Public Document Pack

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Thursday 6 October 2022
TIME:	2.00 pm
VENUE:	Council Chamber, Barnsley Town Hall

AGENDA

1 Welcome and Introductions

2 Declarations of Pecuniary and Non-Pecuniary Interests

3 Minutes of the Board Meeting held on 9th June, 2022 (HWBB.2022.10.6/3) *(Pages 3 - 10)*

For Decision/Discussion

4 Cost of Living Crisis - More Money in Your Pocket (HWBB 2022.10.6/4) *(Pages 11 - 26)*

5 Health and Wellbeing Board/ICS Leads meeting (HWBB 2022.10.6/5) *(Verbal Report)*

6 Creativity and Wellbeing Update and Cultural Strategy (presentation on Barnsley's Cultural Strategy) (HWBB 2022.10.6) *(Pages 27 - 32)*

7 Survivors of Bereavement by Suicide Report (HWBB 2022.10.6/7) *(Pages 33 - 36)*

8 Place-Based Partnership Dashboard (HWBB 2022.10.6/8) *(Verbal Report)*

9 Better Care Fund Plan 2022/23 (HWBB 2022.10.6/9) *(Pages 37 - 128)*

10 Integrated Care Partnership (HWBB 2022.10.6/10) *(Verbal Report)*

Consent Items

11 Minutes from Safeguarding Adults, Safer Barnsley Partnership and Stronger Communities Partnership (HWBB 2022.10.6/11) *(To Follow)*

12 Barnsley Mental Health Partnership Annual Report 2021/22 (HWBB 2022.10.6/12) *(Pages 129 - 142)*

13 Barnsley Pharmaceutical Needs Assessment (HWBB 2022.10.6/13) *(Pages 143 - 208)*

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

Councillor Trevor Cave, Cabinet Spokesperson – Children's
Councillor Caroline Makinson, Cabinet Spokesperson – Public Health and Communities
Councillor Jenny Platts, Cabinet Spokesperson – Place Health and Adult Social

Care
Carly Speechley, Executive Director Children's Services
Wendy Lowder, Executive Director Place Health and Adult Social Care for Barnsley
Julia Burrows, Executive Director Public Health
Chris Edwards, Chief Officer, NHS Barnsley Clinical Commissioning Group
Jeremy Budd, Director of Commissioning and Partnerships, NHS Barnsley Clinical Commissioning Group
James Abdy, Chief Superintendent, South Yorkshire Police
Mark Janvier, NHS England Area Team
Adrian England, HealthWatch Barnsley
Dr Richard Jenkins, Chief Executive, Barnsley Hospital NHS Foundation Trust
Amanda Garrard, Chief Executive Berneslai Homes
Andrew Denniff, Chief Executive, Barnsley and Rotherham Chamber of Commerce

Please contact Elizabeth Barnard on or email governance@barnsley.gov.uk

Wednesday 28 September 2022

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Thursday 9 June 2022
TIME:	2.00 pm
VENUE:	Council Chamber, Barnsley Town Hall

MINUTES

Present

Councillor Jenny Platts, Cabinet Spokesperson - Place Health and Adult Social Care (Chair)
Councillor Caroline Makinson, Cabinet Spokesperson - Public Health and Communities
Wendy Lowder, Executive Director Adults and Communities
Julia Burrows, Director of Public Health
Jeremy Budd, Director of Commissioning and Partnerships, NHS Barnsley Clinical Commissioning Group
Adrian England, Health Watch Barnsley
Kathy McArdle, Service Director, Place (Regeneration and Culture)
Emma Robinson, Senior Performance and Intelligence Officer (BMBC),
Sue Barton, SWYFT
Bob Kirton, Chief Delivery Officer and Deputy Chief Executive BHNFT
Phil Ainsworth, Public Health Senior Practitioner
Emma Labedzki, Public Health Project Officer
Claire Hogley, Business Support Officer, Healthier Communities (Minutes)

1 Appointment of Chairperson

RESOLVED that Councillor Platts be appointed Chair of the Meeting.

Councillor Plats welcomed everyone to the meeting.

2 Declarations of Pecuniary and Non-Pecuniary Interests

There were no declarations of pecuniary or non-pecuniary interest from Members in respect of items on the agenda.

3 Minutes of the Board Meeting held on 3rd February 2022

The meeting considered the minutes of the previous meeting held on 3rd February 2022.

Cllr Makinson raised a query with regards to the Child of the North Report as to whether there was an action plan in place to take the recommendations forward. No colleagues from Children's Services were present at the meeting to respond to the query. The Chair confirmed that she would raise this with Children's Services.

RESOLVED that:

(i) the minutes be approved as a true and correct record; and

(ii) the Chair liaise with Children's Services as to whether an action plan is in place to take the recommendations forward from the Child of the North Report.

4 Message of thanks to Cllr Andrews - Verbal - Nominated Chairperson

At the local elections in May 2022, Cllr Andrews had not been re-elected. He would, therefore, no longer be able to be the Chair of the Health and Wellbeing Board. The Chair recognised that Cllr Andrews' exceptional leadership and hard work was instrumental to shape new Health and Wellbeing strategy. Cllr Andrews was highly thought of for tackling health and social inequalities in Barnsley and for improving the lives of people across the borough.

RESOLVED that:

(i) the Board recognises and is appreciative of the great work undertaken by Cllr Andrews during his time of service; and

(ii) it be noted that Councillor Makinson would take over as Chair of the Board in future, supported by a deputy.

5 Health Inequalities in Barnsley - Emma Robinson

Emma Robinson, Senior Performance and Intelligence Officer (BMBC) presented the current position on Health Inequalities in Barnsley.

Indicators had been updated since the last meeting. PHE Public Health Outcomes Framework divided indicators into 4 key domains.

New data across life expectancy indicators (2018-2020) showed:

- Healthy life expectancy was now falling for both males and females, locally and nationally.
- Improvements in the inequality gap.
- Life expectancy across the borough showed variation for different geographical areas across Barnsley.
- A fall in healthy life expectancy for males, which was now the lowest in South Yorkshire.

Wider determinants around health:

- Children and low-income families' provisional data was treated with caution due to the impact of COVID-19 however geographical variation could be seen once more.
- There was a gap in employment rate with those with a long-term health condition.

Health improvement:

- Excess weight data was higher than national average.

- National data for 2020-21 showed a prevalence of overweight children of primary school age. It was anticipated that there would be a similar pattern in Barnsley's data.

Healthcare and premature mortality:

- Was higher than the national average in Barnsley for conditions such as heart disease and cancer.

Impact of COVID-19:

- There was a risk of exposure to the virus and impacts of lockdowns.
- Mortality rates were higher in more deprived areas.
- ONS data showed Barnsley to have the highest percentage of excess deaths in the Yorkshire and Humber.

Mental Health impacts of COVID-19:

- Although in the recovery period from the virus, ONS survey showed levels of depression was higher than pre-pandemic levels.
- Vulnerable adults were more likely to experience depression.
- There were high levels of depression amongst unemployed adults and those struggling financially.

All 4 goals of Barnsley 2030 linked to health inequalities:

- Inequalities in learning.
- Inequalities in growth.
- Inequalities in sustainability.
- Inequalities in health.

The Chair thanked Emma for her presentation and requested feedback from the Board on any next steps.

RESOLVED that:

(i) it be noted that data and trends shown around health inequalities in Barnsley is particularly useful in determining the next steps;

(ii) the Joint Strategic Needs Assessment be regularly updated and reflect the findings of this data;

(iii) it be noted that the new Integrated Care System (ICS) will have a proactive role in tackling issues of health inequalities;

(iv) the presentation to be shared with the Inclusive Economy Board and any other relevant partnerships;

(v) it be noted that a request has been made for partners to join the Healthy Weight Alliance and that this be reissued to improve engagement; and

(vi) the Board endorse its committed to working collectively and in partnership with relevant organisations to tackle the inequalities shown.

6 Verbal update from the Barnsley 2030 Board - Bob Kirton

Bob Kirton, Chief Delivery Officer and Deputy Chief Executive BHNFT, provided a verbal update on Barnsley 2030 and the recent development workshop which has taken place. Particular reference was made to the following:

- Barnsley 2030 Board - was a new initiative, bringing together public and private sector organisations from a variety of sectors.
- The alignment of work with the four themes of Barnsley 2030: Learning, Growing, Healthy, Sustainable.
- The many links between various areas, such as with inequalities which cut across all four areas.
- The use of data together with stories about people etc.
- The data which showed shocking truths, and was challenging to tackle. There was a need to focus on how to resolve all issues.
- The Workshop particularly focussed on children and transition to adulthood e.g. apprenticeships and employment opportunities. Update from Youth Forum.
- The thinking about plans a decade in advance.
- The voice of children and young people which was crucial to influence those plans.
- The NHS focus on health inequalities. It is felt useful to widen this to general inequalities, focusing on fairness, education, economic inequalities, as they all linked.
- The importance of making good employment accessible and providing a variety of opportunities. Supporting travel links and enabling people to physically get to work.

The Chair praised the Workshop having had many active participants with excellent ideas coming out of it.

RESOLVED that:

(i) It be noted that food is a multi-purpose solution as there are strong links between healthy eating and community cohesion;

(ii) It be noted that there are spaces available around Barnsley that could be utilised for volunteering projects, such as allotments in need of maintenance due to staff shortages;

(iii) That it be noted that the BMBC volunteering scheme offers 4 paid volunteering days per year and links can be made through volunteering through partnership and agency working with organisations such as Age UK Barnsley and Barnsley CVS;

(iv) That it be noted that the Incredible Edible website was a useful point of reference for green spaces being converted into food growing spaces and that Incredible Edible be invited to present at a future meeting, to look at the mechanism for utilising unused council green space; and

(v) the Board work with the initiatives already in place to build on this and strengthen their focus.

7 Director of Public Health Annual Report - Julia Burrows

Julia Burrows, Director of Public Health presented the Board with information about her Annual Report 2021'What matters to me now – the voice of children and young people in Barnsley'.

This report was key as it explained what children and young people were telling us and particular attention was drawn to chapter 4 of the report.

There were currently many quantitative indicators in the Public Health Outcomes Framework. An observation was made that more qualitative data was also needed.

Qualitative data collection for the report contained a high level of engagement via a fun, creative, inclusive and diverse variety of exercises.

The pandemic put the engagement process on hold to an extent, but once resumed, this provided more information on what mattered to children and young people, pre- and post-pandemic.

Themes arising included:

- Connecting with people – family and home; friendships and belonging
- Being active and outdoor play
- Concern for the environment and the planet
- Commitment to education and learning
- Health and Healthcare
- Help and support for those who need it
- Concerns around smoking and alcohol – improving life chances
- Inclusivity and diversity
- Feeling safe
- Public transport
- Having fun and being creative
- Holidays and celebrations

There were a variety of recommendations in the report around supporting children based on the feedback received.

Providing children with a good childhood and allow them to experience joy was also a key priority within Barnsley 2030.

Credit was extended to Amy Baxter, Public Health, for being the driving force behind the report and consultation.

The Chair also praised the work that had taken place and the importance of the recommendations going forward.

RESOLVED that

(i) the Board support the recommendations in the report and is committed to actioning them;

(ii) it be noted that the report and consultation show what is important to children and young people and is very impactful via the artwork collected;

(iii) the Board recognises that the report shows themes of loneliness and isolation and values the importance of enabling children and young people to connect with peers, family, supportive adults, Youth Services, Early Years, and others.

8 Mental Health Strategy - Patrick Otway & Adrian England

Adrian England provided an update on the strategy and requested approval and sign off by the Board.

The Mental Health strategy would be reviewed annually and regularly brought to the Health and Wellbeing Board.

As Chair of Mental Health Partnership, Adrian England thanked all those involved in the creation of the strategy.

Patrick Otway reported that the partnership would link to the mental health dashboard to identify the impact of the strategy going forward.

RESOLVED that:

(i) the Board formally endorse and sing off the publication of the Barnsley Mental Health and Well Being Strategy 2022-26; and

(ii) it be noted that the new integrated care arrangements will determine further actions and greater transparency on funding for mental health and output and outcomes and ensuring money goes to the right place for the right reason.

9 Verbal Update from Creativity and Wellbeing Week - Kathy McArdle

Kathy McArdle, Service Director, Place (Regeneration and Culture) provided a verbal report on the Creativity and Wellbeing Week held between the 16th and 22nd May, 2022.

She particularly commented on the following:

- she recognised the energy and effort from the Public Health team in the launch of the week.
- The week had explored what creativity, culture and wellbeing actually meant in a range of settings.
- Various events throughout the week had been attended by a whole range of providers.
- A wide range of activities ran throughout the week to improve engagement and promote creativity and wellbeing.
- A theme had emerged from the final workshop of living well and how a culture of creativity was key to have a healthy and productive life.

She was keen to co-produce next steps which included:

- Leaders at every level to kickstart these conversations.
- Short-term and long-term actions needed to drive this forward.
- Revisit the terminology to remove complicated jargon.
- Develop a citizen led cultural strategy for the borough.
- Develop a mechanism to promote great practice.
- A Role to support infrastructure around this area – culture, health and creativity role sitting within Barnsley Museums.
- Evaluate communications – assess engagement of activities.
- Develop a Culture Strategy – citizen led, co-produced, involving the Health and Wellbeing Board.
- Projects to develop going forward.
- Support from the Board – engagement with networks to develop strategy.
- Engaging Health and Care Teams across BMBC and partners.

The Chair thanked Kathy McArdle for the update and invited comments from board members.

RESOLVED that

(i) the Board recognises that Creativity and Wellbeing Week was a great opportunity for people to reconnect and pick up different activities; and

(ii) the Board continue to support the work around the Culture Strategy.

10 Minutes from the Safer Barnsley Partnership held on 20th December 2021

The meeting considered the minutes from the Safer Barnsley Partnership held on 20th December 2021.

Wendy Lowder, Executive Director Adults and Communities, commented that the trends around Domestic Violence had increased, and that the pandemic had not helped. Unfortunately, there had been some recent tragic deaths. Domestic Violence featured in 73% of child protection cases. The Partnership is working hard on the Domestic Abuse Strategy.

RESOLVED that the minutes be received.

11 Minutes from the Stronger Communities Partnership held on 11th November 2021 and 18th February 2022

The meeting considered the minutes from the Stronger Communities Partnership held on 11th November 2021 and 18th February June 2022.

RESOLVED that the minutes be received.

12 Better Care Fund Annual Report

RESOLVED that the Better Care Fund Annual Report, submitted for information only, be received.

13 BCF Year End Return

RESOLVED that the Better Care Fund Year End Return, submitted for information only, be received.

14 Pharmaceutical Needs Assessment - Public Consultation

RESOLVED that the report on the Pharmaceutical Needs Assessment Public Consultation held between Monday 16th May and Friday 15th July, 2022 submitted for information only, be received.

Chair

6th October 2022

REPORT TO THE HEALTH AND WELLBEING BOARD
Cost of Living Crisis: More Money in Your Pocket

Report Sponsor: Julia Burrows
Report Author: Jayne Hellowell

1. Purpose of Report

1.1 As the cost of living crisis continues to affect Barnsley residents, Barnsley Council are committed to doing all they can to support everybody through this time. The More Money In Your Pocket webpage has been designed to enable all residents (including staff of Barnsley Council and other anchor institutions) understand what support is available to help them through the cost of living crisis.

1.2 The More Money In Your Pocket webpage can be accessed online here, or by clicking on the following link:
https://www.barnsley.gov.uk/services/advice-benefits-and-council-tax/help-with-the-rising-cost-of-living/
Further details on how to access the site are available in the attached presentation (Appendix 1).

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:

- Note the contents of this report and the attached presentation;
- Assist with cascading the information contained within the attached presentation to their staff, community groups and local business who may benefit from receiving such information – by providing details of appropriate meetings where this information can be presented.

3. Appendices

Appendix 1 – More Money in Your Pocket Presentation

Officer: Ben Brannan **Date:** 6th October 2022

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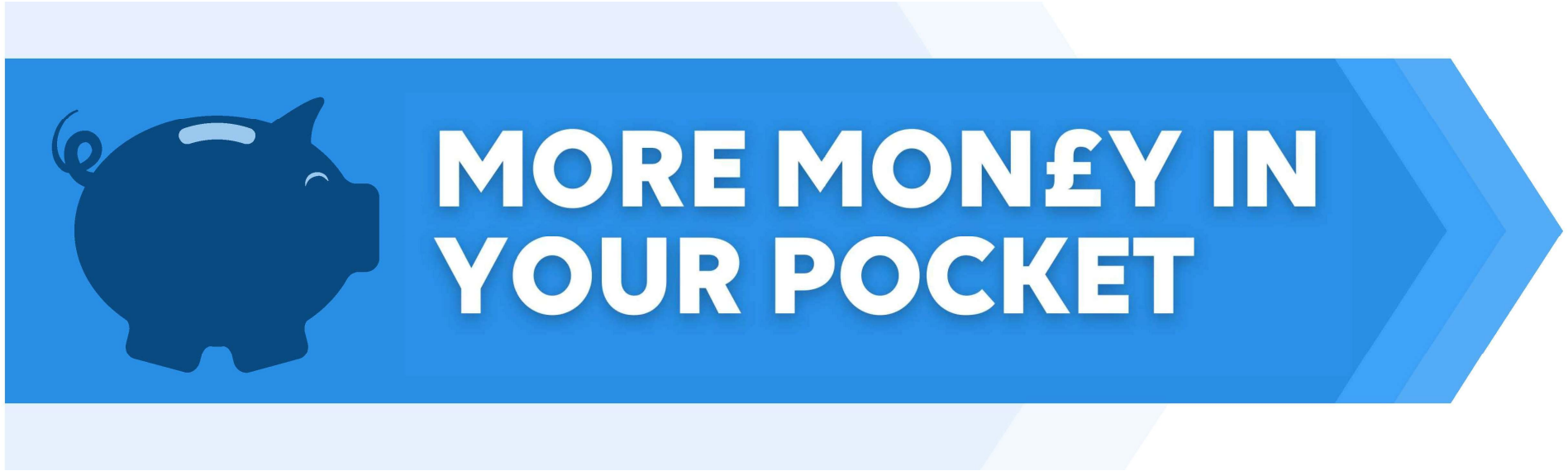
More Money In Your Pocket
Helping you with the cost-of-living crisis



More Money In Your Pocket website – how to locate it?

You can find MMIYP on Barnsley Council's intranet.

https://www.barnsley.gov.uk/services/advice-benefits-and-council-tax/help-with-the-rising-cost-of-living/

Use the QR (Quick Response) code

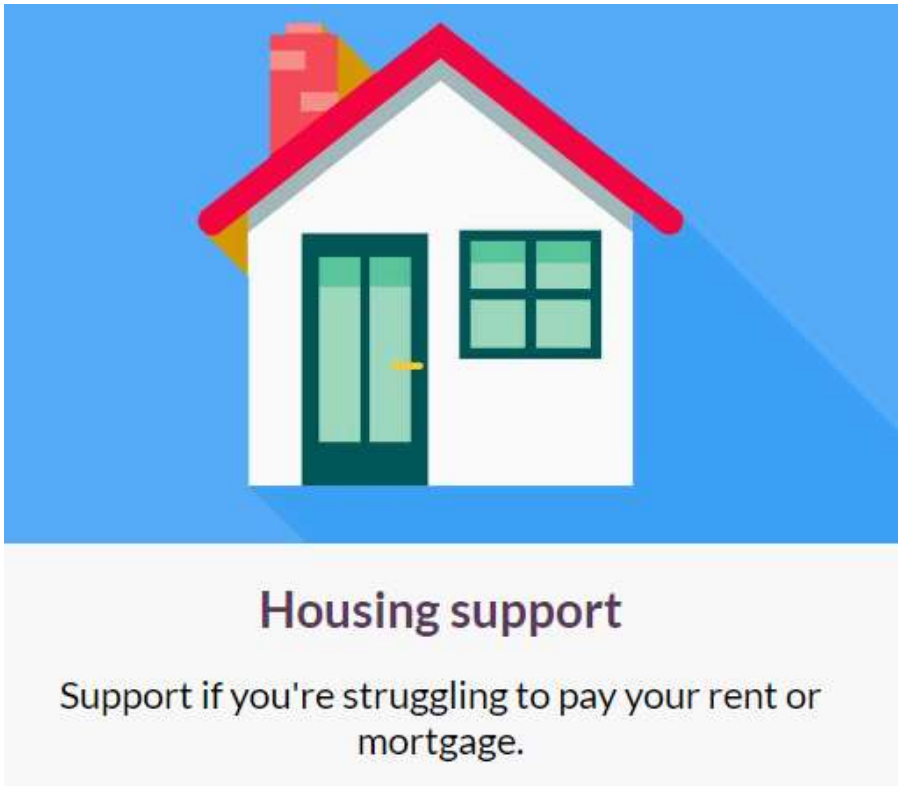
What can you find on MMIYP?

- Up to date information on support to help people through the cost of living crisis.
- It only contains information about **FREE** or **DISCOUNTED** support.
- It pulls in information from across lots of other websites and may direct you to those websites.
- There are 10 tiles on the main webpage and we have designed them to direct people to the most pressing issues relating to the cost of living pressures. The following slides will provide you with an overview of those 10 areas.
- The ‘tile’ format enables the content of each tile to be changed without changing the look or feel of the site, maintaining a consistent user experience.

New support available

This will give you information on any new support that has recently become available. We think this is helpful for those who may have exhausted all other options and are looking for new or additional support. This will include for example, information on new government grants and support how you can access them.

Support if you are struggling to pay your rent or mortgage



Example:

- If you're on a low income, you may be able to claim council tax support to help you pay your council tax bill.

Help to pay your electricity, gas, water or broadband

- **The challenge**
- We know this is one of the most topical areas and we are aiming to ensure that we provide the most up to date information on the governments approach to this. You can also get one off grant support through some community groups. Please see the Household support grants area.

Free schools meals, food vouchers, crisis support and much more.

Did you know that you can become a member of one of our community shops or storehouse and field and save up to £200 per month on your food bill?

We have included lots of low cost recipes to help you cook on a budget.

There is also crisis food support and vouchers to help you.

Household support grant

- The HSG is grant we get from the DWP. It usually amounts to 2.3 million twice a year.
- We have to allocate some of this to people on benefits.
- We are however using a large amount to fund community organisations to help you with food, fuel and other essential household goods.
- We are targeting those on low incomes.

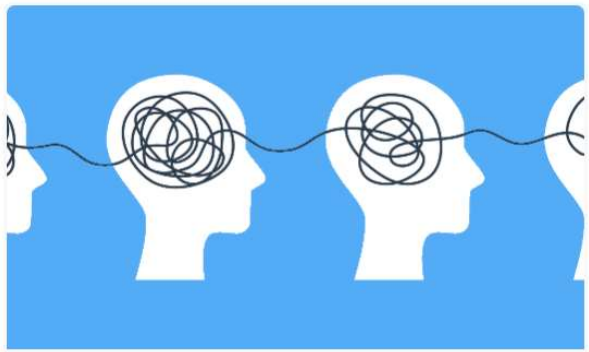
Freebies and money saving ideas

Free

Digital magazines, holiday clubs for your children, family friendly fun activities and much, much, more

Budgeting support

Help to manage your money and budget.



Wellbeing support

Services that can help if you're worried about money, including mental health support.

Employment and skills support

Get advice and support from our team and benefit from opportunities around learning and working.

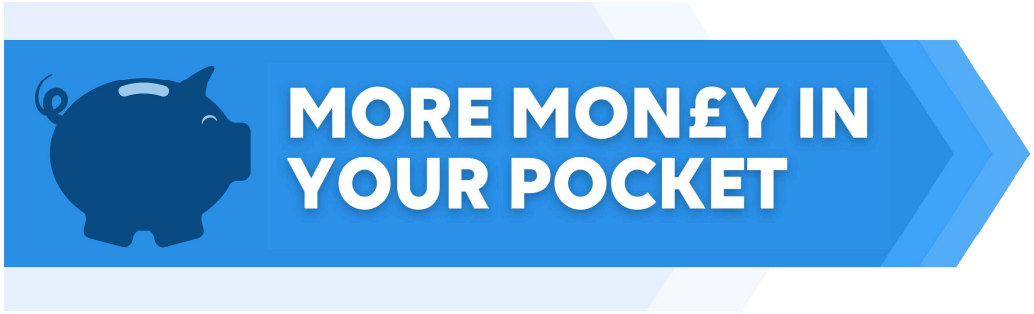
We have included 3 more areas where you can get help with things like budgeting, clubs to get involved in, and help with your mental health if you are struggling to cope.

We have also included information on how you can skills up to step up.

Limitations of the site

As the website is hosted on the wider Barnsley Council website, it is governed by the councils corporate requirements on site management.

In accordance with site management, where links to other pages or websites are shared, these cannot contain descriptors which include content from third party sites. This is to ensure that should the third party content change, the information displayed on More Money in your Pocket remains accurate.



Site demo

https://www.barnsley.gov.uk/mmiyp

We aim to improve the site and keep it up to date and welcome your feedback

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BARNSLEY'S CULTURAL STRATEGY

Update

Thursday October 6th

Challenges Faced By Our Communities

- **Low levels of engagement & participation in community life**
- **Increasingly isolated and disenfranchised communities feeling 'left behind' by economic growth and the pandemic**
- **Significant wellbeing and mental health inequalities and lower life expectancy exacerbated by the impacts of COVID**
- **Barriers to accessing employment which need understanding and alleviating**
- **Challenges particularly acute in Principal Towns**
- **Significant deprivation challenges and a worsening gap in incomes and livelihoods, further emphasised by Cost of Living Crisis**

What this means for culture in Barnsley?

- Democratic and co-created
- Citizen led
- Focus on reducing inequality
- Genuinely Borough wide
- Innovative engagement

BARNSLEY: A PLACE OF POSSIBILITIES

Where people make things happen

Our Current Cultural Priorities

A cultural strategy for Barnsley

Cultural and Creative Industries: mapping the ecology

Good work for artists and creative practitioners

The Civic

Eldon Street High Street HAZ

Connecting the dots: Arts embedded in health and wellbeing, communities, education, social care - commissioning

Cultural place-based partnerships and Local Culture

Spaces and Hubs in every community

Digital Innovation

Great places to visit: Elsecar, Cannon Hall, Experience Barnsley, Cooper Gallery, Archives, Worsbrough Mill and our Principal Towns

Sustainability –financial and environmental

Barnsley's Cultural Strategy

- Must be rooted in the needs and expectations of local people
- Citizens' Assembly model potentially piloted
- Process as important as final product
- Embedding democratic approaches
- Rooted in wider challenges…health
- Creative practitioners play key role

Barnsley's Cultural Strategy

- Arts Council very supportive of approach
- Talking through with key stakeholders
- Identifying funding
- Provisional timescales – late 2022 to late 2023
- Health and Wellbeing Board, and

wider health sector, will be key

18th August 2022

REPORT TO THE HEALTH AND WELLBEING BOARD
Refreshing Barnsley's Joint Strategic Needs Assessment

Report Author: Phil Ainsworth – Public Health Senior Practitioner
Sarah Bedford – SOBS coordinator Barnsley

1. Purpose of Report

1.1 The purpose of this report is to share the valuable experiences and insights from those bereaved by suicide but also highlight some of the key issues those bereaved by suicide experience. These key issues highlight where there may be gaps in provision or reinforce where efforts must be concentrated.

2. Background

SoBS (Survivors of Bereavement by Suicide) is a national charity providing peer to peer, face to face support groups every month for those who have been impacted by suicide. The Barnsley group was set up in September 2021 after training a number of local people who had been bereaved by suicide themselves. On average there are 10 people in attendance each month with new people coming to the group on a regular basis as well as others moving on to access other support or simply them feeling equipped to deal better deal with the grief and getting on with their lives. The group has not been advertised and promoted much yet and is purely people attending and getting in touch by word of mouth. That said Information is sent out to all families who have lost loved ones by South Yorkshire Police Via the South Yorkshire Real Time Surveillance System (RTS). We do plan to do some promotion of the group within primary care, funeral directors, social media soon. Prior to the Barnsley group being set up the nearest group we had was in Sheffield. In our Barnsley group we people attending from Sheffield, Wakefield, Doncaster and Bradford (we are the nearest group to Bradford).

3. Key Issues Raised.

- Families are anxious about inquests and needing further support. This is currently coming from SoBS members who have been through the experience themselves. AMPARO (South Yorkshire Suicide Bereavement Service) also offer additional support as well attending inquests with families where appropriate.
- Lots of nervousness around press attending inquests and press releasing insensitive and inappropriate information. E.g., details of the death include method, locations etc. There have been several incidents regarding this with local and national media which BMBC and partners have worked hard to mitigate and educate media organisations on the impact of this on families. As a result, Barnsley Chronicle have agreed to stop publishing these online but have not reframed from putting articles in the paper, but we have opened up a line of communication through the Chronicle and the Barnsley SOBS groups when families know media have attended

the inquest. We are currently working with OHID to look at a Yorkshire & Humber approach to challenging media organisation through the national Samaritans teams which will be funded but the Y&H Association of Directors of Public Health (ADPH) network.

- There has been lots of discussion around supporting children who have lost parents. SoBS identify local and national services and signpost accordingly but waiting lists are exceptionally long and early intervention for children with trauma and PTSD is crucial. The current CYP & Families Bereavement service is currently funded until 31st July 2023 and already has significant waiting lists due to demand around all types of bereavement.
- Lots of people that attend the group have voiced how they have felt let down by mental health services. That is not to say this is always the case, but this is how families are feeling. This could be due to a lack of understanding of what services actually deliver or could be due to gaps in services and even people on waiting lists awaiting treatment.
- The group has seen an increase in people attending group whose loved ones have taken their own lives with Long Term Conditions and chronic pain being a contributing factor. This also coincides with our RTS data.

3. Recommendations

3.1 Health and Wellbeing Board members are asked to:-

- Continue to challenge irresponsible and insensitive reporting and support the role of a Y&H post based with the national Samaritans.
- Support the bereavement health needs assessment which Public Health are undertaking and start to think where bereavement could strategically sit and be funded. This issue is currently much broader than suicide and children however does highlight some of the current gaps and pressures on the system.
- Think about how we better promote better MH services, manage expectations, and educate residents on the different levels of support and empower people to take positive steps to manage their mental health.

- Consider how current pain management services are fit for purpose. Do current pathways enable fair access? How can services also screen for suicidal ideation and how do they interlink with mental health services as well as community initiatives e.g. Andy's Man Club, Recovery college, Creative Recovery

Appendix 1 – SOBS Case Study

Losing mum and dad -life will never be the same

In December 2021 my dad took his own life aged 71. He was struggling tremendously following the sudden death of my mum in August 2021 from Covid Pneumonia.

Losing both my parents in sudden and traumatic circumstances has been so difficult to deal with practically and emotionally.

I had barely had the chance to process mum's death when dad died. Dad taking his own life brought so many different emotions. I still go over everything in my head most days almost a year later.

Regret and guilt - What could, or should I have done or said differently?

Sadness and disappointment- Why didn't he call me back? Was he in pain?

So many unanswered questions . . . .

This last year I've been on a conveyor belt just getting through each day - looking after my family and young children and dealing with the huge number of practical things that need to happen when someone dies. Two funerals to plan, companies to notify, finances to sort, a house to empty of almost 50 years of memories.

After my parents died I was initially flooded with messages of support and flowers but just a couple of months later everyone was back living their normal lives. I have my sister and her children but no other close family. I felt lost and alone and exhausted from putting on a brave face.

It was then I found SOBS - Survivors of Bereavement by Suicide. I found the group initially on Facebook and then contacted one of the facilitators by telephone. I arranged to attend the monthly face to face group in February.

It's a group of local people who have all lost someone by suicide - a parent, a partner, a child, a friend. At the first meeting I must admit I felt heartbroken listening to some of the tragic stories of others in the group. But I recognised the feelings and emotions they are going through in myself and that helped.

I've attended 6 meetings now and the support really helps. In the early stages the group shared really important information that helped me prepare for the inquest - tips like requesting hard copies of the paperwork in advance to prepare. As the months go by I find that SOBS is now the only place I have to share my feelings - they all understand. They listen. They share their own experiences. It's not a professional counselling group - its normal people supporting each other.

Sometimes we laugh in group. It seems crazy to write that given the nature of what we are there to discuss. But we are all human - loved ones left behind trying to pick up the pieces of our lives. Lives that will never be the same again.

If you are going through a bereavement- a natural death or a suicide, I think the best advice is to be kind to yourself. There are models of grief that professionals refer to, but we are all different - our families are unique, our circumstances are unique - you have to find a way forward that works for you.

