.

> I don't speak that much to my dad unless I go to his. Every so often he will send me a photo of his tea … he likes to be sarcastic because I take photos of my food sometimes and he just sends me a picture of a sandwich which makes me laugh, so I suppose that keeps me connected to him.

> Social media is sometimes negative because of online bullying.

> I use my games console and 'go live' online with people across the world. I play games and speak with the same people, we have built a network. I have even made friends with some of them on Facebook.

> I bet I sound a lot like my grandad here because he hates social media, but I agree with him on one thing which is that pretty much every young person's life revolves around social media and the internet and games. What would happen to the world if all of it wasn't there anymore?

> Social media has helped us all to keep in touch with people more regularly than we would have done and also to speak to people who we would not normally speak to.

> Technology and definitely social media is replacing 'normal' communication.

> People are isolating themselves and not getting out anymore, instead just staying in on social media.

> It's not like you can walk away from it on social media … it's just constant.

> I think it's a relief when you don't have your phone because I remember mine getting taken off me for a week because I wouldn't come off it. It was just that relief of not knowing what's going on.

> Social media makes it easy (and cheap) to have relationships and friendships with people who are out of town. I use it to talk to my sister, brother, parents and cousins who live in other countries.

> Group chats on Facebook means we can support each other as new parents.

> People often express emotion through social media e.g. emojis rather than talking to people. They seek instant gratification.

> You connect less with people if you see their life through social media and compare it to yours. Theirs is perfect; you're not as good as them.

> It's good for friendship making. It makes you feel more accepted by people, so you go onto social media if you're not very good at being social so you can make friends and maybe meet up with those new friends. You can have more people to hang about with which makes you more happy and interactive with people.

KEEPING CONNECTED BY GETTING OUT AND ABOUT

> Everything can be done at home which is very sad. Dad's dog died but now he is older he didn't want another one which also means he doesn't get out anymore.

> I like the women's group. I can make friends and get out of the house. My children like it as they can mix with others and do activities. It improves their social skills which they wouldn't get at home.

> There are voluntary groups within services that enable people to come together like here at HumanKind - the walking group. We meet weekly and only use our phones to take photos.

> Markets are a great way to help people to communicate in person. People go there not only to shop but to meet and talk to people.

> At KeyRing we have our hub where we all come and do things. We share the room with other groups. We have made friends and all know each other by name.

> Coming to the women's group has improved my mental health. Coming here is a good distraction; I can engage with the activities and talk to people. It brings people together. If the group was not here I would be isolated and go into my shell and stay at home. Coming here provides self-relief; I can relate to other women that are here which makes me realise that there are other women like me, in similar situations, it makes you realise you aren't the only one.

> I recently took part in 'my dancing town' which encouraged people to come out during the evening. People had a good time and got involved.

> Community shops are a really good starting point.

OUR RELATIONSHIP WITH TECHNOLOGY

"Technology allows me to contact old friends from school and old colleagues who I would have lost touch with otherwise."

"Not everyone has access to technology which further isolates them."

"I use my phone to video our group trips and share this with our network. We can laugh at the memories we've made."

"Technology has changed the way we communicate; it's made communication instant and in real time."

"My sister (aged 7) sits on YouTube and other stuff and doesn't engage for hours while she is on it; it's scary."

"Technology has isolated people which may result in more mental health problems."

"The internet and social networking and buying online is making global communication an everyday thing for most people, although some people at the older end remain in fear of even learning the technology."

"My kids are at University and it feels good that I can contact them at any time to check how they are."

"We don't communicate in person anymore; even sending birthday greetings by text message."

"Communication through technology helps to get information quicker. It's made the world smaller. I was in the army and I was able to keep in touch with my kids from far away and have video calls with them. This helped us all."

"Technology has enabled people to communicate all hours of the day. If people are lonely or need support they can now talk to someone online during the evening or night. Previously this wasn't possible."

"The use of technology is disconnecting some groups of people from society, those who can't afford, unable to use (the blind) or older people who don't think they can use it."

"It leaves my parents out who are not technology literate and makes them feel isolated when everyone is using phones."

"I don't use self-checkouts anymore because of the less human contact side of things."

SOCIAL ISOLATION AND LONELINESS AFFECTS EVERYONE

> “There are lots of voluntary groups for old older people but nothing for younger.”

> “We need better signposting to groups for families.”

> “People just don’t talk to each other face to face anymore.”

> “We need more groups and other things where young people can get together and just talk about what’s happened to them in their life. There isn’t anything anymore.”

> “Have more intergenerational projects which allow older and younger people to learn more about each other and develop skills which both groups are losing out on.”

> “I have teenagers and their generation doesn’t connect with people as much face to face. I feel that they are losing skills such as social etiquette. My son is back from university and he never leaves the house because everything he needs is online and especially now that his friends all live out of town.”

In April 2018, we held a number of focus groups with older residents to find out more about how they were feeling. The discussion focussed on what more could be done to tackle loneliness and social isolation in Barnsley.

We asked two key questions:

WHAT ARE THE MAJOR ISSUES CONTRIBUTING TO SOCIAL ISOLATION IN OLDER PEOPLE?

WHAT COULD WE DO TO MAKE IT EASIER FOR OLDER PEOPLE TO ENGAGE WITH OTHERS AND SOCIAL ACTIVITIES?

> “THERE ARE CLIQUES AND I WOULDN'T KNOW ANYBODY.”

> “TAKING THE FIRST STEP TO GET OUT IS HARD BUT I'VE DONE IT TODAY.”

TRANSPORT AND GEOGRAPHY

Transport and geography was the most common answer. Many of the participants explained that poor public transport prevented them getting involved with local activities and events. The majority of the residents involved in the focus groups had journeyed to the activities by a lift in a car or by organised transport. The vast geographical spread of Barnsley, coupled with poor transport in some areas, is an obstacle for older people. Furthermore, in relation to travel and transport, residents with a disability have an additional barrier to overcome.

AWARENESS AND INFORMATION

A lack of awareness about activities and events was mentioned countless times. Residents reported that they did not know about the social activities happening in their local area and that they don't always see things advertised. Word of mouth is a popular form of promotion for this age group.

CONFIDENCE AND REASSURANCE

Some of the older people explained that they often felt nervous about going out on their own. The majority of people who attended the focus groups had not come on their own. Women in particular said that if they did not have anybody to go with they would not attend, as they did not feel confident to attemd new things on their own.

When asked why some people don't attend these types of activities, several participants explained that often older people just get used to being on their own at home and don't like going out.

From these discussions it became clear that the need for reassurance or a friendly face made the difference between people getting out of the house and staying home alone. Having reassurance or familiarity increases their confidence to participate.

TECHNOLOGY

Some of the participants believed that technology is making people become more isolated.

“We are constantly told to do it online or go to the self-service machine. I used to like to go out and enjoy the little conversations with people working in the shops and banks but we no longer get that. We don't even get the chance to speak to the bus driver as our bus passes are electronic.”

FRIENDLY FACE

Encouragement to attend activities was also discussed as a positive enabler. Some of the older people, especially women would appreciate a friendly face or a buddy to accompany them to events. They were clear that if a person ‘buddied’ them to an activity it would not be forever; just for the first couple of sessions until they felt more confident to attend on their own. Positive family encouragement and good neighbours were also considered helpful.

5. EXAMPLES OF KEEPING CONNECTED IN BARNSLEY

Our engagement with residents highlighted a number of projects and initiatives across the borough which tackling social isolation and loneliness. Here are just a few...

Pictured are KeyRing Barnsley Members

KeyRing was established in London in 1990 to support people with Learning Disabilities to live the lives they want including a home where they are safe and an income to support themselves. KeyRing's Living Support Network creates the opportunity for its Members, volunteers and people in the community to use their sills and experiences to help each other.

The KeyRing network in Honeywell, Barnsley was established in 2000 and was the first network outside of London.

Through commitment to its vision, KeyRing has helped around 60 residents in Barnsley to achieve great things and have helped people become more independent.

The Hub is a place for Members to meet, talk about what's happening, share interests and discuss and arrange social events and activities. It's also a place to learn new skills and connect with other community groups.

"As a support worker I used to meet one of the Members in a café in Wombwell. After several weeks, other Members had heard about this and started to come along and soon there was a group of about 8 people meeting every week for lunch. The café was across from a Barber shop and one day, a member wanted a haircut so a group of Members decided to go together. Several of them still use this barber.

Steve Pritchard
Support Manager, KeyRing Barnsley

"DEVELOPING YOUR PLACE IN THE COMMUNITY IS ABOUT CONNECTIONS. KEYRING DO THIS IN BARNSLEY THROUGH 1-1 TIME SPENT WITH MEMBERS, SUPPORT PLANNING, ENCOURAGING AND FACILITATING MUTUAL SUPPORT AND WEEKLY HUBS."

Support Manager, KeyRing Barnsley

"WE'VE MADE A FACEBOOK PAGE AND ALL THE KEYRING MEMBERS FROM ACROSS YORKSHIRE USE THIS TO KEEP IN TOUCH AND SHARE PHOTOS OF OUR TRIPS OUT."

Member, Keyring Barnsley

DIAL-A-RIDE

Dial-a -Ride service is provided by Travel South Yorkshire representing a number of organisations and operators that work in partnership to provide residents with access to public transport.

The service provides accessible transport to residents who are disabled and elderly; helping them to lead an independent life. Residents are collected from their home in fully accessible vehicles and driven to destinations around Barnsley; making their travel experience as easy and convenient as possible.

Dial-a-Ride operates on weekdays, and customersare asked to ring two days in advance of the day they would like to travel to secure their booking. Journeys start from £2.50 per single journey.

Barnsley Dial-a-Ride: 01226 732096

Pictured is Joan being picked up from her home by Dial-a-Ride driver, Fred

"I like how the drivers collect you from your front door. They are kind, patient and help me walk to the bus. The drivers will even help with seat belts if needed. Fred is my favourite driver but he's retiring soon. I don't want him to leave. He's very helpful, carries my shopping bags and make sure I get in safe.

Joan is 82 and a frequent user of Dial a Ride

"All the drivers have cheerful smiles and are always very helpful and obliging. They are friendly, they have a laugh with you, and they make me smile. The drivers really pay attention to older people. I think the service is value for money, the bus is always full.

"Dial a ride helps older people get out and about. Without it I'd be stuck in the house going crazy, home alone. If Dial a Ride didn't exist I wouldn't be able to get out. I wouldn't get to meet people or socialise. I'd miss luncheon club. Without it I wouldn't be able to talk to the friends I've made on the bus. I use the service every week and have done for 7 years, ever since moving to Silkstone. I like the social aspect of it.

COMMUNITY GARDEN AT SPRINGVILLE, PENISTONE

Springvale Community Garden

Springvale Community Garden is a vibrant community asset which is becoming increasingly well known for the opportunities for volunteering as well as excellent seasonal vegetables, fruit and plants. It is a 4 acre site on 2 sides of the River Don in Springvale, Penistone.

Springvale Community Garden has an aim of providing:

- Education about healthy eating, growing and wildlife
- Conservation of the 4 acre site for the benefit of the community and wildlife
- Purposeful recreation. Springvale Community Garden is run entirely by volunteers. The act of volunteering as beneficial not just to the garden but also to themselves and visitors.

The community garden is now growing into a place where the whole community can find something that gives them a better quality of life. The garden has been supported by Penistone Ward Alliance funding which has helped with materials for renovations and equipment. Local businesses have helped too. The garden is run entirely by volunteers who look after the site and grow the plants and vegetables.

Volunteers have many different reasons for being involved. Some enjoy getting stuck into physical tasks others play a role with administration. Some enjoy being part of a group and a worthwhile cause, or just coming to the garden for relaxation.

You don't need expertise or experience; just be willing to give it a go. There is always someone to support or guide and everyone can join in.

GPs are now able to signpost to Springvale Community Garden through the social prescribing service, My Best Life, and people can volunteer as much or as little time as they like.

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For this annual report, we asked volunteers at the Community Garden how their involvement had affected their mental wellbeing. Here are the key words they used to describe their experience:

- Relaxing
- Laughing is the best tonic
- Camaraderie, friendship, social connection, supportive
- You are not alone
- Positivity
- Mental agility, problem solving
- Having a purpose
- Rewarding
- Meeting likeminded people
- Mindful
- Builds your confidence

One volunteer, Lyn, said: "...no one judges and when you are doing purposeful tasks there's no room in your head for all the rubbish. It fills up your senses. People tolerate your quirks. It should be prescribed by the doctor."

Another volunteer, Anne said: "there's something fundamental about growing that connects you to what's real."

Volunteer, Margaret said: "it's so positive and satisfying to see seeds become something you can eat."

Maureen commented that for her the garden has been a lifeline. Feeling useful even in a small way has built her self-esteem after illness.

Adam commented that he noticed a "great sense of belonging" and a "warm family feel."

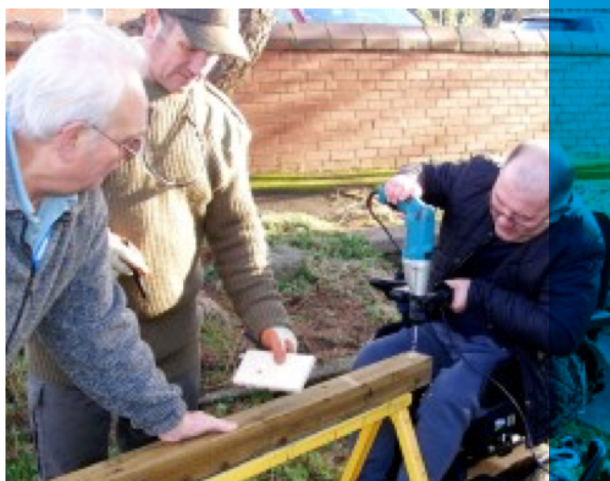
springvalecommunitygarden@yahoo.co.uk

MEN IN SHEDS

Men in Sheds is a place where like-minded older men can come together and have a chat over a cup of tea whilst learning new skills such as woodworking, IT, art and much more...

It is a safe, supportive and friendly place to meet, where men can socialise, do a bit of light work or busy themselves doing a hobby or learn new skills. 'Shedders' will have access to facilities and workshop space where they can share and learn skills.

We received this following letter from a relative of a member of Age UK Barnsley Men in Sheds which speaks volumes about the impact of schemes like this which aim to grow new connections.



For more information please contact Malcolm Poskitt on 01226 730412 or by email: m.poskitt@ageukbarnsley.org.uk

"I feel Peter has been much happier since he has been going to the Barnsley Men in Sheds. Peter really enjoys going and always comes home with a big smile on his face.

Right from the very first day, Peter has thoroughly enjoyed going to the Barnsley Men in Sheds. Peter loves the happy atmosphere where he can relax, have a good chat, share jokes and funny stories, have a good laugh and have fun. Peter has made new friends who have made him feel very included in everything. It is very important to Peter that he has that level of social interaction.

I feel going to Men in Sheds has been very beneficial for Peter. Following retirement, he has needed that level of companionship and friendship which he has found there. He feels he has found somewhere where he can be happy and have that sense of being included in everything. The feedback I get from Peter is always very positive. Peter is always telling other people about Men in Sheds and how much he enjoys going there.