Do reach out for help outside your family. There is a lot out there. It can be very confusing trying to identify where to start. Services through the GP can have long waiting lists but do get yourself on the list for help. There are lots of charitable organisations like SOBS, Samaritans, Mind that have free helplines. It really does help to talk. Sometimes I don't realise how I really have been feeling until I say it out loud.

It's a long and difficult journey. Your life will never be the same. But a bit like Covid, you have to find your own "new normal," a way to live with the tremendous emptiness and loss when your loved one is no longer with you**.**

Appendix 2 – Barnsley SoBS details
https://uksobs.org/
Phone: 07398 135 273
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Officer: **Phil Ainsworth – Public Health Senior Practitioner**
Date: **27/09/2022**

6th October 2022

REPORT TO THE HEALTH AND WELLBEING BOARD
Refreshing Barnsley's Joint Strategic Needs Assessment

Report Sponsor: Wendy Lowder
Report Author: Jamie Wike and Andrew Osborn

1. Purpose of Report

1.1 This report aims to inform the Health and Wellbeing Board of the Better Care Fund Plan for 2022/ 23.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Note the contents of this report
- Provide any constructive feedback on the Better Care Fund Plan 2022/23
- Approve the Better Care Fund Plan for 2022/23

3. Delivering the Health & Wellbeing Strategy

3.1 The 2022/23 Better Care Fund Plan builds on previous plans and continues to be set within the wider context of the Health and Wellbeing Strategy and Barnsley Integrated Care Partnership Health and Care Plan Refresh for 2022/23.

3.2 We feel that it is important that our plans are considered within this context to ensure that our efforts are coordinated and that our plans are connected and come together to maximise the impact that we are able to make across the whole system for the benefit of Barnsley residents. Our Vision for a Healthy Barnsley, as set out in the Barnsley Health and Wellbeing Strategy 2021 – 2030: The Place of Possibilities is that:
All Barnsley Residents are enabled to enjoy long, fulfilling and healthy lives in safe, strong and vibrant communities where every person is equipped with the skills and resources they need to thrive.

3.3 The vision and principles of integration have become well established and in many respects integrated ways of working are now seen as 'business as usual' for delivering the right service, at the right time and in the right place and a number of the BCF schemes as well as other established core services are delivered in an integrated way bringing health and social care providers together to best meet the needs of individuals.

4. Reducing Health Inequalities

4.1 One of the key priorities within the Better Care Fund Plan for 2022/23 is to improve equity of access to care and support; ensuring everyone who needs support can access it at the right time and in the right place.

4.2 Above all we want to improve the quality of life of people in Barnsley and reduce the inequalities that exist in health and wellbeing outcomes. We want to better meet the needs of our population in Barnsley, preventing chronic illness, deaths from preventable causes and see a rise in the number of individuals making informed decisions about their care and support alongside health and care colleagues. The vision of integration in Barnsley is fully aligned to and supports us in delivering the BCF policy objectives:

1. Enable people to stay well, safe and independent at home for longer
2. Provide the right care in the right place at the right time.

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5. Context and governance

5.1 The Better Care Fund (BCF) Plans since 2014/15 have played a key role in helping Barnsley with its integration journey, being delivered within the wider context of our Health and Wellbeing Strategy and Barnsley Health and Care Plan enabling core health and care services to support one another and function as a united approach, to help reduce the pressures on acute services and residential care.

5.2 Our Better Care Fund in Barnsley is used to fund services commissioned by the NHS South Yorkshire Integrated Care Board and Barnsley Metropolitan Council with the overall BCF plan being supported by a range of services which form part of the wider integration plans being taken forward by the Integrated Care Place Partnership.

5.3 The funding from the BCF remains broadly consistent in 2022/23 with that of previous plans to ensure sustainability of those health and social care services and is predominantly focussed upon out of hospital NHS services and Social Care services. The level of funding has been enhanced in 2022/23 to reflect growth in the contribution to Social Care and the continued inclusion of the iBCF. There is a clear correlation between schemes included within our 2022/23 BCF plan and the wider health and care priorities identified. The total BCF funding of £39,908,038 is made up of the following:

NHS South Yorkshire Contribution	£23,080,403
LA contribution (DFG)	£3,77,046
Improved Better Care Fund	£13,450,589
Total	**£39,908,038**

5.4 The strategic governance arrangements for the Better Care Fund remain the same as in recent years with oversight being provided by the Health and

Wellbeing Board and the BCF being managed within the governance structures of the Health and Wellbeing Board. The BCF programme will be overseen by the Health & Wellbeing Board, supported by the Barnsley Place Partnership and Delivery Group who will take responsibility for ensuring delivery against our plans and achievement of our priorities.

5.5 The plan includes trajectories against the four national metrics that are required for the BCF plan. In summary the plan aims to support:

- The reduction in avoidable admissions to hospital
- Maintain the high rates of discharge to usual place of residence
- Reduce the number of people who have their long-term care needs met by admission to residential care
- Maintain the high proportion of people who are able to remain at home after discharge from hospital into reablement services.

5.6 Further detail, including a full narrative report, financial breakdown, and capacity demand planning are included within the appendices.

6. Consultation with stakeholders

6.1 All members of the Health and Wellbeing Board and the Barnsley (Integrated Care) Place Partnership have been engaged in the development of our vision for integrated health and care and our plans including developing and agreeing the BCF Plan. All partners have been involved through participation in meetings and workshops as active contributing members to the Board

7. Appendices

7.1 Appendix 1 – Barnsley Better Care Fund Plan Narrative Report 2022 / 23

7.2 Appendix 2 – Barnsley Better Care Fund Planning Template 2022 / 23

7.3 Appendix 3 – Barnsley Better Care Fund Capacity Demand Template

Officer: Ben Brannan **Date:** 6th October 2022

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Barnsley Health and Wellbeing Board

Better Care Fund Plan Narrative 2022/23

The Better Care Fund in Barnsley has been developed and is set in the context of the Health and Wellbeing Strategy and the Barnsley Integrated Care Partnership - Barnsley Health and Care Plan 2022/23. All members of the Health and Wellbeing Board and the Barnsley (Integrated Care) Place Partnership have been engaged in the development of our vision for integrated health and care and our plans including developing and agreeing the BCF Plan. All partners have been involved through participation in meetings and workshops as active contributing members to the Board

The following organisations are members of the H&WB Board and Integrated Care Partnership.

Organisation	H&WB	ICP
Barnsley Metropolitan Borough Council	Y	Y
NHS Barnsley Clinical Commissioning Group	Y	Y
Barnsley and Rotherham Chamber of Commerce	Y	N
Healthwatch Barnsley	Y	Y
Berneslai Homes	Y	N
NHS England	Y	N
Barnsley Hospital NHS Foundation Trust	Y	Y
South West Yorkshire Partnership Foundation Trust	Y	Y
Barnsley CVS	Y	Y
South Yorkshire Police	Y	Y
Barnsley Healthcare Federation	N	Y
Barnsley Hospice	N	Y

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Executive Summary

The 2022/23 Better Care Fund Plan builds on previous plans and continues to be set within the wider context of the Health and Wellbeing Strategy and Barnsley Integrated Care Partnership Health and Care Plan Refresh for 2022/23.

We feel that it is important that our plans are considered within this context to ensure that our efforts are coordinated and that our plans are connected and come together to maximise the impact that we are able to make across the whole system for the benefit of Barnsley residents.

Our Vision for a Healthy Barnsley, as set out in the Barnsley Health and Wellbeing Strategy 2021 – 2030: The Place of Possibilities is that:

All Barnsley Residents are enabled to enjoy long, fulfilling and healthy lives in safe, strong and vibrant communities where every person is equipped with the skills and resources they need to thrive.

The vision and principles of integration have become well established and in many respects integrated ways of working are now seen as 'business as usual' for delivering the right service, at the right time and in the right place and a number of the BCF schemes as well as other established core services are delivered in an integrated way bringing health and social care providers together to best meet the needs of individuals.

One vision (for integration) for Barnsley

Barnsley is now embarking on its next step of the integration journey and building a stronger Integrated Care Place Partnership for Barnsley, as one of the four place partnerships in our wider South Yorkshire Integrated Care System, working with the South Yorkshire Integrated Care Partnership (ICP) and Integrated Care Board (ICB).

The Barnsley Place Partnership brings together commissioners and providers of health and care services in Barnsley to design and deliver integrated services for patients and deliver improved health outcomes for the Barnsley population.

The Barnsley Health and Care Plan 2022/23 sets out our local priorities, reflecting our partnership of health and social care and focus on wider determinants. The plan is very much a continuation and refresh of the 2021/22 plan reflecting on the achievements and progress made but also recognising that in some areas progress has been impacted by the continuing impact of the COVID Pandemic and the focus on recovery of services.

For 2022/23 we have identified 4 priorities as set out in the diagram below:

1. Growing our workforce (capacity, capability and resilience)	We will work with partners across our place to increase opportunities for people from deprived communities and those under-represented in the health and care workforce, embed career pathways across health and care and provide exemplary employee assistance and support programmes.
2. Strengthening our joint approach to prevention (making every contact count)	We will work with our communities, VCSE sector and partners to increase capacity across three tiers of support (self/guided, one-to-one and directed) with an initial focus on preventing and reversing deconditioning for older people, bereavement, emotional wellbeing and resilience.
3. Improving equity of access (no wrong door)	We will ensure that everyone who needs support can access it at the right time and in the right place. We will start with the customer experience, ensure different point of access in our system operate to the same guiding principles and create safe space for people in mental health crisis.
4. Joining up care and support for those with greatest need (integrated personalised care)	We will work to ensure that care we provide is holistic, person centred and coordinated. To deliver this we will deliver phase three of neighbourhood teams including social care and mental health and developing care pathways for eating disorders, personality disorders, frailty and dementia.

There is a clear correlation between some of the schemes included within our 2022/23 BCF plan and the wider health and care priorities identified above. Examples of schemes which specifically help people to maintain independence in their own home, prevent hospital admission by providing earlier intervention or support discharge processes and minimise delayed discharges include:

- Residential and domiciliary (Home) care services
- Services to support carers
- Equipment and adaptations
- Extra care housing provision
- Reablement support
- 7 day Social Work
- Increased Occupational Therapy
- Intermediate care (Step up and Step down) bed based and community/home based
- Falls Services
- Neighbourhood Nursing (including Urgent Crisis Response)

The funding from the BCF remains broadly consistent in 2022/23 with that of previous plans to ensure sustainability of those health and social care services and is predominantly focussed upon out of hospital NHS services and Social Care services. The level of funding has been enhanced in 2022/23 to reflect growth in the contribution to Social Care and the continued inclusion of the iBCF.

The Better Care Fund 2022/23 has been developed to meet the national conditions of the Better Care Fund Policy Framework.

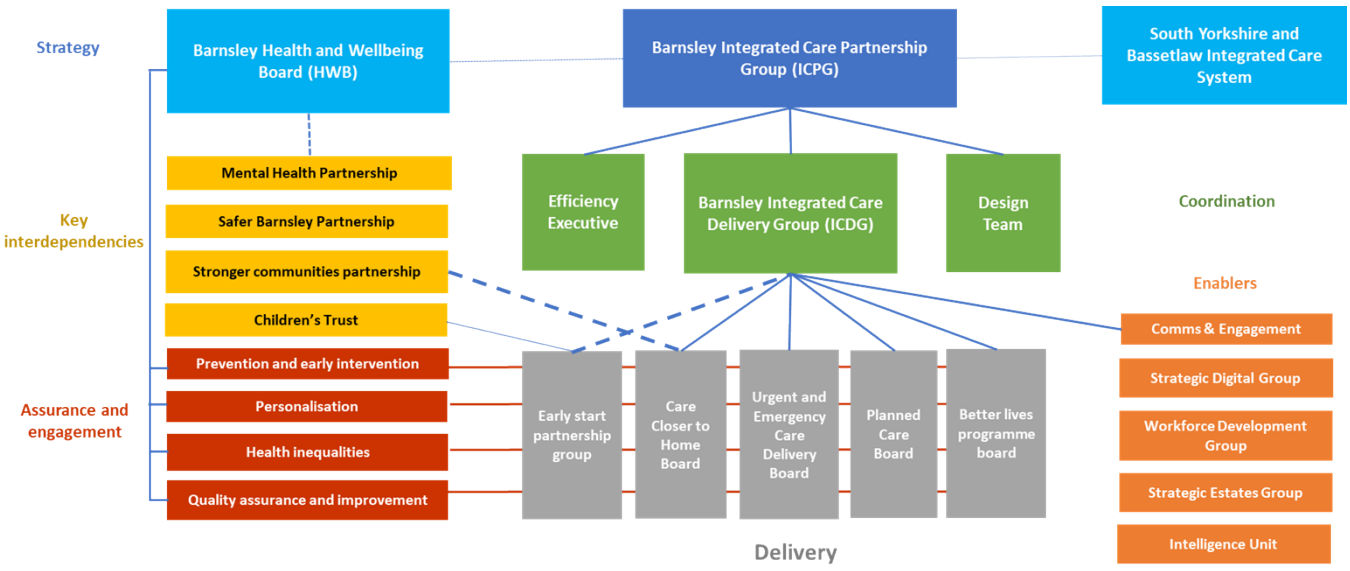
1. The Plan has been jointly agreed between local health and social care commissioners with engagement and input from other stakeholders including members of the Health and Wellbeing Board and Integrated Care Partnership
2. The NHS contribution to adult social care has been increased in line with the uplift to the CCG minimum contribution allowing for continued investment in all schemes and offsetting cost increase and pressures in Social Care
3. Investment in NHS commissioned out of hospital services is significantly above the minimum required ensuring support is available for those who need it to avoid unnecessary admission to hospital or to recover following an hospital admission.
4. The BCF plan and schemes include key services that support our discharge model and approach to support safe and timely discharge including our embedded home first, discharge to assess model – implementing the BCF policy objectives of enabling people to stay well, safe and independent at home for longer, and providing the right care in the right place at the right time.

Governance

The strategic governance arrangements for the Better Care Fund remain the same as in recent years with oversight being provided by the Health and Wellbeing Board and the BCF being managed within the governance structures of the Health and Wellbeing Board.

The BCF programme will be overseen by the Health & Wellbeing Board, supported by the Integrated Care Place Partnership Board and Delivery Group who will take responsibility for ensuring delivery against our plans and achievement of our priorities.

In our planning work we recognise the interdependencies with other partnership groups and forums. The diagram below shows this overall governance structure and the interdependencies, illustrating how we will organise ourselves to deliver:



A robust programme management approach has been established to support the delivery of our plans with each of the Delivery Groups (shown in the grey boxes) having clear priorities and plans against which delivery is monitored and reported on a regular basis to the Place

Partnership Delivery Group and in turn any risks or issues identified for escalation are reported to the Integrated Care Place Partnership Board and through to the Health and Wellbeing Board as appropriate.

The section 75 agreement remains in place and sets out the detailed management arrangements for the BCF plan including how financial risks associated with the services commissioned using the BCF will sit with the commissioning organisation and be managed as part of their financial management arrangements.

Each organisation has robust risk management arrangements in place with corporate risk registers identifying the most significant risk to the organisation. Where risks relate to the services which are funded from the BCF, these are managed and contained by the commissioning organisation in the first instance but where the risks may have a wider adverse impact, these are escalated through the PMO arrangements described above.

Overall BCF plan and approach to integration – Implementing the BCF Policy Objectives

Barnsley has a long history of partnership working across health and social care and is proud of its integration journey, embracing the Health Act flexibilities to develop pooled budgets, joint commissioning arrangements and integrated provider roles, ahead of many other areas.

The 2022/23 Better Care Fund Plan builds on previous plans and continues to be set within the wider context of the Health and Wellbeing Strategy and Barnsley Integrated Care Partnership Health and Care Plan for 2022/23, contributing to delivery of the key priorities and enabling us to move towards our overall vision for Health and Wellbeing and integration.

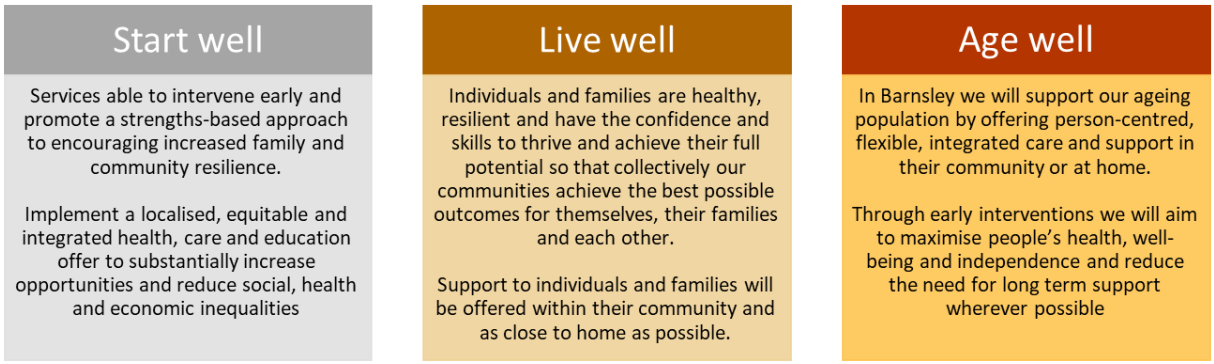
We feel that it is important that our plans are considered within this context to ensure that our efforts are coordinated and that our plans come together to maximise the impact that we are able to make across the whole system for the benefit of Barnsley residents.

The Barnsley 2030 Plan sets out our collective long-term vision and ambition for the Borough. A key theme of Barnsley 2030 is Healthy Barnsley, and the ambition is that everyone in Barnsley is able to lead a good life in good physical and mental health, with everybody having a sense of self-worth. The Barnsley Health and Wellbeing Board is the key delivery board for the Healthy Barnsley theme of Barnsley 2030.

Our Vision for a Healthy Barnsley, as set out in the Barnsley Health and Wellbeing Strategy 2021 – 2030: The Place of Possibilities is that:

All Barnsley Residents are enabled to enjoy long, fulfilling and healthy lives in safe, strong and vibrant communities where every person is equipped with the skills and resources they need to thrive.

The Strategy is set out how we are adopting a life-course approach to improving health and wellbeing and creating a system that is accountable for health outcomes and all determinants of health and wellbeing. We have split this ‘life course’ approach into 3 elements:



Our goal is to dismantle boundaries at the point of delivery of care. These boundaries exist because of the complexity of separate funding, multiple contracts, different organisations with different accountabilities, responsibilities and regulators.

We want people who use our services to be supported and empowered by what feels like 'one team', each delivering their part without duplication along common pathways of care. One team that is responsible to the people of Barnsley.

Above all we want to improve the quality of life of people in Barnsley and reduce the inequalities that exist in health and wellbeing outcomes. We want to better meet the needs of our population in Barnsley, preventing chronic illness, deaths from preventable causes and see a rise in the number of individuals making informed decisions about their care and support alongside health and care colleagues.

The vision of integration in Barnsley is fully aligned to and supports us in delivering the BCF policy objectives:

1. Enable people to stay well, safe and independent at home for longer
2. Provide the right care in the right place at the right time.

The vision and principles have become well established and in many respects integrated ways of working are now seen as 'business as usual' for delivering the right service, at the right time and in the right place and a number of the BCF schemes as well as other established core services are delivered in an integrated way bring health and social care providers together to best meet the needs of individuals.

The vision for integrated care in Barnsley is for:

- An integrated joined up health and care system where people of Barnsley experience continuity of care
- A shift in focus on treating patients with health problems to supporting the community to remain healthy in the first instance
- Patients and their families are supported and empowered by what feels like "one team" each delivering their part without duplication
- Integrated care that delivers the best value for the Barnsley pound

The principles that come with such a vision include:

- System leadership covering the whole system
- A population health based approach
- Person centred and asset based ways of working with people and communities
- Care delivered closer to where people live

- Focus on staying well, prevention and self-care
- A single whole population budget to maximise use of resources

Barnsley is now embarking on its next step of the integration journey and building a stronger Integrated Care Place Partnership for Barnsley, as one of the four place partnerships in our wider South Yorkshire Integrated Care System, working with the South Yorkshire Integrated Care Partnership and Integrated Care Board. The Barnsley Integrated Care Place Partnership brings together commissioners and providers of health and care services in Barnsley to design and deliver integrated services for patients and deliver improved health outcomes for the Barnsley population.

The Barnsley Health and Care Plan 2022/23 sets out our local priorities, reflecting our partnership of health and social care and focus on wider determinants. In determining our priorities we also identified a series of cross-cutting themes. These are also priority areas but the delivery of these priorities span all parts of our system.

Our 4 priorities and 'plan on a page' is set out in the diagram below:

Sitting beneath our priorities are 26 deliverables that are our immediate priorities for the integrated care place partnership. These are included in the table below:

Growing our workforce	Launch Barnsley CARE academy to support employers with recruitment, pre-employment training and work experience and work with education and training providers to put in place provision that supports quality care and career development. Deliver a series of joint online recruitment fairs online and face to face targeting deprived communities and those under-represented in our workforce. Increase student placements and create local enhanced pathways that provide a range of experiences across different settings and services, promoting Barnsley as a great place to start or continue a career in health and care

	Work as a network of employers and with employee networks to share and develop best practice in employee assistance and support, leadership development and talent management that is inclusive. Create a five-year workforce plan for Barnsley place with Health Education England and following principles of population health management.
Strengthening our joint approach to prevention	Create a joint strategy for prevention and early help across three tiers – self/guided, one-to-one and directed Continue to proactively contact those identified as most vulnerable in our communities and offer support – finance, emotional health and wellbeing, warms home, weight management, physical activity and falls Continue to build community capacity and alliances that can offer preventative support and embed this offer into local care pathways Work with industry partners to deliver the BETA service evaluation for Stride – a digital pathway that aims to prevent and reverse Project Stride Through the Heart Health Alliance, initiate a programme of targeting blood pressures checks in community settings beginning in our most deprived neighbourhoods and reintroduce targeted health checks
Improving equity of access	Expand and grow the Children and Young People's single point of access for emotional and mental health wellbeing Develop our access model for community and adult social care with appropriate professional input to maximise customer experience Continue our work with iUEC to improve access to urgent treatment and emergency care Work to improve crisis care including the creation of "safe space" Establish the lung health checks service Create a community diagnostics hub at the Glassworks Expand patient initiated follow up (PIFU) and virtual appointments to improve access and experience for service users and staff Implement new ways of working to increase capacity and reduce the backlog in elective care Community reablement pathways and continue to embed strengths-based practice in our approach

	Continue to embed new roles in primary care to enable earlier access
Joining up care and support for those with the greatest need	Develop a strategy and delivery plan to develop closer working between the excellent maternity and early years services Fully implement the recommendations from the recent review of support for special educational needs and disability Phase three of the neighbourhood teams mobilisation including community mental health and social care Create a personalised care team in primary care to provider person-centred support including social prescribing, health and wellbeing coaching and care coordination Create care pathways for eating disorders and personality disorders Coordinate the local response to the national virtual ward initiative building on the strong service provision in Barnsley and increasing specialist input into community and primary care

The Better Care Fund (BCF) Plans since 2014/15 have played a key role in helping Barnsley with its integration journey, being delivered within the wider context of our Health and Wellbeing Strategy and Barnsley Health and Care Plan enabling core health and care services to support one another and function as a united approach, to help reduce the pressures on acute services and residential care.

Our Better Care Fund in Barnsley is used to fund services commissioned by the NHS South Yorkshire Integrated Care Board and Barnsley Metropolitan Council with the overall BCF plan being supported by a range of services which form part of the wider integration plans being taken forward by the Integrated Care Place Partnership. The funding from the BCF remains broadly consistent in 2022/23 with that of previous plans to ensure sustainability of those health and social care services and is predominantly focussed upon out of hospital NHS services and Social Care services. The level of funding has been enhanced in 2022/23 to reflect growth in the contribution to Social Care and the continued inclusion of the iBCF.

There is a clear correlation between schemes included within our 2022/23 BCF plan and the wider health and care priorities identified above. Examples of schemes which specifically help people to maintain independence in their own home, prevent hospital admission by providing earlier intervention or support discharge processes and minimise delayed discharges include:

- Residential and domiciliary (Home) care services – ensuring capacity is in place to continue to deliver high quality care and meet the needs of those people requiring services when they are required.
- Services to support carers, including access to advice and guidance, respite and other support including personal budgets.
- Equipment and adaptations – including use of digital technology and new equipment to maximise capacity of the carer workforce.

- Increased Occupational Therapy to provide timely therapy assessments which support individuals to maintain independence through the use of aids, adaptations and equipment as well as inform the provision of care input.
- Extra care housing provision linking care and support services with housing support .
- Reablement support to help people to regain confidence to maintain independence.
- 7 day Social Work to support discharge planning and ensure timely provision of care packages (links to D2A pathways)
- Intermediate care (Step up and Step down) bed based and community/home based
- Falls Services – linking with the other services to increase the provision of physical activity, strength and balance and falls prevention services across Barnsley.
- Neighbourhood Nursing (including Urgent Crisis Response) to ensure people continue to receive response care and support within their own home.

The work taking place through our Care Closer to Home Board is ensuring that a collaborative approach is taken to commissioning and development of services and pathways linked to many of the schemes identified above.

The Intermediate Care model is a good example of collaborative commissioning with the ICB and Local Authority working together to commission all elements of the service including community elements and beds in our Acorn Unit which is based within an independent sector care home. Reflecting the collaborative approach to Intermediate Care Model is delivered through an alliance approach between hospital, community and primary care providers.

We have also taken a collaborative approach around falls and frailty with a proactive care group established bringing together commissioners and providers to improve coordination and access to a range of services, alongside the BCF funded Falls service to provide strength and balance activities, exercise in the community etc.

Other examples of key activities of the Care Closer to Home Board include:

- Completing the next phase of the neighbourhood teams service to deliver our community operating model, streamline and improve access to out-of-hospital care by bringing together key front-line service to deliver a multi-disciplinary single approach to assessment and provision of care and support in the community.
- Developing our approach to ‘Proactive (anticipatory) Care’ to ensure that we are prepared for delivery of the new anticipatory care requirements across all parts of the health care system in Barnsley.
- Development of integrated pathways for falls, frailty and dementia.
- Implementing a joint approach to prevention with our communities and the VCSE sector.

In Barnsley we are proud of our partnership work to support discharge from Hospital. Historically performance has been good with low numbers of delayed discharges from hospital and a low number of inpatients in in hospital for over 14 days and over 21 days.

We have regularly reviewed and self-assessed against the High Impact Change Model and during 2022/23 have built upon this further as part of the NHS 100 day challenge to ensure that no patient who is fit for discharge does not need to remain in hospital any longer than they need to. Our self-assessment, confirmed via check and challenge across South Yorkshire was that the arrangements that have been put in place in Barnsley over recent years mean that we rate as Green against each of the 10 best practice initiatives:

1. Identify patients needing complex discharge support early

2. Ensure multidisciplinary engagement in early discharge plan
3. Set expected date of discharge (EDD), and discharge within 48 hours of admission
4. Ensuring consistency of process, personnel and documentation in ward rounds
5. Apply seven-day working to enable discharge of patients during weekends
6. Treat delayed discharge as a potential harm event
7. Streamline operation of transfer of care hubs
8. Develop demand/capacity modelling for local and community systems
9. Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges
10. Revise intermediate care strategies to optimise recovery and rehabilitation

The 10 best practice initiatives correlate across the High Impact Change Model 'changes' and therefore we considered the assessment together to identify areas for further development.

To drive forward the development of our 'home first' approach and discharge processes we have a strong out of hospital operational group (Bronze Cell) who take responsibility for highlighting and escalating operational challenges, identifying solutions and improving pathways and flow through and out of hospital. This group is made up of partners from all parts of the health and care system including primary care, community care, social care, hospital, and ambulance services ensuring that all developments are agreed by all partners. Each member of the group takes responsibility for engaging with others within their organisations and ensuring formal sign off where required. All of the discharge arrangements described have the full support of all partners including hospital and community trusts and the local authority.

During 2021/22 and continuing to 2022/23 key developments have included:

- Embedding a new model of Intermediate Care and commencing a review of bed and community capacity to ensure that it continues to meet the changing needs of patients
- Embedded a robust Discharge to Assess model (see further details of model below)
- Supported the implementation of earlier discharge planning with social care involved at the beginning of the process
- Continuation of long stay Wednesdays – to review all patients who have been in hospital over 14 days to identify actions required to support discharge
- Strengthened the delivery of the Enhanced Health in Care Homes model, building on the established MDT approach ensuring input from care home staff, community services, primary care, social services and other professionals as required e.g. Health and Wellbeing Coaches.

Through the use of the BCF and other funding opportunities we have also been able to continue to support the resilience of the care market through the provision of an uplift in fees and funding to support increased payment for care staff to support with recruitment and retention and ensure that carers pay is in line with that in other sectors.

Home First/Discharge to Assess – Case Study

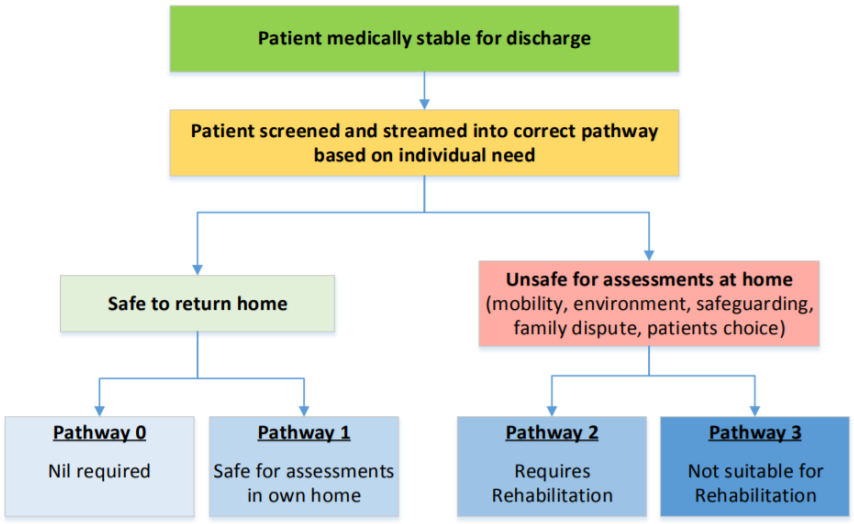
Learning from previous work to implement the High Impact Change Model for Managing Transfers of Care and utilising the guidance included in the High Impact Change Model on Patient Flow and Hospital Discharge we have established a robust Home First/Discharge to Assess model which includes:

- Early Discharge Planning
- Arrangements to monitor and support patient flow including long stay reviews and using red2green.
- Implementation of multi-agency and multi-disciplinary discharge arrangements
- 7 day community and social services arrangements to support discharge
- Development of a trusted assessor model
- Improving work with and support for care homes through implementation of the EHIC framework.

The model is made up of 4 pathways and the aim is to:

- Identify the appropriate discharge pathway based on the patient's individual needs
- Functional assessments to take place in patients own home and not in the acute hospital setting
- Maintain the Discharge Hub within the acute to provide a link between the acute and community to ensure a streamlined approach and track all patient discharges

The Discharge to Assess four patient pathways are:



Supporting Unpaid Carers

Our Barnsley Carers Strategy sets out a vision that more unpaid carers in our community will be identified and recognised and have access to information, advice, and both practical and emotional support to help them achieve the outcomes which matter most to them. To enable our vision and improve outcomes for carers the BCF funding is used to contribute to a range of information, guidance and support offered to unpaid carers.

This includes the following:

- Development of a borough wide strategy, co-produced with carers, which highlights seven key priorities that pay particular attention to the carer journey and enable us to focus on the key touch points and make improvements where carers tell us they face challenges and change is needed.

- Section 2 of the Care Act (2014) gives local authorities a general responsibility to prevent needs for care and support from developing. To fulfil this responsibility the council commissions a Carers Support Service which has a strong emphasis on targeted prevention and early intervention with a key aim of preventing, reducing, or delaying carers' needs (and those that they care for) from developing and requiring support from more costly interventions. Central to this approach is a focus on delivering good quality information and advice, guidance and support to enable the carer to continue in their caring role whilst also looking after their own health and well-being and having a life of their own in terms of opportunities for work, training, education, leisure and social interaction.

- A Service is also commissioned to support young carers and siblings to prevent inappropriate caring and provide support to help them balance their caring role with their rights to be children/young people.

- The Council also offers a one-off annual payment of between £150 and to £300 to unpaid carers – this payment is to acknowledge and recognise the valuable caring role that they provide. Monitoring of the grant payments show that a large number of recipients use this payment to fund short breaks. This is currently being reviewed as part of the carers strategy and any changes to the offer to carers will be influenced by the involvement of carers in the development of the strategy.

- Barnsley Council complete more carers assessments when compared to our Y&H partners. The council use the assessment of need to identify the support that carers require to enable them to carry out their caring role and balance . As part of the assessment, support such as direct payments and respite provision are offered to carers so they are able to take a break from their caring role or purchase help and support to assist them.

Disabled Facilities Grant and wider services

The BCF is fully aligned with wider strategies including the Barnsley Housing Strategy 2014-2033. The Housing Strategy includes a specific objective to support people to live independently by improving the range of options for supported housing and providing more choice and options to help vulnerable and older people live independently in their own homes. Ambitions include ensuring extra care provision is fully integrated into the wider health and care pathways and that there is access to aids and adaptations across all tenures.

The BCF in 2022/23 has been developed with input from both housing strategy (DFG) lead and Berneslai Homes to ensure that the BCF Plan continues to contribute to ambitions and objectives of the overall housing strategy and that the delivery of the housing strategy also contributes to improving health outcomes for Barnsley residents through more joined up approaches and effective use of DFG. The BCF continues to support the delivery of housing strategy ambitions through the aids and adaptations and community home loans services and the ongoing funding to provide 24/7 onsite care provision in extra care housing schemes.

DFG Policy is aligned to the ambitions of the H&WB Strategy and BCF and aims to support people to live independently within their own home and to return home. The DFG policy and use of the DFG funding has been agreed by the Local Authority as the housing authority in Barnsley.

The Disabled Facilities Grant (DFG) provides funding (or fund works and adaptations) to help disabled and elderly people to live independently in their own homes. Means tested funding is provided to home owners or tenants to make the adaptations. The DFG policy identifies the additional help and flexibility the Council will offer in relation to providing home adaptations for disabled people in the future.

The policy also allows for aids and adaptions to be undertaken for people who are supporting people with their care needs as part of the shared lives programme, helping people to receive care and support in a home based setting rather than in hospital.

A number of the services and schemes funded through the BCF and aligned to the specific funding for DFG related services, including Community Home Loans, Equipment and Adaptations and Occupational Therapy aim to ensure that people are able to quickly access the support they need to maintain their independence. Increased occupational therapy support is key to maximising the effectiveness of aids, adaptations and equipment funded through the DFG and through the assessment processes are able to ensure that people are given the best solutions to meet their needs.

A new programme commenced in 2021/22, but running into 2022/23, to target better use of digital technologies, aids and adaptations. This area has moved forward in recent years and Barnsley wants to look at how promoting assistive technology and supporting innovation we can improve the way people are supported. We will be looking at use of technology around dementia support, manual handling and options that will promote greater levels of independence. We plan to work with providers and new businesses to help bring to market new ideas and approaches.

Better links have been made with the Housing Teams and the new Housing Strategy includes significant investment to address fuel poverty. Fuel poverty is a key issue amongst private rented accommodation and contributes to excess inter deaths.

Equalities and Health Inequalities

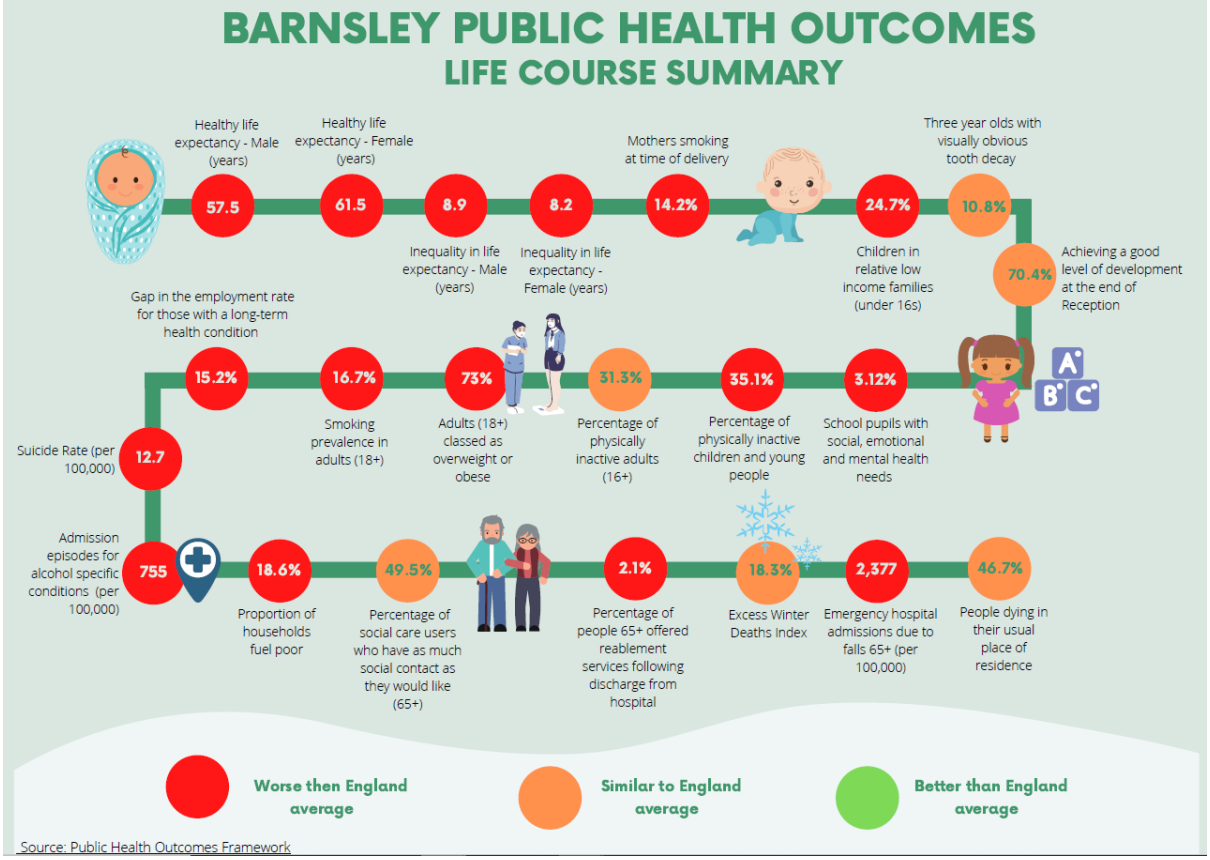
We know we have an issue in relation to health inequalities in Barnsley and we also recognise that making real progress will not always happen quickly and therefore our priorities remain consistent with 2021/22 and the longer-term Barnsley 2030 plan.

Barnsley is the 39th most deprived local authority area in England. Inequalities in social and economic circumstances are key drives of inequality in health and health outcomes. This means residents of Barnsley are more likely to experience ill-health, multi-morbidity, and earlier death from preventable illnesses than the average across the country. This in turn correlates to higher levels of hospital attendance and admission and higher demand on healthcare services to support people with long term conditions.

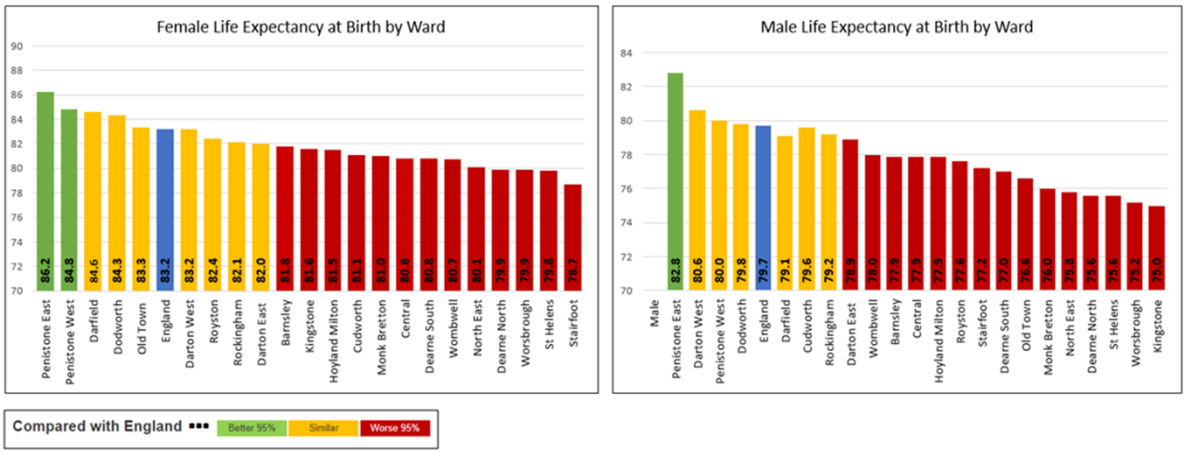
The BCF in Barnsley and the services funding through the BCF are all aimed at supporting people to maintain independence (social care, falls prevention, supported housing), recover from illness (through rehabilitation and reablement) and received the ongoing care and support that they need whether that be in their own home or in a long-term residential care setting. When commissioning services or developing schemes either as part of the BCF or wider commissioning work, engagement activity and equality, inequality and quality impact

assessments are a core feature of our approach to developing business cases and specifications.

The diagram below provides a life course summary of health outcomes in Barnsley and demonstrates some of challenges we face.



There are also inequalities between communities in Barnsley. This is illustrated in the chart below which shows the different in life expectancy by ward.



Life Expectancy at Birth for the latest period available at Ward level is 2015-2019.
Life Expectancy for Barnsley is 1.4 years less than the **England average** for Females and 1.8 years less for Males.
Inequality in life expectancy: For Females, there is 7.5 years difference between the wards with the highest and lowest life expectancy at birth. For males this difference is 7.6 years.

To support our work and also to ensure that action is focussed in the right areas the Barnsley Place Partnership has established a Health Inequalities Action Group (HIAG) with representatives from secondary care, local authority, community health, mental health, and primary care. The group is chaired by a consultant in public health and reports into the Place Partnership Delivery Group and is responsible for developing our framework to reducing healthcare inequalities in line with the core 20 plus 5 approach.

Health Inequalities leads (Exec Director Leads) from across the partnership, have supported the development of our a three-tier framework to embed action on health inequalities across partner organisations and programmes and linking to Barnsley 2030 ambitions and underpinned by a gradual shift of focus and investment from treating advanced illness to keeping people happy and healthy.

For tier one our approach is to use data and insights to identify groups within our population who are experiencing health inequalities, engage representatives in rich dialogue that starts with the assumption that the majority of solutions lie with individuals and within their communities, and then devise a series of initiatives that will improve how health and care organisations serve their needs. This work sits with the Care Closer to Home Board predominantly. Learning from Covid, one of the key areas of work currently taking place is to ensure that carers are able to receive the support they require and are able to access health and care support for themselves. This includes support to access annual health checks and work with GP practices to develop and Carers Support Quality Mark. Linked to this work we are also working with services and carers to reduce the inequalities for people with severe mental health and people with learning disabilities to access their annual health checks and immunisations.

For tier two we will use the best evidence available to determine how we prioritise access to health and care across all of our core services. This work will sit with the planned care and urgent and emergency care delivery groups predominantly.

For tier three we will work with partners to advocate for, promote and prioritise the needs of groups in our population that are currently disadvantaged. This will be achieved through our work on anchor institutions, inclusive economy, Barnsley 2030, workforce development and other areas.

During 2022 we have also commenced our participation in the national Population Health Management development programme delivered by Optum. Health inequalities is a key theme of this work as we look to target underserved communities across the Borough and within our neighbourhoods.

Running alongside the PHM programme and building upon the health index for residents created in 2021, we will build a mapping tool that shows the picture of need and inequalities across the Barnsley population using deprivation, protected characteristics and then applying the vulnerabilities index. The HIAG is also working with engagement, equality and experience leads to prioritise engagement with groups who experience health inequalities.

The HIAG is also helping organisations including Barnsley Hospital, SWYPFT, Barnsley Primary Care Network and Adult Social Care to use the framework to finalise plans and align ambitions across partners. This includes where work is taking place to further develop schemes and initiatives that are included within the BCF Plan for 2022/23.

To help us to understand the impact of our work as a partnership, and the BCF schemes on addressing inequalities, in addition to the four key metrics included in the Better Care Fund, the Care Closer to Home Board and Place Partnership Delivery Group will monitor the following measures. This will support further improvements in the programme design and delivery.

- Inequality of emergency inpatients admission for Urgent Care Sensitive and Ambulatory Care Sensitive conditions (IMD and Ethnicity)
- Inequality of rate of reablement episodes and proportion that go on to longer term care (IMD and Ethnicity)
- Neighbourhood teams caseload (IMD and ethnicity)
- Long length of stay in hospital
- A&E attendances for falls

BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.

6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

HM Government

NHS

Version 1.0.0

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Barnsley
Completed by:	Jamie Wike
E-mail:	jamie.wike@nhs.net
Contact number:	01226 433702
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	Thu 06/10/2022
If using a delegated authority, please state who is signing off the BCF plan:	Wendy Lowder - Place Director Health and Care Barnsley and SY I

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Place Director – Health & Care Barnsley Barnsley MBC & South Yo
Name:	Wendy Lowder

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Caroline	Makinson	cllrcarolinemakinson@barnsley.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Wendy	Lowder	wendy.lowder@nhs.net
	Additional ICB(s) contacts if relevant		Roxanna	Naylor	roxanna.naylor@nhs.net
	Local Authority Chief Executive		Sarah	Norman	sarahnorman@barnsley.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Wendy	Lowder	wendylowder@barnsley.gov.uk
	Better Care Fund Lead Official		Jamie	Wike	jamie.wike@nhs.net
	LA Section 151 Officer		Neil	Copley	neilcopley@barnsley.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	LA Service Director Commissioning and Integration		Andrew	Osborn	andrewosborn2@barnsley.gov.uk

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Barnsley

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£3,377,046	£3,377,046	£0
Minimum NHS Contribution	£23,080,403	£23,080,403	£0
iBCF	£13,450,589	£13,450,589	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£39,908,038**	**£39,908,038**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£6,558,796
Planned spend	£10,638,317

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£12,442,085
Planned spend	£12,442,086

Scheme Types

Assistive Technologies and Equipment	£2,929,450	(7.3%)
Care Act Implementation Related Duties	£451,200	(1.1%)
Carers Services	£1,035,000	(2.6%)
Community Based Schemes	£5,387,285	(13.5%)
DFG Related Schemes	£3,377,046	(8.5%)
Enablers for Integration	£365,000	(0.9%)
High Impact Change Model for Managing Transfer of (	£178,000	(0.4%)
Home Care or Domiciliary Care	£69,300	(0.2%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£1,822,679	(4.6%)
Bed based intermediate Care Services	£3,462,948	(8.7%)
Reablement in a persons own home	£1,672,130	(4.2%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£190,000	(0.5%)
Residential Placements	£18,231,299	(45.7%)
Other	£736,701	(1.8%)
Total	**£39,908,038**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)			

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.9%	93.4%	93.1%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	660	848

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Barnsley

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Barnsley	£3,377,046
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£3,377,046**

iBCF Contribution	Contribution
Barnsley	£13,450,589
Total iBCF Contribution	**£13,450,589**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

NHS Minimum Contribution	Contribution
NHS South Yorkshire ICB	£23,080,403
Total NHS Minimum Contribution	**£23,080,403**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£23,080,403**	

	2021-22
Total BCF Pooled Budget	**£39,908,038**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Barnsley

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£3,377,046	£3,377,046	£0
Minimum NHS Contribution	£23,080,403	£23,080,403	£0
iBCF	£13,450,589	£13,450,589	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	**£39,908,038**	**£39,908,038**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£6,558,796	£10,638,317	£0
Adult Social Care services spend from the minimum ICB allocations	£12,442,085	£12,442,086	£0

>> Link to further guidance

Checklist

Column complete:

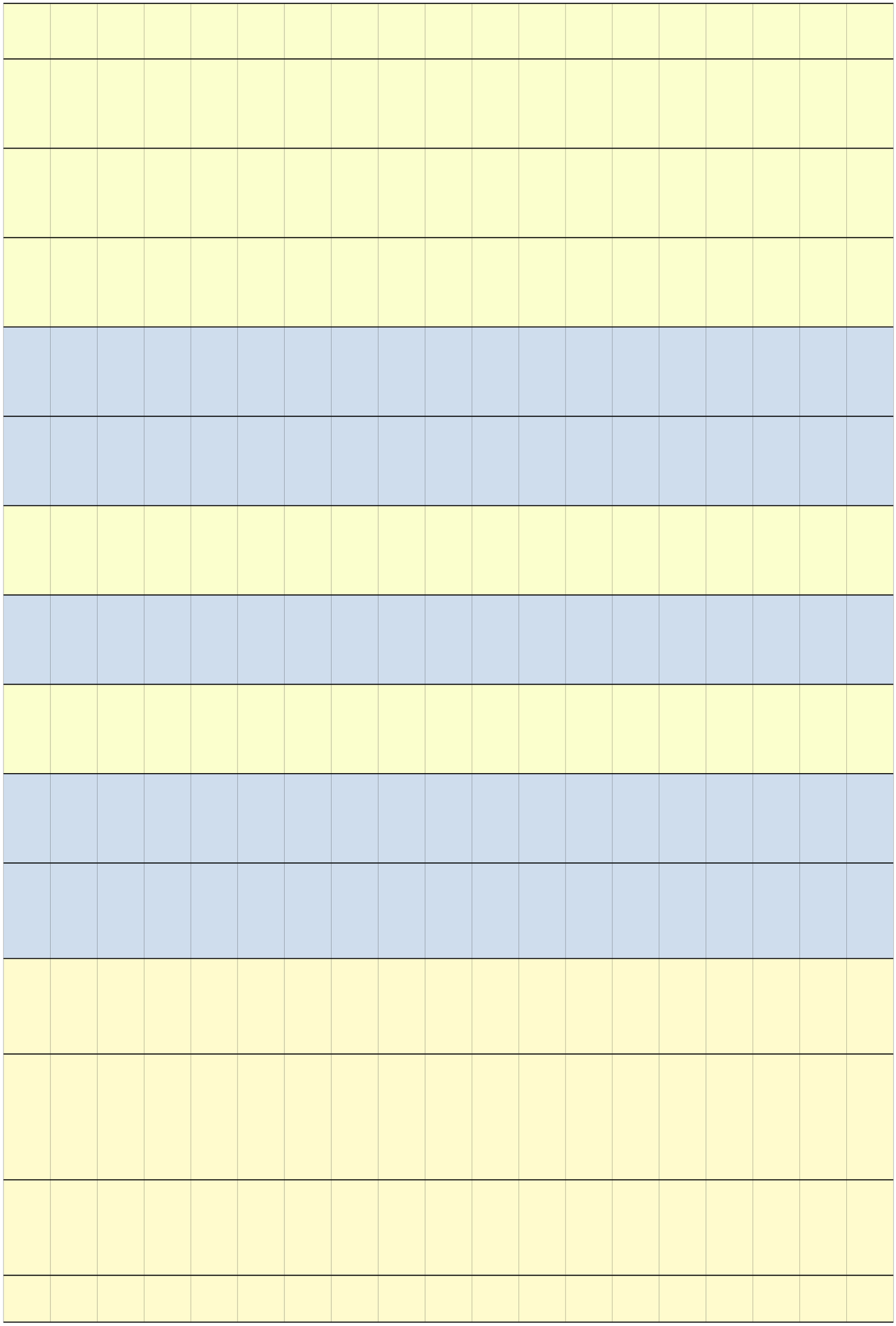
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

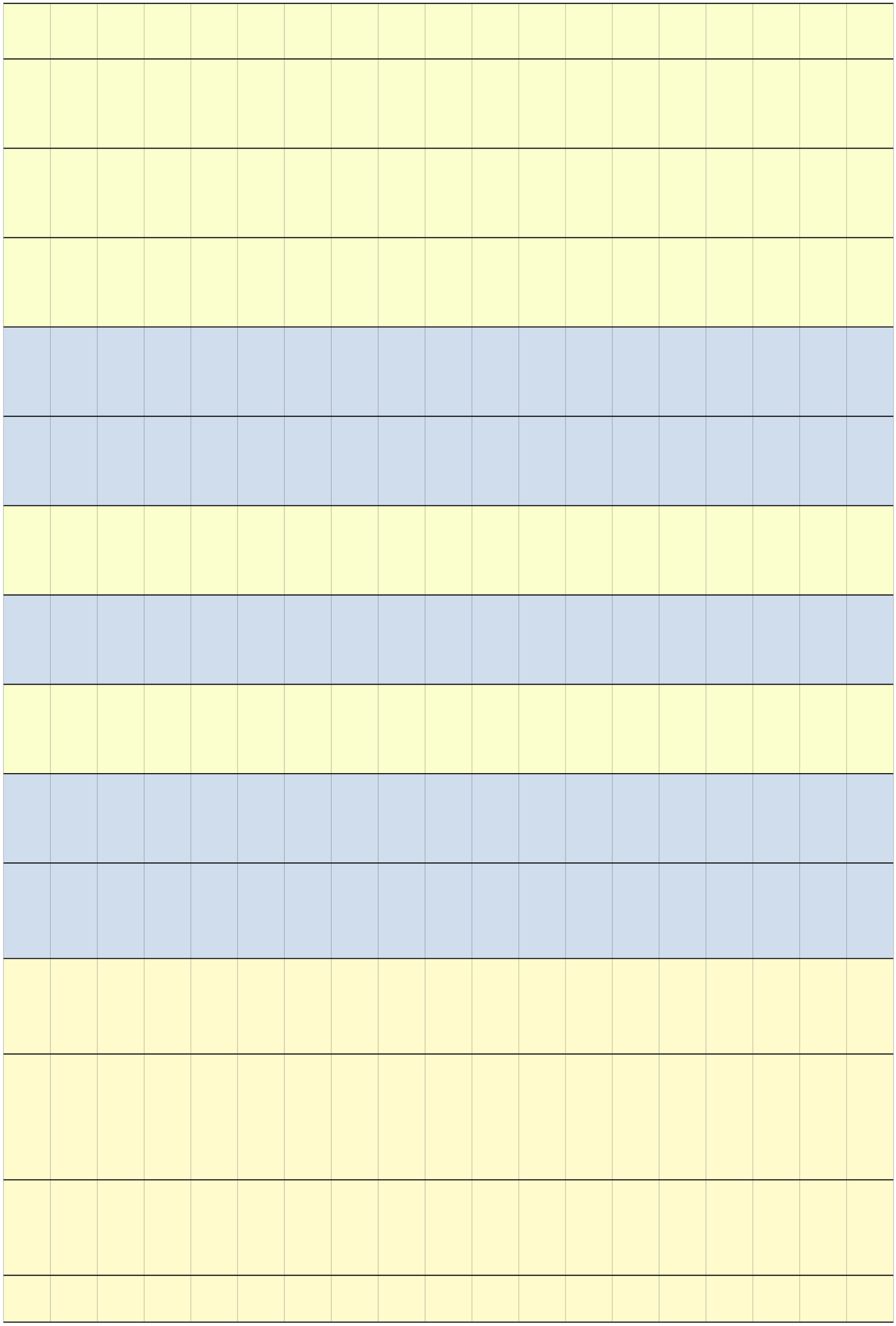
Sheet complete

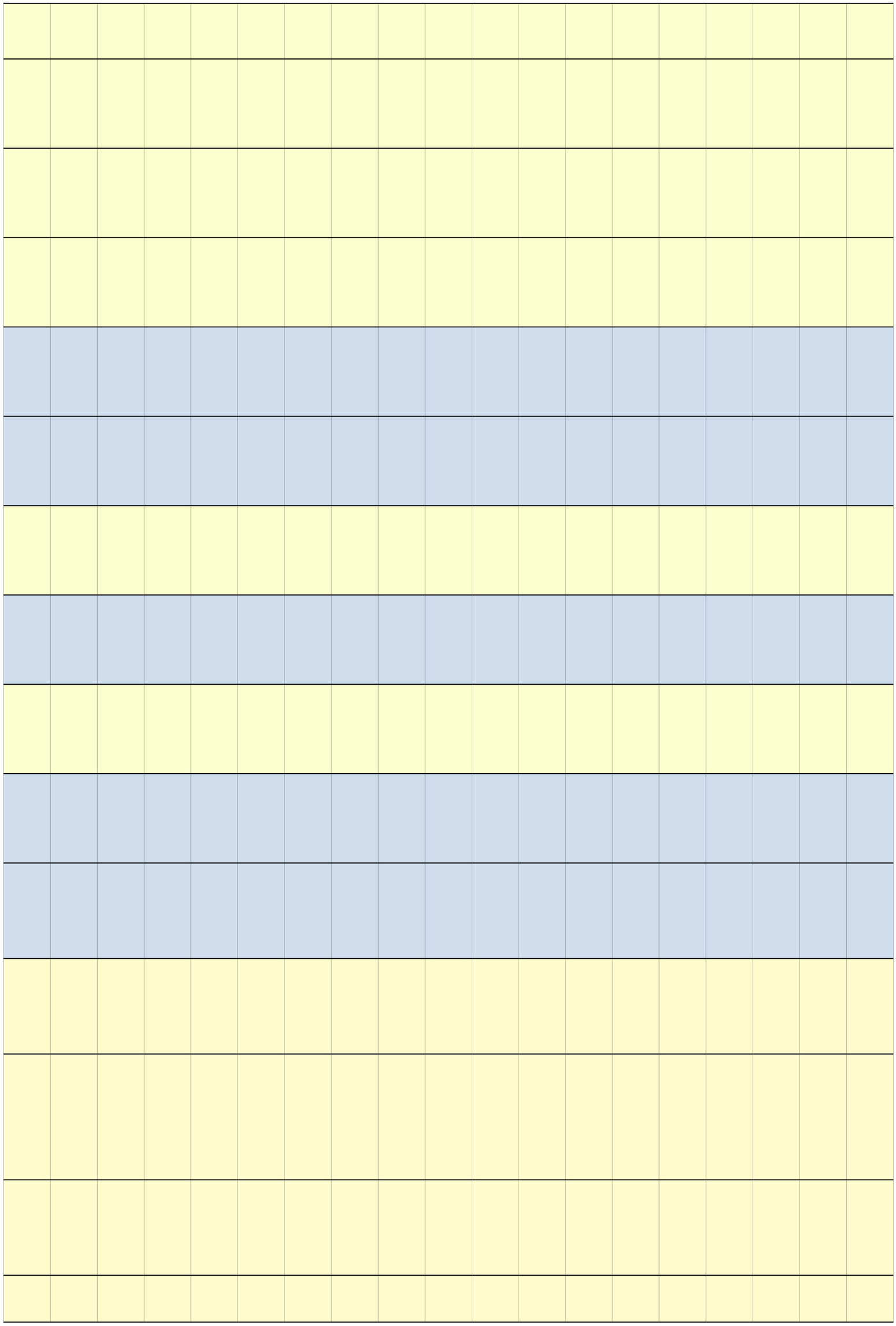
						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Long Term Care Provision	Contribution towards adult social care provision costs i.e.	Residential Placements	Care home		Social Care		LA			Private Sector	Minimum NHS Contribution	£6,837,111	Existing
2	Short term and respite provision	Short term residential provision (including support to carers and	Carers Services	Respite services		Social Care		LA			Private Sector	Minimum NHS Contribution	£810,000	Existing
3	Mental Health Community Social care team	Adult social care community Mental Health Teams; Assertive	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum NHS Contribution	£800,279	Existing
4	Other ASC provisions - LPS and	Liberty protection safeguards (LPS) team and i.e. BIAs, health	Care Act Implementation Related Duties	Other	Deprivation of liberty safeguards	Social Care		LA			Local Authority	Minimum NHS Contribution	£421,200	Existing
5	Commissioned contracts	Includes the Equipment and Adaptions contract (SWYPFT) and other	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£1,141,366	Existing
6	Reablement provision	Short-term provision to preserve the independence of people	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,294,000	Existing
7	Extra Care Housing scheme provision	wrap around care model within extra care schemes to improve the	Residential Placements	Extra care		Social Care		LA			Private Sector	Minimum NHS Contribution	£570,000	Existing

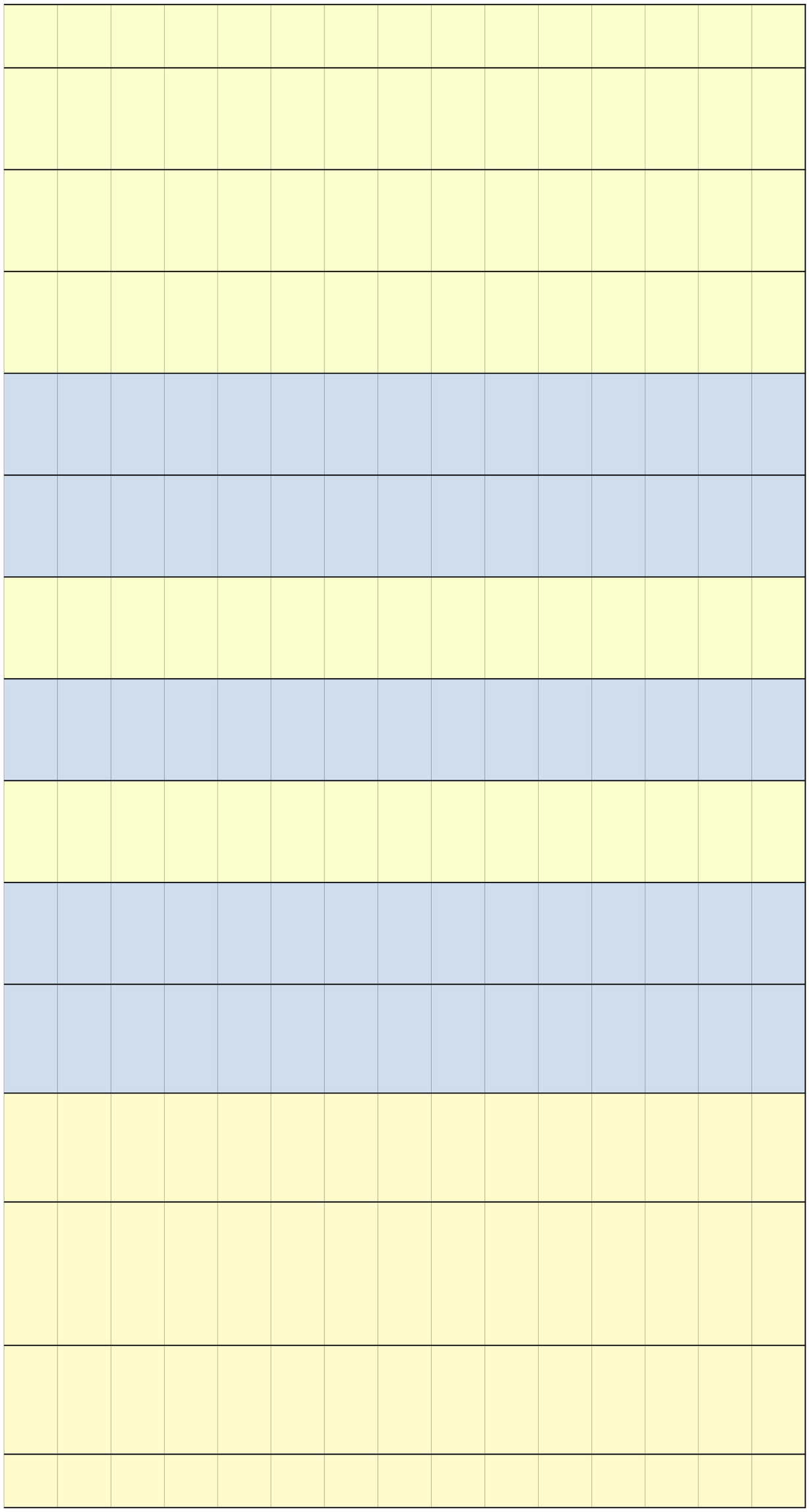
8	Community Reablement support	extend Reablement offer to all community-based referrals	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum NHS Contribution	£378,130	Existing
9	Older People - Health & Wellbeing service	improved early intervention and prevention model to	Prevention / Early Intervention	Other	provision of support for older people	Social Care		LA			Local Authority	Minimum NHS Contribution	£190,000	Existing
10	Long term care provision (Older People)	contribution to core funding to cover demographic and	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£6,965,188	Existing
11	Long term care provision (Learning	contribution to core funding to cover demographic and	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£2,609,000	Existing
12	Long term care provision (Mental Health)	contribution to core funding to cover demographic and	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£1,250,000	Existing
13	Uplift in weekly fees - stabilisation of the care market	address ongoing pressures for a sustainable fee payment	Enablers for Integration	Other	residential care fee uplift	Social Care		LA			Private Sector	iBCF	£300,000	Existing
14	Increased contract management capacity -	effective management of care contracts and maintaining effective	Enablers for Integration	Other	supporting the care market	Social Care		LA			Local Authority	iBCF	£65,000	Existing
15	7 days hospital social work team - Reducing delayed	to ensure timely discharge of people requiring care / support	High Impact Change Model for Managing Transfer	Flexible working patterns (including 7 day working)		Social Care		LA			Local Authority	iBCF	£120,000	Existing
16	Maintaining care provision (OP Review team +	Mainstreaming the Review Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£317,500	Existing
17	Increased service management	expand management to cater for the size and complexity of the service	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£330,500	Existing
18	Support for carers (incl care centre model)	provision of personal budgets for carers and the development of a	Carers Services	Other	personalised budget and information,	Social Care		LA			Private Sector	iBCF	£225,000	Existing
19	Community Bridge Building	improve access / signposting to community and	Care Act Implementation Related Duties	Other	information, advice & guidance	Social Care		LA			Charity / Voluntary Sector	iBCF	£30,000	Existing
20	Increased social worker / hospital team capacity	Increasing social work capacity in the locality / hospital teams including	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£374,400	Existing
21	Increased Occupational Therapist	additional OT capacity in the Reablement team	High Impact Change Model for Managing Transfer	Early Discharge Planning		Social Care		LA			NHS Community Provider	iBCF	£58,000	Existing
22	Homecare Bridging contract	To act as a provider of last resort in the event of increased demand	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£69,300	Existing
23	Increased domiciliary / residential care	additional care packages to meet increased need	Other		additional care packages	Social Care		LA			Private Sector	iBCF	£736,701	Existing
24	Disabled facilities grant funded schemes	housing adaptations, minor equipment, DFG team	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£3,377,046	Existing
25	Intermediate Care	Intermediate Care Services	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Acute Provider	Minimum NHS Contribution	£2,802,960	Existing
26	Intermediate Care	Intermediate Care Services	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£4,634,199	Existing