I feel Peter has really improved since going to Men in Sheds. I can see the difference it has made to him. Peter is now much happier and more relaxed. As I said, he always comes home with a big smile on his face. For this I would like to say a big thank you to Men in Sheds."

*Names have been changed to protct anonimity

BARNSLEY ARMED FORCES AND VETERANS BREAKFAST CLUB

Armed Forces and Veterans Breakfast Clubs are free. There are no subscription or joining fees. All any veteran or service personnel will ever have to pay for is their own breakfast. Involvement aims to end isolation, giving veterans particularly a sense of belonging.

The original concept started in 2007 based on a 'brew' and a 'butty' and has since expanded with more than one new breakfast club starting every week. There are now over 260 clubs and 26,000 members worldwide.

The breakfast clubs are having huge benefit on the lives of many veterans and their families. The mutual support they offer and the connections they are making is incredible.

Ray was a Royal Engineer and at aged 60, he joined the Barnsley Armed Forces and Veterans Breakfast Club 18 months ago which has helped him to reconnect with colleagues he had not seen for almost 30 years.

Between 30 and 40 veterans attend the breakfast club every week and in addition to fund raising, the group organise lots of other social activities including museum trips, meals, nights out and boat trips.

Ray described how he didn't have much of a social life before joining the breakfast club but now told us "I'm happier now; I have more things to occupy myself. I don't want to be sat at home doing a jigsaw. I don't know what I'd be doing if I had not found the club. We meet up and have a laugh; it's great. With all the eating and drinking we do the club isn't doing my waistline any good but it's certainly helping my mental health!"

The Barnsley Armed Forces and Veterans Breakfast Club is held every Saturday, starting at 9.30am, at The Joseph Bramah, 15 Market Hill, Barnsley, S70 2PX.

For further information visit the AFVBC website:

www.afvbc.net

Here is what some veterans from across the country have to say about the Armed Forces and Veterans Breakfast Clubs they attend across the country...

THE AFVB IS A GREAT PLACE TO MEET UP WITH OTHER EX-MILITARY PERSONNEL (AND THEIR OTHER HALVES) FROM ALL SERVICES. I LOOK FORWARD TO ATTENDING WHEN I CAN BUT THERE IS NO COMMITMENT TO ATTEND EVERY TIME.

I ENJOY GOING TO THE BREAKFAST CLUB AS IT GIVES ME CHANCE TO MEET UP WITH LIKE-MINDED PEOPLE. WE HAVE A LAUGH AND CHAT ALL OVER A GOOD BREAKFAST.

GREAT WAY TO SPEND A MORNING WITH OLD FRIENDS, GOOD FOOD AND REMEMBERING GOOD TIMES. THE BREAKFAST CLUB IS AN EXCELLENT WAY TO BRING US TOGETHER AFTER MANY YEARS.

6. RECOMMENDATIONS

Our aim for this year's annual report was to examine how we can help everyone who lives, works or studies in Barnsley to support and grow our connections with other people. We all have a role to play and as a borough I believe we can be very proud of everything that our communities and volunteers are already doing.

Personal support networks are so important for our quality of life and wellbeing. Knowing someone you can ask for advice or practical help, being involved in a group or community association and feeling that you can make your views heard and influence local decisions are all indicators of health and happiness (Think Local Act Personal, 2011).

Live Well Barnsley is a place where you can find information about help and support services within the borough. The website contains information and contact details about all types of services and activities that can help you look after yourself, stay independent and get involved in your community, including making connections with other people.

Barnsley LiveWell

www.livewellbarnsley.co.uk

WHAT WE WILL DO

A connected society: a strategy for tackling loneliness recognises that nationally, while we increasingly understand the impact of loneliness; there is less certainty about its drivers and what works to reduce it (HM Government, 2018). We recognise this in Barnsley which is why I have not recommended we set a target to reduce loneliness and social isolation locally; although we must continue to work extremely hard to do so. Instead, using what we do know and proposals within the new Government strategy, I recommend the following:

- That we work with the Government to establish a clearer picture of the prevalence of loneliness through the development of a new national measure that we monitor locally and set a target to reduce.
- Ensure local social prescribing service My Best Life helps residents to connect with community support to restore social contact in their lives.
- That any evaluations from the many projects established to improve our connections with others within Area Councils are shared for future learning and to help build our local knowledge around what works.
- We will develop a local campaign which aims to reduce stigma and raise awareness of the importance of our connections with others, on our physical and mental health and wellbeing, for example it costs nothing to say 'hello'.
- We will work with local employers to develop business champions who can tackle loneliness in the workplace.
- We will consider how tackling loneliness can be embedded in all our strategic plans and decision making through the Health and Wellbeing Board.
- Ensure that the Health and Wellbeing Board is fully sighted on loneliness locally and the steps we need to take to improve our connections.
- Step up our public health support to Area Councils to continue growing community spaces to encourage social connections including chatty cafes and gardens.
- Develop the evidence-base around the impact of different initiatives in tackling loneliness, across all ages and within all communities

In addition to asking for your views on why so many people feel lonely and isolated, we also asked for your ideas on how we can work together to tackle this public health issue. As always, I was overwhelmed by your interest, enthusiasm and ideas for us to take forward as a community. These included:

"We need to create space to encourage people to interact."

"We need to work with young people who might spend too much of their time gaming."

"Running activities like family picnics would be good. If everybody brought some food to contribute that would be nice. Perhaps at Locke Park. This would help people to mix, make friends and spend time together. It would help with people's knowledge, understanding and respect."

6. RECOMMENDATIONS

WHAT YOU CAN DO:

- Connect with Live Well Barnsley to find out how you can meet new people and make connections with others.
- Be Happy to Chat - each of us can tackle loneliness by starting a conversation whether with a neighbour or in the supermarket queue. As Jo Cox said, we can all help by "Looking in on a neighbour, visiting an elderly relative, or making that call or visit we've been promising to a friend we haven't seen in a long time."
- Volunteer; there's good evidence that volunteering helps both the person who volunteers as well as the people and cause they support.
- Advise; if you or someone you know is experiencing loneliness, take a look at the advice from The Campaign to End Loneliness www.campaigntoendloneliness.org or log onto www.livewellbarnsley.co.uk

If we work together we can achieve so much more and build a brighter future and a better Barnsley. Through Town Spirit, we have introduced a new way of connecting with our communities, customers and businesses.

#LiveIt helps us to support the most vulnerable people, making sure they can access support at the earliest possible stage. Own it by keeping your employees', your own and your family's health at its best, asking for support when you need it and looking out for your friends and neighbours.

Town Spirit

Working together for a better Barnsley

Buildit
Building a better Barnsley

Loveit
Having pride in where you live

Achieveit
Helping you realise your potential

Changeit
Having your say on things that matter

Developit
Helping businesses to thrive

Protectit
Protecting our wonderful borough

Liveit
Looking after yourself and others

Imagineit
Creating a brighter future

7. REFERENCES

HM Government (2018). A connected society: a strategy for tackling loneliness – laying the foundations for change.

Jo Cox Commission on Loneliness. (2017). Combatting loneliness one conversation at a time.

Office for National Statistics. (2018). Children's and young people's experiences of loneliness.

Public Health England. (2015). Local action on health inequalities: reducing social isolation across the lifecourse.

Think Local Act Personal. (2011). Are we there yet? A planning tool and checklist for building community connections.

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BARNSLEY METROPOLITAN BOROUGH COUNCIL

This matter is a Key Decision within the Council's definition and has been included in the relevant Forward Plan

**REPORT OF THE
EXECUTIVE DIRECTOR OF COMMUNITIES
TO CABINET ON 1st April 2019**

STOP SMOKING BUSINESS CASE

1. PURPOSE OF REPORT

1.1 This report provides an overview of the business case for the Specialist Stop Smoking Service. The contract for the service is due to expire at the end of October 2019 and the business case provides recommendations for a recommission.

2. RECOMMENDATIONS

2.1 Cabinet to approve option 3 as set out in the business case (page 28) which involves a revision of the current specification with a strong focus on secondary care including midwifery and integration.

2.2 Cabinet authorise officers within BMBC to approach the market to inform the procurement of a Specialist Stop Smoking Service from 1st November 2019.

2.2 Cabinet authorise the Director of Public Health and Executive Director, Communities to have delegated authority to award the contract for the Specialist Stop Smoking Service following a competitive process.

3. INTRODUCTION

3.1 The Health and Social Care Act 2012 transferred the responsibility for Public Health from the NHS to the local authority from 1 April 2013. The current provider of the Barnsley Specialist Stop Smoking Service (SSS) is South West Yorkshire Partnership Foundation Trust (SWPFT) and this is funded as part of the Public Health Grant. The contract is due to expire on the 31st October 2019.

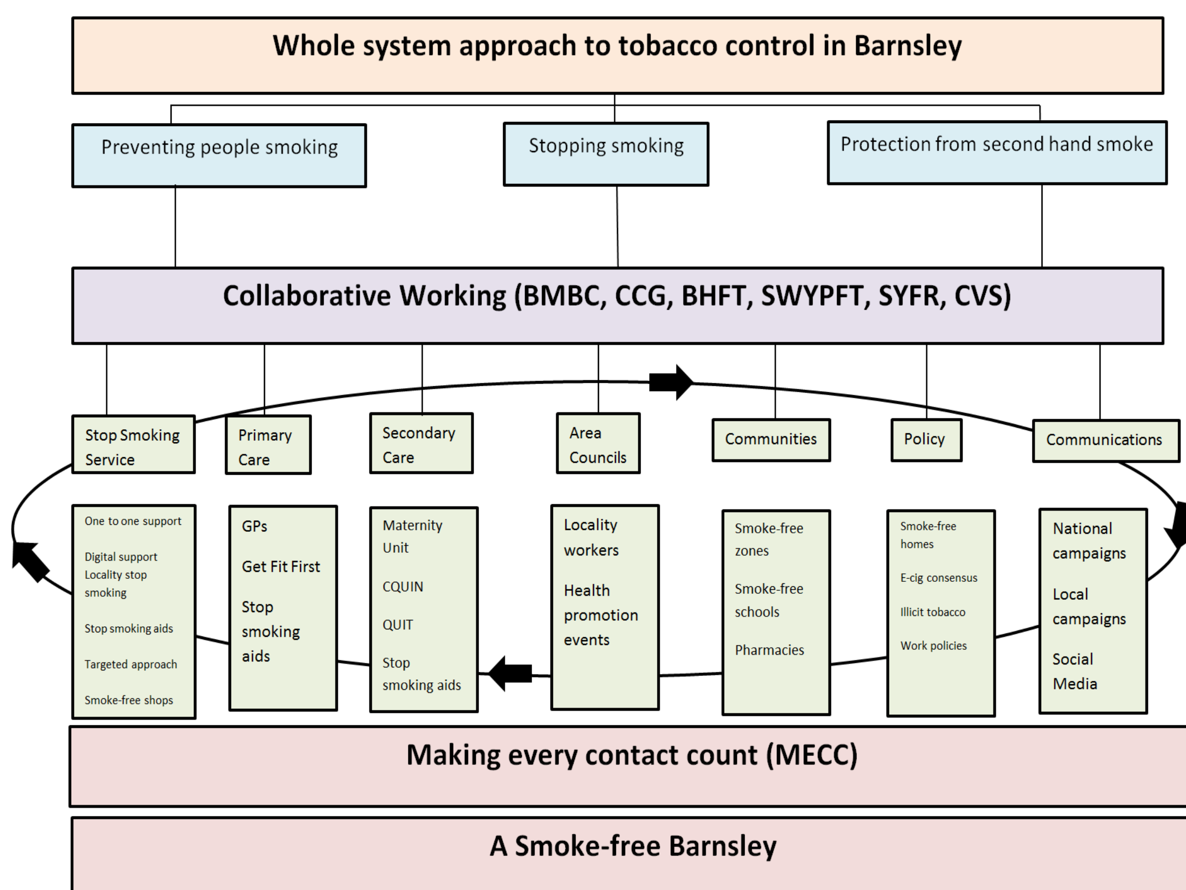
3.2 Despite the decline in smoking rates in previous years Barnsley still has one of the highest adult smoking prevalence's within the country at around 1 in 6 people who smoke (18.2%), although this has dropped significantly since the previous year (20.6%) (PHE Fingertips 2017).

Barnsley Health & Wellbeing Strategy, Barnsley Place Based Plan and more recently, the NHS long term plan (2019) has highlighted a focus on prevention and health inequalities and there has been a national and local priority for four priority cohorts, which remain the focus throughout the business case:

- Routine and manual as a result of low income.
- Secondary care – as a result of presenting illnesses.
- Pregnant women.
- Mental health.

3.3. The Department of Health and Social Care has developed The Tobacco Control Plan for England 2017-2022. In addition, the regional Breathe 2025 campaign, developed by Public Health England sets out to achieve a tobacco free generation using a multifactorial approach.

Significant progress has been made in Barnsley around this agenda through the implementation of the Smokefree Barnsley Action plan, to reduce the prevalence, improve prevention and make smoking invisible. This is a result of the collective work from all organisations, with the Specialist Stop Smoking Service playing a key part.



4. PROPOSAL AND JUSTIFICATION

4.1 The proposal is to develop a specification for a stop smoking service that delivers interventions detailed in 3.2 of the business case and to go out to market to procure the service.

4.2 The newly commissioned service will build on the existing service but with an increased focus on secondary care. This will include specialist workers based in the hospital and the continued provision of specialist midwifery services.

4.3 The justification is based on the fact that smoking remains a major cause of preventable ill health and premature mortality. Two-thirds of smokers say that they want to quit and smokers who get the right support are up to four times as likely to quit successfully. The most effective approach to supporting people to stop smoking remains the provision of specialist stop smoking services.

5. CONSIDERATION OF ALTERNATIVE APPROACHES

Three options were identified within the business case for the new service. The analysis provides the Council with two alternatives, noting that the 'do nothing' option was ruled out due to the significant level of smoking prevalence across the borough. The second option to recommission the same service would not allow an increased focus on secondary care, due to resources being targeted elsewhere. This increased focus would have a significant impact on those people who needed it most.

6. IMPLICATIONS FOR LOCAL PEOPLE/SERVICE USERS

6.1 Individuals who smoke on average will lose around 10 years of their life attributed by their habit. It is clear that smoking is a key contribution towards poor life expectancy and health inequalities and so providing people with the opportunity and support to quit is of vital importance.

Smoking has been a priority for the Public Health Strategy over the last few years and continues to have an important focus, particularly in relation to the wider determinants of health. The Public Health Strategy for Barnsley also supports the principles detailed in future council.

Work continues to focus on the fact that health is shaped about 'where and how we live' and that there is still a need to '….reduce the stark inequalities which mean the most vulnerable and most deprived bear the heaviest burden of disease' – and smoking is a key feature of this. It is important to create and sustain good health and wellbeing across the life course in Barnsley (DPH 2017)

7. FINANCIAL IMPLICATIONS

7.1 The current funding available for the Specialist Stop Smoking Service is a maximum of £450,000.

7.2 Consultations have taken place with representatives of the Service Director – Finance (S151 Officer).

8. EMPLOYEE IMPLICATIONS

8.1 The current service is delivered by South West Yorkshire Partnership Foundation NHS Trust (SWYPFT) and there approximately 9 staff employed in a variety of roles including; Healthy lifestyles Advisors, Team leader, Administrative support as well as 2 staff as part of the Stop Smoking In Pregnancy Service employed by BHNFT all funded within the current budget.

9. CUSTOMER AND DIGITAL IMPLICATIONS

9.1 A specialist stop smoking service will be accessible to all members of our community. We are considering digital solutions to support people to quit, such as the use of phone apps to prompt and support people to quit.

10. COMMUNICATIONS IMPLICATIONS

10.1 The stop smoking business case has been shared with a range of key partners who have contributed to its development.

11. CONSULTATIONS

11.1 As part of the Wider Tobacco Control Agenda, and number of Healthcare partners have been consulted with regard to the focus of the Business Case. These include;

Barnsley Clinical Commissioning Group – David Lautman, Lynsey Bowker, Patrick Otway, Jeremy Budd
Barnsley Hospital NHS Foundation Trust – Dr Andy Snell, Consultant in Public Health
Barnsley Council – Carrie Abbott, Diane Lee & Kaye Mann

12. THE CORPORATE PLAN AND THE COUNCIL'S PERFORMANCE MANAGEMENT FRAMEWORK

12.1 As part of the 'Future' council's corporate vision for 'working together for a brighter future, a better Barnsley,' there is a clear strategy to continue developing capacity and capabilities within our communities and shift the balance from a 'paternalistic' approach to one that 'empowers' individuals, families and communities to do more for themselves; key areas include; Early Help, behaviour change and making better use of technology. We need to take opportunities around the smoking agenda to build on this further.

Alongside this will be the achievement of a number of 2020 Corporate Outcomes. The proposed service will contribute to the following corporate priorities:

People achieving their potential
Reducing demand through access to early help
Children and adults are safe from harm
People are healthier, happier , independent and active
Strong & resilient communities
Customers can contact us easily and use more services online

13. PROMOTING EQUALITY, DIVERSITY AND SOCIAL INCLUSION

13.1 An Equality Impact Assessment (EIA) has been developed to ensure that any changes to the commissioned minimize adverse impact on Service users, especially those from groups with protected characteristics.

14. TACKLING THE IMPACT OF POVERTY

14.1 The average gross income per person in Barnsley is £495.70 a week which is lower than the England average and it is well evidenced that those individuals who live in poverty experience poorer health outcomes. Given that the poorest fifth of the working-age population in the UK will need to spend approximately 70-80% of their income for e.g. rent, fuel, food etc., a smoking habit of 20 per day (£72.80 per week) is likely to impact significantly on their disposable income. It is clear to see the cost of smoking to individuals and society, and the contribution towards increasing health inequalities is significant.

15. TACKLING HEALTH INEQUALITIES

15.1 The Marmot Review (2010) highlights the need for tobacco control to be central to any strategy to tackle health inequalities, as smoking is the single most important driver for health inequalities. Prevalence varies across the population translating into major differences in death and illness rates between difference socio-economic groups. National data on tobacco usage suggests we are still seeing:

- A decline in Smoking prevalence overall, but it is slower among disadvantaged groups
- Smoking-related deaths are two to three times higher in low income groups than in wealthier social groups.
- Approximately half of the difference in life expectancy between the lowest and highest income groups.
- Smoking has a consistent and strong relationship with both years of life lost and years of healthy life with as much as 14 years for smokers compared to non-smokers. This demonstrates both the morbidity and mortality effects of smoking.
- People with no qualifications, who are around twice as likely to smoke as those with qualifications
- Smoking amongst people with mental health disorders is substantially higher than among the general population.

15.2 Measuring life expectancy is a measurement used to assess health inequalities. In addition we can measure healthy life expectancy which helps identify the years lived in disability free health and the determinants of health will influence life expectancy e.g. tobacco usage. The highlights from BMBC data for life expectancy and healthy life expectancy at birth are as follows:

At Birth Males:

- Life Expectancy at birth in Barnsley in 2015-2017 is 78.1 years; lower than the Yorkshire and The Humber and England rates of 78.7 years and 79.6 years respectively.
- Healthy Life Expectancy at birth in Barnsley could expect to live 59.7 years in “good” health (3.7 years less than men in England overall).

At Birth Females:

- Life Expectancy at birth in Barnsley in 2015-2017 is 81.9 years; lower than the Yorkshire and The Humber and England rates of 82.4 years and 83.1 years respectively.

- Healthy Life Expectancy at birth in Barnsley could expect to live 61.0 years in "good" health (2.8 years less than women in England overall).

16. RISK MANAGEMENT ISSUES

A Risk Assessment will be undertaken as part of the development of the new service specification to identify any issues.

17. GLOSSARY

N/A

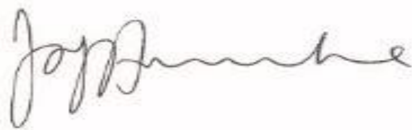
18. LIST OF APPENDICES

Appendix 1: Full Business Case – Stop Smoking Service.

If you would like to inspect background papers for this report, please email governance@barnsley.gov.uk so that appropriate arrangements can be made

Report author: Cath Bedford, Public Health Principal

Financial Implications/Consultation



…………………………………………………………..
(To be signed by senior Financial Services officer where no financial implications)

Stop Smoking Service

DETAILED BUSINESS CASE

Project Sponsored By:

HEALTHIER COMMUNITIES

i) Contacts

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Version	**Status** *(draft, approved, signed off)*	**Details**	**Prepared By**	**Reviewed By**	**Approved By**	**Date**
2	DRAFT		Sam Crowson	Cath Bedford		4/12/18
3	DRAFT		Sam Crowson	Jayne Hellowell		12/12/18
4	DRAFT		Sam Crowson	David Lautman and Lynsey Bowker		13/12/18
5	DRAFT		Sam Crowson	Diane Lee & Kaye Mann		13/12/18
6	DRAFT		Sam Crowson	David Lautman and Lynsey Bowker		02/01/19
7	DRAFT		Sam Crowson	Andrew Snell		02/01/19
8	DRAFT		Sam Crowson	Diane Lee & Kaye Mann		02/01/19
9	DRAFT		Sam Crowson	Jayne Hellowell		03/01/19
10	DRAFT		Sam Crowson	Jeremy Budd		24/01/19
11	FINAL DRAFT		Sam Crowson	Cath Bedford		13/02/19
12	DRAFT Approved		Cath Bedford	Communities DMT	Wendy Lowder	21/02/19
13	DRAFT Approved		Cath Bedford	Public Health DMT	Julia Burrows	25/02/19

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Name	Position/Capacity	Telephone
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Diane Lee	Head of Public Health, BMBC	
Carrie Abbott	Service Director of Public Health, BMBC	
Kaye Mann	Public Health Senior Practitioner, BMBC	
David Lautman	Lead Commissioning and Transformation Manager, Barnsley CCG	

Lynsey Bowker	Lead Commissioning and Transformation Manager, Barnsley CCG	
Patrick Otway	Head of Commissioning (Mental Health, Children's, Maternity and Specialised Services)	
Andy Snell	Consultant in Public Health, BHNFT	
Wendy Lowder	Executive Director of Communities, BMBC	
Phil Hollingsworth	Strategic Director, Stronger, Safer & Healthier Communities, BMBC	
Julia Burrows	Director of Public Health, BMBC	

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Programme Management Office

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List of abbreviations:

BHNFT – Barnsley Hospital NHS Foundation Trust

CCG – Clinical Commissioning Group

CVS – Community and Voluntary Sector

E-cigs – Electronic Cigarettes

ICS – Integrated Care System

LES – Local Enhanced Service

MECC – Making Every Contact Count

NCSCT – National Centre for Smoking Cessation and Training

NRT – Nicotine Replacement Therapy

OMSC – Ottawa Model for Smoking Cessation

SMI – Serious Mental Illness

SSIPC – Stop Smoking Interventions in Practise

SSS – Stop Smoking Service

STP – Sustainable Transformation Plans

SWYPFT – South West Yorkshire Partnership Foundation Trust

SYFR – South Yorkshire Fire and Rescue

TCCC – Tobacco Control Collaboration Centre

TTM – Trans Theoretical Model of Change

1. Introduction

The Health and Social Care Act 2012 transferred the responsibility for Public Health from the NHS to the local authority from 1 April 2013. The current provider of the Barnsley Stop Smoking Service (SSS) is South West Yorkshire Partnership Foundation Trust (SWPFT) and this is funded as part of the Public Health Grant. The contract is due to expire on the 31st October 2019.

Smoking was once seen as a behavioural habit of the affluent but now is recognised as the single biggest preventable cause of death in England (ASH, 2016). Despite the decline in smoking rates in previous years Barnsley still has one of the highest levels of adult smoking prevalence within the country at around 1 in 6 people who smoke (18.2%), although this has dropped significantly since the previous year (20.6%) (PHE Fingertips 2017). The NHS long term plan (2019) has also highlighted the importance of prevention and health inequalities, with a national and local focus on four priority cohorts;

- Routine and manual as a result of low income.
- Secondary care – as a result of presenting illnesses.
- Pregnant women.
- Mental health.

The data included in the section below supports the importance of targeting these groups in Barnsley.

1.1. Key highlights for Barnsley

- Smoking prevalence in Barnsley is reducing but we still have one of the highest smoking rates in the country.
- The latest data illustrates that 18.2% of the adult population In Barnsley are smokers - **significantly higher** than the England average (14.9%) (PHE 2017).
- The prevalence amongst routine and manual workers (27.5%) within Barnsley **is similar** compared to the England average (25.7%) (PHE 2017).
- The smoking status at time of delivery (14.2%) is **significantly worse** than the England average (10.8%) (PHE 2017/18).
- Smoking prevalence in adults with serious mental illness (SMI) (43.7%) and is **significantly worse** than the England average (40.5%) (PHE 2017).
- Smoking prevalence in adults with long term mental health condition **is significantly worse** in Barnsley (34.5%) compared to the England average 27.8%) (PHE 2017).
- Smoking attributable mortality of over 35s (299.7 per 100,000 people) is **significantly worse** than the England average (262.6 per 100,000 people) (PHE 2017).
- Roughly £63.5 million per year to society is estimated to be spent on smoking in Barnsley. This is on average around £1,323 per smoker per year. When net income and smoking expenditure is taken into account, 8,326 (32%) households with a smoker fall below the poverty line. If these smokers were to quit, 2,140 households would be elevated out of poverty, these households include around 1,707 dependent children (ASH 2015).

1.2 Tobacco Control in UK

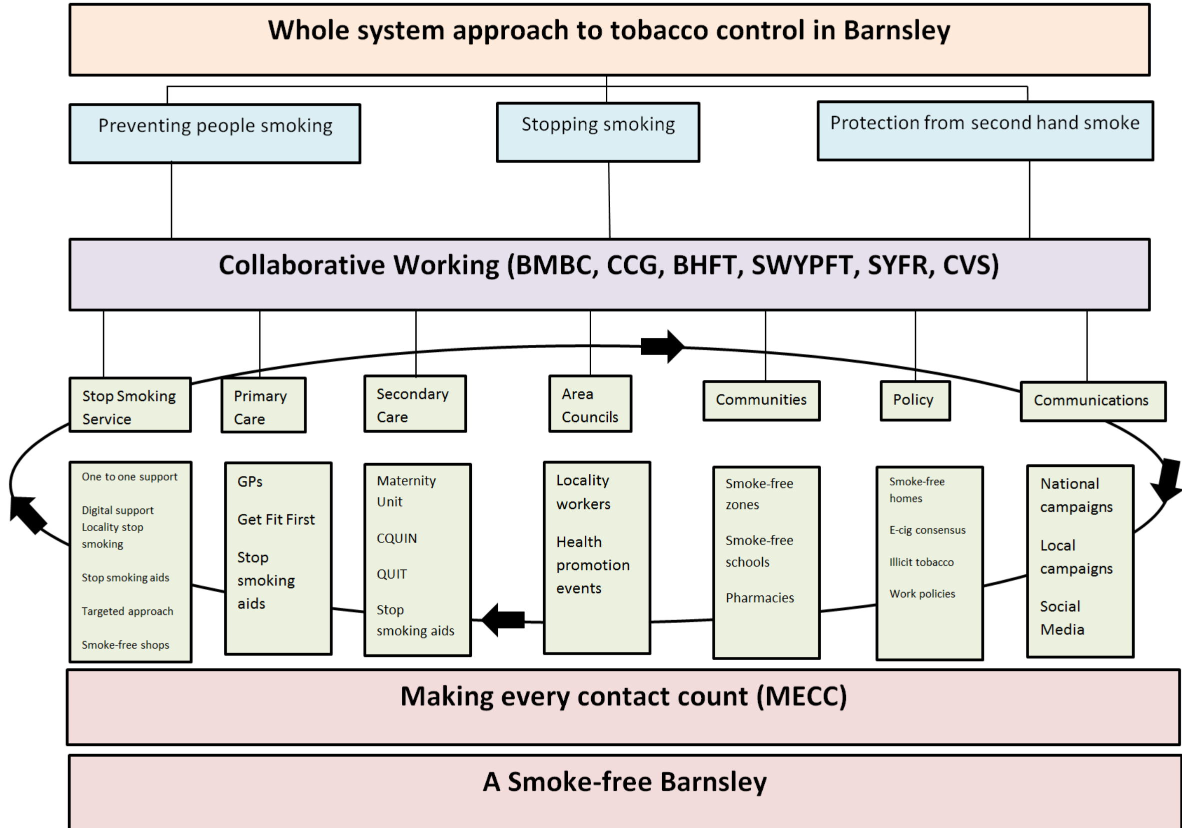
The Department of Health and Social Care has developed The Tobacco Control Plan for England 2017-2022. In addition, the regional Breathe 2025 campaign, developed by Public Health England sets out to achieve a tobacco free generation using a multifactorial approach.

The plan and the campaign work provided Barnsley with a steer on taking a whole system approach to tobacco control working towards a 'Smoke-free Barnsley,' and this is being addressed through robust governance arrangements. The Tobacco Control Alliance has an action plan drawn together in partnership with the Clinical Commissioning Group (CCG), Barnsley Hospital NHS Foundation Trust (BHNFT), South West Yorkshire Partnership Foundation Trust (SWYPFT), Area Councils, South Yorkshire Fire and Rescue (SYFR) and the Community and Voluntary Sector (CVS). Each organisation contributes to the three pillars of a whole system tobacco control approach which are:

- **Preventing people from smoking**.
- **Stopping people from smoking**.
- **Protecting people from second hand smoke**.

The progress made in reducing the prevalence and making smoking invisible is a result of the collective work from all organisations with the current stop smoking service playing a key part. This works alongside e.g. Smoke-free public places across Barnsley and enforcement around illegal/illicit tobacco. There are also ongoing national and local developments including harm reduction techniques using E-cigarettes, and the Q.U.I.T and CQUIN initiatives in secondary care which help identify smokers and offer very brief advice.

Many of the elements that contribute to this success are featured in the diagram below.



This whole approach needs to be strengthened and communicated further which will ensure effective outcomes for the residents of Barnsley.