27	Intermediate Care	Intermediate Care Services	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum NHS Contribution	£659,988	Existing
28	Falls service	Prevention and support service	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£140,244	Existing
29	Community home loans	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£473,599	Existing
30	Equipment and adaptions	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,314,485	Existing
31	Neighbourhood Nursing Team	Prevention and support service	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£612,842	Existing









Further guidance for completing Expe

National Conditions 2 & 3

Schemes tagged with the following will count towards th

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribu

Schemes tagged with the below will count towards the p

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, o
- **Source of funding** selected as 'Minimum NHS Contribu

2022-23 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes

5	DFG Related Schemes
6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
18	Other

nditure sheet

ıe planned **Adult Social Care services spend** from the NHS min:

ution'

planned **Out of Hospital spend** from the NHS min:

nly the NHS % will contribute)
ution'

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other
1. Respite Services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other

1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other
1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

1. Step down (discharge to assess pathway-2)
2. Step up
3. Rapid/Crisis Response
4. Other

1. Preventing admissions to acute setting
2. Reablement to support discharge -step down (Discharge to Assess pathway 1)
3. Rapid/Crisis Response - step up (2 hr response)
4. Reablement service accepting community and discharge referrals
5. Other

1. Mental health /wellbeing
2. Physical health/wellbeing
3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of ‘home ward’ for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Barnsley

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	344.7	304.5	342.8	296.9	Work to reduce avoidable admissions has seen a positive impact on admissions for ambulatory care sensitive condition in Barnsley and latest data shows a slight decrease in admissions and therefore the ambition is to maintain this reduction through 2022/23. The Q4 ambition is higher than the reported figure in 2021-22 but is reflective of longer term trends which indicate that the low figure was unusual given the winter period.	Through the work of the Care Closer to Home Board and the Proactive Care Group we continue to deliver services and initiatives aimed at preventing admission - examples include activity to support those with frailty such as access to physical activity. The Rightcare Barnsley Service and IC and reablement step up offers also continues to support people in their own homes or the community by providing access to apporpriate community support.
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value	325	287	323	355		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.5%	93.3%	93.0%	92.3%	In Barnsley the rate of discharge to normal place of residence is high as a result of the comprehensive discharge pathways and community/Social Care services in place to support people to live independantly or with support. The 2022-23 plan is therefore to maintain the good levels of performance from 2021-22	Continued delivery and development of the strong discharge arrangements including D2A. Strengthening of Neighbourhood Teams approach and integtrated service delivery across Primary/Community and Social Care Services
	Numerator	6,592	6,612	6,434	5,977		
	Denominator	7,128	7,086	6,915	6,474		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)	92.9%	93.4%	93.1%	92.3%		
	Numerator	6,177	6,498	6,344	5,901		
	Denominator	6,647	6,958	6,815	6,392		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	659.7	641.1	849.5	847.7	Targets were based on adoption of new approach to screening and referrals. This has led to a significant drop in the number of people being assessed. However targets for placements was impacted by a drop in community homecare capacity and continued recovery from pandemic across the system, which increase the need for residential short term placements.	Changes to the way people access Adult Social Care will be introduced that make better use of community resources and look to promote prevention and reablement support to delay or avoid admissions
	Numerator	321	320	424	432		
	Denominator	48,660	49,914	49,914	50,959		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.5%	85.5%	90.6%	90.0%	Reablement is a key priority for ensuring the right support is offered to people and we are not supporting people before they need to be. Service is being supported through a development programme for adopting strength based conversations with people to change the way reablement support is offered. The plan is to maintain the high proportion of people still at home at 91 days from 2021/22	Introduce a new reablement pathway that enables all referrals for long term adults social care support to be offered reablement support. This would be supported by continued partnership / joint working with health colleagues to maximise use of reablement and intermediate care capacity to support the discharge pathways
	Numerator	124	124	126	126		
	Denominator	145	145	139	140		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Barnsley

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	H&WB Strategy Barnsley Integrated Care Partnership Place Plan		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			

Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans,

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to
- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
Data for capacity and demand should be provided on a month by month basis for the third and fourth

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as defined in appendix 4 of the BCF Planning Requirements.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists in the relevant sheet or in

The details of each sheet in the template are outlined below.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, cont
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green

england.bettercarefundteam@nhs.net

(please also each copy in your respective Better Care Manager)

If you have any queries on the template then please direct these to the above email inbox or reach out via

3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital.
You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest level of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)

- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

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HM Government

NHS

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Barnsley
Completed by:	Jamie Wike
E-mail:	jamie.wike@nhs.net
Contact number:	01226 433702
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Place Director – Health & Care Barnsley Barnsley MBC & South Yor
Name:	Wendy Lowder

How could this template be improved?	

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

[<< Link to the Guidance sheet]

[^^ Link back to top]

Better Care Fu

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board:

3. Demand

This section requires the Health & Wellbeing Board to re
Data can be entered for individual hospital trusts that ca
each trust by Pathway for each month. The template use
https://www.gov.uk/government/publications/hospital-
If there are any 'fringe' trusts taking less than say 10% of
The table at the top of the screen will display total expec
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB le
- Data from the NHSE Discharge Pathways Model.

Any assumptions made:

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
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BARNSLEY HOSPITAL NHS FOUNDATION TRUST

nd 2022-23 Capacity & Demand Template

Barnsley

cord expected monthly demand for supported discharge by discharge pathway.
re for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You w
s the pathways set out in the Hospital Discharge and community support guidance -
discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
patient flow then please consider using the '**Other**' Trust option.
ted demand for the area by discharge pathway and by month.

vel from NHS plans for 2022-23

Totals Summary (autopopulated)	Oct-22
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	2018
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	190
2: Step down beds (D2A pathway 2)	74
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	13

Below table completed in line with figures put forward in the Operational Planning submission earlier in the year

Demand - Discharge	
Pathway	Oct-22
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	1810
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	170
2: Step down beds (D2A pathway 2)	66
3: Discharge from hospital (with reablement) to long term residential care (Discharge to	12

assess pathway 3)	

/ill then be able to enter the number of expected discharges from

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
2041	2132	1973	1591	1840
154	156	165	140	139
72	85	94	65	54
7	10	7	12	41

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
1831	1912	1770	1427	1650
138	140	148	126	125
65	76	84	58	48
6	9	6	11	37

Better Care Fund 2022-23 Capacity & Dema

3.0 Demand - Community

Selected Health and Wellbeing Board: Barnsley

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from commur
The template does not collect referrals by source, and you should input an overall estir
discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. T
purposes of this exercise.

Any assumptions made:	1) Unable to pr

Demand - Intermediate Care

Service Type	Oct-22
Voluntary or Community Sector Services	0
Urgent community response	1525
Reablement/support someone to remain at home	45
Bed based intermediate care (Step up)	22

nd Template

ıity sources, such as multi-disciplinary teams, single points of access or 111.
nate each month for the number of people requiring intermediate care (non-

his includes the NICE Guidance definition of 'intermediate care' as used for the

ɔvide a break down of expected referrals from community to VS/CSS services 2

Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0	0	0	0	0
1475	1525	1525	1375	1525
43	45	45	40	45
21	22	22	19	22

Better Care Fund 2022-23 Capacity & Demand

4.0 Capacity - Discharge

Selected Health and Wellbeing Board:	Barnsley

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this wil service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or av

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a pe own home. For services in a person's own home then this would need to take into accoun

Any assumptions made:	1) VCS - we do not contract with VCS orga 2) UCR referrals: Please see capacity-comr provider including hospital discharge and a not 2hr response. 3) Includes the therapy capacity to assess

Capacity - Hospital Discharge	
Service Area	**Metric**
VCS services to support discharge	Monthly capacity. Number of new clients.
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.

Template

acute hospital. You should input the expected available capacity to support

ll be (Caseload*days in month*max occupancy percentage)/average duration of

erage length of stay in a bedded facility

rcentage? This will usually apply to residential units, rather than care in a person's
t how many people, on average, that can be provided with services.

nisations and therefore are unable to quatify
nunity section for the total capacity. UCR accept referrals from any
a range of non-hospital discharge referrals. IV first infusion excluded as

patient on hospital discharge (pathway 1b), who, then decide which

Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0	0	0	0	0	0
See comm cap	See comm cap	See comm cap	See comm cap	See comm cap	See comm capacity tab
435	415	435	435	385	435
66	64	66	66	60	66
0	0	0	0	0	0

Better Care Fund 2022-23 Capacity & Demand

4.2 Capacity - Community

Selected Health and Wellbeing Board: Barnsley

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expecte

You should include expected available capacity across these service types for eligible refer services to support recovery, including Urgent Community Response and VCS support. The

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this wil service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or av

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a pe own home. For services in a person's own home then this would need to take into accoun

Any assumptions made:	1) VCS - 0 - we do not commission VCS org

Capacity - Community	
Service Area	**Metric**
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.
Urgent Community Response	Monthly capacity. Number of new clients.
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.

Template

ed available capacity across the different service types.
rals from community sources. This should cover all service intermediate care
template is split into 5 types of service:

ll be (Caseload*days in month*max occupancy percentage)/average duration of

erage length of stay in a bedded facility

rcentage? This will usually apply to residential units, rather than care in a person's
t how many people, on average, that can be provided with services.

ganisations and therefore can not quantify 2) UCR referrals via RCB from

Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0	0	0	0	0	0
1800	1890	1950	1950	1760	1950
See Capacity -	See Capacity -	See Capacity -	See Capacity -	See Capacity -	See Capacity - Discharge tab
37	36	37	37	33	37

5.0 Spend

Selected Health and Wellbeing Board:

5.0 Spend
This sheet collects top line spend figures on intermediate care which includes: - Overall spend on intermediate care services (BCF and non-BCF) for the who - Spend on intermediate care services in the BCF (including additional contrib These figures can be estimates, and should cover spend across the Health and beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	£8,447,147
BCF related spend	£8,097,147
Comments if applicable	

3 Capacity & Demand Template

Barnsley

le of 2022-23
utions).
Wellbeing Board (HWB). The figures do not need to be broken down in this template

Only funding not included within BCF is health funding to provide for additional step up bed capacity in independent sector residential care

BARNSLEY MENTAL HEALTH PARTNERSHIP ANNUAL REPORT 2021 - 2022

Barnsley – the place of possibilities.

BARNSLEY Metropolitan Borough Council

Foreword

“Partnership is not a posture but a process - a continuous process that grows stronger each year as we devote ourselves to common tasks.” John F. Kennedy

Barnsley’s Mental Health Partnership (MHP) was established by the Health and Wellbeing Board to drive improvements in mental health across the borough. The partnership brings together leaders from across Barnsley, with the aim of working collaboratively to improve mental health and wellbeing for all, by adopting a system wide focus on the prevention of the onset of mental health problems whilst ensuring that services are able to meet the needs of people with mental ill health with empathy and compassion.

As a partnership, we recognise that everyone has mental health and wellbeing and therefore anyone can suffer from mental ill health. However, one of the guiding principles of the partnership, and indeed of the Health and Wellbeing Board, is that just like physical health, mental wellbeing is closely linked to inequality within society. This is why we’re focussed not only on improving clinical services for people with mental health conditions, but also taking action on the social determinants of mental health and adopting a public mental health approach to attempt to prevent mental health issues occurring in the first place. This report highlights some of what we have done to support peoples’ mental health from early intervention and prevention right through to improving our response to mental health crisis over the last 18 months.

This is the first annual report of the MHP and it highlights some our key achievements since the partnership’s inception in January 2021. This report isn’t the sum of everything that has been achieved to improve mental health in Barnsley in the last 18 months, it is a snapshot of the key achievements of our partners. We’ve brought together a series of case studies, which highlight the collective impact our partners have had over the last 18 months.

During the time since the MHP has been in existence, we’ve been responding to, and beginning to recover from, the Covid-19 pandemic which has undoubtedly placed an additional strain on the mental health and wellbeing of Barnsley residents. In turn this has created an increased demand for support services, many of whom have simultaneously experienced staffing shortages. Despite services being stretched, they have continued to provide outstanding care and support to the people of Barnsley, and I hope this report goes some way to demonstrating the incredible dedication of our services within the borough. I want to use this opportunity to thank all partners for their commitment and hard work to improving outcomes for residents of Barnsley, in some of the most challenging circumstances.

Adrian England, Independent Chair, Barnsley Mental Health Partnership

Mental Health in Barnsley

Barnsley's Joint Strategic Needs Assessment (JSNA) provides a picture of the health needs of the population, including mental health and wellbeing. We have also produced a Mental Health Dashboard, which enables the Partnership to monitor a number of key performance indicators across the mental health system. Moving forward, the Partnership will use this dashboard to ensure we're delivering on our mental health strategy for the people of Barnsley. From these sources, along with the Public Health Outcomes Framework, we know that:

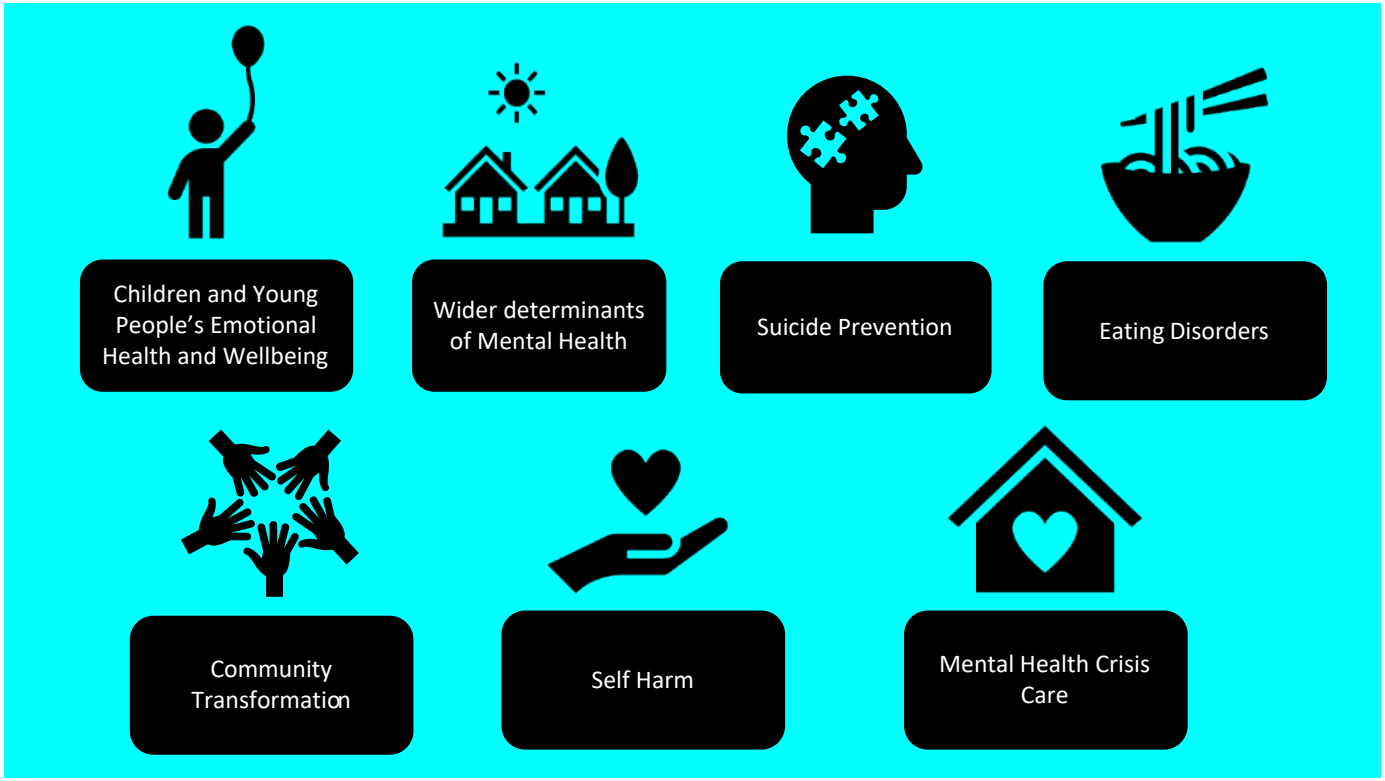
- Just under 14% of adults in Barnsley have been diagnosed with depression, which equates to around 34,000 people, as of 2019/20. This number has increased year on year since 2013 /14 – which, on the face of it, suggests mental health issues in the borough may be getting worse. However, an increasing number is not necessarily a bad thing – as it suggests that more people are willing to seek support for mental health conditions, and doctors are better at identifying and diagnosing such conditions, which could imply that we're beginning to reduce the stigma around mental health in Barnsley.
- The prevalence of Serious Mental Illness (SMI) has increased slightly in 2020 / 21, to 0.8% of the population (all ages) – this figure remains well below the national and regional averages, which may represent that SMIs are being under-diagnosed in Barnsley. We have conducted a Health Needs Assessment, which analyses the physical health needs of those with an SMI.
- 7.9% of people in Barnsley report having a low happiness score, which is better than the national average. However, around 1 in 4 adults report having high levels of anxiety, this is an increasing trend that is likely to have been impacted by the Covid-19 pandemic.
- In 2021, 3.12% of Barnsley school pupils report having social, emotional and mental health needs; which is higher than both regional and national averages.
- Hospital admissions as a result of self-harm for 15 – 19 year olds remains significantly higher than both regional and national averages. Indeed, Barnsley has the highest rate of hospital admissions due to self-harm in the Yorkshire and Humber region. This rate increases in our more deprived communities.
- Eating disorders have been a particular area of concern since the pandemic hit. Nationally, the number of children with an eating disorder waiting to start treatment was 4 times higher in 2021. Locally, we also saw a significant increase, with access to treatment also impacted by staffing pressures.
- A key determinant of mental health is deprivation. Higher levels of overall deprivation and health inequalities exist within Barnsley, with just under 22% of our neighbourhoods being in the 10% most deprived in England.

The data above shows a disparaging picture for Barnsley. Levels of self-harm and the impact of eating disorders are notably high, whilst the percentage of school pupils with mental health needs remains a concern. However, we must take some comfort in the fact that the percentage of people who report low levels of happiness, is lower than both national and regional averages.

For many of these indicators, it is likely that the true impact of the Covid-19 pandemic is yet to be realised; and this is likely to be compounded by the cost-of-living crisis which is gripping the nation. That means that, unfortunately, we may see these indicators get worse before they get better. Going forward, the Mental Health Partnership will therefore strive to mitigate this impact for

everyone in Barnsley; with a particular focus on protecting the mental wellbeing of our most deprived and vulnerable communities. Our priorities for the next 12 months are set out below.

MHP Priorities for 2022 / 23



The Mental Health Partnership has agreed our priorities for 2022 / 23 in the new Mental Health Strategy, which will be reviewed annually.

Our key priorities for improving mental health in Barnsley throughout 2022 / 23 will be:

- Improving children and young people's emotional health and wellbeing.
- Acting on the wider and social determinants of mental health.
- Suicide prevention
- Eating disorders
- Community transformation
- Self-harm
- Mental Health Crisis Care

These themes, along with the chapters from our mental health strategy will form the basis of our next annual report.

Our Partnership

Establishing a Mental Health Partnership was a priority for Barnsley's Health and Wellbeing Board, to help us achieve one of the key ambitions of the Health and Wellbeing Strategy: improving mental health and wellbeing in Barnsley. We have brought together leaders from across Barnsley including from organisations such as: Barnsley Council, Barnsley Hospital, Berneslai Homes, Chilypep, Healthwatch Barnsley, Mind, NHS South Yorkshire ICB (formerly Barnsley CCG), Samaritans, South West Yorkshire Partnership NHS Foundation Trust and South Yorkshire Police.

In addition, our partnership is supported by the Mental Health Partnership Delivery Group, which includes the Barnsley Mental Health Forum – to ensure the voice of patients and service users is a key part of our decision-making process.

The Mental Health Partnership and the Health and Wellbeing Board work collaboratively with other key partnership boards (Safeguarding Adults' Board; Safeguarding Children Partnership; Safer Barnsley Partnership; Children's Trust Executive Group; Barnsley 2030 Board; and the Integrated Care Delivery Group), to improve health and wellbeing outcomes for Barnsley residents.

Governance arrangements for the Partnership will continue to be reviewed, to ensure we are having the best possible impact for the people of Barnsley.

Case studies

The following section of the annual report provides a series of case studies that highlight some of our achievements under each chapter of the new mental health strategy. This isn't a comprehensive list of all our achievements, it is a summary of some of the key work that has been undertaken which highlights some of the things that have been achieved to improve mental health in Barnsley since January 2021.

Whilst we haven't been able to include all case studies that have been provided to us, we'd like to take this opportunity to thank all Partners who sit on the Partnership and its Delivery Group for the continued dedication and resolve they have shown to improve mental health and wellbeing outcomes for all people in Barnsley.

Early Intervention and Prevention

Early intervention and prevention of mental illness is at the heart of the work of the Mental Health Partnership. The Umbrella service provide an early intervention service to support people who struggle with their mental health, but don't necessarily meet the entry criteria for more clinical mental health services. Umbrella provide a range of assistance, and aim to prevent mental health issues from escalating, enabling people to thrive without requiring NHS services; this is demonstrated by the case study below:

'Tom is 22 years old, who self-referred into the service in July 2021 after visiting his GP, as he was struggling to express his emotions and was experiencing issues with anxiety. This was due to having to move back into the family home due to circumstances outside of his control, which was fuelling

his recent decrease in wellbeing. Tom also has Asperger syndrome which he was struggling with at the start of his engagement with Umbrella; he was also experiencing an increase in anxiety, felt unable to process his thoughts effectively, and was experiencing thoughts and emotions that had been suppressed since childhood.

Throughout his time with Umbrella, Tom has worked closely with his case manager to complete sessions on stress management and managing emotions. This has provided Tom with the relevant tools to handle situations that he would have otherwise struggled with and to come to terms with his diagnosis of Asperger syndrome.

One to one sessions with his case manager continued and it was identified that Tom may benefit from counselling sessions. The service prepped Tom for counselling, which enabled Tom to enter counselling with a clear idea of the issues he would like to discuss. In November 2021 he begun counselling sessions, which were delivered by the service.

Counselling has given Tom the much-needed space he craved to process his thoughts and express his emotions in a way that felt safe. He has been able to discuss unresolved issues from the past and work through his present day feeling of anxiety. This combined with continued one to one support from his case manager has given Tom a better understanding of his Asperger syndrome and how that impacts on thought processes. He has explored techniques that he can use when feelings of panic rise and mindfulness has become an outlet for Tom, which he is using outside of sessions.

Tom has now come to the end of his counselling sessions and during a recent review, he has expressed that he feels ready to be discharged from service. Through his time working with Umbrella, we have seen a reduction in Tom's anxiety and low mood and an increase in his confidence. We feel that delivering this support at an early stage has reduced the need for higher level interventions.

Tom feels that the support he has received from Umbrella has allowed him to explore past issues, resolve them and move forward. He is due to move into his own accommodation in the coming weeks and is now feeling optimistic about his future, having the tools to deal with unexpected events life may bring and with more understanding of himself.'

Start Well

The emotional health and wellbeing of our children and young people is important to us and we are keen to ensure they have positive experiences during their early years through to adolescence as this helps to build resilience, contributing towards fulfilled lives and thriving communities. We work in partnership with several organisations and agencies to support the emotional health and wellbeing of children and young people. The case study below highlights the positive impact that dedicated Mental Health Support Teams have made in schools and educational establishments across the borough:

In 2021 Compass UK was awarded the contract to provide Mental Health Support Teams across Barnsley as part of a national trailblazer project designed to improve access to early mental health and wellbeing support for children and young people. In addition to working directly with children and young people, Mental Health Support Teams build partnerships in schools to encourage and support mental wellbeing and mental health awareness across the school community.

Throughout 2021/22 the Mental Health Support Teams have worked with schools and education settings across Barnsley, supporting 11 secondary schools and more than 20 primary schools through the provision of mental health and wellbeing activities relating to healthy peer relationships, physical health and mental health, as well as mental health and wellbeing awareness raising activities and workshops for parents. This has helped to promote a positive mental health and wellbeing culture within education settings by encouraging a 'whole community' approach involving pupils, students, parents, carers and staff. In Barnsley, the Mental Health Support Team has supported:

- The development of wellbeing displays, assemblies, consultation on how mental health is covered in the curriculum
- Hosting 'marketplace' events so pupils and staff can find out about local support services available
- Delivering wellbeing activities and workshops in schools with children, young people, parents and school staff

Key activities that have taken place over the last 12 months include:

- Assemblies and activities in primary and secondary schools across Children's Mental Health Awareness week, including a coffee morning for parents and carers.
- Getting active in primary schools for 'Red January' and talking about the relationship between physical activity and mental health
- Parents' coffee morning at Milefield Primary School to hear about mental health and the work of the Mental Health Support Team
  Working in primary schools in Barnsley talking about kindness and friendship as part of the Healthy Peer Relationships project

The work of the Mental Health Support Teams will continue to evolve using a 'whole school' approach to develop emotional and mental wellbeing in schools over the coming years, with an ambition to extend the offer to all primary schools, colleges and special education settings over the next 12 months and to work with school mental health leads to plan and deliver bespoke mental health and wellbeing activities in each school that recognise the unique needs of the school and pupil population.

Supporting and maintaining young people's wellbeing is an important part of their engagement, sense of belonging and their social and professional development, and helps them to reach their full potential. Chilypep are one of the local service providers who offer support for children and young people's emotional health and wellbeing in Barnsley. Their Young Commissioners group enables young people to have a 'voice' and influence how the services they use to look after and treat their mental health are run. Members address the stigma often attached to mental health using their lived experiences to tell their stories and help others who may be experiencing similar challenges. This approach reaps benefits for young people, giving them the support, skills and confidence to initiate action that will make a positive difference to their future personal and professional development, as the case study below explains.

'Chloe's journey with Chilypep began at 17 and she is now 23 years old. Through her engagement with Chilypep, Chloe developed greater resilience and coping skills, helping her deal more effectively with the difficulties she as a young person faced during key development transitions. She is now in her final year of training to become a qualified Mental Health Nurse.

Chloe found out about Chilypep and the Young Commissioners group through a flyer at Barnsley College advertising the peer mentoring project and saw some information about the group at CAMHS. Chloe took a particular interest in mental health due to her own lived experience.

Chloe had self-harming behaviours and thoughts of suicide that led to her getting support from CAMHS which helped her find more positive ways to cope. Chloe also experienced transition from children to adult mental health services. These experiences helped her support the voice of young people and influence work locally through the Barnsley 'Future in Mind' Transformation Plan.

Chilypep recognised Chloe's potential through her role as a Young Commissioner with the organisation and supported her professional development to volunteer and become a qualified Youth Mental Health First Aid Instructor. Chloe is now Chilypep's Assistant Project Worker, working alongside and supporting the new cohort of Young Commissioners. Chloe has been supported to co-deliver vital training offered to young people, schools' staff and the children and young people's workforce here in Barnsley, using skills and methods learned from her Young Commissioner's role with Chilypep, which has included adapting quickly to online teaching methods during the Coronavirus pandemic.

As a result of Chilypep's ongoing support and commitment to developing young people, Chloe now:

- Feels empowered to persevere with the ongoing support she is receiving from Chilypep staff whilst she continues to volunteer and deliver Youth Mental Health First Aid Training to the young people's workforce in Barnsley.
- Has structure and feels a valued member of the community offering continued support to Chilypep's Young Commissioner's groups
- Feels confident highlighting personal mental health issues and addressing stigma - at 17 years of age, Chloe was afraid of judgment around her lived experiences of mental illness and asked for her experiences to be anonymised to '17-year-old, female' because she felt ashamed of her struggles and was worried that it would impact on her future career prospects. Chloe is now happy to include her name and can speak openly and honestly in person to influence change, based on her lived experiences in a time where stigma is being broken down and more supportive conversations are taking place.'

Living Well and Wider Determinants of Mental Health

The Mental Health Partnership supports the view that everyone should have the opportunity to live a life with good mental health and wellbeing, regardless of their personal circumstances and where they live in the borough. However, we know that the environment in which a person is born, lives, works and ages all impact upon their mental health and wellbeing. The determinants of mental ill health often reflect inequalities within society, which puts certain groups of people at greater risk of poor mental health than others. Evidence shows the value of community-based skills and learning courses to support people with mild symptoms of mental ill health and to improve their own self esteem. The case study below, demonstrates the impact of the community learning on improving mental wellbeing, and supporting people towards employment.

'Cameron had been attending courses with Adult Skills and Community Learning for a while, studying maths and English, but was struggling with attendance and commitment. He was also trying to care for his mum and suffering from low confidence and depression due to being unable to see his young daughter.

It was suggested he enrol on a creative wellbeing course to restore his confidence and build his self-worth, so he started a course that involved painting with acrylics. He was very pleased with the first picture that he painted and remarked that he was surprising himself as he never thought he was any good at art.

The course was attended solely by men and he found that this helped him to open up about his anxieties and share his concerns and views with the other members of the group. He says "These classes are really benefitting me. I've met people who also have wellbeing issues and it makes me realise that I'm not the only one out there."

As a result of the success in his creative wellbeing course, Cameron also enrolled on a Positive Thinking course at Wellington House, which he says benefitted him greatly. He has begun to recognise his positive qualities and is using the confidence he has gained in class to try new things. He has been volunteering at the local hospital and has enrolled on a training course for construction workers. For the first time in a long while he is feeling optimistic about the future.'

Support to employers through Be Well @ Work

Being in good quality work is important for mental wellbeing: it helps give people a purpose, promotes independence and self-esteem, helps to develop social connections and reduce loneliness and is recognised as a factor in preventing both physical and mental health problems. Employers therefore have an important role to play in terms of supporting employees' mental health and wellbeing. In Barnsley, our Be Well @ Work programme provides a tailor-made health and wellbeing offer to support businesses across Barnsley. The case study below shows one business we have worked with, to enable them with supporting employees' mental health and wellbeing:

'In 2020, Barnsley Premier Leisure (BPL) achieved the silver Be Well @ Work award. Since then, BPL have committed to make improvements in a number of areas in order to work towards achieving the gold award. This has included developing a mental health strategy and policy; holding team events and activities with staff; creating an internal wellbeing website for staff; recruiting and training mental health first aiders; working towards 'Moving Mental Health Forward' accreditation and undertaking twice yearly staff wellbeing surveys.

Within the staff wellbeing survey, BPL have seen a gradual and encouraging rise in mental health disclosure and removing the stigma at work. In the last three surveys, staff were asked "do you, or would you, feel comfortable discussing a mental health issue at work?" 50% agreed in March 2021, 54% in July 2021 and 60% in January 2022. This compares to a recent BHSF report, where 48% of UK workers do not inform employers when suffering from mental health. This has been achieved through embedding the role of the Wellbeing Champion, including welfare calls to employees that may be experiencing difficulties and delivering a varied wellbeing programme.

BPL have encouraged access to the facilities and support available in their leisure venues to help staff maintain healthy lifestyles and achieve wellbeing goals. In March 2021, 64% of our staff described their health and wellbeing as "very good or good" this increased to 70% in the latest survey in January 2022, with 43% of staff agreeing that BPL had helped them to achieve their wellbeing goals.'

Ageing Well

We want everyone in Barnsley to enjoy healthy and active ageing. Age Friendly communities make it possible for people to continue to stay living in their homes, participate in the activities they value and contribute to their communities, for as long as possible. Within Barnsley, organisations and local charities such as Age UK Barnsley, Barnsley Councill Healthier Communities Team and other partners, including South Yorkshire Passenger Transport Executive, Barnsley CCG, Barnsley DAA, and Barnsley U3A have come together to create an 'Age Friendly' Barnsley. This commitment to supporting older people to live their best lives meets the aims set out in the World Health Organisation's Age Friendly Cities Framework.

During 2021-2022 we have:

- Created welcoming and supportive community spaces for local groups to gather across a range of areas, e.g., health and wellbeing related groups as well as groups for people with shared hobbies and interests such as sewing and playing the ukulele
- Taken part in Innovative Intergenerational Projects; building bug hotels, children writing letters to older people, young people making food hampers for older people
- Made changes to digital systems so that they are accessible to all, making improvements to the way people receive benefits and do their shopping
- Developed and supported age friendly projects and events, such as:

- 'Take a Seat Barnsley,' a new campaign which supports older people to get out and about through the provision of additional seating in various locations across the borough. These will be sited in a variety of settings, i.e. outdoors, urban, rural, in shops and indoor areas, in response to consultations and conferences held with older people

- A ground-breaking energy partnership between Age UK Barnsley, Berneslai Homes and Energise Barnsley has been successful in obtaining over £200,000 of funding for a pilot project which will see 75 Berneslai Homes' properties for older people having batteries installed to complement their existing solar panels. The 'Smart Solar' project will potentially see savings of up to 30-40% off people's current electricity bills

- 'Drink Wise, Age Well' has launched a dedicated helpline for people over the age of 50 struggling with alcohol. The helpline is monitored by experienced practitioners and is completely free and confidential and offer advice. Support and advice is also available for older people who are suffering from loneliness and isolation

- Provision of a concessionary senior bus pass to support 'Age-Friendly' travelling in Barnsley - if you're of retirement age, you can apply for a concessionary bus pass. The senior pass will give free travel on local bus and tram services within South Yorkshire between 9.30 am and 11 pm on weekdays, any time at weekends and bank holidays. Pass holders can also use Stagecoach buses in South Yorkshire to travel free of charge to their hospital appointments before 9.30 a.m.

- The Age Friendly Barnsley Festival was held between 27 September and 1 October 2021 with events across the borough, including positive images of ageing, love later life, introductions to exercise, bowling, walking, tai chi, football, and live brass bands.

Age Friendly Barnsley Awards

Some of these achievements have been acknowledged and celebrated through the 'Age Friendly Barnsley' awards which are presented every month to say thank you and to recognise and encourage innovation and good practice. 'Age Friendly Barnsley' awards recognise individuals or organisations who have been involved in projects that embody the Age-Friendly spirit. The photographs below show some of the previous recipients of the 'Age Friendly Barnsley' Award

You can find out more information about the 'Age Friendly Barnsley' awards, including details of previous winners by visiting the link below:

https://www.barnsley.gov.uk/services/community-and-volunteering/age-friendly-barnsley/age-friendly-awards/

Mental Health Crisis Care

One of the early priorities of the mental health partnership was to respond to pressures within the mental health system, particularly around crisis care. As a result, the Crisis Prevention and Implementation group was established with the dual aim of: ensuring the s.136 suite[1] at Kendray Hospital could remain open 24/7 in order to meet demand; and secondly to provide a more professional means whereby Police Officers who were considering detaining someone under s.136 of the Mental Health Act could, through their personal IT device and video triage, receive information from a mental health practitioner to assist them in deciding whether or not a detention should be made.

In order to achieve the first aim, and as part of business continuity plans, the Intensive Home-Based Treatment (IHBT) team was to take responsibility for the staffing of the s.136 suite, between the hours of 8pm and 8am daily. Secondly, members of the IHBT team were trained in the use of anti-barricade doors and the general workings of the s.136 suite, so it could be operated safely. Members of the IHBT team were provided with laptops and mobile phones to enable them to communicate via video link with police officers on the ground to assist them with making s.136 detention decisions.

By taking this action, we have enabled the s.136 facility to remain open for people who are detained under the mental health act, whilst also facilitating the effective use of police resources by enabling a timely and informed mental health assessment to be made. This approach has been recognised by South Yorkshire Police as the gold standard response for responding to mental health issues.

[1] Section 136 is part of the Mental Health Act which gives the police emergency powers to detain someone where they believe they have a mental disorder and need immediate help. Police can then take the person to a place of safety, where their mental health can be assessed. Barnsley's s.136 is a local place of safety, based at Kendray Hospital.

Following this project, a business case has been submitted by SWYFT to Barnsley CCG, seeking to secure funding so the S136 suite can be operated by a stand-alone team; this funding has since been agreed, in order to secure the 24/7 operation of Barnsley's s.136 suite.

The key learning point from this project has been identifying the value in staff being empowered to make changes in operational practice for the benefit of Barnsley people.

Suicide Prevention

In May 2021 Barnsley's Mental Health Partnership made a commitment to a Zero Suicide ambition, undertaking a bold and ambitious pledge to work together to identify innovative approaches to improve Barnsley residents' mental health and wellbeing, including support for people contemplating suicide. We want to instil hope into individuals and communities that suicide is preventable and address the stigma associated with poor mental health. We also want to ensure people know where to go for help when they need it and have access to early interventions and timely support that can increase personal and community resilience and reduce the risk of suicide in the most vulnerable population groups.

Our case study focuses on the work of the 'Team Talk' project which, since its launch in June 2021, has made a significant difference to improving the mental health of men in Barnsley.

With weekly sessions taking place at Oakwell Stadium, home of Barnsley Football Club, 'Team Talk' is a low-level mental health initiative for men experiencing and at risk of experiencing mental health problems. Men can meet, open up, take some time out and talk about any issues in a safe and relaxed environment with support from male coaches, some of whom have lived experience of mental health problems. It offers a combined approach to suicide prevention through social activities and peer support using football as the vehicle to bring people together and connect. 'Team Talk' enables local men to:

- Build new relationships with others facing similar challenges
- Share experiences, tips and coping mechanisms
- Access and offer peer support
- Realise they are not alone, and support is available

Paul Wheatley has been attending 'Team Talk' for a few months and told us about the positive impact that the sessions have made to his life:

'I have been going to team talk for around 3 months now, this is something I really look forward to going to. I have met new friends and get on well with everyone, it's nice just to get out of the house and relax, we play pool or table tennis and listen to music. The support team are always there for us if we need someone to talk too. I have also joined the Barnsley FC golf group and we are currently in a match play off with Doncaster, again I have made friends by joining in.

I would recommend this group to anyone that needs a friend or just needs that break away and wants to chill and meet some new friends.

Sean, Jack, Clem and the team have been brilliant and supportive, I look forward to spending time with this group.'

Due to the success of the project, Team Talk has expanded to a further site in the North of Barnsley. The project at Oakwell has also been funded for a further year with the adaptation of the programme including exercise. The same programme has been developed aimed at supporting women which will be delivered at Oakwell and is due to launch in the near future.

Conclusion

Since the inception of the Mental Health Partnership, we've achieved a great deal to improve mental wellbeing in Barnsley. We hope this report provides a snapshot of some of our key achievements over the last 18 months and demonstrates the tangible impact that our work has for the people of Barnsley.

By coming together and working collaboratively, we have achieved a great deal – and we will continue to work in this way to improve outcomes for the people of Barnsley and tackle inequalities. Moving forward, our mental health strategy has been published and sets our priorities for the next 12 months. Our strategy follows a 'life course' approach, to ensure we are improving mental health and wellbeing for people of all ages; and one of the overarching themes is to reduce mental health inequalities, by a combination of prevention and ensuring that those who require mental health support can access the services they need.

As a partnership, we will create a delivery plan to ensure we are achieving the ambitions set out within the strategy and delivery of this will be held to account through the relevant governance arrangements. To ensure that content remains valid and relevant, we will review and update the Mental Health Strategy annually to reflect any changes to service delivery and organisational reporting arrangements. With effect from Autumn 2022, the Mental Health Partnership will expand to include learning disabilities and autism and these areas will be captured in future reviews of the Mental Health Strategy.

We recognise the challenges faced by Barnsley residents and that it won't necessarily be an easy road ahead, as we grapple with a cost-of-living crisis, but through the collective endeavours and determination of all our partners, we know that we can make a difference to improve mental health and wellbeing for everyone within the borough.

REPORT TO THE HEALTH AND WELLBEING BOARD

October 2022

BARNSLEY PHARMACEUTICAL NEEDS ASSESSMENT

Report Sponsor: Julia Burrows
Report Author: Sohaib Akhtar
Date of Report: 6th October 2022

1. Purpose of Report

1.1 The purpose of the report is to present the final draft Barnsley Pharmaceutical Needs Assessment (PNA) for approval and publication.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Approve the publication of the Barnsley PNA 2022-2025

3. Delivering the Health & Wellbeing Strategy

3.1 The PNA is a statutory responsibility of the H&WB. It contributes to all three of the H&WB ambitions for Barnsley, Starting Well, Living Well and Ageing Well.

3.2 It particularly contributes to the Living Well ambition since the PNA will ensure that everyone in Barnsley can access the pharmaceutical resources they need to live a healthy life. This can include both physical and mental health since Pharmacies offer a range of wellbeing services.

4. Reducing Health Inequalities

4.1 The PNA will ensure we have local community pharmacies which meet the needs of the Barnsley population. Community Pharmacy teams are often well established within local communities and have a good understanding of their needs and challenges.

4.2 The PNA aims to:

- Identify gaps in provision or accessibility, including by area or population group
- Provide area profiles with insights into the health burden in different areas of Barnsley.

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5. Introduction/ Background

5.1 The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWB). The Act also transferred responsibility to develop and update Pharmaceutical Needs Assessments (PNA) from Primary Care Trusts (PCTs) to HWBs. Barnsley HWB has a statutory duty publish a new PNA for 2022-2025 by October 2022.

5.2 The PNA is a legal document which details services which would be desirable and necessary in a locality based on the local health needs and population demographics.

5.3 PNAs will inform commissioning decisions by local authorities (public health services from community pharmacies) and Clinical Commissioning Groups (CCGs). NHS England area teams will also use the PNA to inform whether a pharmacy application would be desirable for a particular location.

5.4 Following the production of the draft report by the Barnsley PNA Steering Group local partners and residents were given the opportunity to comment on the document during the 60-day statutory consultation period. A final draft was discussed and agreed at the Barnsley PNA Steering Group on 5th August 2022.

6. Summary of the Pharmaceutical Needs Assessment

6.1 The PNA looks at the current provision of pharmaceutical services across Barnsley's HWB footprint and whether this meets the needs of the population and identifies any potential gaps to service delivery. The PNA will be used by NHS England in its determination as to whether to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013[i].

6.2 The conclusion of this PNA is that the population of Barnsley has sufficient service provision to meet their pharmaceutical needs. This is clearly demonstrated by the following points:

- Community pharmacies have an important role to play in improving the health of the Barnsley population. They can contribute to the identified health needs of the population in a number of ways, including motivational interviewing, providing information and brief advice, providing on-going support for behaviour change and signposting to other services.

- Barnsley has good coverage across the borough for pharmaceutical services in terms of choice, access and opening hours, with no gaps in current provision.

- Barnsley and each of the six Area Councils have slightly better or similar coverage of community pharmacies or dispensing GP practices than the England and Yorkshire and the Humber averages.

- The majority of Barnsley residents live within a 1 mile radius or a 10 minute drive of a pharmacy.

- An increase in population is likely to generate increased demand for pharmaceutical services, but on a local level change in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical services providers. The Health and Wellbeing Board will need to monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, in accordance with regulations.

7 Conclusion/ Next Steps

7.1 The Barnsley PNA report should be the basis for all future pharmacy commissioning intentions. Members of the Health and Wellbeing board will be consulted on the scope for future reports.

11. Appendices

11.1 Appendix 1 – PowerPoint Presentation to be shared along with this briefing.

Officer: Sohaib Akhtar **Date: 6th October 2022**

[i] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Accessed 12.01.15 http://www.legislation.gov.uk/uksi/2013/349/contents/made

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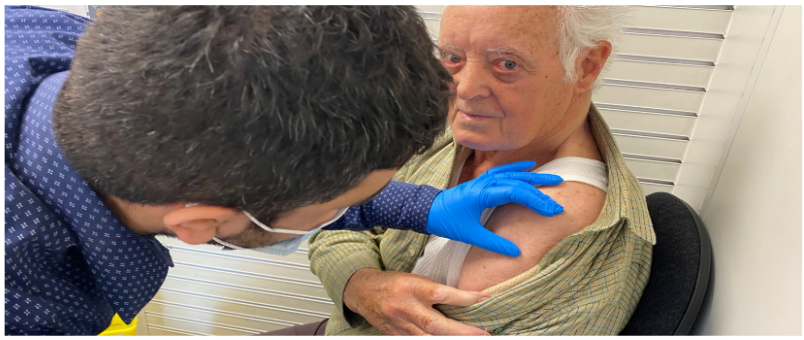

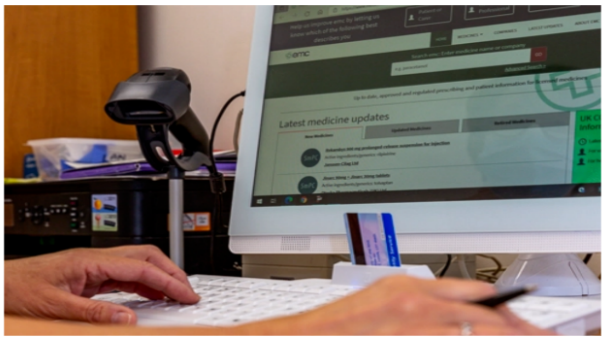

PHARMACY
the Heart of our Community

BARNSLEY PHARMACEUTICAL NEEDS ASSESSMENT 2022-2025

Document Control

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Contents Page

1. Acknowledgements

For Information:

- From 1 October 2021, PHE's health protection functions were formally transferred into the UK Health Security Agency (UKHSA), while its health improvement functions were transferred to the Office for Health Improvement and Disparities (DHSC), NHS England, and NHS Digital.
- Clinical commissioning groups were subsumed into integrated care systems and therefore from the end of June 2022, Barnsley CCG became South Yorkshire Integrated Care Board (SY ICB), Barnsley.

STEERING GROUP MEMBERS:

- **Sohaib Akhtar** - Public Health Practitioner, Barnsley Council
- **Thomas Bisset** - Local Pharmacy Committee representative
- **Rebecca Clarke** - Public Health Principal, Barnsley Council
- **Alan Hart** - Senior Planning Officer, Barnsley Council
- **Emma Robinson** - Business Improvement & Intelligence Advisor, Barnsley Council
- **Helen Hickson** - Business Improvement & Intelligence Officer, Barnsley Council
- **Kaye Mann** - Public Health Specialist Practitioner, Barnsley Council
- **Graham Hoggard** - Local Medical Committee representative
- **Chris Lawson** - Head of Medicines Management, SY ICB Barnsley
- **Verena Marshall** - Clinical Advisor NHS England & NHS Improvement
- **Mark Smith** - Vice Chair, Healthwatch Barnsley

2. Executive Summary

2.1 Statement and Purpose of the Pharmaceutical Needs Assessment

Since 1 April 2013, every Health and Wellbeing Board (HWBB) in England has had a statutory responsibility to publish a Pharmaceutical Needs Assessment (PNA) and keep it up to date. The primary purpose of the PNA is to enable NHS England to determine whether or not to approve applications to join the pharmaceutical list under The National Health Service.[1]

The PNA has looked at the current provision of pharmaceutical services across Barnsley to assess whether it meets the needs of the population, and to identify any gaps in service delivery. Pharmaceutical services are provided by Community Pharmacies, Dispensing Practices, Distance Selling Pharmacies and Dispensing Appliance Contractors.

The Borough has 50 Community Pharmacies and 1 Distance Selling Pharmacy. There are also 3 Dispensing Practices and 2 Dispensing Appliance Contractors (DACs).

A comprehensive range of sources have been used to describe the health and social conditions of the Borough. This document provides details of:

- Population demographics: age, deprivation and health needs.
- Number and location of community pharmacies, dispensing practices, distance selling pharmacies, DACs and the services commissioned.
- Identification of any gaps in necessary services.
- Impact of population changes and house building.
- Formal consultation on the final draft PNA.

If significant changes in the need for pharmaceutical services occur during the three years of the life of the PNA, then the Health and Wellbeing Board is required to publish a revised assessment as soon as is reasonably practicable. Supplementary statements to the PNA can be made if the provision of pharmaceutical services changes

2.2 Conclusions

The PNA concludes:

- Barnsley has good coverage across the borough for pharmaceutical services in terms of choice, access, and opening hours, with no gaps in current provision.

- Barnsley and each of the six Area Councils have slightly better or similar coverage of community pharmacies or dispensing GP practices compared to the national average.

- The majority of Barnsley residents live within a 1.6km (1 mile) walk of a pharmacy and a 10-minute drive of a pharmacy.

- The existing distribution of pharmacies corresponds to where future new housing will be located.

3. Introduction and Scope

[1] Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013.

The PNA is used to inform the planning of services that can be delivered by community pharmacies to meet the health needs of the population and is used by NHS England to identify the pharmaceutical needs of the local population and to support the decision-making process for pharmacy applications.

PNAs describe:

- current pharmaceutical services;
- the need for such services;
- potential future need, and
- potential need for new services.

This PNA has assessed the current provision of pharmaceutical services across Barnsley to ensure it can meet the needs of the population over the three years from 1 October 2022 to 31 March 2025. It replaces the last Pharmaceutical Needs Assessment published in 2018.

Pharmaceutical services are an important part of the health care system. They play a major role in improving health and reducing health inequalities. The main roles of pharmacies include:

- supplying prescribed medicines and appliances; and
- delivering a wide range of commissioned services. These include treating minor ailments, reviewing medications, and helping those with specific needs.

Community pharmacies provide most of these services. There are other types of pharmacy providers and the PNA describes these where relevant.

A range of organisations use PNAs to guide developments and commissioning intentions. NHS England considers all applications to introduce new pharmacies and uses the PNA to help assess such applications. Local Authorities and Clinical Commissioning Groups use the PNA to guide commissioning of services from pharmacies. The PNA is not a stand-alone document and organisations use other evidence in their planning. Other evidence includes Joint Strategic Needs Assessments, and Joint Health and Wellbeing Strategies.

Legislative Background

The development of the PNA is covered by regulations issued by the Department of Health in 2013[2] These regulations set out the legislative basis for developing and updating PNAs. Each Health and Wellbeing Board must in accordance with regulations:

- Assess the need for pharmaceutical services in its area.
- Publish a statement of its first assessment and of any revised assessment.

Under the 2013 regulations, a person who wishes to provide NHS pharmaceutical services must generally apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA.

Scope

Regulation 3(2) in the 2013 regulations defines the scope of PNAs. These state:

[2] Pharmaceutical Services and Local Pharmaceutical Services Regulations, 2013.

"The pharmaceutical services to which each pharmaceutical needs assessment must relate are all the pharmaceutical services that may be provided under arrangements made by NHS England:

- *The provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list.*
- *The provision of local pharmaceutical services under an LPS (Local Pharmaceutical Service) – not local pharmaceutical services which are not pharmaceutical services.*
- *The dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements by the NHS Commissioning board with a dispensing doctor)."*

There are 3 main types of pharmaceutical services in relation to PNAs:

- **Essential Services –** services that every community pharmacy providing NHS pharmaceutical services must provide. These include dispensing medicines, promoting healthy lifestyles, and supporting self-care.
- **Advanced Services –** community pharmacies can provide advanced services subject to accreditation by NHS England. These include New Medicines Service and Appliance Use Reviews.
- **Locally Commissioned Services –** Local Authorities and CCGs commission community pharmacies to provide local services. Examples include Emergency Hormonal Contraception, Needle Exchange, and Palliative Care Drugs Services.

A pharmaceutical list includes the following:

- **Pharmacy contractors** – healthcare professionals working for themselves or as employees who practice in pharmacy.
- **Dispensing appliance contractors** – appliance supplier's supply, on prescription, appliances including stoma and incontinence aids, dressings, bandages etc. They cannot supply medicines.
- **Dispensing doctors** – medical practitioners authorised to provide drugs and appliances in designated rural areas.
- **Local Pharmacy service contractors** – these provide a level of pharmaceutical services in some HWBB areas.

Community pharmacies can provide services to patients that are not commissioned by NHS England, Local Authorities or CCGs. For example, some pharmacies provide a home delivery service as an added value service to patients. Community pharmacists are free to choose whether to charge for these services as part of their business model.

In line with the 2013 regulations this PNA does not consider pharmacy provision in prisons or hospital settings.

The full range of legislation and regulation that specifies the development of PNAs is available here https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

4. Process and Methodology

The duty to publish a PNA falls on the Health and Wellbeing Board. The Director of Public Health (DPH) in the local authority leads on the process and makes sure the PNA meets regulations.

Previously, South Yorkshire Directors of Public Health agreed to a combined approach in the production of the PNA to make the most efficient use of resources. However, due to the Covid-19 pandemic and its unprecedented demand on the work force, there has not been regional approach for this current PNA.

The Business Intelligence Team at Barnsley Council undertook analysis and mapping of the data for the Barnsley PNA. This included working with Public Health England to use their "SHAPE" (Strategic Health Asset Planning and Evaluation) mapping tool to analyse pharmacy locations by demographic, and access factors. In addition, information about proposed housing developments was obtained from Barnsley Council's Housing Department.

To identify health and pharmaceutical need the PNA uses a wide variety of data and information. These include the Joint Strategic Needs Assessment and other relevant strategies. The PNA uses these sources of information to assess current and future population size, measures of health and ill-health and other service provision. The current provision of pharmacy and pharmaceutical services was compared with current and potential future demographic and health needs.

A 60-day consultation on the first full draft of the PNA took place for 60 days from 16 May to 15 July 2022. This consultation was open to members of the public and was sent to the list of stakeholders as defined by the regulations.

The final version of the PNA was approved by the HWBB at its meeting on (insert date of meeting). A copy of this report and associated map of pharmacies in Barnsley will be available to download from the Council's website here (insert link).

4.1 Governance

The Barnsley PNA has been developed using a project management approach. A steering group was established to build on expertise from across the local healthcare community and ensure that views of the main stakeholders are considered throughout the process of preparing the PNA document.

The PNA Steering Group consisted of council staff from Planning, Business Intelligence, and Public Health, and representatives from South Yorkshire Integrated Care Board Barnsley (SY ICB) Medicines Management Team, the Area Team of NHS England (as the main commissioners of these services), the Local Pharmaceutical Committee (representing the professional views of local providers), Healthwatch Barnsley (representing the interests of patients and the public) and the Local Medical Committee (representing the professional views of NHS GPs). The Steering Group has been responsible for the completion of the PNA and to ensure that the PNA exceeds the minimum requirements. This Steering Group approved the timetable, the Communications Plan, outline of the PNA, and the draft for consultation.

The Steering Group reported directly to the Health and Wellbeing Board.

4.2 Equality Impact Assessment

An Equality Impact Assessment (Appendix 4) will be completed following the statutory 60-day consultation with guidance from Barnsley MBC Equality and Diversity Advisors.

5. Context for the Pharmaceutical Needs Assessment

The PNA for Barnsley is undertaken in the context of the needs of the local population. The health and wellbeing needs of the local population are described in the Barnsley JSNA www.barnsley.gov.uk/jsna.

This PNA does not duplicate these detailed descriptions of health needs and should be read in conjunction with the JSNA.

5.1 Overview of Barnsley

Barnsley lies at the mid-point between the region's two main cities of Leeds to the north, and Sheffield to the south, and covers an area of 329 square kilometres.

Historically, Barnsley was centred on coal mining resulting in the borough's dispersed pattern of small towns and villages. Because people lived where they worked and coal was moved by rail, road links between towns and villages were poor and communities were self-contained.

The borough has a varied geography. The west of the borough is predominantly rural in character with open moorland, arable farmland and natural woodland. It is characterised by attractive hilly countryside part of which lies in the Peak District National Park and is centred on the rural market town of Penistone. In the centre of the borough is Barnsley itself and the surrounding urban area which is the main shopping, administrative, business and entertainment centre. To the east of the borough stretching from the M1 motorway to the Dearne Valley are the towns of the former Barnsley coalfield which form a dense settlement pattern and have a relatively high level of deprivation.

Barnsley's local distinctiveness stems from its historical character and culture, including its settlements and architecture. Barnsley Town Centre with its market and role as a knowledge hub and administrative centre for the borough, the friendly traditional market towns and the former mining settlements with their strong communities who have a traditional belief in self-improvement and learning, along with the attractive rural villages all define Barnsley's distinctiveness. It also includes Barnsley's rural heritage, the Pennine topography, the varied landscapes, and the National Park.

The boundary of Barnsley Metropolitan Borough Council (BMBC) is coterminous with Barnsley Clinical Commissioning Group (CCG) and the borough is divided into 21 electoral wards and six Area Councils. Figure 1 identifies the Area Councils and locations of community pharmacies and dispensing practices within Barnsley and surrounding areas.

5.2 Barnsley Healthcare Landscape

The NHS in South Yorkshire and Bassetlaw (SYB) has developed an Integrated Care System (ICS). The SYB ICS was set up initially as a 'Sustainability and Transformation Partnership' in October 2016 to modernise and improve the way health, social care, local authorities, and the third sector across SYB work together to provide healthcare for the 21st century. Since 2016, the ICS has secured a total of £129 million, which has enabled it to progress with a number of schemes and initiatives to improve regional healthcare services. A further £129 million, which is detailed in the Five-Year Plan (2019 – 2024), is secured for transformation schemes.

The Five-Year Plan focuses around four key ambitions:

1. Developing a population health system
2. Strengthening our foundations
3. Building a sustainable health and care system
4. Broadening and strengthening our partnerships to increase our opportunity

Primary care networks were introduced into the NHS in England as part of the NHS Long Term Plan, published in January 2019. The 2019 General Practitioner Contract gave the opportunity for GP practices to join networks, each with between 30,000 and 50,000 patients. The stated aim is to create a fully integrated community-based health services which will be an important component of integrated care systems.

Practices in Barnsley have also come together, firstly to create Barnsley Healthcare Federation and then to form Barnsley Primary Care Network (PCN).

Barnsley PCN is made up of 29 member GP practices which are independently managed but share a common purpose to enhance the level of Primary Care support available within the borough through one large PCN, the largest PCN in the country, supported by six neighbourhoods.

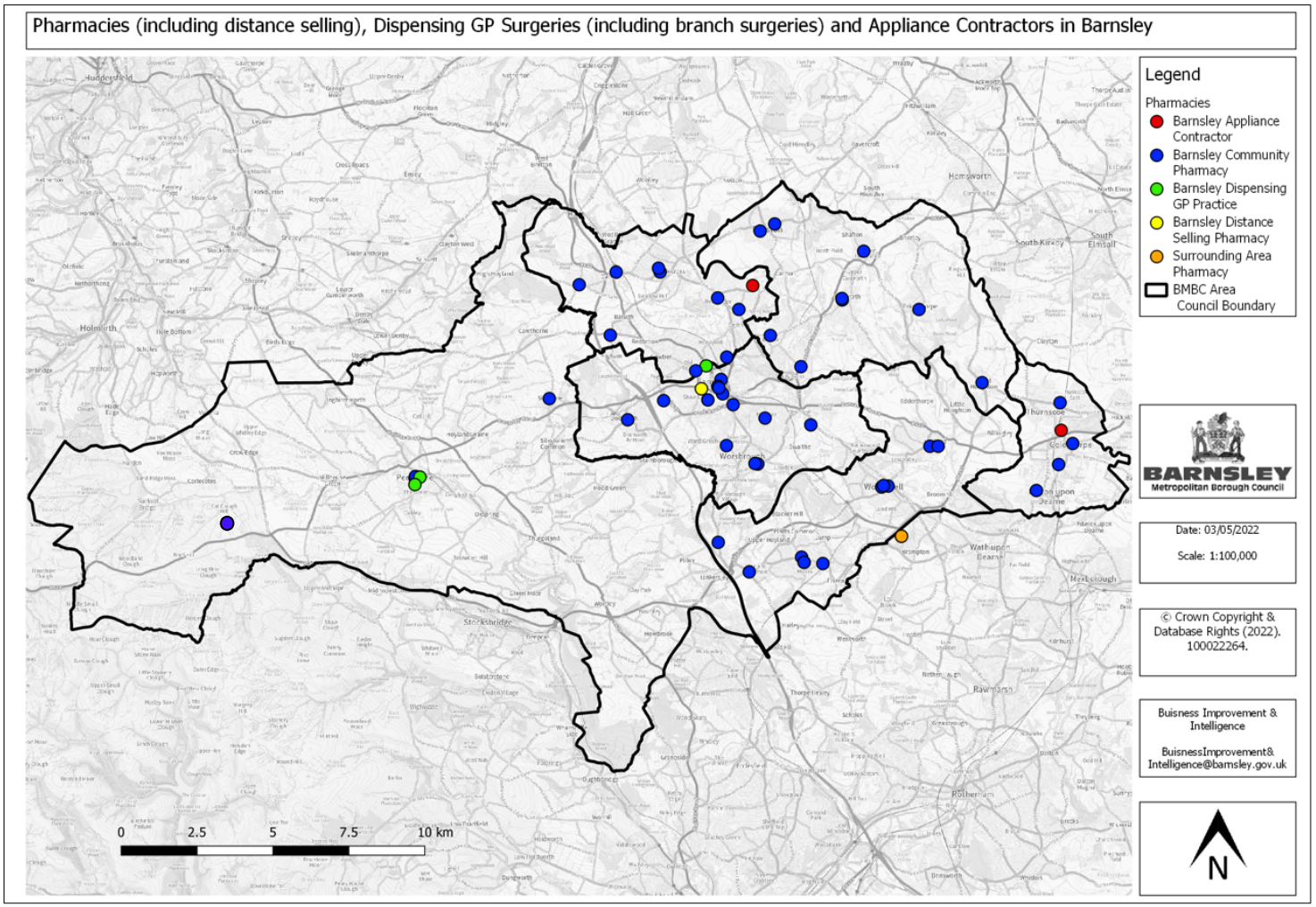
The Neighbourhood Networks are:

- Network one – Penistone
- Network two – Central
- Network three – North
- Network four – North East
- Network five – Dearne
- Network six – South

It is important that community pharmacy teams are fully involved in the work of their PCN and this is being encouraged via the Pharmacy Quality Scheme.

Each of the PCN areas in Barnsley has a community pharmacist working to represent the interests of ALL community pharmacies within the PCN area. Their role is to attend meetings and to share and gather feedback with their pharmacy colleagues.

Figure 1. Pharmacies (including distance selling, dispensing general practices and appliance contractors in Barnsley *(Requirement schedule 1:7 NHS and Pharmaceutical Services Regulations 2013) based on data verified 27 April 2022*



Note: there are two surrounding pharmacies co-located just over the border as indicated on the map. Although these pharmacies are in the Rotherham Health and Wellbeing Board area, they are supported by Barnsley Local Pharmaceutical Committee (The LPC) and are considered close enough to improve access for Barnsley residents.

5.3 Population

5.3.1 Current Population

Latest estimates from the Office for National Statistics (ONS mid-year estimates 2020) put this at approximately 248,071. Figure 2 illustrates this data in a population pyramid and table.