1.3 Purpose of the document

This business case provides the evidence, current position and options for a future stop smoking service.

Two-thirds of smokers say that they want to quit and smokers who get the right support are up to four times as likely to quit successfully. The most effective approach to supporting people to stop smoking remains the provision of specialist behavioural support combined with pharmacotherapy as provided by evidence based local stop smoking services.

The business case for this Specialist Stop Smoking Service recommends supporting a number of targeted groups of people to maximise resources and impact, and includes a more universal offer to other people who want to quit that is available through e.g. online services, national campaigns & recommended quitting aids as well as community and family support.

The recommissioning of any service provides an opportunity to review the current provision (which is performing well) and explore options to strengthen the service where possible as part of future commissioning.

This will be achieved by:

- Understanding the need, value and benefits of the service, understanding the overarching Tobacco Control Agenda for Barnsley, national and local evidence base around Smoking & Smoking prevalence data.
- Analysis of current service & resources including structure, finance and performance against key performance indicators.
- Identifying and evaluating options for the new Stop Smoking Service.

2. Evidence base

2.1 Reducing Health Inequalities – national overview

People in England experience avoidable differences in health, well-being and length of life (Marmot Review 2010). This is also reflected within the circumstances in which people are born, grow, live, work and age. Marmot also highlights the need for tobacco control to be central to any strategy to tackle health inequalities, as smoking is the single most important driver for health inequalities. Smoking prevalence varies across the population which translates into major differences in death and illness rates between difference socio-economic groups. It is suggested that to reduce inequalities in England, sustainability and assets within the community also need to be improved to reduce the gap between the most affluent and deprived.

Measuring life expectancy is a measurement used to assess health inequalities. In addition we can measure healthy life expectancy which helps identify the years lived in disability free health and the determinants of health will influence life expectancy e.g. tobacco usage. The highlights from BMBC data for life expectancy and healthy life expectancy at birth are as follows:

At Birth Males:

- Life Expectancy at birth in Barnsley in 2015-2017 is 78.1 years; lower than the Yorkshire and The Humber and England rates of 78.7 years and 79.6 years respectively.
- Healthy Life Expectancy at birth in Barnsley could expect to live 59.7 years in “good” health (3.7 years less than men in England overall).

At Birth Females:

- Life Expectancy at birth in Barnsley in 2015-2017 is 81.9 years; lower than the Yorkshire and The Humber and England rates of 82.4 years and 83.1 years respectively.
- Healthy Life Expectancy at birth in Barnsley could expect to live 61.0 years in “good” health (2.8 years less than women in England overall).

Individuals who smoke on average will lose around 10 years of their life attributed by their habit. It is clear that smoking is a key contribution towards life expectancy and health inequalities.

2.2 Smoking Prevalence – National and local

There has been significant progress in tobacco control in the UK. There are a number of influences that underpin tobacco usage such as social norms, addiction, religion, ethnicity, self-perceived health, education level and social economic status (ONS 2018).

Nationally, the prevalence for people over the age of 18 smoking is 14.9% (PHE fingertips 2017) and research suggests males are statistically more likely (17%) to smoke than women (13.3%) except amongst 11-15 year olds where the opposite seems to be true. A similar trend can also be seen across other comparators for example, The British Thoracic Society; Smoking Cessation Audit (2016) reported that inpatients in secondary (25%) are more likely to smoke than the general population due to the causal link between tobacco and disease. There is also evidence to suggest that routine

and manual workers are statistically more likely to smoke compare to managerial and professional positions.

National data on tobacco usage suggests we are still seeing:

- A decline in Smoking prevalence overall, but it is slower among disadvantaged groups
- Smoking-related deaths are two to three times higher in low income groups than in wealthier social groups.
- Approximately half of the difference in life expectancy between the lowest and highest income groups.
- Smoking has a consistent and strong relationship with both years of life lost and years of healthy life with as much as 14 years for smokers compared to non-smokers. This demonstrates both the morbidity and mortality effects of smoking.
- People with no qualifications, who are around twice as likely to smoke as those with qualifications
- Smoking amongst people with mental health disorders is substantially higher than among the general population.

This evidence further supports the requirement to target these four specific cohorts and the local highlights detailed in section 1.

2.3 The harmful effect of smoking - Smoking related diseases

There is widespread misconception amongst smokers and health professionals that most of the harm of smoking comes from the nicotine. While nicotine is the addictive substance in cigarettes, it is relatively harmless. In fact, almost all of the harm from smoking comes from the thousands of other chemicals in tobacco smoke, many of which are toxic (PHE 2018).

The impact of smoking https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works

Smoking can increases the risk of developing more than 50 serious health conditions and others causing irreversible long-term damage to health. This includes at least 14 different types of cancer,

damage to the heart and blood circulation and harmful effects from passive smoking. Smoking causes around 90% of lung cases and can cause cancer and complications in various other body parts. (See infographic above);

2.3.1 Second Hand Smoke

Second hand smoke comes from the tip of a lit cigarette and the smoke that the smoker breathes out. Breathing in second hand smoke increases the risk of getting the same health conditions as smokers. For example, non-smokers exposed to second hand smoke increase their risk of lung cancer by a quarter (NHS 2016). To help reduce the risk of second hand smoke at a local level, BMBC are aiming to shift the social norms by make smoking invisible in their Smoke-Free Barnsley Tobacco Alliance Action Plan 2018-2020 by encouraging smoke-free places including:

- Smoke-free schools
- Smoke-free zones e.g. town centre, markets, parks, high streets
- Smoke-free homes
- Smoke-free hospitals

2.3.2 The Cost of Smoking to Society

Smoking attributable mortality in England is 262.6 per 100,000 people in the UK (PHOF, 2017) and is estimated to cost the UK economy in excess of £11 billion per year. Of this, it is estimated to cost £2.5 billion to the NHS, where smokers see their GP 35% more than non-smokers. Another £5.3 billion fell to employers as smokers, on average, are absent from work 2.7 days more per year than ex and non-smokers (PHE 2017).

In Barnsley, smoking related deaths is 333.9 per 100,000 and smoking attributable hospital admissions is 2,799 per 100,000. These are significantly worse than the national averages. However every year it is estimated that the smoking costs to society is **around £63.5 million:** This includes factors such as lost productivity, the cost of social care, smoking-related house fires, tobacco litter, illicit tobacco and organised crime.

The average gross income per person in Barnsley is £495.70 a week which is lower than the England average and it is well evidenced that those individuals who live in poverty experience poorer health outcomes. Given that the poorest fifth of the working-age population in the UK will need to spend approximately 70-80% of their income for rent, fuel, food etc., a smoking habit of 20 per day (£72.80 per week) is likely to impact significantly on their disposable income. It is clear to see the cost of smoking to individuals and society, and the contribution towards increasing health inequalities is significant.

3. National Strategic Priorities

3.1 Tobacco Control

'Towards a Smoke-free generation; Tobacco Control Plan for England 2017-2022' was published to support the continued leading national effort on tobacco control. The vision is to have smoking prevalence 5% or below. To deliver this the government has set out the following national ambitions using a whole system approach for tobacco control:

National Ambitions
The first smoke-free generation
A smoke-free pregnancy for all
Parity of esteem for those with mental health conditions
Backing evidence based innovations to support quitting

The delivery plan aims to look at prevention first, supporting smokers to quit, eliminate variation in smoking rates and explore effective enforcement of taxation and illicit tobacco. An element of this includes eliminating health inequalities through targeting those populations where smoking rates remain high, within the borough this equates to routine and manual workers and smoking at time of delivery in Secondary Care. After 2022, the ambition is to reduce smoking prevalence further to achieve a smoke-free generation.

3.2 NICE Guidance

3.2.1. Stop Smoking Services

NICE [NG92] published on March 2018 provides guidance which covers stop smoking interventions and services delivered in primary care and community settings for everyone over the age of 12. It aims to ensure that everyone who smokes is advised and encouraged to stop smoking and given the support they need to quit. It emphasises the importance of targeting vulnerable groups who find giving up smoking difficult or for those who smoke a lot (NICE 2018).

NICE [NG92] recommendations for stop smoking services
Commissioning and providing stop smoking interventions and services
Monitoring stop smoking services
Evidence-based stop smoking interventions
Engaging with people who smoke
Advice on e-cigarettes
People who want to quit
People who are not ready to quit
Telephone quit lines
Education and training
Campaigns to promote awareness of local stop smoking services
Closed institutions
Employers
Aim to treat 5% of their smoking population each year with a success rate of at least 35%

2.2.2 Smoking in Pregnancy

NICE guidance [PH26] published in June 2010 called "Smoking: stopping in pregnancy and after childbirth" covers support to help women stop smoking during pregnancy and in the first year after childbirth. Further NICE guidance [PH48} published in November 2013 called "Smoking: acute, maternity and mental health services. General recommendations from these guidelines include:

Recommendations from NICE [PH26] & (PH48)
Identifying patients/pregnant women and other patients who smoke and referring them to NHS Stop Smoking services – this may include intensive support if required
Contacting and supporting pregnant women who have been referred
Use of nicotine replacement therapy (NRT) and other pharmacological support
Meeting the needs of disadvantaged pregnant women who smoke
Partners and others in the household who smoke
Putting referral systems in place for people who smoke
Developing smoke-free policies and commissioning smoke-free secondary care services
Supporting staff to stop smoking and providing stop smoking training for frontline staff

3.3. Stop Smoking Services (SSS) Guidance

SSS were first established in England in 1999-2000 and were piloted in areas of higher deprivation (NCSCT 2013). The aim was to prioritise supporting less affluent smokers to quit in recognition of smoking's contribution to causing health inequalities and today this is still the main emphasis for the services. These services have been built around the principle of a universal offer of support available for all smokers, with a combination of behavioural support and pharmacotherapy.

Evidence suggests that in contrast to other health interventions, SSS were effective at both reaching and treating disadvantage groups and around 60% of smokers want to quit and individuals who access SSS, are four times more likely to quit than if they were to attempt to quit by themselves.

Recommendations for commissioning effective Stop Smoking Services include the following;

- Ensure those in priority populations (also detailed in section 1) are offered, and can easily access effective support (e.g. behavioural support and medication) to maximise reductions in smoking prevalence and health inequalities; Routine & Manual, Smoking in Pregnancy, People with Mental Health Problems and those with long term conditions i.e. secondary care
- The intensity of support offered is an important factor, this should be sufficient to address the needs of the population so as to have the required impact.
- If commissioning intensive behavioural support is not possible, a minimum service offering smokers access to medication and support with appropriate use should be made available e.g. telephone/online support & information.

(PHE 2017 Models of delivery for stop smoking services: Options and evidence)

Individuals who attend a SSS make a commitment to stopping smoking on or before a particular date and the smoking cessation service provide a combination of behavioural support and pharmacotherapy to help with the quit attempt (NICE 2013). This is formed around the National Centre for Smoking Cessation and Training (NCSCT) standard programme, and involves practitioners trained to its standards or the equivalent (NICE 2013).

3.3.1 Stop smoking aids

There is good evidence to show that using stop smoking aids increases the chances of quitting successfully, particularly when combined with expert face-to-face support from a local stop smoking service. There are 3 types of aids:

- Prescription tablets (Varenicline and Bupropion)
- Nicotine replacement therapy products such as patches, inhalers and gum
- E-cigarettes or vapes (advice only due to not being licensed products)

Prescription tablets

There are 2 prescription-only stop smoking medicines - Varenicline (Champix) and Bupropion (Zyban). Neither medicine is licensed for use during pregnancy or by people with certain pre-existing conditions or by under-18s.

Prescription tablet	
Verenicline	Reduces cravings for nicotine by blocking the rewarding and reinforcing effects of smoking which take place in the brain. It increases the chances of long-term quitting success between 2 and 3 times compared to a quit attempt without the use of a stop smoking aid.
Bupropion	Reduces urges to smoke and helps with withdrawal symptoms. The likelihood of staying smoke-free using this medication is similar to that for nicotine replacement therapy.

Nicotine replacement therapy (NRT)

NRT is a medicine that provides users with nicotine without the tar, carbon monoxide and other poisonous chemicals present in tobacco smoke. It can help to reduce tobacco withdrawal symptoms, such as irritability and cravings.

NRT is an effective stop smoking method, increasing chances of stopping smoking for 6 months or more by more than half. There is also strong evidence to show that combination of NRT is more effective than single product use.

Nicotine is addictive but the level of addictiveness depends on the delivery system. The addictiveness of tobacco cigarettes is enhanced by compounds in the smoke other than nicotine.

NRT products are available in different strengths so that nicotine intake can be gradually reduced when the person feels ready. Premature cessation of NRT is associated with relapse to smoking.

A nicotine patch releases nicotine slowly into the body's system to help keep it on a constant level, while a fast-acting product such as an inhaler, lozenge or gum helps with immediate cravings. NICE recommends that combination NRT should be considered as a viable option for all smokers wanting to quit. There are many types of NRT available on prescription which includes: Skin Patches, Chewing Gum, Inhalers, Oral Strips, Lozenges, Microtabs and nasal/mouth sprays

Since October 1st 2018 residents of Barnsley are able to get a free prescription of NRT.

Electronic Cigarettes (E-cigs)

E-cigs are devices which convert liquid nicotine into a vapor or mist which the user inhales. As with tobacco products there is a minimum age of sale of 18 for e-cigs and they cannot be purchased on behalf of someone under the age of 18.

The modern E-cigs have been around since 2003 which were originally designed for stopping smoking and have been successful. In the first half of 2017 quit rates were at their highest rates observed for the first time and it is plausible that e-cigs were a contributing factor. Is it currently estimated that E-cig usage in the UK is around 6%.

Public Health England published a review on the 'evidence of e-cigarettes and heated tobacco products in 2018' to help clear up the confusion of the effectiveness and safety of their use. Some of the highlights relevant for the business case include:

E-cigarettes and heated tobacco products highlights
E-cigs are 95% less harmful compared to smoking cigarettes and nearly half the population was unaware of e-cigs being much less harmful.
They do not contribute significantly to non-smokers taking up e-cigarette smoking with less than 1% of E-cig users never smoked.
Despite some experimentation with these devices among never smokers, e-cigs are attracting very few young people who have never smoked in regular use.
Poisoning from accidental ingestion of e-cigs liquids are usually short in duration and of minimal severity.
Cancer potencies of e-cigs were largely under 0.5% of the risk of smoking.
To date there is no evidence to health risk of second hand vapour from e-cigs

There are three main types of e-cigs:

- Disposable products (non-rechargeable and single use only) - These present potential environmental problems through unregulated or improper disposal, storage and recycling of reusable and non-reusable components (Science for Environment Policy 2015).
- An electronic cigarette kit that is recharged and replaced with pre-filled cartridges.

- An electronic cigarette that is rechargeable and has a tank or reservoir which has to be filled with liquid nicotine.

E-cigarette use, alone or in combination with licensed medication and behavioural support from a SSS, appear to be helpful in the short term. However, e-cigarettes are not licensed products and cannot be prescribed by the SSS.

4. Local Strategic Priorities

4.1 Corporate Vision and Priorities

As part of the 'Future' Council's corporate vision for 'working together for a brighter future, a better Barnsley,' there is a clear strategy to continue developing capacity and capabilities within our communities and shift the balance from a 'paternalistic' approach to one that 'empowers' individuals, families and communities to do more for themselves; key areas include; Early Help, behaviour change and making better use of technology. We need to take opportunities around the smoking agenda to build on this further.

Alongside this will be the achievement of a number of 2020 Corporate Outcomes. The proposed service will contribute to the following corporate priorities:

People achieving their potential
Reducing demand through access to early help
Children and adults are safe from harm
People are healthier, happier , independent and active
Strong & resilient communities
Customers can contact us easily and use more services online

4.2 Barnsley Health and Wellbeing Strategy

'Feel Good Barnsley 2016-2020' sets out how the Health and Wellbeing Board will drive to improve services to join up care and support people in Barnsley to better help themselves by improving health and wellbeing and reducing health inequalities across the borough with the vision of:

> "…..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, whoever they are and wherever they live."

Reducing smoking is an identified area of improvement within the strategy as part of a wider transformation agenda to help people to get the right support at the right time. This will be achieved through four principles; focus on "efficiencies and outcomes", "inspire and empower, connect", "collaborate and co-produce" and "go further faster" supporting the outcomes set out in the Future Council 2020 plan.

4.3 Public Health Annual Report, Strategy & Priorities

Smoking has been a priority for the Public Health Strategy over the last few years and continues to have an important focus, particularly in relation to the wider determinants of health. The Public Health Strategy for Barnsley also supports the principles detailed in future council.

Work continues to focus on the fact that health is shaped about 'where and how we live' and that there is still a need to '….reduce the stark inequalities which mean the most vulnerable and most deprived bear the heaviest burden of disease' – and smoking is a key feature of this. It is important to create and sustain good health and wellbeing across the life course in Barnsley (DPH 2017)

4.4. Smoke-Free Barnsley Tobacco Alliance Action Plan 2016-2018

The "Smoke-Free Barnsley Tobacco Alliance Action Plan Refresh 2018-2020" aims "to see the next generation of children in Barnsley born and raised in a place free from tobacco, where smoking is unusual". This is in line with the Breathe 2025 campaign and will be achieved by;

- Setting a clear example
- Making it harder for children and young people to access and use tobacco
- Making tobacco less affordable, especially for children and young people
- Limit tobacco marketing and exposure to smoking seen by children and young people
- Educate young people to make healthier choices around smoking and tobacco
- Reduce exposure to second hand smoke

The Smoke-free Barnsley Tobacco Alliance also has a consensus statement (see Appendix 1) on electronic-cigarettes informed by the best current evidence from Public Health England, Royal College Physicians, Action on Smoking and Health, National Centre Smoking Cessation Training and NICE guidance on Smoking Harm Reduction. The aim of this policy statement is to develop an agreed consensus in Barnsley on e-cigarettes that all partners in the borough are signed up to. This is to ensure that the public receive clear, evidenced based consistent advice on e-cigarettes.

4.5 BMBC Smoking and Vaping at work policy

The Smoking and Vaping at Work policy indicates that smoking and vaping is not permitted in any designated council workplace; in the immediate vicinity of the entrance or exit of any council workplace where you would be in the view of the public; in council vehicles or in enclosed public places (including public buildings) owned by the council. Smoking/vaping is to be taken on your own time, and any smoking breaks are fully recorded when taken during the working day.

The Public Health campaign "Breathe 2025" aims to remove the normality of people smoking and making smoke invisible to inspire a smoke-free generation by 2025. The leadership culture within the council is supportive of this and it forms a key part of the BMBC Corporate Council Plan 2015-2018: where people are encouraged to achieve their potential and to be healthier happier, independent and active". Smokers in the council are entitled to 4.5 hours of special leave over a maximum 12 week period to attend smoking/vaping cessation support.

The existing commissioned service provides advice via Yorkshire Smoke-free Freephone 0800 612 0011 (landline) or 0330 660 1166 (mobile) or by visiting http://yorkshiresmokefree.nhs.uk/

4.6 Barnsley Integrated Care System (ICS)

In 2016, NHS organisations and local councils came together to develop 44 Sustainability and Transformation Plans (STPs) covering the whole of England. Some areas were identified as 'trail - blazers' to develop partnerships to form an integrated care system which proposes to improve health and care for patients built around collaborative working. The STP or Integrated Care System (ICS) as it is now known, covers South Yorkshire and Bassetlaw, of which Barnsley is one of five 'places'.

A 'Place' based Plan has been developed for each place within the ICS, and in Barnsley, this has led to the development of a local network to include; BMBC, CCG, SWYFT, BHNFT and the Community & Voluntary Sector called 'Barnsley Health and Care Together'.

The delivery of this agenda forms a significant part of the newly published 10 year plan for the NHS (2019) where local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere. ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health.

Integrated Care System Outcomes Framework

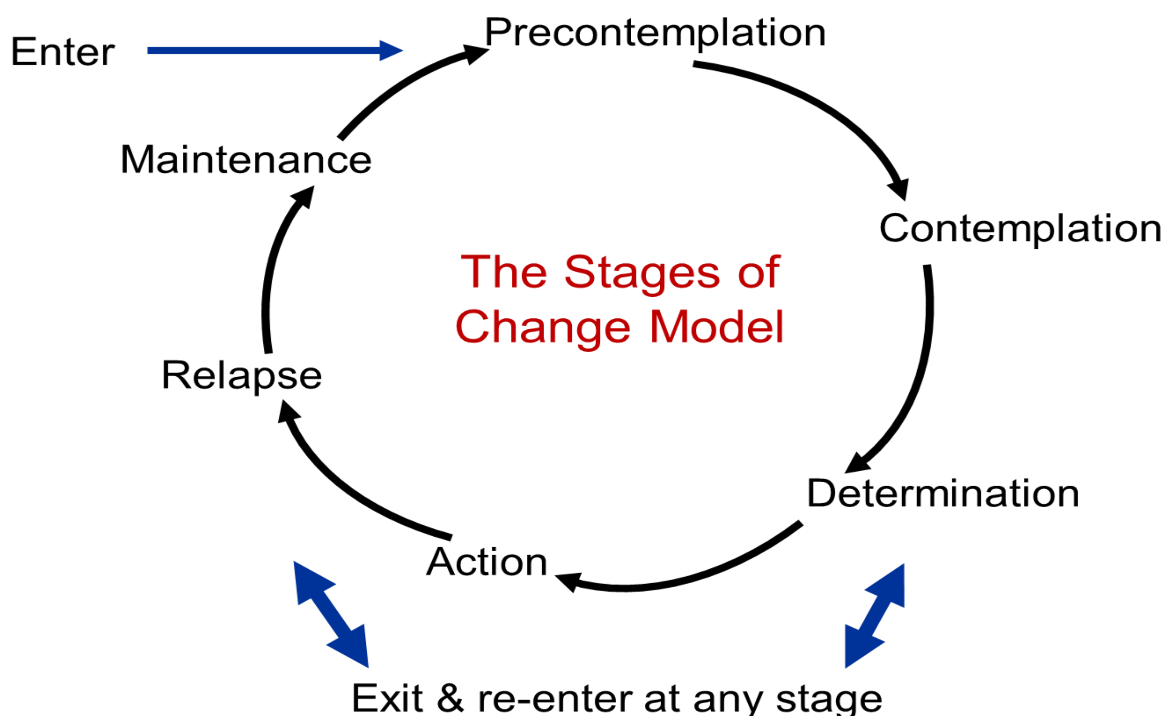
5. Models/Theories for Behaviour Change

There are number of behaviour change theories that can be considered when developing a Specialist Stop Smoking Service. Both the models detailed below are widely recognised in relation effective stop smoking services and will allow us to consider the requirements for the new service in Barnsley.

5.1 Trans-theoretical model of change (TTM)

The Trans-theoretical Model (also called the Stages of Change Model) (TTM), developed by Prochaska and DiClemente examined the experiences of smokers who quit on their own with those requiring further treatment to understand why some people were capable of quitting on their own. It was determined that people quit smoking if they were ready to do so.

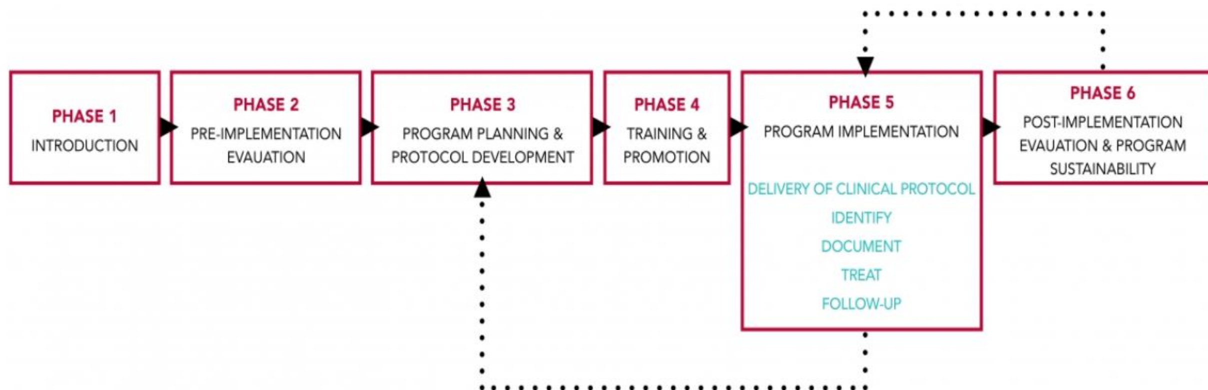
The TTM focuses on the decision-making of the individual and is a model of intention and readiness to change. The TTM operates on the assumption that people do not change behaviors quickly and decisively. The breakdown of the stages of change is detailed below



5.2 Ottawa Model for Smoking Cessation

The Ottawa Model for Smoking Cessation (OMSC) is a systematic, comprehensive approach to clinical tobacco dependence for secondary care. This approach assists healthcare organisations and health professionals to transform clinical practices appropriate to the treatment of smokers through knowledge translation, implementation support, and quality evaluation (see model below).

OMSC = PRACTICE CHANGE PROCESS + EVIDENCE-BASED SMOKING CESSATION TREATMENT PROTOCOL



The programme's success rate is unparalleled, with 44% of participants remaining smoke free for 6 months or longer. The Ottawa Model now offers options for outpatient and primary care clinics since 2009. This adaption of the programme included the revision of protocol and tools to meet the needs of the primary care professionals. Pilots of 8 primary care practices in the Champlain Local Health Integration Network were involved. Evaluation of the data from the pilot showed significant increase in the number of patients who received advice to quit and assistance with quitting (Ottawa Model for Smoking Cessation Primary Care Program Summary 2018).

This model has been adapted by Greater Manchester under their CURE project in secondary care for treatment of tobacco addiction in October 2018 and awaits evaluation. This model has also been adopted by South Yorkshire and Bassetlaw Integrated Care System as part of the QUIT program.

5.3 BabyClear – Stopping Smoking in Pregnancy

BabyClear © is a whole system approach to help pregnant woman remain smoke-free during their pregnancy and post-partum period.

The BabyClear approach to smoking cessation in pregnancy
CO screening for all pregnant women
An opt out referral system
Briefing sessions for midwifery staff and other relevant health professionals
Protocols and care pathways reflecting the evidence base and NICE guidance
Advanced skills training to support Stop Smoking Advisors to work effectively with pregnant women
Ways to reach out to those pregnant smokers who currently do not engage with the Stop Smoking Services, including a Risk Perception Intervention.
Administrative / call centre staff training to increase the number of women accepting appointments
Awareness raising and engagement with all health professionals involved with pregnant smokers
Supporting materials developed with the support of young pregnant smokers.
A performance management system
Monitoring and evaluation of effectiveness

The programme follows NICE guidance (detailed above) and the Tobacco Control Collaborating Centre (TCCC) has worked with local areas to identify how to apply the guidance and evidence to ensure a significant impact on local prevalence is sustainable.

6. Current Provision in Barnsley

The current service provider for Stop Smoking Services in Barnsley is South West Yorkshire Partnership Foundation NHS Trust (SWYPFT). This contract is due to expire on 31st October 2019.

As mentioned in the introduction, this specialist service forms one part of the of the whole system approach to tobacco control across the Borough, incorporating work with various different partners. The service is a single point of contact and accepts self-referrals in multiple delivery points in GP practices and community venues across the borough. However more recently work has been done locally to target groups with significant high prevalence rates which include routine and manual, mental health (diagnosed) pregnancy and secondary care.

The SSS team has adopted the use of the SSIPC (Stop Smoking Interventions in Practice) Framework. SSIPC is an evidenced systems based tiered approach to help health care practitioners deliver stop smoking interventions and forms the basis of their stakeholder engagement work across Barnsley. SSIPC includes the agreement of a treatment pathway with individual stakeholders and the delivery of training, provision of resources and activity feedback. The aim of SSIPC is to encourage stakeholders to provide 2 elements;

- Very Brief Advice (VBA) and offer of referral to the specialist service
- Behavioural support - which is provided "in-house" via a subcontracting arrangement with the specialist service

The service aims to provide universal information in a variety of languages (including access to interpretation services and BSL, large print and braille), advice, and guidance through personalised face to face support, or the use of technology to build resilience. The team works holistically to support other services across the borough and signpost people to a range of universal and specialist services to address wider lifestyle issues including debt, welfare and housing. This also includes supporting other organisations in health promotion, developing and maintaining information sharing protocols and delivering a range of training to professionals and partners including harm reduction.

Stop Smoking Services in Barnsley Hospital Foundation Trust (BHNFT)

The SSS has a presence in BHNFT supporting Maternity Stop Smoking Services (see below) and wider secondary care services; this includes both inpatients and outpatients. The Stop Smoking Service core opening hours are 9am-5pm, with at least one late night clinic per week.

Stop Smoking in Pregnancy (BHNFT)

The Maternity Stop Smoking Service consists of two whole time equivalent staff working on a 1:1 basis providing support and treatment to women and their families who smoke. This service is commissioned through a sub-contract arrangement with SWYFT.

In addition to this, a Public Health Specialist Midwife (PHSM) provides the management and leadership to the team, monitoring progress and meeting on a regular basis with the team and the commissioners to ensure the team is performing to the required standard. The team is also represented at the Tobacco Control Alliance, and is the Chair and host of the Regional Stop Smoking

meeting, as well as a member of the Hospital trust led QUIT programme. This PHSM is funded by the maternity unit at BHNFT.

As a Maternity Unit, there are plans to develop a new way of working to promote 'Continuity of care.' The plan for 2019 is to achieve 20% of women in Barnsley who choose to have their baby within the local maternity service, to be placed on a Maternity Continuity pathway. This will mean that these women will be cared for in the antenatal, intrapartum and postnatal period by a small team of six midwives. In addition to the Maternity Stop Smoking service these six 'continuity' midwives will be receiving level 2 stop smoking practitioner training to deliver not only very brief advice but the whole quit programme. This is an innovative approach being developed in Barnsley. These midwives are employed by the Maternity Service, hence adding added value to the commissioned Stop Smoking Service arrangements.