Figure 2: Barnsley population by age group and gender

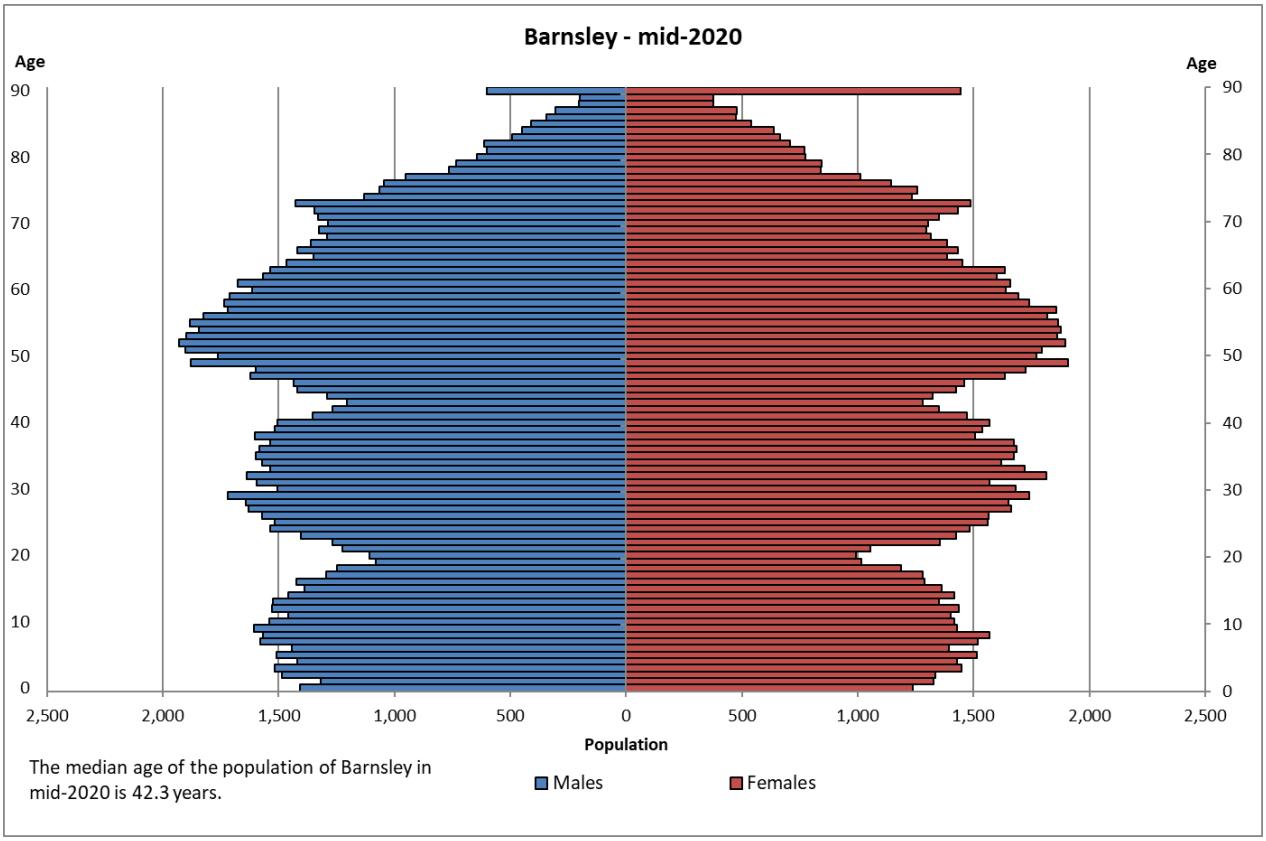


Table 1. Mid-year population estimates, ONS 2020

Age Band	Males		Females		Persons	
	Number	%	Number	%	Number	%
00-04	7,147	5.8	6,779	5.4	13,926	5.6
05-09	7,705	6.3	7,426	5.9	15,131	6.1
10-14	7,509	6.1	7,021	5.6	14,530	5.9
15-19	6,432	5.3	6,135	4.9	12,567	5.1
20-24	6,537	5.3	6,315	5.0	12,852	5.2
25-29	8,080	6.6	8,180	6.5	16,260	6.6
30-34	7,843	6.4	8,410	6.7	16,253	6.6
35-39	7,833	6.4	8,081	6.4	15,914	6.4
40-44	6,621	5.4	7,000	5.6	13,621	5.5
45-49	7,957	6.5	8,161	6.5	16,118	6.5
50-54	9,336	7.6	9,202	7.3	18,538	7.5
55-59	8,870	7.2	8,982	7.1	17,852	7.2
60-64	7,858	6.4	7,991	6.4	15,849	6.4
65-69	6,750	5.5	6,819	5.4	13,569	5.5
70-74	6,518	5.3	6,809	5.4	13,327	5.4
75-79	4,556	3.7	5,100	4.1	9,656	3.9
80-84	2,800	2.3	3,558	2.8	6,358	2.6
85+	2,057	1.7	3,693	2.9	5,750	2.3

5.3.2 Future Population Changes

Over the coming years the population in Barnsley is expected to increase, with the largest increases seen in older age groups. An increase in population is likely to generate increased demand for pharmaceutical services, but on a local level, changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers.

The estimated population of Barnsley was 239,855 in 2015 and is expected to increase by 9% to 262,376 by 2030. Barnsley is also expected to experience a 35% increase in people aged over 65 years and over. Table 2 illustrates the population forecasts for specific age groups.

Table 2. Barnsley population projections by age groups, 2015 to 2030

Age Band	2015	2030	% change
0-4 years	14664	13,276	-9.5%
5-9 years	14162	13,620	-3.8%
10-14 years	12670	14,704	16.1%
15-19 years	13584	15,122	11.3%
20-64 years	139928	145,183	3.8%
65 years and over	44847	60,471	34.8%
Total	239855	262,376	9.4%

Source: ONS 2018 based sub-national population projections

To facilitate commissioning of pharmaceutical services, responsive to population needs, the Health and Wellbeing Board partners will monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, in accordance with regulations.

5.4 Housing Growth

The Barnsley Local Plan is the statutory development plan for the period of this PNA update. The adopted plan sets out how the council will manage physical development of the borough on behalf of residents and businesses.

The Plan proposes to achieve the completion of at least 21,546 net additional homes during the period 2014 to 2033. The distribution of the new housing is set out in Table 3. The supply of housing sites is made up of Local Plan allocations and sites that already have planning permission. There are some site allocations that require the production of a masterplan framework. These masterplan frameworks give more detail on the major mixed use proposals.

The local plan spatial strategy concentrates the majority of development in Urban Barnsley and the Principal Towns (Wombwell, Hoyland, Penistone, Goldthorpe (Dearne Towns), Cudworth and Royston). Some development in villages will be encouraged where it meets local needs and sustains the village economy and the vitality and viability of the local community.

Whilst the spatial units of the local plan do not directly correspond with the six Area Councils, it is the case that the existing distribution of pharmacies corresponds to where future new housing will be located.

Table 3. The distribution of new homes in Barnsley, 2014 to 2033

Core strategy areas	Number of homes	Planning permissions	Total	% of overall supply[3]
Urban Barnsley	**5812**	**3258**	9070	43
Cudworth	1088	215	1303	6
Dearne	1969	922	2981	14
Hoyland	2263	304	2567	12
Penistone	637	366	1003	5
Royston	886	416	1302	6
Wombwell	1370	699	2069	10
Other Settlements	211	590	801	4
Total	**14236**	**6770**	**21006**	**100**

Source: Barnsley Local Development Framework (LDF) Core Strategy, 2019. Page 58.
https://www.barnsley.gov.uk/media/17249/local-plan-adopted.pdf

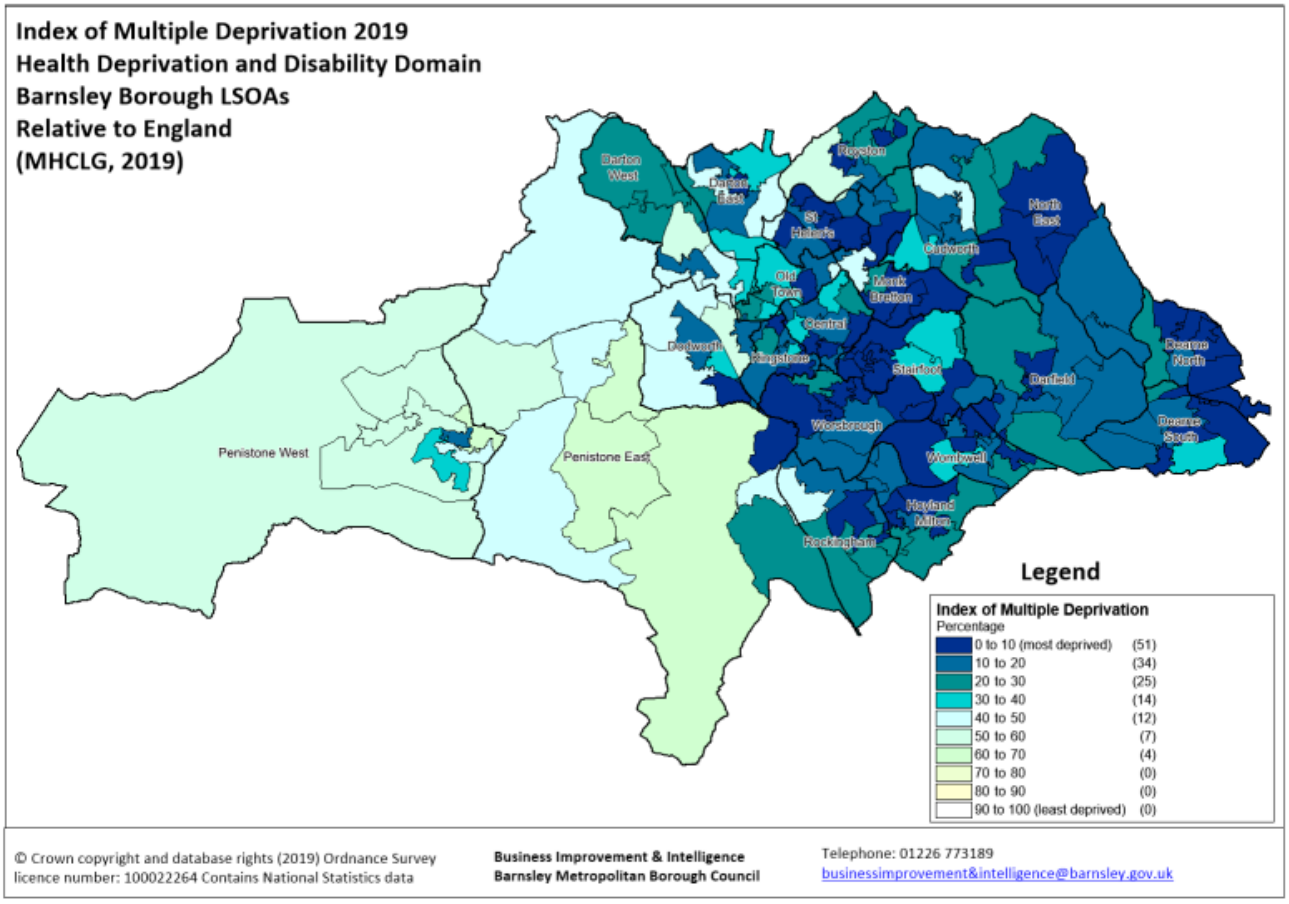
[3] Includes 4295 dwellings proposed as part of mixed use sites.

5.5 Deprivation

The Index of Multiple Deprivation 2019 (IMD 2019) is used to measure inequalities in the wider determinants of health. It combines a range of economic, social, and housing indicators to provide the most up to date and comprehensive picture of deprivation for each local authority in England. It is made up of seven indices of deprivation that are grouped together and weighted to produce the overall index (higher scores indicate greater level of deprivation). The seven indices cover: income; employment; health and disability; education, skills and training; barriers to housing and services; crime; and living environment.

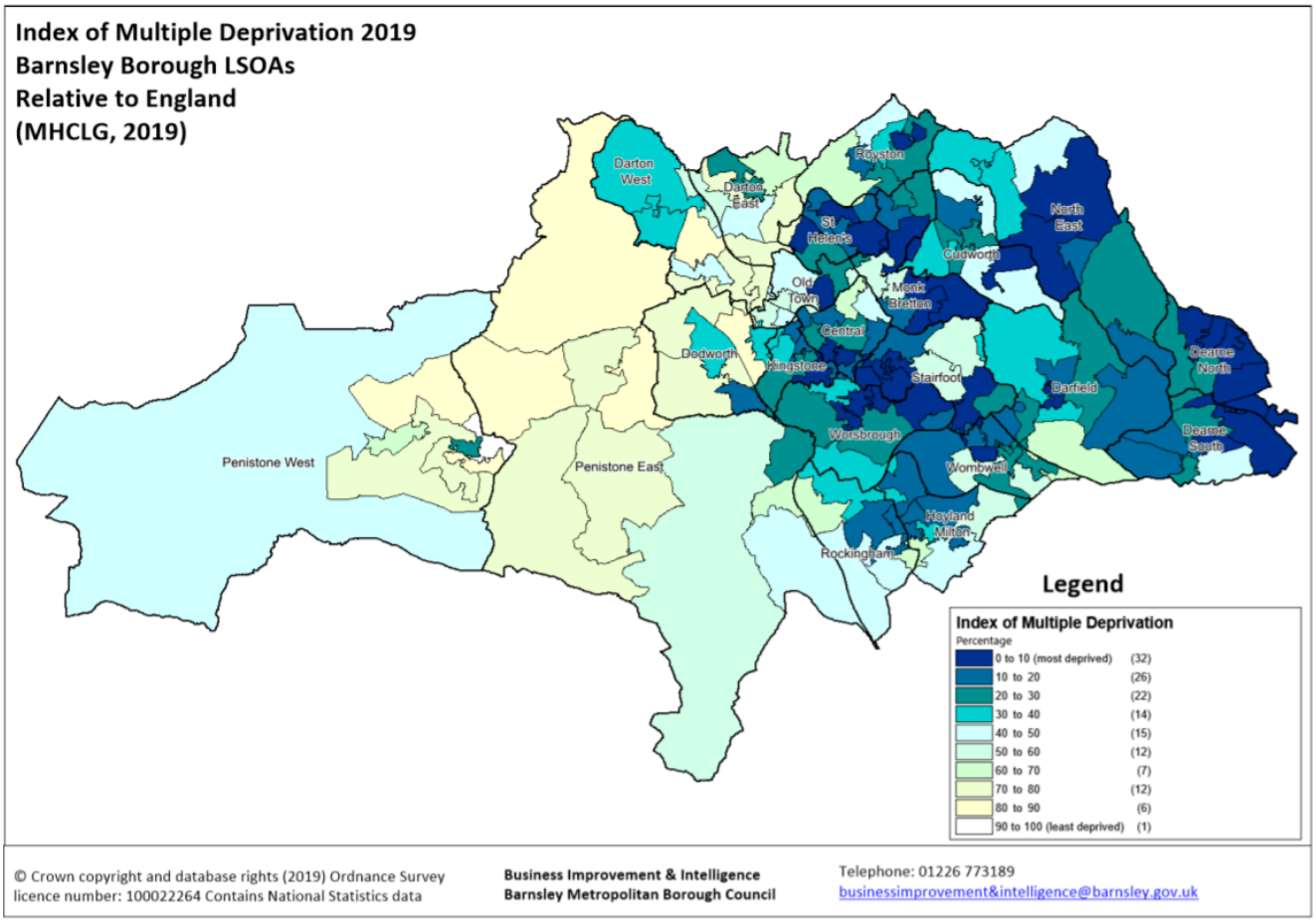
Figure 3 illustrates that there are clear geographical inequalities in the wider determinants of health in Barnsley, with 22% of Lower Super Output Areas (LSOAs) being in the 10% most deprived areas in England.

Figure 3. Index of Multiple Deprivation 2019, Barnsley



When looking at the health and disability domain, Barnsley ranks 22/317 nationally in terms of average score (where 1 = most deprived, 317 = least deprived). Figure 4 shows the geographical inequalities in health and disability with darker areas of the map indicating higher levels of health deprivation.

Figure 4. Health deprivation and disability domain (IMD 2019) Barnsley



A more detailed breakdown on the IMD in Barnsley (including ward and LSOA individual decile scores) can be accessed via the IMD interactive dashboard.

6. Health and Wellbeing

A detailed analysis of health and wellbeing needs in Barnsley is set out in our Joint Strategic Needs Assessment (JSNA). This can be accessed from the Council's website: https://www.barnsley.gov.uk/services/our-council/research-data-and-statistics/joint-strategic-needs-assessment/

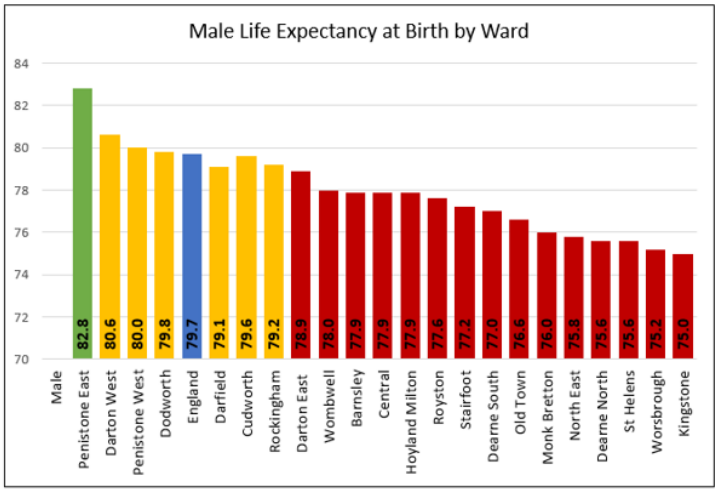
The data outlined in the section is updated and published on an annual basis on the Public Health Outcomes Framework at https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

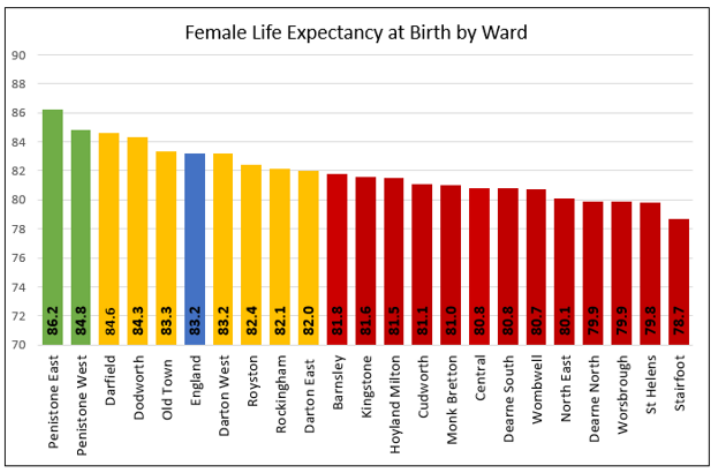
6.1 Life Expectancy in Barnsley

Life expectancy at birth in Barnsley for both men and women (2018-20) is significantly lower than national rates. For men in Barnsley, life expectancy has been on a declining trend and is now at its lowest rate in ten years.

Significant health inequalities exist within Barnsley at electoral ward level. Latest published data (see Figure 6) shows that male life expectancy at birth ranges from 75 years in Kingstone to 82.8 years in Penistone East – a difference of 7.8 years (2017-2019). For women, rates range from 78.7 years in Stairfoot to 86.2 years in Penistone East – a gap of 7.5 years (2017-2019).

Figure 6. Life expectancy at birth in Barnsley - ward level





In terms of healthy life expectancy at birth, men in Barnsley could expect to live 5.7 years less in "good" health than men in England, whilst for women, the difference is 2 years (2017-2019).

The 'inequality gap' in life expectancy at birth has reduced over recent time periods and now stands at 8.9 years for males and 7.9 years for females (2018-20). These figures are currently below both regional and national averages. However, existing heath inequalities are likely to have been exacerbated by Covid-19, with the impact of the pandemic, and measures to control the virus, falling unevenly across society. In addition, significant changes to household income brought about by the end of furlough support, Universal Credit changes, National insurance increases and the rising cost of living and fuel prices are likely to push more households into poverty. Locally, the biggest impact is likely to be on those groups already struggling and we may see the declining trend in inequality stall (or even reverse) in the near future. It remains a priority of our Health and Wellbeing strategy to work with the wider health system to enable recovery from the pandemic and to build sustainable and healthier futures. The next section covers Covid-19 and health inequalities in more detail.

6.2 Covid-19 and Health Inequalities

The Covid-19 pandemic has had a profound impact on people's health and wellbeing. The Health Foundation's Covid Impact Inquiry explored how people's experiences of the pandemic were influenced by their pre-existing health and health inequalities:

> People's experiences of the pandemic have varied greatly. Not everyone faced the same risk of exposure to the virus nor equivalent severity in health outcomes. The measures taken to suppress the virus have affected people's lives and livelihoods differently – with both immediate and longer term consequences for people's health and wellbeing.

The report also highlights that the immediate risks to people's health go beyond direct harm caused by the virus. Re-prioritisation of health care services to manage Covid-19 related demand have led to an increased unmet need for care. Further analysis by the Health Foundation identified 6 million 'missing patients' who did not seek treatment in 2020, which could mean many people living with poor health for longer. In cases of acute need, such as cancer care, it is likely we will see a reduction in survival rates. The loss of education during the pandemic also risks widening the gap in future health outcomes. The cohort of children and young people who have missed periods of education could lag behind pre-pandemic cohorts. The loss of education has also not fallen evenly, with children from more disadvantaged backgrounds having experienced a greater deterioration in their educational outcomes.

'Build Back Fairer: The Covid-19 Marmot Review', highlights that Covid-19 has exposed and amplified the inequalities observed in the earlier '10 Years On' report, and that the economic harm caused by containment measures - lockdowns, tier systems, social isolation measures – will further damage health and widen inequalities. Inequalities in Covid-19 mortality rates also follow a similar social gradient to that seen for all causes of death. Mortality rates from all causes are higher in more deprived areas, and prior to the pandemic health inequalities related to deprivation had been increasing.

The total number of excess deaths during the first wave was highest for older age groups, with 41% of all deaths among those aged 85 and older. Once the virus had spread, the age and health of the UK population (including underlying health conditions and comorbidities) played a role in the severity of outcomes. As healthy life expectancy improvements have not kept pace with life expectancy in the UK, people are living more years in poor health – particularly in older age. This could have led to greater vulnerability to Covid-19.

A recent publication from ONS on excess mortality during the period of the Covid-19 pandemic (to end December 2021), shows that Barnsley has the highest percentage of excess deaths from all causes in Yorkshire and Humber (24.7% vs an average of 13.2% for Yorkshire and Humber) and for excess deaths excluding deaths due to COVID-19 (-1.1% for Yorkshire and Humber, 5.5% for Barnsley). Barnsley has one of the highest percentages nationally, with only nine London boroughs scoring higher for excess deaths from all causes. We will continue to look at this in more detail, but the data again appears to suggest that our local population has high susceptibility to premature illness and death from a range of causes including Covid-19.

As highlighted in research from Sheffield University, older industrial towns and the former coalfields entered the pandemic with an older and less healthy population, at higher risk from the virus. This is true of Barnsley where we have an older population, a higher number of care homes and greater levels of chronic disease and deprivation compared with the rest of the country. This means the population of Barnsley has been more susceptible to infection, serious illness, and death during the pandemic.

As we continue to realise the impact of Covid-19 on our communities, our Health and Wellbeing Strategy 2021-2030 sets out a life-course approach to improve the health and wellbeing of our residents, ensuring that no communities are left behind in our recovery. A central part of tackling health inequalities in this recovery phase will be to protect those at greatest risk.

6.3 Health Needs and Health Inequalities

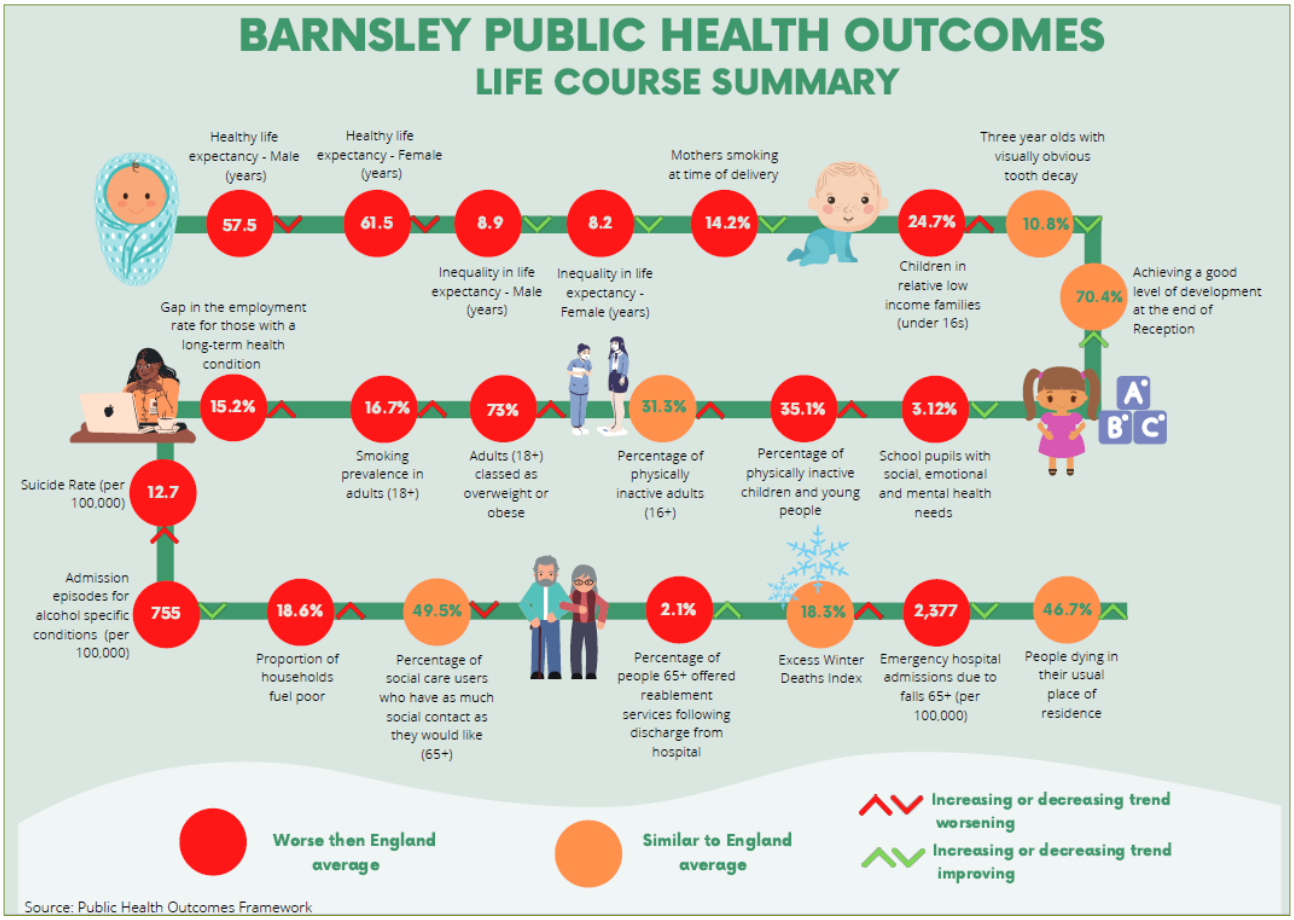
Barnsley's population is ageing, and the number of residents aged 65+ is projected to reach over 60,000 by 2030. An ageing population with a range of health issues will put pressure on health and social services. The JSNA provides further detail on specific health needs, but key points for health needs in Barnsley include:

- Deprivation is higher than average and almost a quarter (24.7%) of children under 16 live in relative poverty.
- Life expectancy for men (77.1 years) and women (80.2) is lower than the England average (79.4 for men and 83.1 for women), with a significant life expectancy gap between the most and least deprived areas of the Borough.
- Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.
- Smoking prevalence amongst Barnsley adults although slowly declining (from 24.4% in 2012 to 18.3% in 2019), remains significantly higher than the England average of 13.9%.
- 73% of adults in Barnsley are classified as overweight or obese, significantly worse than the average for England (62.8%).
- Emergency hospital admissions for alcohol related conditions (546 per 100,000) are significantly worse than the average for England (456).

- The rate of smoking related deaths is significantly worse than the rate for England, with over 1,000 deaths per year for Barnsley.
- Estimated levels of physical activity amongst Barnsley adults are significantly worse than the England average.
- 18.6% of households in Barnsley are considered fuel poor, and recent data estimates from the End Fuel Poverty Coalition suggest that this figure could double to 37% of households in Barnsley, following the new energy price cap coming into effect in April 2022.

A life-course summary of public health outcomes for Barnsley is provided in Figure 7.

Figure 7. Barnsley Public Health Outcomes Summary



6.4 Health and Wellbeing Priorities

Health improvement and inequality continue to be a challenge for the borough, and this is influenced by a number of factors such as the quality of healthcare, lifestyle and wider factors such as employment, education, housing and poverty.

Barnsley's Health and Wellbeing Board has a statutory duty under the Health and Social Care Act 2012 to produce a joint Health and Wellbeing Strategy. The purpose of the Health and Wellbeing Strategy is to articulate the key strategic priorities for the Health and Wellbeing Board, whilst providing a justification for those priorities. It draws upon a range of sources including our Joint Strategic Needs Assessment (JSNA), the Public Health Outcomes Framework (PHOF), along with national policy research and other local intelligence, such as the Poverty Needs Assessment.

Similarly, the Strategy is intended to convey the Board's strategic position and how it will work in synergy with other key strategic Boards, such as the Barnsley 2030 Board, Safer Barnsley Partnership, and the Children and Young People's Trust Executive Group (amongst others). The Strategy is intended to complement other strategies and plans (e.g. the Health and Care Plan) by setting out our ambition and plan to achieve a Healthier Barnsley, through the combined efforts of partners on the Health and Wellbeing Board.

The refreshed Strategy reflects on the impact of the Covid-19 pandemic on the state of the Borough's health and wellbeing; acknowledging that the pandemic has highlighted and exacerbated existing health inequalities within the borough. As we continue to realise the impact of Covid-19, the Health and Wellbeing Board will focus on ensuring that our recovery is fair and equitable and that we don't risk widening existing health and social inequalities across Barnsley.

We have set out our new strategy across a 'life course' approach, which sets a series of ambitions at different stages of a person's life from 'Starting Well' (pre-birth to 18 years), 'Living Well' (working age adults) to 'Ageing Well' (aged 65+). Whilst we have structured our Strategy in this way, many of the ambitions contained therein are applicable right across the life-course.

Within each stage of the life course, we set a series of ambitions. These are summarised below:

Starting Well:

1. Barnsley is a great place for a child to be born and every child is given the best possible start in life.
2. Fewer children live in poverty, and everyone has the resources they need to look after themselves and their families.
3. All our children and young people have a healthy diet and are physically active.
4. Barnsley will have a culture which promotes positive emotional health and wellbeing and builds resilience in our children and young people.

Living Well:

1. Everyone in Barnsley can access the resources they need to live a healthy life (including having a fulfilling occupation, access to a safe, warm, and sustainable home and having a good friend to talk to).
2. Levels of mental ill health across the borough are reduced, by a combination of prevention and ensuring people of all ages, have access to quality, age friendly services at the right time.
3. Everyone can safely be physically active, to support their physical and mental health.

Ageing Well:

1. Older people are able to live independent and active lives, enjoying their later years in comfort in their own communities, for as long as possible.
2. Our older people have quality of life with choice and control over their care and support needs.

Community pharmacies are ideally placed as a provider of services, a community asset and as employers to contribute towards improving population health in the borough. They are easily accessible and are often the first point of contact, including for those who might otherwise not access health services. Community pharmacies can contribute to the local public health agenda in a number of ways, including but not limited to:

- motivational interviewing;
- providing education, information and brief advice;
- providing on-going support for behaviour change;
- sign-posting to other services or resources.

The range of services provided by community pharmacies varies due to several factors, including availability of accredited pharmacists, capacity issues in the pharmacy, changes to service level agreements and the need for a service (for example, in response to pandemic flu).

The following areas represent those aspects of health and wellbeing where community pharmacies have the greatest contribution to make.

6.4.1 Smoking

Smoking is the single biggest cause of preventable death in Barnsley and nationally, claiming more lives each year than the next six most common risk factors combined. Tobacco use is a major cause of coronary heart disease, lung and other cancers, and respiratory diseases, particularly Chronic Obstructive Pulmonary Disease (COPD).

In 2019, 15% of all deaths in England (74,600 people) were attributable to smoking, which is decreasing compared to previous years (18% in 2009). Of all deaths from respiratory disease in England, 35% were attributable to smoking. This percentage was 25% for cancers, 12% for circulatory diseases, and 3% from diseases of the digestive system. In Barnsley in 2019, the age-standardised death rate attributable to smoking for those aged 35+ was 266.4 per 100,000 (approx. 1,143 people). This is worse than the regional figure (239.4) and much worse than England (202.2).