The Maternity Unit is also part of an NHS Improvement plan called 'The Maternal and Neonatal Health Safety Collaborative' which is a three-year programme, launched in February 2017. The aims of the plan are to improve the safety and outcomes of maternal and neonatal care by reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020. There are five drivers all underpinned by a strong focus on safety culture, systems and processes, engaging with staff, women and families, and learning from both error and excellence. One of these drivers is 'Improving the proportion of smoke-free pregnancy' as part of this work there has been a real appetite for change and further training and consultation with staff, women and families.

Local Enhanced Service (LES) – Primary Care

The team works with both GP Practices and pharmacies to provide locally enhanced services where staff within practices and pharmacies can be trained to deliver stop smoking support. For those that do not have a LES, direct referrals are made to the Stop Smoking Service.

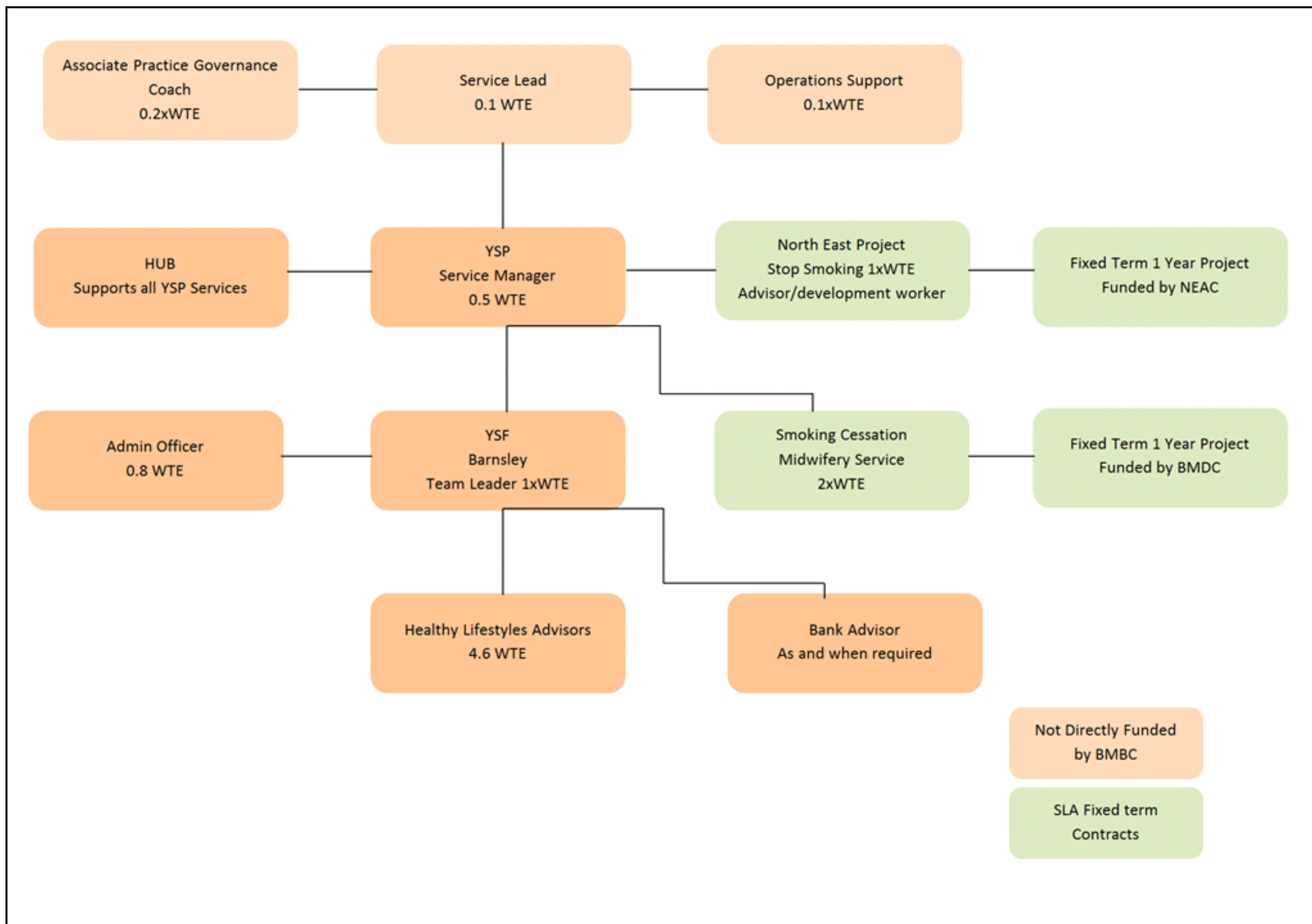
Locality based working

The Service has a number of advisors working across different localities within Barnsley, roughly aligned to the Area Council Footprint. Each of these advisors has a role in engaging in local communities and linking with key stakeholders to promote the stop smoking agenda. Each advisor leads on a specific cohort e.g. Routine & Manual, Young People, People with Long Term Conditions, and have developed expertise and good practice that is shared across the team. The team recognise the opportunities for working holistically and linking with other services in each locality.

It is also worth noting that the North East Area Council has commissioned an additional Stop Smoking Adviser (not part of this service commission) to help reduce smoking prevalence within their area and to support primary care colleagues. Local evidence suggests that a locality based co-ordinator engaging and encouraging local communities to quit smoking has had some positive impacts. A year-end evaluation of this work is planned to compare and contrast the impact and to use the Social Return on Investment (SROI) toolkit.

Stop smoking service structure

The SSS works across a system wide approach with having staff situated in Primary and Secondary Care. The service structure is detailed below;



6.1 Assessment of performance

The current service reports on 13 indicators (A full breakdown is provided in appendix 3) with two main BMBC corporate indicators that record that we are "aiming to treat 4% of the smoking population based on a prevalence of 21%" and "aiming to get 55% of those in treatment (Setting a quit date) to have quit by 4 weeks**". Both of these indicators have exceeded the target and are performing consistently.**

NICE [NG92] recommends "Aim to treat 5% of their smoking population each year with a success rate of at least 35%" however since the healthy lifestyles contract was separated in 2016/7 and the previous provider missing targets it was negotiated between BMBC and the service provider to aim to treat 4% of the smoking population (with a stretch to 5%).

There have been new indicators to report on, for which baseline data is not yet available, but the service is performing consistently well across a number of other indicators. The service is

underperforming on two indicators; "Aiming to get 50% of those which have quit at 4 weeks to quit at 12 weeks" and "Referral's from midwives at BDHT processed by SWYPFT within two working days". On further investigation, there seems to be a reporting error with the data from the midwives and since the error has been reported the new 12 week data was not available at the time of the end of year report. However, this issue has been resolved now and the midwifery service is meeting the 48 hour targets.

A breakdown of the key performance indicators the SSS end of year report is as follows;

Stop Smoking Service End of Year Report KPIs				
Key Performance Indicators	**Target**	**Actual (end of year)**	**Rag Rating**	**Notes**
Aiming to treat 4% of the smoking population based on a prevalence of 21% (52,253) with a stretch target of 5%.	2090	3057		
Aiming to get 55% of those in treatment (Setting a quit date) to have a quit date by 4 weeks	1,155 (55%)	2,448 (66%)		
Aiming to get 50% of those which have quit at 4 weeks to quit at 12 weeks	488 (50%)	390 (40%)		This is a new indicator so no RAG rating available.
Measuring the number of users who are CO validated – Target is 70% - against face to face quits (90% of total quits)	614 (70%)	643 (72%)		
Number still quit 8 weeks after birth		6		This is a new indicator and no baseline is available.
Referrals from Midwives at BDHT processed by SWFT within 2 working days	707 (100%)	489 (69%)		
Targeted Cohorts				
Routine and Manual		264 (27%)		New Measure
Mental Health (Diagnosed)		61 (6%)		New Measure
Pregnant		124 (13%)		New Measure
Secondary Care		124 (13%)		New Measure

Stop Smoking Service: Key performance indicators baseline and end of year figures

6.2 Other Initiatives linked to Services in Barnsley

6.2.1 QUIT Programme – developing options in Barnsley Hospital

QUIT has been developed by the Integrated Care System across South Yorkshire and Bassetlaw and builds on the principles of the Ottawa Model. The aims of the programme include:

- Every health care professional is aware of the smoking status of every patient they care for
- Every health care professional has the competence and confidence to offer help to stop smoking through direct action and referral
- Every patient has access to the best available treatments and expert support to treat this disease
- There is recognition that tobacco addiction is a chronic and relapsing disease, not a lifestyle choice
- Staff policies support all hospital staff to quit or remain tobacco-free during working hours, including the offer of smoking cessation support and appropriate short term medication.
- All the hospitals in SY&B become institutions of health promotion and truly smoke-free zones

Four comprehensive steps for the programme;

Principles of Q.U.I.T	
Q – ask the question	All hospital patients should be asked if they are a current smoker.
U – understand their addiction	All hospital patients should be asked to exhale into a CO monitor and their result noted in patient records. This provides not only evidence of the conversation taking place, but provides a strong indicator of level of addiction which will support and indicate further treatment, but also contributes to triggering quit attempts.
I – inform patients about smoke-free sites	All patients should be informed that the hospital site is smoke-free and that patients and visitors are not permitted to smoke anywhere on site, but that they can access support for nicotine replacement.
T – initiate treatment	Refer patients to smoking cessation support including advice and treatment (NRT, varenicline and other options) as soon as possible, enabling them to quit during their inpatient stay where possible and ensuring appropriate ongoing support after discharge. The gold standard is that patients should be offered nicotine replacement support within 30 minutes of arrival on the ward.

Barnsley Hospital has fully signed up to implement QUIT with the Chief Executive being the executive sponsor and the Consultant in Public Health leading the work in partnership with Barnsley Council and the South Yorkshire and Bassetlaw Integrated Care System.

The provider of the stop smoking service is expected to work with hospital colleagues in order to provide a service that meets the needs of QUIT.

6.2.2 Preventing Ill Health by risky Behaviours CQUIN -Alcohol and Tobacco - Barnsley Hospital

The CQUIN indicator applies to Mental Health Trusts and Community Trusts 17/18 and 18/19 (SWYPFT). The indicator applies to Acute Trusts in 18/19 (BHNFT).

There are five parts to the CQUIN, three of which relate to tobacco, specifically;

9a) Tobacco screening
9b) Tobacco brief advice
9c) Tobacco referrals and medication offer

A comprehensive review shows that stopping smoking interventions are effective for hospitalised patients regardless of the admitting diagnosis. Inpatients stopping smoking leads to a reduced rate of wound infections improved wound healing and increased rate of bone healing.

During 18/19 BHNFT recruited two 'Healthy Behaviour Nursing Auxiliary' posts to support implementation of the CQUIN requirements. Brief advice training for these staff has been provided by the SSS. An e-form has been developed to meet the reporting requirements of the CQUIN.

6.2.3 Get Fit First (GFF)

The Get Fit First is an initiative set up by Barnsley Clinical Commissioning Group to encourage individuals to lose weight/give up smoking or both prior to undergoing surgery. It is estimated that approximately 4000 patients per annum may be asked to undergo a health improvement period due to Get Fit First. A third of these patients (1,330 will be smokers) therefore supporting identification from primary care. GPs are able to refer patients into the SSS. Of the total population:

- 36% of the population have a BMI of 30+
- 18% are smokers only
- 6% are combined smokers and BMI of 30+

7. Equality Impact and Risk Assessments

These will be completed as part of the service specification.

7. Options going forward

Overview	Pros	Cons	Evidence
Option 1: Do not commission a service	Allocate money into other services	Barnsley smoking prevalence is too high to not commission a service.	PHE fingertips database SSS data
Option 2: Recommission with the same service specification Self-support for those who want to stop but do not want professional support. 4x targeted cohorts (R&M, Pregnancy, MH and Secondary Care) Evidence-based specialist support for smokers who need it and are willing to make the necessary commitment to quit (including combination of behaviour and pharmacotherapy)	Service is performing well The KPI's show the SSS has greatly improved over the last couple of years. Sound theory based on PHE recommendations The model includes universal approach, targeted and specialist support.	Considerations given to under/over performing indicators Secondary care underperforming Treating more than 4% of the smoking population should be more aspirational.	SSS data Models of delivery for stop smoking services: Options and evidence (2017)
Option 3: Revise specification with a strong focus on secondary care including midwifery and integration. To include Self-support for those who want to stop but do not want professional support. 4x targeted cohorts (R&M, Pregnancy, MH and Secondary Care) Evidence-based specialist support for smokers who need it and are willing to make the necessary commitment to quit (including combination of behaviour and pharmacotherapy) Integrated and neighbourhood working. Brief advice/support and a stop-smoking medicine for those who want help but are not willing to commit to a specialist course Ottawa model adapted in secondary care to build on QUIT and MECC Extend targets for smoking population	Links to national and local priorities Targeted interventions Opportunities for developments in integrated care Increase capacity in secondary care Smokers in hospital more likely to be ill (causal response from smoking)	Smokers in hospital might not be ready to quit e.g. other health concerns.	Manchester CURE project Models of delivery for stop smoking services: Options and evidence (2017) Ottawa Model

Finance:

The available annual budget for the commission of the new service is between - £415,000 - £450,000.

8. Conclusion

Smoking is the leading cause of preventable death, as well as presenting a significant economic and social impact for the people living and working in Barnsley.

The service should offer universal support, work holistically with partners and also focus our intensions on cohorts of interests that have the highest prevalence: Routine and Manual, Secondary Care, Pregnancy and Mental Health.

The evidence provided clearly demonstrates the need for a stop smoking service in Barnsley to continue to support a reduction in smoking prevalence, and to continue the good work towards the national and local ambitions of a healthier and smoke free generation.

Appendices

Appendix 1: The Smoke-free Barnsley Tobacco Alliance Consensus Statement on Electronic Cigarettes

The Smoke free Barnsley Tobacco Alliance consensus statement on electronic-cigarettes

This policy statement is informed by the best current evidence from Public Health England, Royal College Physicians, Action on Smoking and Health, National Centre Smoking Cessation Training and NICE guidance on Smoking Harm Reduction. The aim of this policy statement is to develop an agreed consensus in Barnsley on e-cigarettes that all partners in the borough are signed up to. This is to ensure that the public receive clear, evidenced based consistent advice on e-cigarettes.

Evidenced statements:

1. Smoking remains the leading cause of illness and early death in Barnsley and is a significant cause of inequalities in health outcomes.

2. Electronic-cigarettes (e-cigarettes) present a real opportunity to contribute to a reduction in smoking prevalence in Barnsley and reduce harm from combustible tobacco.

3. The Smokefree Barnsley Tobacco Alliance, in line with current evidence from PHE, **advise all smokers to stop completely and immediately** and to access support via the Yorkshire Smokefree Barnsley Service and utilise a combination of behavioural support and stop smoking medication such as Nicotine Replacement Therapy (NRT) or Champix. Smokers are four times more likely to be successful in quitting if they access this type of support.

4. Smokers who cannot or do not want to stop using nicotine are encouraged to **switch to using an e-cigarette as a harm reduction measure.**

5. The aim of the Smokefree Barnsley Tobacco Alliance is to achieve a smoke free generation in Barnsley by 2025 (in line with *Breathe 2025: Inspiring a Smoke Free Generation*, a bold Yorkshire and Humber vision to see the next generation of children born and raised in a place free from tobacco, where smoking is unusual).