Smoking is the main cause of inequalities in death rates between communities. Smoking is most common in 25–29-year-olds, in areas of deprivation and in routine and manual workers. Smoking prevalence amongst adults in Barnsley is estimated at 18.3% as of 2019; well above the regional target of 10% by 2024, as well as the England average of 13.9%. The figure for 2020 is 13.7% but this is to be interpreted with caution due to bias risk caused by data collection method and is likely to be an underestimate.

Smoking in pregnancy is reducing nationally but is a particular problem for Barnsley compared to England and the Yorkshire and Humber region. Prevalence of smoking at the time of delivery in Barnsley is estimated at 14.2% in 2020/21; well above the regional target of 6% by 2024, as well as the England average of 9.6%. SATOD prevalence tracks above both the England and regional averages, but notably this gap has narrowed significantly in recent years, as prevalence is declining more rapidly in Barnsley. The estimated absolute number of mothers smoking at the time of their delivery has reduced from approximately 650 in 2010/11 to 388 in 2020/21, and this has been accompanied by a reduction in the overall proportion SATOD in the Borough from 22%

Within Barnsley, adult smoking ward prevalence varies from 14.2% in Penistone, 18.5% in the North-East Area, 18.1% in the Central Area, 17.8% in the South Area to 19.1% in the Dearne Area (2019/20).

Barnsley Council commissions South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) to deliver to community universal Stop Smoking Service offer and Barnsley Hospital NHS Foundation Trust (BHNFT) are commissioned to deliver Smoking in Pregnancy service.

Role of local pharmacies

- Provision of the Stop Smoking Service.
- Dispensing of stop smoking medications.
- Provision of oral anti-smoking agents and signposting.
- Referral to the Stop Smoking Service.
- Public Health campaigns related to Tobacco Control.

6.4.2 Sexual Health

Although sexual health affects all ages in the population, the burden is not evenly distributed across society, as young people, black and minority ethnic communities, men who have sex with men and people who are recently divorced or separated, can be disproportionately affected by Sexually Transmitted Infections (STIs). The age and gender structure of the population has important implications for sexual health and maternity services.

Barnsley Council commissions services from Spectrum to deliver a range of sexual health and contraceptive provision including Long Acting Reversable Contraception (LARCs). This includes testing and treatments for all STIs. Spectrum also commissions services from community pharmacies to provide free provision of emergency hormonal contraception to women aged under 25 years.

6.4.3 Chlamydia

Young people especially women under the age of 25 years are most likely to get a chlamydia infection which can cause infertility if not treated due to the lack of symptoms.

The chlamydia detection rate per 100,000 young people aged 15-24 years in Barnsley was 2,354 in 2019, better than the rate of 2,043 for England. Chlamydia causes avoidable sexual and reproductive ill health especially in women, including symptomatic acute infections and complications such as Pelvic Inflammatory Disease (PID), ectopic pregnancy and tubal-factor infertility.

Chlamydia remains one of the most prevalent STIs in Barnsley. Increasing the diagnostic rate through initiatives such as the National Chlamydia Screening Programme (NCSP) will reduce the prevalence of infection. The UK Health Security Agency (UKHSA) recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15-24. In Barnsley, this detection rate is 2,261 per 100,000 aged 15-24.

The NCSP has now moved the programme from prevalence reduction to harm reduction through early detection and treatment of asymptomatic infection and onward transmission. Opportunistic screening of young women only is now recommended outside of sexual health services.

6.4.4 Teenage Conceptions

There are strong links between teenage pregnancy and deprivation, and even stronger links with attainment and a range of other risks for young people (e.g. alcohol use, low aspirations, emotional wellbeing). These contribute to a complex picture requiring both significant cultural and behavioural shifts to reduce teenage conception rates in the short term.

Barnsley has seen a reduction in the rate of teenage conceptions from 51.8 per 1000 in 2001 to 19.6 per 1000 in 2020. Despite this reduction, Barnsley's rate is still higher than the regional and national rates of 16.5 and 13.0 respectively, and it is important therefore that this remains a priority area. Barnsley Council commissions Spectrum to provide emergency hormonal conception service for women aged under 25 years in the following community pharmacies:

- AM Clark Chemist Penistone
- Asda Old Mill Lane
- Lo's Pharmacy Worsbrough
- Lo's Pharmacy Grimethorpe
- Lo's Pharmacy Cockerham Hall Mews
- Lo's Pharmacy Park Grove
- McKay Healthcare Silkstone
- Rotherham Chemist Great Houghton
- Stone Pharmacy Darfield
- Wedricks Pharmacy Goldthorpe Green
- Weldricks Pharmacy Royston
- Weldricks Pharmacy Thurnscoe

The pharmacy provision for free EHC in Barnsley offers easier access to EHC with longer opening hours to those under 25 years old.

Role of local pharmacies

- Providing free emergency hormonal conception to under 25s.
- Providing over the counter EHC to those not eligible for free EHC.
- Advice on and signposting to Long Acting Reversible Contraception (LARC).
- Referral to relevant treatment and advice services.
- Public Health pharmacy campaigns.

New Pilot

Barnsley pharmacies have become one of the pilot areas for South Yorkshire. The new pilot will see community pharmacists being able to deliver a contraception service that encompasses the initiation and management of ongoing, regular contraception (in 2022), including the pill, patch, vaginal rings, implants and depot injection (from 2023) from their local pharmacist. There will be a tiered approach with pharmacies signing up to different levels of support. It will start by increasing the options for continued supply and monitoring for oral contraceptives which has been an issue during Covid-19 restrictions.

Eventually the overall aim is to expand patient access to contraception thereby giving patients choice and convenience with better access to services and support for high-risk communities and vulnerable patients. Better access to services for those that fall outside of typical community pharmacy contraception services e.g. those over 25 and increased use of effective good quality contraception (LARCs).

This will increase the availability of hormonal contraception and LARCs in the community and integrate pharmacies into the provision of sexual health prevention and treatment by testing referrals into pharmacy by General Practice and sexual health clinics.

6.4.5 Alcohol and Drug Misuse Related Harm

Alcohol and drug use are associated with a wide range of health and social harms for the individual, their family and the community. It is both a cause and a consequence of wider issues, including poor physical and mental health, difficulties securing and sustaining employment and housing and crime and antisocial behaviour. All of these issues may also have an impact on family life and the children living within the family unit.

There is a growing awareness about the considerable overlap of populations that experience severe and multiple disadvantage such as:

- alcohol and drug misuse
- homelessness
- poor mental health
- offending behaviours
- domestic abuse

Estimates show that the health, social and economic costs of alcohol related harm amount to £21bn[4], while harm from illicit drug use costs £19.3bn[5]. These include costs associated with crime, the NHS and social care, deaths, and in the case of alcohol, lost productivity in the workplace.

Alcohol and drug prevalence

A study undertaken by the University of Sheffield indicates that there are an estimated 3,839 adults in Barnsley who are alcohol dependent which equates to 1.97% of the adult population. The refreshed figures (published March 2021) show an increase of 8% (n: 288).

[4] PHE (2016) *Health matters: harmful drinking and alcohol dependence* https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence
[5] Dame Carol Black (2020) *Review of Drugs: phase one report* https://www.gov.uk/government/publications/review-of-drugs-phase-one-report

Whilst there are no estimated prevalence figures for individuals who are drinking at harmful levels but are not dependant on alcohol, the Health Survey for England 2011–2014, showed that a large proportion of the Barnsley adult population reported that they drank alcohol (85.5%), which was above both the regional and national averages of 83.2% and 84.5% respectively.

Using the responses from the Health Survey for England 2011–2014, showed that around 1 in 4 adults in Barnsley (25.8%) drank more than 14 units of alcohol a week, which was below of the regional rate (26.2%), but slightly above the national rate (25.7%).

The percentage of those aged 18 years and over who reported drinking more than 6 units of alcohol for women and more than 8 units of alcohol for men on their heaviest drinking days in the last week is used to qualify the binge drinking risk population. Based on the survey results, 19.9% of total adult population in Barnsley were defined as binge drinkers, which was above the regional rate of 17.5% and the national rate of 16.5%.

In 2019 the Public Health Institute Liverpool John Moore's University published a refreshed estimate for the Opiate and Crack using (OCU) population in England and all local authorities. The latest drug prevalence estimates indicate that there are an estimated 1,853 adults in Barnsley who use opiates and crack cocaine (OCU) which equates to 1.2% of the Barnsley population. 1,656 adults use opiates, and 799 adults use crack cocaine, which equates to 1.1% and 0.5% of the Barnsley adult population respectively.

Barnsley Council work closely with key partners to roll out the implementation of national and local drug and alcohol strategies and plans with the overall aim of reducing alcohol and drug related harm across our communities.

Support for alcohol and drug use

Barnsley Council also commission an integrated substance misuse service called Barnsley Recovery Steps. The service is commissioned to deliver drug and alcohol treatment and support to anyone aged 18 years or over who is experiencing problems with substance misuse. This includes alcohol, all illicit and performance enhancing drugs, novel psychoactive substances (previously known as legal highs) and the problematic use of prescribed and 'over the counter' medications.

The service provides a wide range of support which is tailored to individual need and includes harm reduction and early intervention/prevention support as well as structured treatment programmes.

https://www.humankindcharity.org.uk/service/barnsley-recovery-steps

As part of the substance misuse service, Barnsley Recovery Steps are responsible for contracting directly with pharmacies to deliver two pharmacy-based schemes: supervised consumption service, and the community needle and syringe exchange programme.

To support these services Barnsley Recovery Steps hold regular training events to ensure pharmacies and their staff deliver an informed and sensitive service, which links in to the wider treatment service.

There are 8 community pharmacies, delivering the needle and syringe exchange programme covering the following areas: Penistone, Barnsley town centre, Darfield, Hoyland, Wombwell,

Goldthorpe, and Royston. Forty-six pharmacies provide supervised consumption in addition to normal prescription dispensing.

The role of the local pharmacies includes:

- Providing brief interventions and signposting to treatment to address alcohol misuse.
- Needle and syringe exchange.
- Supervision of medication.
- Provide advice and awareness regarding the transmission of Hepatitis B and C.
- Promotion of the benefits of testing for Hepatitis B and C and signposting.
- Referral to treatment services.
- Medicines optimisation.

6.4.6 Older People's Health

There were 52,239 residents in Barnsley aged 50-64 years old in 2020 (see Table 1). This equates to 21% of the Barnsley population. This age group can be described as "older working age" and so can be used when considering the older working age adults' health and need for services. The proportion of the older working age population (aged between 50 and the state pension age) is predicted to increase to 34% in 2050, from a base of 26% in 2012. This is due partly to the state pension age increasing but also to other demographic and societal changes such as a decrease in the younger age population.

In August 2020, Public Health England's Covid-19 Cabinet commissioned the Health Economics and Modelling Team (HEMT) to undertake work to identify the wider public health impacts of Covid-19 and carry out modelling in priority areas to quantify these impacts. One of the areas identified as high priority for further work was older people. This study looks at how the wider impacts of Covid-19 have affected older people (over 65-year-olds), with a focus upon deconditioning and falls. Deconditioning – the loss of physical, psychological, and functional capacity due to inactivity – can occur rapidly in older adults, is not straightforward or quick to remedy and, among other health impacts, increases the risk of falls. This creates a risk that, without mitigation, would see an increase in the rate of falls starting in the summer of 2021 as older adults engage in more physical activity as lockdown restrictions are lifted. This increase is likely to continue if levels of physical activity remain at their current reduced levels. This may increase demand for falls services and put additional strain on hospitals due to emergency admissions and health and social care costs.

Key findings were:

- 32% of older people were inactive (did either no activity or less than 30 minutes of moderate activity per week) between March to May 2020. This has increased from 27% in the corresponding period in 2019.
- Average duration of strength and balance activity decreased from 126 to 77 minutes per week in March to May 2020 compared to the corresponding period in 2019.
- Inequalities in physical activity have persisted, older people in the most deprived group (defined by Index of Multiple Deprivation) were more likely to be inactive than those in the least deprived group in both 2019 and 2020.
- Older people experienced a considerable reduction in strength and balance activity between March to May 2020, with the greatest change in the 70 to 74 age group with a 45% (males) and 49% (females) decrease observed in activity.

- Without mitigation, modelling predicts that:

    - 110,000 more older people (an increase of 3.9%) are projected to have at least one fall per year as a result of reduced strength and balance activity during the pandemic.
    - The total number of falls could increase by 124,000 for males (an increase of 6.3%) and 130,000 for females (an increase of 4.4%).
    - For each year that the lower levels of strength and balance activity observed during the pandemic persist, there is projected to be an additional cost to the health and social care system as a result of the change in predicted related falls of £211 million (incurred over a 2 and half year period).

By 2025 it is estimated that there will be a 30% increase in people aged over 75 years living alone, and an increase of 20% in people over 65-years-old unable to manage at least one self-care activity on their own.

The growing population of older people is also estimated to increase demand for care homes. The changing age profile of residents is anticipated to change the support required with individuals already presenting with increasingly complex, high dependency needs. National evidence suggests we can expect to see a gender difference in dependency, with higher numbers of women experiencing severe disability or requiring help with self-care tasks.

In the context of an ageing population, greater attention will need to be paid to the way in which we provide prevention and early intervention and increasingly integrated, community-based support when problems occur that will help to maintain the independence of the older person. Key health needs relate to mental health (particularly depression), sensory impairment, frailty/disability, dementia, multiple morbidity (and related medicine use), and health and social care service use.

Role of local pharmacies

- Medicines use reviews.
- Medicines optimisation.
- Minor ailments scheme.
- Access to palliative care medicines.
- Advice to care homes.
- Falls care pathway.
- Seasonal influenza vaccination.
- Dementia Friendly Pharmacy.
- Providing support and advice for carers.
- Provide support and advice around maintaining independence.
- Promoting the benefits of and signposting to screening for sight/hearing problems including Public Health pharmacy campaign related to preventable sight loss.

6.4.7 The Health of Families, Children and Young People

There is now overwhelming evidence that conception through to the early years is a crucial phase of human development and is the time when focussed attention can bring huge rewards for society. Infants thrive when they feel safe, secure, and loved. Therefore, the foundations for children's communication, social and emotional development and nutrition lie in the quality of the parent-infant relationship, and the interactions they experience.

Child poverty and deprivation is one of the most important factors determining health inequalities in childhood and throughout life. We now have a very good understanding from research that a child's physical, social, and cognitive development during the early years strongly influences their school readiness, educational attainment, their employment chances, and general health and wellbeing outcomes through to adulthood and older age.

Supporting parent-infant relationships is a priority for Barnsley. We know that the mental and physical health of mothers during and immediately after pregnancy can have lifelong impacts on the child. Factors such as nutrition, smoke exposure and decisions about immunisation will impact on the child's future health and wellbeing. Key priorities continue to include reducing maternal obesity, improved support for post-natal depression, increasing breastfeeding, reducing smoking in pregnancy, reducing teenage pregnancy, and increasing childhood vaccination and immunisation.

Role of local pharmacies

- Promoting the values of breastfeeding and signing up to the Barnsley 'Breastfeeding Welcome Here' Scheme.
- Promoting the importance of immunisation and vaccination, including signposting to relevant support.
- Raising awareness of the potential consequences of leaving children unvaccinated, especially within vulnerable communities.
- Promote and provide advice and support in relation to stopping smoking, reducing alcohol consumption, and maintaining a healthy weight, particularly during pregnancy.
- Promoting the Healthy Start Scheme and providing information about when vitamin supplements should be taken in pregnancy and infancy, and where Healthy Start vitamins can be obtained.
- Supplying vitamin supplements in pregnancy and infancy.
- Promoting and providing advice in relation to adolescent health needs – particularly as these relate to sexual health, mental health, smoking, alcohol consumption and drug misuse.
- Providing free Emergency Hormonal Contraception (EHC) and signposting to sexual health services.
- Minor ailments scheme.
- Seasonal influenza vaccination (pregnant women).

6.4.8 Obesity

Obesity, poor diet, and increasingly sedentary behaviour are associated with a higher risk of hypertension, heart disease, diabetes, and certain cancers. It can also impair a person's wellbeing, quality of life and ability to work.

As is the case regionally and nationally, excess weight is a major public health issue in Barnsley. More than 7 out of 10 (73%) of the Barnsley adult population are classified as being overweight or obese; this is significantly worse than the England average of 62.8%.

Barnsley Metropolitan Borough Council commissions the Barnsley Wellbeing Programme which is a free 12-week initiative that supports adults to make positive lifestyle changes to help manage weight and control health.

The Barnsley Wellbeing Programme includes:

- An initial one-hour health assessment at the Metrodome Leisure Centre, Hoyland Leisure Centre, Royston Leisure Centre or Dearneside Leisure Centre.
- One-to-one and group support to help increase your awareness of diet, nutrition, and physical activity.
- Check-ins on weeks four and eight to review progress. You can contact the team at any time for additional support.
- Diet and nutrition support from an onsite nutritionist throughout the programme.
- A full review and assessment at week 12 to record the progress you have achieved.
- Unlimited access to gym, swim, and group exercise classes.

You can request a referral from your GP or can view more information and self-refer online here: https://bpl.org.uk/community-health/weight-management/

Barnsley SY ICB commissions a Tier 3 Change4Life weight management service to support obese residents (adults and children) in Barnsley to achieve a healthier weight. This includes medical assessment of clients, treatments, and lifestyle changes such as improved diet, increased physical activity, behavioural interventions, low and very low-calorie diets, pharmacological treatments, psychological support, and the consideration of referral for bariatric surgery if clinically appropriate.

More information can be found here: https://www.southwestyorkshire.nhs.uk/services/barnsley-tier-3-change4life-weight-management-service/

Role of local pharmacies

- Promoting, signposting, providing advice and support to maintaining a healthy weight.

6.4.9 Physical Activity

Active in Barnsley is the physical activity strategic plan for Barnsley. It feeds into the Barnsley Health and Wellbeing Strategy and the Barnsley 2030 Plan. Increasing physical activity levels across the population is a complex challenge with no single solution. Therefore, in Barnsley we will continue to work together to help all Barnsley residents, especially those in greatest need, experience the benefits of being more physically active. Our vision is:

Physical activity includes any form of movement which raises the heart rate. It can include daily living tasks such as housework and gardening, transport such as cycling, walking, and scooting, as well as more organised activities such as using the gym, Parkrun or playing team sport.

Physical activity and exercise can help:

- Strengthen our heart, lungs and bones.
- Improve our mood and reduce anxiety.
- Reduce the risk of developing several diseases such as type 2 diabetes, cancer, and cardiovascular disease.
- Positively boost our immune system, strengthen our heart, lungs, and bones.

The latest data indicates that 54.2% of adults in Barnsley are active (doing at least 150 minutes physical activity per week). This is less than the England rate of 60.9%. The data also indicates that 35.8% of adults are physically inactive (doing less than 30 minutes physical activity per week). This is significantly higher than England's rate of 27.5%. (Active Lives Survey, November 2019/20).
The Barnsley data picture shows that that there is more we need to do to help people to be more active. One of the best ways we can promote being more active is through our What's Your Move campaign (www.BarnsleyWhatsYourMove.co.uk)

Role of local pharmacies

- To advertise the What's Your Move campaign assets as a way of encouraging people to be active.
- Promote physical activity as part of condition management.

6.4.10 NHS Health Checks

The NHS Health Check programme aims to prevent heart disease, stroke, type 2 diabetes, kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups. Adults between the ages of 40 and 74, who have not already been diagnosed with one of these conditions can be invited (once every 5 years) to have a check to assess their cardiovascular risk and be offered support and advice to help the individual to reduce or manage their risk.

The NHS Health Checks programme in Barnsley has been delivered by general practices since its introduction in 2009. In 2018, the programme was commissioning by a separate provider who used an opportunistic community outreach approach and subcontracted to GP practices and pharmacies.

Due to the Covid-19 pandemic in 2020, the NHS Health Check service was significantly affected due to national guidance around face-to-face contact. Due to ongoing uncertainty the contract was allowed to expire on 31 March 2021. Data from March 2020 to April 2021 show that 34% of eligible people offered an NHS Health Check received one. This is significantly lower than the England average of 39%.

NHS Health Checks are a statutory public health service commissioned by Barnsley Council and the authority intend to recommission a service following the latest recommendations from an evidence based national review of the programme by Public Health England.

Role of local pharmacies

- Promoting the benefits of and signposting to Health Checks.

7. Current Provision of NHS Pharmaceutical Services in Barnsley

The PNA identifies and maps the current provision of pharmaceutical services in order to assess the adequacy of provision of such services.

7.1 Pharmacy Service Providers – number and geographical distribution

Community Pharmacies

There are a total of 50 community pharmacies in Barnsley as of 24/03/2022. Figure 1 illustrates their location.

Dispensing GP Practices

There are three GP dispensing practices in Barnsley as of 24/03/2022. Figure 1 illustrates their location.[6]

Distance Selling Pharmacies

There was one distance selling pharmacy within Barnsley as of 24/03/2022. This pharmacy is based in Central Area Council.

Patients have the right to access pharmaceutical services from any community pharmacy including mail order/internet pharmacy of their choice and therefore can access any of the many internet pharmacies available nationwide.

Dispensing Appliance Contractor

There are currently two Dispensing Appliance Contractors (DACs) in Barnsley:

- Fittleworth Medical Ltd, Thurnscoe.
- Atos Medical, Carlton.

Appliances are also available from community pharmacies, dispensing GP practices and other DAC outside Barnsley.

[6] NHSBSA Dispensing Contractors data, March 2022

7.2 Comparison with Pharmaceutical Service Provision Elsewhere

Assuming a population of 248,071, in Barnsley and 50 community pharmacies; there is an average of one pharmacy provider per 4,961 people. This is slightly higher than the England average of 4,781 people per pharmacy.

This can also be quantified as 20 pharmacies per 100,000 people in Barnsley which is similar to the England average, and slightly below the Yorkshire and Humber average (see Table 4 below). The figure for England (11,826) is the lowest number of active contractors since 2015/16.

Table 4. Community pharmacies on the pharmaceutical list and population by NHS England Region, 2019/20

	Number of community pharmacies	ONS Population (000s) mid 2020	Pharmacies per 100,000 population
ENGLAND	11,826	56,286,961	21
Yorkshire & Humber	1,303	5,502,967	24

Sources: NHS Prescription Services, Population estimates - Office for National Statistics, NHS Digital https://www.nhsbsa.nhs.uk/statistical-collections/general-pharmaceutical-services-england/general-pharmaceutical-services-england-201516-201920

7.3 Area Council Pharmaceutical Service Provision

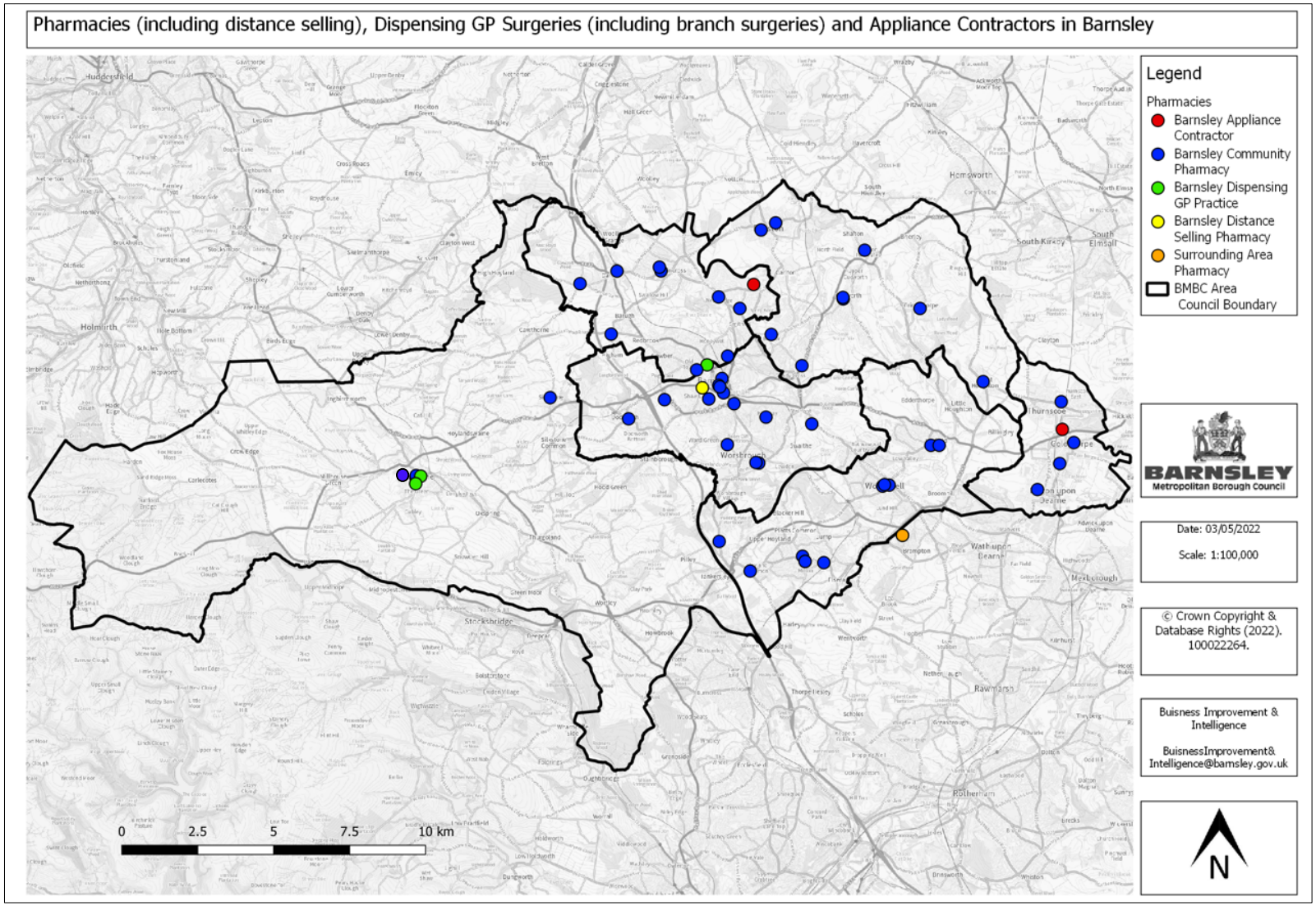
Table 5 illustrates that at an Area Council level there are between 3,841 and 8,340 people per pharmacy. Overall, this is lower than the average for England of 4,759 people per pharmacy, representing slightly better or similar coverage to the national position. Whilst Penistone Area Council has the highest population per pharmacy (8,340), this area also has the largest proportion of dispensing GP practices in the borough.

Table 5. Community Pharmacies by Area Council

	Number of pharmacies	Population	Population per pharmacy	Pharmacies per 100,000 population	Pharmacies per 100,000 population (previous PNA)
Central	14	57,628	4,116	24	27 (-3)
South Barnsley	11	47,765	4,342	24	24 (-)
North Barnsley	9	44,201	4,911	20	21 (-1)
Dearne	5	23,583	4,716	21	22 (-1)
North East	9	48,667	5,407	18	19 (-1)
Penistone	3	25,022	8,340	8	12 (-)

Source: PHE Shapeatlas & ONS mid-2020 population estimates

Figure 8. Pharmacies (including distance selling, dispensing general practices and appliance contractors in Barnsley)



8. Access

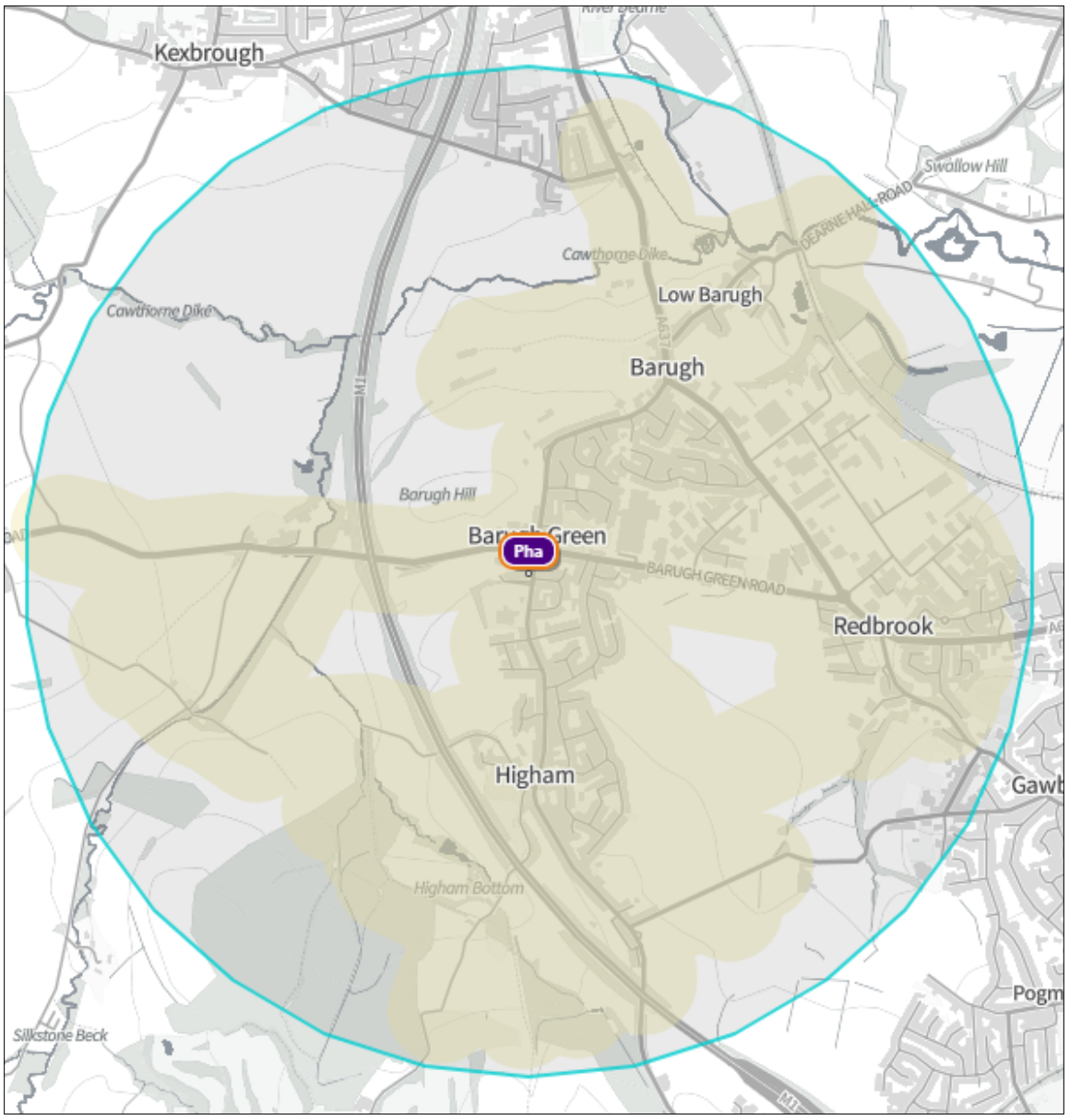
An important part of the PNA is to assess how accessible pharmacies are to residents. This is measured by geographical access and opening times

8.1 Geographical Access

Geographical access is measured by the proportion of residents who are within a 1.6km (1mile) walk of a pharmacy and by the proportion of residents who are within a 10-minute drive of a pharmacy.

Analysis in the SHAPE tool is undertaken to determine access. This helps to give a better indication of access, particularly walking access, than using a fixed radius around a pharmacy. This is demonstrated below. Figure 9 shows a 1.6km circle around Barugh Green Pharmacy in light purple and a 1.6km walking distance in pale yellow.

Figure 9. Example of geographical access analysis – Barugh Green Pharmacy



8.1.1 Results

Using the SHAPE access tool, the following results have been calculated. To prepare these results consideration was also given the pharmacies outside of Barnsley that could be reached within a 1.6km walk. Twenty-one such pharmacies were identified within 1.6km of the Barnsley boundary. Of these, only the two pharmacies located at Cortonwood (as indicated on Figure 1) are close enough to improve access.

The analysis shows that the proportion of Barnsley residents within a 1.6km (1 mile) walk of a pharmacy is 92%, and 99.2% are within a 10-minute drive of a pharmacy.

The walking access measure shows an increase from 88.8% reported in the 2018-2021 PNA, though it should be noted that the lower number in the previous PNA was deemed to be a result of a change in the methods of analysis rather than a change in the population or pharmacy provision. Previously, walking access had been reported as 95.2%.

The driving access measure shows a similar picture to the previous PNA with access within a 10-minute drive to over 99% of residents. Analysis shows that everyone in Barnsley is within a 15-minute drive of a pharmacy.