6. The latest evidence published by Public Health England (PHE, 2018) estimate that **vaping is around 95% safer for users than smoking**.

7. Evidence does not support the concern that e-cigarettes are acting a route into smoking for young people.

8. To date there have been no identified health risks of passive vaping to bystanders.

9. The review found that chemicals in tobacco smoke that harm health – including cancer causing chemicals – are either absent in e-cigarette vapour or, if present, they are mostly at levels much below 5% of smoking doses.

10. Most people continue to smoke due to addiction to nicotine and not lifestyle choice. Nicotine itself is not carcinogenic and does not cause serious adverse health effects such as acute cardiac events, coronary heart disease or cerebrovascular disease.

11. Public perceptions of harm from e-cigarettes remain inaccurate; only half of smokers believe that e-cigarettes are less harmful than smoking and these decreases to one third among smokers who have never tried e-cigarette.

12. Pregnant women who find it difficult to stop smoking are recommended to use licensed nicotine replacement therapy (NRT) products. However if a pregnant woman makes an informed choice to use an e-cigarette and if that helps them to stay smokefree, they should not be discouraged from doing so.

Commitment statements:

1. We want to combine the most popular with the most effective. The stop smoking service in Barnsley is 'e-cigarette friendly' and will provide behavioural support for those who want to stop smoking and use e-cigarettes as a quit aid.

2. We recommend that smokers who wish to use e-cigarettes to quit or switch should purchase their products from a retailer that is committed to selling products that are registered with Medicines and Healthcare Products Regulatory Agency (MHRA) under the TPD and are compliant with the requirements of the TPD. A number of standards must now be met in order to be compliant with the TPD including;
   - Child resistant tamper evident packaging is required for liquids and devices
   - The device must be protected against breakage and leakage and capable of being refilled without leakage.

- Devices must deliver a consistent dose of nicotine under normal conditions
- Tank and cartridge sizes must be no more than 2ml in volume and nicotine strengths of liquids must be no more than 20mg (this must appear on the label)
- The packaging must have a 30% health warning ‘this product contains nicotine which is a highly addictive substance’ on front and backs of packs. Cover 30% of packs.
- Packs must contain information leaflet on use of the product and ingredients within the e-liquid
- e-cigarettes must not be sold to anyone under 18 years of age

3. In the event that licensed e-cigarette products become available and potentially eligible for NHS prescription, they will be assessed in order to establish best practice. The assessment will consider clinical effectiveness, clinical safety, cost-effectiveness and affordability.

4. We will continue to be vigilant and ensure we protect tobacco control activities in relation to e-cigarettes from the vested interests of the Tobacco Industry in line with our commitment to the WHO FCTC Article 5.3.

5. We will review and update our position on electronic cigarettes as evidence continues to emerge.

The following partners of the Smokefree Barnsley Tobacco Alliance endorse and support this Barnsley consensus statement on e-cigarettes.

Appendix 2: Models of delivery for stop smoking services: Options and evidence (2017)

Rank	Component[1]	Summary	Evidence of effectiveness[vii]	When done properly, boosts quit rates by …[4]	Commissioning recommendation
1.	**Face–to-face group support with pharmacotherapy**	Weekly group sessions facilitated by one or more specialist stop smoking practitioners[2] with a number of smokers at a specified time and place, lasting approx. 1 hour for between 6 and 12 weeks. All smokers have access to their choice of pharmacotherapy and smoking status is verified by Carbon Monoxide (CO) monitoring at each session.	A	300%	This format has a very strong evidence base and will produce high success rates. It may be more applicable in an area or setting with a fairly large pool of smokers (a minimum of eight members is recommended to start a closed group). It is important that practitioners receive specialist training and continued supervision.
2.	**Face-to-face individual support with pharmaco-therapy**	Weekly sessions for an individual smoker with a specialist stop smoking practitioner, at a specified time and place, sessions averaging approx. 30 – 45 minutes over a 6 – 12 week period. All smokers have access to their choice of pharmacotherapy and smoking status is verified by Carbon Monoxide (CO) monitoring at each session.	A	200-300%	The majority of stop smoking interventions currently take place through one-to-one sessions[viii]. It is important that practitioners receive specialist training and continued supervision.
3.	**Supported use of pharmacotherapy**	This option involves providing smokers with stop smoking medication(s) (varenicline, NRT, bupropion) of their choice and giving appropriate information and support to use it in a way that will maximise effectiveness. It just needs one appointment to get started and one follow-up to check progress.	A[3]	50-100%	The easiest way to commission this is through GP prescriptions, but pharmacies may also be an option. It is essential to make varenicline and dual form NRT (eg transdermal patch plus a faster acting form) available as these offer the best chances of success.
4.	**Telephone support**	Multiple sessions of proactive telephone support provided by a trained advisor for 6 – 12 weeks[ix]. Sessions average 15 – 30 minutes and work best with multiple sessions in the first	A	50-100%	The boost in quitting rates depends on following optimal treatment protocols, with proactive telephone calls made by the specialist advisor to the individual

		week. Important to have a system for smokers to access stop smoking pharmacotherapy. While evidence of effectiveness is strong in the US, it is weaker for programmes tried in the UK.			who has sugned up for this support. If a way can be found for smokers easily to access medication, the boost should be greater.
5.	**Text message support**	Although evidence is a bit more limited on text messaging, it is clear that it can improve quit success rates compared with nothing. Because we have less evidence it is important to use a programme that has been tested directly.	B	40-80%	If considering this option, commissioners should look to existing programmes that have been fully tested. It is not recommended that new local programmes are developed without evaluation.
6.	**Online**	There is evidence that online information (websites) can be effective in supporting smokers to stop but none of the sites evaluated in randomised trials are available currently so websites should not be the only support offered to smokers[x].	B	Unknown	Websites can be a very cost-effective way of informing smokers about methods of stopping. If they are to be used as tailored support programmes it is important to understand that each website needs to be evaluated and these are not a substitute for the strongly evidence-based sources of support (behavioural support and pharmacotherapy)[xi].
7.	**Mobile digital applications**	There is limited evidence to date on the effectiveness of mobile applications and more good quality research is required before this option can be recommended.	C[3]	Unknown	There are a few mobile applications that appear to follow good practice but none has been proven effective, so these should not be used **instead** of the strongly evidence-based programmes (behavioural support and pharmacotherapy)[xii].

[1]Components: These interventions should adhere to the abrupt model that requires a smoker to set a quit date and commit to the 'not one puff' rule after that date.
[2] Stop smoking practitioners: Any practitioner delivering stop smoking interventions should be trained to the appropriate NCSCT standards.
[3]Graded by experts based on evidence published since the NCSCT Service and Delivery Guidance in 2014 (eg West et al 2015) from which other ratings are obtained .
[4]Assessment of improved success rates complied by Professor Robert West based on combined evidence from peer reviewed publications and NICE Guidance.

BARNSLEY
Metropolitan Borough Council

BUSINESS CASE

Appendix 3: Barnsley Stop Smoking Performance Monitoring October 2017 – September 2018

Barnsley Stop Smoking Performance Monitoring October 2017 - September 2018																	
Key Performance Indicators																	
Barnsley Population as of 2011 Census is 239,300. The smoking prevalence is 21% (2016 JSNA) in adults or 52,253. Of this 32% are routine & manual or 16,060.																	
THOSE IN TREATMENT - target 4%																	
Ref No.			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Annual target	Annual performance	Difference
C2	Mental Health (diagnosed) - M	Number counted	7	5	3	9	5	8	3	2	2	6	6	5		61	
		Performance as a %	7%	7%	5%	8%	7%	11%	3%	2%	3%	8%	7%	6%		6%	
C3	Pregnant - P	Number counted	1	1	2		1		1	1		2	1	1		11	
		Performance as a %	1%	1%	3%	0%	1%	0%	1%	1%	0%	3%	1%	1%		1%	
C4	Secondary Care - S	Number counted	13	15	8	18	7	8	8	6	9	9	12	11		124	
		Performance as a %	13%	22%	14%	15%	10%	11%	9%	7%	12%	12%	14%	14%		13%	
C5	RM	Number counted	4	2	1	5		1	3	1	4	2	1	4		28	
		Performance as a %	4%	3%	2%	4%	0%	1%	3%	1%	5%	3%	1%	5%		3%	
C6	RP	Number counted	1	1	1	2	3	8	12	8	13	8	10	6		73	
		Performance as a %	1%	1%	2%	2%	4%	11%	13%	10%	17%	11%	12%	8%		7%	
C7	RS	Number counted	9	4	6	5	4	5	5	8	3	4	5	2		60	
		Performance as a %	9%	6%	10%	4%	6%	7%	5%	10%	4%	5%	6%	3%		6%	
C8	MP	Number counted	2					1								3	
		Performance as a %	2%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%		0%	
C9	MS	Number counted	9	2	6	9	2	4	5	1	3	3	3	10		57	
		Performance as a %	9%	3%	10%	8%	3%	6%	5%	1%	4%	4%	4%	13%		6%	
C10	PS	Number counted														0	
		Performance as a %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%	
C11	RMPS	Number counted														0	
		Performance as a %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%	
C12	RMP	Number counted							1							1	
		Performance as a %	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%		0%	
C13	RMS	Number counted	1	2		1	1	1		2						8	
		Performance as a %	1%	3%	0%	1%	1%	1%	0%	2%	0%	0%	0%	0%		1%	
C14	MPS	Number counted														0	
		Performance as a %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%	
C15	RPS	Number counted														0	
		Performance as a %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%	

Appendix 1

		WARD PROFILES													
Central	Number counted	25	13	16	32	24	15	25	26	20	18	23	20		257
	% of total quitters	26%	19%	27%	27%	33%	21%	27%	32%	26%	24%	28%	25%		26%
Dearne	Number counted	6	9	5	15	7	15	12	7	8	6	8	9		107
	% of total quitters	6%	13%	8%	13%	10%	21%	13%	9%	11%	8%	10%	11%		11%
North Area	Number counted	16	11	6	16	14	10	18	15	10	19	6	11		152
	% of total quitters	16%	16%	10%	13%	19%	14%	19%	18%	13%	25%	7%	14%		16%
North East	Number counted	19	18	9	22	9	10	23	13	18	12	18	19		190
	% of total quitters	20%	27%	15%	18%	13%	14%	24%	16%	24%	16%	22%	24%		19%
Penistone	Number counted	2	1	6	6	3	5	5	1	2	1	7	5		44
	% of total quitters	2%	1%	10%	5%	4%	7%	5%	1%	3%	1%	8%	6%		5%
Out of Area	Number counted	4	3	4	2	1	2	1	5	1	4	3			30
	% of total quitters	4%	4%	7%	2%	1%	3%	1%	6%	1%	5%	4%	0%		3%
South	Number counted	25	12	12	27	14	13	10	15	17	16	18	15		194
	% of total quitters	26%	18%	20%	23%	19%	19%	11%	18%	22%	21%	22%	19%		20%
Homeless	Number counted			1											1
	% of total quitters	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%

References:

1. Barnsley Health and Wellbeing Strategy 2016 - 2020
2. BMBC Smoking and Vaping at work policy (DATE)
3. BMBC Future Council 2020 Plan
4. British Thoracic Society; Smoking Cessation Audit Report: https://www.brit-thoracic.org.uk/document-library/audit-and-quality-improvement/audit-reports/bts-smoking-cessation-audit-report-2016/
5. Models of delivery for stop smoking services; options and evidence (2017) Martin Dockrell Public Health England
6. NICE Guidance [PH26] Smoking: Stopping in pregnancy and after childbirth
7. NICE Guidance [NG92] Stop smoking interventions and services
8. NICE Guidance [PH48] Maternity, Acute and Mental Health settings
9. Ottawa Model for Smoking Cessation https://ottawamodel.ottawaheart.ca/sites/ottawamodel.ottawaheart.ca/files/omsc_hmpg/omsc_highlight_document_2016.pdf
10. Ottawa Model for Smoking Cessation Primary Care Program Review https://ottawamodel.ottawaheart.ca/sites/default/files/program_summary_2018_-_october_smallest.pdf
11. Public Health Annual Report, Strategy & Priorities 2018-2021
12. Renewing Action for a Healthier Barnsley Public Health Strategy 2018-2021
13. Science for Environment Policy: E-cigarette waste poses potential environment risks (2015)
14. Smoke-free Barnsley Tobacco Alliance Action Plan 2018-2020
15. Stop Smoking Services and Health Inequalities – NCSCT (2013) http://www.ncsct.co.uk/usr/pub/NCSCT_briefing_effect_of_SSS_on_health_inequalities.pdf
16. The Marmot Review: Fair Society, Healthy Lives (2010)
17. The Tobacco Control Plan for England 2017-2022
18. Using multi-theory model to predict initiation and sustenance of small portion size consumption among college students Sharma et al., (2016) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5002880/

BARNSLEY METROPOLITAN BOROUGH COUNCIL

This matter is a Key Decision within the Council's definition and has been included in the relevant Forward Plan

REPORT OF THE EXECUTIVE DIRECTOR OF ADULTS & COMMUNITIES TO CABINET ON 1 APRIL 2019

DIGITAL FIRST – ENABLING TECHNOLOGY

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide detail of the proposed Enabling Technology theme as part of the Digital First Programme and seek approval to progress with the recommendations.

2. RECOMMENDATIONS

It is recommended that:

2.1 Funding is approved as part of the Digital First programme to fund the work packages detailed within the report and accompanying business case.

2.2 The procurement of a Third Party Supplier is to be undertaken following approval using public sector framework agreements to ensure the project delivery timescales are met.

3 INTRODUCTION

3.1 This business case was agreed in principle by the Digital Leadership Team on 8th February 2019.

3.2 Digital First is a programme of work which will completely modernise the Council's IT provision; enabling changes to current ways of working and our digital culture to allow the organisation to make the best use of our resources in an era of Digital Transformation. Digital First aims to:

- Enable Future Council by providing the right technology to deliver and develop local services that are truly available anytime and anywhere.
- Fundamentally change the way that the Council 'does digital' with a disruptive approach to introducing improved technology solutions, business processes and governance arrangements across the Council.

3.3 Within the Digital First programme there are 12 key themes, each of which will be supported by a number of work packages. Some themes are around investing in technology and resources to develop our digital capability and others aim to support culture change and improve digital skills, generally adopting a more digital

approach. This report relates to a specific work package under the Enabling Technology theme.

3.4 The theme will create a step change in IT provision for the organisation, enabling capability, capacity and agility. It is a fundamental redesign of some of our core technology on a strategic basis, rather than the incremental approach which has led to our current difficult to manage landscape of hardware and software.

3.5 Our ambition to build a Digital Barnsley requires us to make a significant investment, allowing us to start to consolidate our existing technology and make effective use of Cloud technology where appropriate.

3.6 In preparing this business case, we have sought feedback from Senior Leaders within the council regarding their perception of our ‘digital readiness’ using industry standard methodologies. Our conclusion is that we are very much at the beginning of the cycle, and lack many of the ‘foundations’ on which digital services need to be built.

3.7 The scope of the Enabling Technology Business Case is articulated through six key work packages:

1) **Infrastructure and Disaster Recovery:** Enhancing and standardising the underlying infrastructure.
2) **Windows 10 and EndPoint Management:** A key deliverable to support a modern workplace transformation designed to increase productivity, mobility and security.
3) **Microsoft 365:** Brings together Windows 10, Office 365 and Enterprise Mobility and Security into a single, integrated modern workplace service offering.
4) **Collaboration:** Migration to SharePoint Online and OneDrive for Business to reduce on premise storage while increasing findability, compliance and version control and enhancing the collaboration experience for users.
5) **SQL Database Rationalisation:** This will improve performance, but also enable licencing savings.
6) **Transformation Programme:** Rationalising and consolidating infrastructure to improve performance and deliver licencing savings.

All of the above will be underpinned by a Change Management and Adoption programme of work which will harness the changes in technology provision and ensure they are adopted by the business to enable the benefits to be realised.

4. PROPOSAL AND JUSTIFICATION

4.1 In order to formulate and ratify the contents of this complex business case we have engaged in soft market testing with a Third Party Supplier who have provided an indicative project plan and costs to assist the development of the Business Case. Following Cabinet approval we recommend the procurement of a Third Party Supplier should be explored through the use of public sector framework agreements to ensure the ambitious project delivery timescales are met.

4.2 It is recommended that the Council takes advantage of the six key work packages within the Enabling Technology Workstream to drive our Digital ambitions forward by creating a comprehensive transformation programme.

4.3 The use and adoption of these technologies will need to be supported by a change management programme to ensure that the council realises the benefits of this significant investment.

4.4 The key changes brought by the Enabling Technology Workstream include:

- All staff given access to the latest Microsoft productivity which includes sophisticated collaboration tools to enable much more efficient working;
- Our servers will be rationalised and modernised, making them less susceptible to security risks and easier to run;
- We will establish a presence in 'the cloud' which means in future we will be less susceptible to outages and loss of data;
- Core software (such as our databases) will be rationalised and modernised and made robust to technical failures;
- Our users will be able to securely work in a flexible and mobile manner;
- Our IT services will be more resilient.

5. CONSIDERATION OF ALTERNATIVE APPROACHES

5.1 The only potential alternative approach is a continuation of the "As-Is". Many of the short-term activities would still be required and cost similar amounts of money but not taking the opportunity to 'transform' using that money means it will be difficult to reduce complexity and achieve the 'new world' in a short timescale.

5.2 The option is not recommended as there are a number of risks associated with this course of action.

5.3 A continuation of the current as is approach would mean:

- Reducing BAU support for existing IT to divert staff to a refresh and upgrade programme;
- It will be difficult to achieve the level of standardisation and consolidation as the focus will need to be replace and upgrade rather than clean up legacy;
- Day to day pressures are proven to divert and slow the rate of roll out and achievement of benefits;
- Additional resource would need to be brought in however, if this is piece meal it will be less co-ordinated and efficient;
- Continued costs incurred in supporting legacy technology.

5.4 The disadvantages of this approach are as follows:

- Restricts and delays the enablement of core council strategies;
- Limits the ability to provide a resilient stable service;
- Limits the ability to provide a secure and flexible service ;
- Vendors will inevitably remove the ability to continue with conventional licencing models and on premise software delivery approaches.

6. IMPLICATIONS FOR LOCAL PEOPLE/SERVICE USERS

6.1 N/A

7. FINANCIAL IMPLICATIONS

7.1 Consultations have taken place with representatives of the Service Director – Finance (S151 Officer).

7.2 Cabinet approved the Digital First business case for this work stream as detailed in (Cab 5.9.2018/17), approving a funding package of £2.339M.

7.3 In order to formulate and ratify the contents of this complex business case officers have undertaken soft market testing with a Third Party Supplier who have provided an indicative project plan and indicative costs to assist with the development of the business case.

7.4 The cost estimates provided below are therefore presented on basis of best available information at the time of writing this report – it is important to note that final costs will not be known until formal procurement has taken place.
The formal procurement of a Third Party Supplier will be explored following DLT and Cabinet approval through the use of public sector framework agreements to ensure the project delivery timescales are met.

7.5 The soft market test has found the original funding approval of £2.339m is likely to be insufficient to deliver this work package, resulting in an estimated shortfall of £0.154M in “one-off” capital funding and an additional £0.044M in ongoing revenue pressures.

7.6 Whilst it is reasonable to expect a marginal tolerance to the projected costs through procurement it is recommended that a tolerance or upper limit is set so that any variations in excess of 5% of the total costs estimates provided below will require resubmission to Cabinet for further consideration.

It is important to note that the procurement process contains clauses to protect the council against entering into formal contracting arrangements should the bid submission be in excess of the above stated tolerance.

7.7 The table below provides a high level summary of the revised capital and revenue implications required to deliver the Enabling Technology business case over the initial 3 year implementation period to 2020/21 and then on an annual recurring full year equivalent basis. Any variances against the original business case cost estimates, as presented to SMT in March 2018, are included to show the revised funding gap.

Table 1: Comparison of Funding Approved by SMT to Current Cost Estimates

	Funding Approved by SMT 2018/19 to 2020/21 £	Revised Business Case - Feb 19 DLT 2018/19 to 2020/21 £	Variance 2018/19 to 2020/21 £	Funding Approved by SMT Future years £	Revised Business case - Feb 19 DLT Future years £	Variance Future years £
Total Capital	1,462,394	2,202,000	739,606	0	0	0
Total Revenue	1,634,310	971,500	-662,810	528,706	535,200	6,494
Total Expenditure	**3,096,704**	**3,173,500**	**76,796**	**528,706**	**535,200**	**6,494**
Savings Generated	-758,000	-680,500	77,500	-379,000	-341,100	37,900
Cost of Business Case	**2,338,704**	**2,493,000**	**154,296**	**149,706**	**194,100**	**44,394**

7.8 Key points to note:

- **Total Capital Costs** - over the Implementation Period (2018/19 to 2020/21) capital costs show an increase of £0.740M rising from £1.462M to £2.202M. This is reflective of the emerging requirement to procure the specialist expertise necessary to deliver the Enabling Technology solution;

- **Total Revenue Costs** – these largely comprise those costs required to purchase the Microsoft licenses necessary to support business case delivery. Whilst a considerable decrease of £0.663M in cost estimates can be seen when compared to original forecasts this is largely due to slippage i.e. the initiative now commencing in 2019/20 rather than 2018/19.

  In terms of Future Year Revenue Costs a relatively small increase in annual revenue costs of £0.006M can be seen.

- **Total Expenditure** - from 2018/19 to 2020/21 combined Capital and Revenue expenditure is £3.174M representing an increase of £0.077M when compared to the original estimate of £3.097M;

- **Savings Generated (or return on investment)** - during the Implementation Period have been revised to £0.681M (a decrease of £0.078M); this is due to the refinement of revisions to expectations around software and licensing costs. The associated ongoing annual (FYE) savings post-implementation show a saving of £0.341M, a reduction of £0.038M;

- **Cost of Business Case -** the table shows the following adverse variances/funding shortfalls:

- ➢ **One-off costs of £0.154M relating to the Implementation Phase** – this has been discussed with the Capital Oversight Board and it is proposed that this is covered off from Residual Capital Funds held by the Communities Directorate.

- ➢ **A Future Year Revenue Budget Pressure of £0.044M** – representing a combination of increased Future Year expenditure (£0.006M) and a reduction in 'Savings Generated' expectations (£0.038M) the recurrent shortfall will be accommodated from elsewhere within the Digital First in line with the total agreed budget allocation for the Programme.

7.9 Whilst implementation of this business case in isolation will result in increased revenue cost it is an essential component in the implementation of the Council's Digital First strategy, supporting the delivery of the £1.488m in planned savings across the Council.

7.10 These savings will be detailed in subsequent reports but will include:

- reductions in support required to core products such as Outlook and Office;
- reduced deskside support required as end user compute will be consistent and reliable;
- improved automation of service desk tasks and enhancements to end user asset management;
- significantly enhanced capability to rationalise software around the Microsoft stack;
- reductions' in hardware maintenance contracts brought about by data centre rationalisation.

7.11 The Appendix A attached to this report shows the detail of the revised business case.

8. EMPLOYEE IMPLICATIONS

8.1 The procurement and implementation of the six key work packages within this programme will impact every employee positively. It will provide them with tools to allow increased agility, reduced complexity and dependencies and they will be cohesive, consistent and reliable.

8.2 To drive our Digital ambitions forward we will work to the following principles:

- We will work as one team;
- We will embed great leadership at every level;
- Strong and ambitious workforce;
- Clear ambitions and outcomes from the programme;
- Focused on our customers and the community;
- Continually looking to improve.

8.3 A further report will be presented to Cabinet in due course detailing the revised IT service provision and how this will contribute to the cross cutting KLOE.

9. LEGAL IMPLICATIONS

9.1 The Council must ensure that all contracts that are exited as part of this project are done so in accordance to contractual terms and conditions stated in the contract and do not breach any legal regulations.

9.2 The Council must ensure that any contracts entered into as part of this project are done so in accordance to any related legal governance and the agreed contractual terms and conditions do not breach any legal regulations.

10. CUSTOMER AND DIGITAL IMPLICATIONS

10.1 This programme will revolutionise IT Provision in the organisation, creating a council with capability, capacity and agility.

10.2 The 6 key themes will support us at the start of our Digital Transformation journey focusing on empowering our citizens, our employees and building a confident, capable council with growth.

11. COMMUNICATIONS IMPLICATIONS

11.1 Business units to be informed of the Enabling Technology Programme of work by engaging with colleagues within Corporate Communications to formulate a comprehensive communications plan to cover all aspects of this complex and large scale programme of work.

12. CONSULTATIONS

12.1 The Councils Digital Leadership Team have approved the Enabling Technology Business Case in principle, and the Capital Oversight Board and SMT have considered this.

13. THE CORPORATE PLAN AND THE COUNCIL'S PERFORMANCE MANAGEMENT FRAMEWORK

13.1 This proposal supports the One Council element of the Corporate Plan (2017-2020), specifically in respect of the following areas:

- Efficiency delivery of projects and programmes;
- Innovative and managed risk taking;
- Learning organization;
- Flexible workforce;
- Working with our partners, communities and residents;
- Enabling the organization.

13.2 In addition, this also contributes to the following:

- **Thriving and vibrant economy**
  Making the changes proposed in this business case will provide us with a digital platform that allows us to more openly interact with the local economy. We will be using the same digital tools and services businesses in our local community use. The proposed IT strategy will enable access to new social channels of

communication that millennials, as well as more mature residents and businesses are already exposed to. We will be better placed to work in partnership with other local businesses and organisations.

- **People achieving their potential**
  We promote the ideas of good schooling, early access to support services, keeping our children safe from harm and having a community where people are healthier, happier, independent and active. Standardising our IT services will make it far easier to analyse the data we collect across various council systems to measure performance in these areas and identify where interventions might be required as trends change. The proposed solution promotes our openness to more flexible ways of working.

- **Strong and resilient communities**
  With an IT platform that can support improved social networking tools, we will can better support local voluntary organisations and help them reach potential supporters. We can vastly improve the ways our customer facing staff interacts with local residents and businesses with more efficient access to the council's data assets.

14. PROMOTING EQUALITY, DIVERSITY AND SOCIAL INCLUSION

14.1 An equalities and impact assessment was undertaken and relevant mitigations will be put in place working closely with the equality and diversity team.

15. TACKLING THE IMPACT OF POVERTY

15.1 N/A

16. TACKLING HEALTH INEQUALITIES

16.1 N/A

17. REDUCTION OF CRIME AND DISORDER

17.1 N/A

18. RISK MANAGEMENT ISSUES

18.1 This programme of work includes a robust approach to project management to provide the following:

- Project Governance – To ensure that effective management of resources, and to mitigate risks and issues
- Technical Assurance – Ensuring design integrity and the implementation of a standardised and field proven reference architectures
- Implementation planning – Following the structured, best practice approach to implement this technology.
- Service Readiness and Transition – Ensuring that each project deliverable is fully supportable and ready for production service.
- Business Alignment – Consistently ensuring alignment of the project objectives and outputs with business requirements

18.2 Tight governance arrangements are in place to ensure delivery of the KLOE in a timely manner.

19. HEALTH, SAFETY AND EMERGENCY RESILIENCE ISSUES

19.1 The tendered contractor will deal with any third parties where there is a health and safety risk for Council staff to perform the support or requires specialist equipment, such as working at height.

19.2 The tendered contractor will be expected to meet agreed Service Level Agreements to resolve any service issues that arise as a direct result of this programme of work.

19.3 The IT Department has existing business continuity plans regarding recovery of services and systems which will be invoked should a major problem occur during this transformational programme of work. All changes will be approved via the IT department's current Change Management procedures to minimise impact to operational services.

20. COMPATIBILITY WITH THE EUROPEAN CONVENTION ON HUMAN RIGHTS

20.1 This proposal is fully compliant with the European Convention on Human Rights.

21. CONSERVATION OF BIODIVERSITY

21.1 N/A

22. GLOSSARY

22.1 DLT: Digital Leadership Team

22.2 SQL: Structured Query Language (SQL) is a standard computer language for relational database management and data manipulation. SQL is used to query, insert, update and modify data.)

23. LIST OF APPENDICES

23.1 Appendix A – Financial Implications

24. BACKGROUND PAPERS

24.1 Digital First - Enabling Technology Business Case.

24.2 If you would like to inspect background papers for this report, please email governance@barnsley.gov.uk so that appropriate arrangements can be made.

Report author: Rachel Ruston

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Prepared on Behalf of the Director of Finance

FINANCIAL IMPLICATIONS

IT Technology Transformation - Digital First Enabling Technology

i) **Capital Expenditure**	**2018/19**	**2019/20**	**2020/21**	**Total**
	£	**£**	**£**	**£**
End User refresh and upgrade Programme resources incl. project tools	0	2,202,000	0	2,202,000
Total Funding Requirement	**0**	**2,202,000**	**0**	**2,202,000**
To be financed from:				
The Digital First Programme - Agreed Capital Allocation		-1,462,394		-1,462,394
Communities Directorate Residual Capital Funds		-154,296		-154,296
Digital First Programme - Revenue contribution to Capital		-585,310		-585,310
	0	**-2,202,000**	**0**	**-2,202,000**

ii) **Revenue Effects**	**2018/19**	**2019/20**	**2020/21**	**Later Years**
	£	**£**	**£**	**£**
Microsoft Licenses	0	436,300	535,200	535,200
	0	436,300	535,200	535,200
Funded via:				
		-3,019,204		
		3,096,704		
Digital First Programme - Agreed Revenue Allocation		-96900	-194,100	-149,706
Existing MS End User License costs		-212,000	-212,000	-212,000
Existing SQL Database Costs		-127,400	-127,400	-127,400
Password reset software			-1,700	-1,700
Recurring shortfall to be met from Digital First Programme				-44,394
	0	-436,300	-535,200	-535,200

Impact on Medium Term Financial Strategy:

None.

Agreed by: ....On behalf of the Service Director - Finance, Section 151 Officer

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