8.2 Opening Times

The majority of Barnsley's community pharmacies are open Monday to Friday between 9.00am and 6.00pm. Two pharmacies are open until 11.00pm (one opens at 7.00am and the other at 8.00am). The remaining pharmacies' opening times vary, opening between 7.00am and 9.00am and closing between 5.30pm and 10.30pm. One pharmacy opens at 6:30am Tuesday to Saturday, closing at 22:30 Tuesday to Friday and 22:00 on a Saturday.

Twenty pharmacies open on a Saturday, 10 of which close by 1.00pm. Three pharmacies are open until 10.00pm and one closes at 11.30pm. The remaining pharmacies that open on a Saturday have varying opening times, opening between 6:30am and 9.00am and closing between 5.00pm and 8.00pm.

Seven pharmacies open on a Sunday. Two of these open at 9.00am with the remainder opening at 10.00am. Closing times vary between 2:00pm and 5:00pm (6 pharmacies), and 10.00pm (one pharmacy).

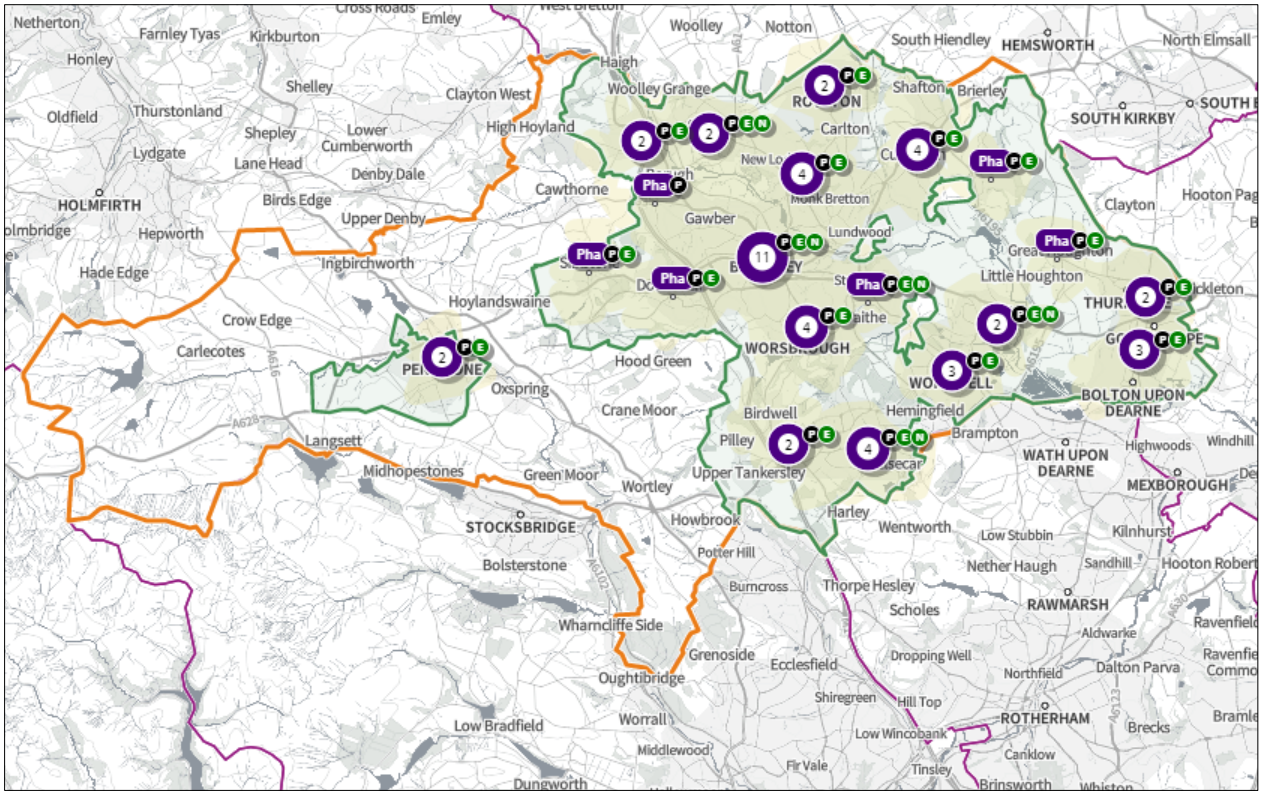
Community pharmacy opening times and contact details can be accessed via the NHS Choices website http://www.nhs.uk/Service-Search/Pharmacy/LocationSearch/10

The opening hours for dispensing GP practices and branch dispensing GP practices were identified using the NHS Choices website http://www.nhs.uk/Service-Search/

It is assumed that the dispensaries at the dispensing GP surgeries are open at the same hours as the rest of the practice.

SHAPE tool analysis shows that 92% of Barnsley residents live with a mile of a pharmacy that has evening or Sunday opening.

Figure 10. Population within a mile of pharmacies that have evening or Sunday opening



8.2.1 Extended Opening Hours

There are currently five ‘100 hour’ pharmacies in Barnsley. These are included in the pharmaceutical list under regulation 13(1)(b) of the National Health Service (Pharmaceutical Services) Regulations 2005; premises which the applicant is contracted to open for at least 100 hours per week for the provision of pharmaceutical services. The 100-hour pharmacies are:

- Stone Pharmacy, Darfield
- Asda Pharmacy, Barnsley
- Cohens Chemist, Hoyland
- Gatehouse Pharmacy, Mapplewell
- Tesco Instore Pharmacy, Barnsley

The ‘100-hour’ pharmacies are geographically located across the borough giving good access to pharmaceutical services on Saturdays, Sundays and late-night opening.

Due to changes in shopping habits a number of pharmacies now open on many Bank Holidays, although they are not contractually obliged to do so. NHS England works with community pharmacies to ensure an adequate rota service is available for Christmas Day, Boxing Day, New Year’s Day and Easter Sunday as these are days where pharmacies are still traditionally closed. NHS England is responsible for working with community pharmacies to ensure an adequate rota.

9. Pharmaceutical Services

Community pharmacies provide three tiers of pharmaceutical services:

- Essential services – services all pharmacies are required to provide.
- Advanced services – services to support patients with safe use of medicines.
- Enhanced services – services that can be commissioned by NHS England.
- Locally commissioned services – services that are mainly commissioned by the CCG and local authority.

Appendix 2 outlines the enhanced and commissioned services by pharmacy in the Borough.

9.1 Community Pharmacy Essential Services

All community pharmacies are required to provide all the essential services. These services are:

- Dispensing Medicines
- Dispensing Appliances
- Repeat Dispensing
- Clinical Governance
- Discharge Medicines Service
- Public Health (Promotion of Healthy Lifestyles)
- Signposting
- Support for Self-Care
- Disposal of Unwanted Medicines

NHS England is responsible for ensuring that all pharmacies deliver all of the essential services as specified. Each pharmacy has to demonstrate compliance with the community pharmacy contractual framework by providing sufficient evidence for delivery of every service. Any pharmacy unable to provide the evidence will be asked to provide an action plan, outlining with timescales how it will then achieve compliance. These self-assessments are supported by contract monitoring visits.

All Barnsley pharmacies have been assessed as compliant with the contract to date. NHS England will continue the work previously undertaken by NHS Barnsley to work with pharmacies and their representative organisation to provide this assurance of service delivery.

9.2 Public Health Campaigns

As part of the essential services, at the request of NHS England, NHS pharmacists are required to participate in up to six campaigns each year to promote public health messages to their users.[7] Participation in these campaigns is part of the community pharmacy essential services.

[7] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 No.349 Schedule 4 http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf (Accessed 25th March 2022).

Pharmacies can download a variety of marketing campaigns and resources and materials from Public Health England's campaigns resource centre:
https://campaignresources.phe.gov.uk/resources/

Campaigns include Healthier You, 10 Minute Shake Up, Change 4 Life, Be Clear on Cancer, Act F.A.S.T., Sepsis, Every Mind Matters, Stoptober; Stay Well This Winter, Breast Cancer, NHS 111, and NHS Health Checks.

Pharmacies can use the materials to promote public health messages to members of the public and share with colleagues involved in workplace health and wellbeing.

9.3 Community Pharmacy Advanced Services

In addition to essential services the community pharmacy contractual framework allows for several advanced services. Community pharmacies can choose to provide any of these services if they meet the requirements set out in the Secretary of State Directions. Advanced services currently include Appliance Use Reviews (AUR), Community Pharmacist Consultation Service (CPCS), Flu Vaccination Service, Hepatitis C Testing Service, Hypertension Case-Finding Service, New Medicine Service (NMS), Stoma Appliance Customisation (SAC), and Smoking Cessation Service.

9.4 Community Pharmacy Enhanced Services

Pharmaceutical service providers are an important part of primary care. As well as dispensing prescriptions they provide information about medicines, self-care, general health care, and other sources of advice. They complement services provided by general practice.

The third tier of pharmaceutical service that can be provided from pharmacies are the Enhanced Services. These are services that can be commissioned from pharmacies by NHS England.

Every pharmacy has a responsibility to direct patients to an alternative pharmacy that can provide the service they need.

These services can only be referred to as enhanced services if they are commissioned by NHS England. If local services are commissioned by the CCG or a local authority they are referred to as locally commissioned services (see 9.5).

9.5 Barnsley Clinical Commissioning Group Locally Commissioned Services

For Barnsley, the following services are locally commissioned by the Clinical Commissioning Group. Further information on locally commissioned services is available on the Barnsley LPC website at https://psnc.org.uk/services-commissioning/locally-commissioned-services/.

9.5.1 Advice to Care Homes Service

Community pharmacies may be commissioned to provide advice and support to the residents and staff of care homes in Barnsley to improve safety and patient care. This service extends beyond the Dispensing Essential service and aims to ensure:

- Medicines are ordered within a safe, timely process, which ensures the maintenance of adequate stock of medicines whilst avoiding waste.
- Medication and appliances are used in a clinically appropriate, cost effective manner.
- Safe systems exist in relation to the storage, administration, and disposal of medication, whether it is prescribed or purchased.
- Proper record keeping is used to support the delivery and continuity of care.

Care Homes in Barnsley, registered with the Care Quality Commission (CQC) are contacted about receiving the service. The service may also be available to care homes whose residents are predominantly registered with a GP in the Barnsley area. Community pharmacies providing the service are expected to visit the care homes they serve, actively maintaining a relationship. The pharmacy does not however need to be situated geographically within Barnsley.

The service is commissioned by Barnsley CCG.

9.5.2 Specialist Drug Stockist Service (on demand availability of specialist drugs service)

The Specialist Drug Stockist Service aims to create a network of community pharmacies who will stock a locally agreed range of specialist drugs, the demand for which may be urgent and/or unpredictable, for example, palliative care drugs. The service aims to ensure that users of the service have prompt access to these specialist drugs when they are required. The service can be provided by any pharmacy, though due to the nature of the service community pharmacies are invited to provide the service based upon their opening hours and location to ensure these specialist drugs can be easily accessed when needed. Barnsley's Palliative Care Team is the most frequent user of the service which is accessed as and when required by palliative care staff.

The service is commissioned by Barnsley CCG.

9.5.3 Medication Management System Service (medicines assessment and compliance support service)

The Medication Management System Service aims to implement a controlled safe environment where home carers are able to carry out the controlled administration of medication that meets the specific needs of each service user. The service can be provided by pharmacists who hold a relevant Medicines Use Review (MUR) qualification and have undergone a Disclosure and Barring Service (DBS) check. Service users are referred to the nearest pharmacy which provides the service, and an initial Medical Management Service Medication Review is undertaken, usually in the service user's home. From this information a Medication Plan detailing the nature and level of support required for the service user is created. Service providers are expected to undertake reviews to ensure the service user's Medication Plan remains current.

The service is commissioned by Barnsley CCG.

9.5.4 Pharmacy First (minor ailment scheme)

The Pharmacy First scheme aims to direct Barnsley patients to local pharmacies for the initial treatment of minor conditions such as pain, dermatitis, heartburn, nasal congestion, constipation, headache, and cough. Pharmacy staff will use their existing knowledge and procedures to undertake the patient consultations and will advise patients to obtain appropriate treatment should their symptoms indicate a more serious condition or supply an 'over the counter' pack of medication.

The service is open to all patients registered with a Barnsley GP. As with NHS prescriptions, medicines supplied to patients who don't normally pay for their prescriptions will be free. Patients who pay for their prescriptions may be encouraged to purchase their medication, as the cost of the medication should be much less than the prescription charge. However, all patients may still benefit from the additional printed advice material about their symptoms. Further information is available on the Barnsley CCG website:
http://www.barnsleyccg.nhs.uk/patient-help/pharmacy-first.htm

9.5.5 "Not Dispensed" Scheme

The Barnsley CCG "Not Dispensed" Scheme is to help address the substantial waste medicines problem. The scheme allows the pharmacist to intervene, identify and thus prevent the dispensing of those items included on repeat prescriptions, which the patient does not require at the time of dispensing.

Pharmacists or appropriately qualified staff should check with all patients presenting at their pharmacy with a repeat prescription. The patient will be asked if all the items prescribed need to be dispensed or supplied that month. For any items which the patient indicates they do not take regularly, the following questions may be asked:

1. Have they stock at home of the item?
2. Do they require all the items ordered on the prescription?

For any items that are not required by the patient, the prescription item will be endorsed with a clear 'not dispensed'.

The overall aim of the service is to reduce medicinal waste and unnecessary ordering of repeat items. Further information is available on the Barnsley LPC website at:
http://psnc.org.uk/barnsley-lpc/bccg-payment-not-to-dispense/

9.5.6 Minor Eye Care Service (MECS)

The Minor Eye Care Service (MECS) is a free eye care service available to all patients registered with a Barnsley GP, for minor eye conditions that might normally require a visit to the doctor. It is hoped that this will reduce unnecessary appointments at GP practices and at the acute services.

The service was reviewed early in 2018 and the CCG has now expanded what is available to include assessments for people who may need cataract surgery. Appointments are available at over 25 opticians across the borough. Patients will be asked questions about the symptoms to assess how serious the problem is and will be seen by an optician within 24 hours if required or within a few days if it is less urgent.

The optometrist assesses and treats the condition or can make an onward referral for further treatment and or advice in relation to a number of specified minor eye conditions for example dry or painful eyes, sudden reduced vision or in-growing eyelashes.

Further information is available on the LPC website at:
https://barnsley.communitypharmacy.org.uk/locally-commissioned-services/barnsley-ccg/mecs/

10. The Changing Face of Pharmacy

It is important to note the ways in which pharmacy and its role within the community has changed since the last PNA was produced and how this may develop over the next three years.

The Community Pharmacy Forward View (2016)[8] sets out the sector's ambitions to radically enhance and expand the personalised care, support, and wellbeing services that community pharmacies provide. The document outlines how pharmacy teams could be fully integrated with other local health and care services in order to improve quality and access for patients, increase NHS efficiency and produce better health outcomes for all. In particular, it focuses on the following three key roles for the community pharmacy of the future:

As the facilitator of personalised care for people with long-term conditions

Community pharmacists and their teams will support people with long-term conditions and their carers by providing a one-stop hub for advice, treatment and co-ordination of care related to medicines. This will include support following diagnosis, monitoring, and adjusting treatment according to outcomes defined in an individual's care and support plan, and ensuring that all medicine's related aspects of care are managed safely and efficiently when someone's circumstances change, for example, when admitted to or leaving hospital.

To achieve this vision, community pharmacists and their team will work in partnership with their colleagues across the wider health and care system. In some areas, people will be able to register with a community pharmacy to coordinate their care and support them with management of their long-term condition, where this is agreed as appropriate between the individual, their GP, and pharmacist.

As the trusted, convenient first port of call for episodic healthcare advice and treatment

Thinking 'pharmacy first' for non-emergency episodic care will become the public norm. To achieve this vision, systems that enable seamless triage to, and referral from, community pharmacy will be include in all local urgent care pathways and in the NHS 111 service. Pharmacies will provide access to diagnostics and be able to make appointments with other health professionals. Pharmacists will be able to prescribe as well as supply products.

As the neighbourhood health and wellbeing hub

Pharmacies will operate as neighbourhood health and wellbeing centres, becoming the 'go-to' destination for support, advice, and resources on staying well and living independently. As a trusted local community resource, all pharmacies will be connected with other organisations that support health, wellbeing and independence – ranging across local community groups, charities, places of worship, leisure and library facilities, social care, education, employment, housing, and welfare services – and will be able to refer and sign-post people to them. Community pharmacists and their teams will work closely with employers to support workplace health initiatives, and will help people make best use of data, technology, and devices they use to monitor and manage their own physical and mental health and wellbeing.

[8] https://psnc.org.uk/national-pharmacy-services/community-pharmacy-forward-view/ (Accessed 8th July 2022)

11. Conclusions

The aim of a pharmaceutical needs assessment is the requirement to assess the extent to which the demography of the local population and its health needs are met by the current provision of pharmaceutical services.

Based on the information available at the time of developing this PNA no gaps have been identified in the:

- Provision of essential services.
- Provision of essential services outside normal working hours.
- Provision of advanced or enhanced services.
- Need for essential, advanced or enhanced services in specified future circumstances have been or would provide improved access and choice.

In summary, our analysis of this information shows that:

- Community pharmacies have an important role to play in improving the health of the Barnsley population. They can contribute to the identified health needs of the population in a number of ways, including motivational interviewing, providing information and brief advice, providing on-going support for behaviour change and signposting to other services.

- Barnsley has good coverage across the borough for pharmaceutical services in terms of choice, access, and opening hours, with no gaps in current provision.

- Barnsley and each of the six Area Councils have slightly better or similar coverage of community pharmacies compared to the England average. In the Area Council where pharmacy coverage is slightly lower than regional and national averages, there is good coverage provided by dispensing GP practices, and this is not considered a gap in provision.

- The majority of Barnsley residents live within a one-mile (1.6km) radius or a ten-minute drive of a pharmacy.

- An increase in population is likely to generate increased demand for pharmaceutical services, but on a local level, changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical services providers. The Health and Wellbeing Board will monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, in accordance with regulations.

Appendix 1. What services do pharmacists offer?[9]

Pharmacists dispense prescriptions and other medicines, offer testing and screening for common conditions, and can advise on minor ailments. Not all pharmacies supply the same services and depend on NHS priorities in that area.

The services that may be available from your local pharmacy are:

Essential Services – which are set out in schedule 4 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the 2013 Regulations). All pharmacy contractors must provide the full range of essential services, these include:

- Dispensing medicines and actions associated with dispensing (e.g. keeping records).
- Dispensing appliances.
- Repeat dispensing.
- Clinical governance.
- Discharge Medicines Service.
- Disposal of unwanted medicines.
- Public health – (promotion of healthy lifestyles).
- Signposting.
- Support for self-care.

Advanced Services

There are several Advanced Services within the NHS pharmacy contractual framework (CPCF). Community pharmacies can choose to provide any of these services if they meet the requirements set out in the Secretary of State Directions.

- Appliance Use Review (AUR)
- C-19 Lateral Flow Device Distribution Service[10]
- Community Pharmacist Consultation Service (CPCS)
- Flu Vaccination Service
- Hepatitis C Testing Service
- Hypertension Case-finding Service
- New Medicine Service (NMS)
- Pandemic Delivery Service
- Stoma Appliance Customisation (SAC)
- Smoking Cessation Service (SCS)

A breakdown of Advanced Services delivery by pharmacies in Barnsley is provided in Appendix 2.

[9] https://www.nhs.uk/nhs-services/prescriptions-and-pharmacies/pharmacies/how-your-pharmacy-can-help/ (accessed 30/03/2022)

[10] Following the Prime Minister's announcement on 21 February 2022 and the publication of the Government policy document 'COVID-19 Response: Living with COVID-19', free Covid-19 mass testing ended from 1 April 2022. This means the last day on which the Pharmacy Collect service and Pandemic Delivery Service operated was 31 March 2022.

Enhanced Services - Only those contractors directly commissioned by NHS England can provide these services. The National Health Service Act 2006, The Pharmaceutical Services (advanced and enhanced services) (England) Directions 2013, Part 4 14.-(1) outlines the enhanced services: https://www.gov.uk/government/publications/pharmaceutical-services-advanced-and-enhanced-services-england-directions-2013

Appendix 2. Advanced Services

A breakdown of advanced services by pharmacies in Barnsley is provided below (as at 24/03/2022).

= Dispensing appliance contractor

Pharmacy ODS Code	Pharmacy Name and Type	Area	NMS	AUR	Stoma	CPCS	Flu
FA174	Penistone Pharmacy	Penistone	*	-	-	*	*
FAW19	Ward Green Pharmacy	Ward Green	*	-	-	*	*
FC277	Rowlands Pharmacy	Wombwell	*	-	*	*	*
FC898	Weldricks Pharmacy	Royston	*	-	*	*	*
FCL44	Well Cudworth - Barnsley Rd	Cudworth	*	-	-	*	*
FCR37	Lloyds Pharmacy	Kendray	*	-	-	*	*
FD418	Asda Pharmacy 100 hour	Old Mill Lane, Barnsley	*	-	-	*	*
FDC49	Atos Medical		-	*	-	-	-
FDP29	Cohens Chemist	Hoyland	*	-	-	*	*
FDW01	Cohens Chemist 100 hour	Hoyland	*	-	-	*	-
FDX94	Darton Pharmacy	Darton	*	-	-	*	-
FE054	Lo's Pharmacy	Grimethorpe	*	-	-	*	*
FEE20	Weldricks Pharmacy	Bolton-upon-Dearne	*	-	*	*	*
FEM92	Rowlands Pharmacy	Wombwell	*	-	*	*	*
FEN19	Rowlands Pharmacy	Mapplewell	*	-	*	*	*
FET26	Weldricks Pharmacy	Thurnscoe	*	-	*	*	*
FFR35	Barnsley Enterprises Ltd		-	-	-	-	-
FFV49	Well - The Roundhouse Medical Centre	Wakefield Rd, Barnsley	*	-	-	-	*
FG196	Weldricks Pharmacy	Goldthorpe	*	-	*	*	*
FG545	Weldricks Pharmacy	Royston	*	-	*	*	*
FGA75	Shafton Pharmacy	Shafton	*	-	-	-	*
FGJ55	Lloyds Pharmacy	Barnsley Interchange	*	-	-	*	*
FH042	Ellisons Chemist	Huddersfield Rd, Barnsley	*	-	-	*	*
FHE60	Rotherham Road Pharmacy	Rotherham Rd, Barnsley	*	-	-	*	*
FHW40	Tesco Instore Pharmacy 100 hour	Stairfoot	*	-	-	*	-

FJ350	Your Local Boots Pharmacy	Worsbrough	*	-	-	*	*
FJ831	Gatehouse Pharmacy 100 hour	Mapplewell	*	-	-	*	*
FJM57	Well Hoyland - Hoyland	Hoyland	*	-	-	*	*
FK428	Lloyds Pharmacy	Cemetery Rd, Barnsley	*	-	*	*	*
FKD60	Lo's Pharmacy	Worsbrough	*	-	-	*	*
FL895	Ellisons Chemist	Park Grove, Barnsley	*	-	-	*	*
FLG43	Well Darfield - Snape Hill Rd	Darfield	*	-	-	*	*
FLH72	Weldricks Pharmacy	Goldthorpe	*	-	*	*	*
FLJ06	Superdrug Pharmacy	Cheapside, Barnsley	*	-	-	*	-
FM248	Well Hoyland Common - Hoyland Road	Hoyland Common	*	-	-	*	*
FMV43	A M Clark	Penistone	*	-	-	*	*
FND79	R D Hill (Chemists) Ltd	Athersley South	-	-	-	*	*
FNK91	Birdwell Pharmacy	Birdwell	*	-	-	*	*
FNN73	Silkstone Pharmacy	Silkstone	*	-	-	*	*
FPF32	Z A Akram Ltd	Wombwell	*	-	-	*	*
FPJ07	Cohens Chemist	Dodworth	*	-	-	*	*
FQH55	Cohens Chemist	Hoyland	*	-	-	-	*
FR397	Z A Akram Ltd	Monk Bretton	*	-	-	*	-
FTF36	Kexborough Pharmacy	Kexborough	*	-	-	*	*
FTH41	SKF Lo Chemist Ltd	Lundwood	*	-	-	*	*
FTK41	Stone Pharmacy 100 hour	Darfield	*	-	-	*	*
FTP17	Tripharm	Woodland Drive, Barnsley	*	-	-	*	*
FV303	Cohens Chemist	Victoria Cres West, Barnsley	*	-	-	*	-
FV519	Well Cudworth - Cudworth	Cudworth	*	-	-	*	*
FWX74	Barugh Green Pharmacy	Barugh Green	*	-	-	*	*
FXF21	R T Elliott Ltd	Burleigh St, Barnsley	-	-	-	-	-
FXG29	Fittleworth Medical Ltd		-	-	*	-	-
FY192	Boots	Cheapside, Barnsley	*	-	-	*	-

Appendix 3. Results from the Statutory 60-day Consultation (16 May to 15 July 2022)

This summary outlines the response from the Pharmaceutical Needs Assessment (PNA) Steering Group to the feedback obtained in the consultation on the PNA for Barnsley.

The PNA consultation ran from 16 May until 15 July 2022, and was made known to key stakeholder organisations and members of the public:

- Barnsley Community Pharmacies
- Dispensing GPs
- Barnsley Pharmaceutical Needs Assessment Steering Group
- Barnsley Council's Senior Staff Development Group
- South Yorkshire Integrated Care Board (SY ICB), Barnsley
- BCCG's Patient Safety and Quality Committee
- Barnsley Hospital NHS Foundation Trust
- Local Healthwatch
- Local Pharmaceutical Committee
- Local Medical Committee
- South West Yorkshire Partnership NHS Foundation Trust
- Barnsley Health and Wellbeing Board
- Doncaster Health and Wellbeing Board
- Rotherham Health and Wellbeing Board
- Sheffield Health and Wellbeing Board
- Wakefield Health and Wellbeing Board
- Kirklees Health and Wellbeing Board

and through a variety of communication channel and targeted correspondence:

- Barnsley Council's website (www.barnsley.gov.uk/pna)
- Barnsley Council's social media accounts (twitter @barnsleycouncil and Facebook www.facebook.com/barnsleycouncil)

To facilitate the consultation the draft PNA report was uploaded onto Barnsley Council's website. To allow comment and feedback a short survey form was developed to complete. This method of consultation was undertaken to reduce the amount of paper sent out and to limit the environmental impact. Hard copies were available upon request as we considered people who could not access the survey digitally.

There were 38 respondents to the consultation questionnaire. The consultation was undertaken in a manner which made it possible for many of those who have a stake in pharmaceutical services in Barnsley to respond, should they wish to do so. Of note, the consultation was sent to neighbouring Health and Wellbeing Boards in accordance with the national PNA guidance.

A summary of the feedback obtained through the consultation is described in the table below. The table sets out the response from the PNA Steering Group where appropriate. It is noted that the majority of responders were supportive of the messages reported in the draft PNA.

Summary of feedback to the consultation on the draft Pharmaceutical Needs Assessment for Barnsley and responses to this feedback including revisions to the final PNA report

Consultation Question: Q1. Has the purpose of the PNA been clearly explained?	
Summary of Feedback	**Response from the PNA Steering Group on behalf of Barnsley Health and Wellbeing Board**
27 respondents felt that the purpose of the PNA had been clearly explained. **3 respondents strongly disagreed. 7 neither agreed nor disagreed and 1 did not know.** The reasoning provided by the respondents who strongly disagreed was in relation to the length of the document being 54 pages long.	• We would agree that the PNA is a long document, however the PNA is a complex process that needs to fully comply with Pharmaceutical Regulations - A failure to produce a legally compliant PNA could result in a legal challenge.
Consultation Question: Q2. Are you aware of any current pharmacy services that are not mentioned in the draft PNA?	
Summary of Feedback	**Response from the PNA Steering Group on behalf of Barnsley Health and Wellbeing Board**
Two respondents replied with 'Yes'. The respondent requested for all pharmacies to provide additional services which can prevent waiting in general practices, such as infection testing, prescribing antibiotics, wider prescription authorities, ear wax removal suction etc.	• **It is noted that the majority of respondents were not aware of any current pharmacy services that are not mentioned in the draft PNA.** • The question asks for any current pharmacy services that are not mentioned in the draft PNA. The respondents' comment is in relation to all pharmacies providing additional services rather than any gaps in current services.
Consultation Question: Q3. Do you feel the pharmaceutical needs of the Barnsley population have been accurately reflected in the PNA?	
Summary of Feedback	**Response from the PNA Steering Group on behalf of Barnsley Health and Wellbeing Board**
21 respondents felt that the PNA accurately reflected the pharmaceutical needs of the Barnsley population. **7 respondents disagreed. 7 neither agreed nor disagreed and 3 did not know.** The following concerns were raised by these respondents:	• **Pharmacy stock levels -** The level of stock held within a pharmacy is outside the scope of the PNA. Shortages of medicines are becoming an increasingly frequent issue that can hinder pharmacy teams' efforts to dispense medicines in a timely manner. The Department for Health and Social Care (DHSC) produces a monthly update of shortages for primary and secondary care, this can be found on the Specialist Pharmacy Service (SPS) website. We know that supply issues can occur due to a range of unforeseen events and may be down to a combination of factors ranging from manufacturing issues to panic buying. • **Improving access and services for disabled people, their families, and carers -** From 2005, the funding of the NHS Pharmaceutical Services has included an element to recognise the additional cost of

- Very few pharmacies maintaining suitable stock levels and large queues when attending community pharmacy. - Improving access for disabled people and their carer/s. - Community pharmacy in the Penistone area.	complying with disability legislation. All pharmacies in Barnsley meet their legal responsibilities as well as standards to comply with the Equality Act 2010. Whilst we recognise there may be individual issues with some pharmacies, further improvement of access lies beyond the scope of the PNA. • **Community pharmacy in Penistone -** We have acknowledged this in the PNA report and reiterate that whilst Penistone Area Council has the highest population per pharmacy (8,340), this area also has the largest proportion of dispensing GP practices in the borough. The PNA has identified three community pharmacies in the Penistone area, and this does not reflect a gap.
Consultation Question: Q4. Is the draft PNA easy to read and understand?	
Summary of Feedback	**Response from the PNA Steering Group on behalf of Barnsley Health and Wellbeing Board**
20 respondents felt that the PNA was easy to read and understand. **7 respondents disagreed, 10 respondents neither agreed nor disagreed and 1 did not say.** The 7 respondents who disagreed mentioned how this document was not written in a way accessible for the public and is too lengthy.	• We would agree that the PNA is a long document, however the PNA is a complex process that needs to fully comply with Pharmaceutical Regulations - A failure to produce a legally compliant PNA could result in a legal challenge.
Consultation Question: Q5. Do you agree with our assessment of the ways pharmacies could make a greater contribution to improving health of people in Barnsley?	
Summary of Feedback	**Response from the PNA Steering Group on behalf of Barnsley Health and Wellbeing Board**
Only 5 respondents disagreed with this question. One of these respondents referenced back to the challenges faced by disabled people accessing pharmacies. The other respondents mentioned how the PNA does not reflect the long waiting times and staff capacity when being served in a pharmacy.	• **It is noted that the majority of respondents agreed with our assessment of ways in which pharmacies can make a greater contribution to improving the health of Barnsley residents.** • **Improving access and services for disabled people, their families, and carers -** From 2005, the funding of the NHS Pharmaceutical Services has included an element to recognise the additional cost of complying with disability legislation. All pharmacies in Barnsley meet their legal responsibilities as well as standards to comply with the Equality Act 2010. Whilst we recognise there may be individual issues with some pharmacies, further improvement of access lies beyond the scope of the PNA.

	• **Pharmacy waiting times -** This is a very complex situation due to the multifactor chain of events which precede to a patient receiving their medication. Waiting times may be affected due to circumstances outside the control of your pharmacy staff.
Consultation Question: Q6. Is there anything else that you feel should be included in the PNA?	
Summary of Feedback	**Response from the PNA Steering Group on behalf of Barnsley Health and Wellbeing Board**
5 of the 38 respondents answered this question. The following were expressed: - Pharmacies to adequately stock medications. - Issue with staff members not wearing a face mask to protect themselves and customers. - Needs of disabled people accessing pharmacies. - No patient representative present on the PNA Steering Group. - Widening the remit for pharmacy prescriptions. - A very comprehensive PNA assessment.	• **Pharmacy waiting times -** This is a very complex situation due to the multifactor chain of events which precede to a patient receiving their medication. Waiting times may be affected due to circumstances outside the control of your pharmacy staff. • **Pharmacy staff wearing of face masks -** NHS England and NHS Improvement (NHSE&I) published a letter to support NHS service providers including community pharmacy contractors, to interpret the updated Infection Prevention and Control (IPC) guidance published by the UK Health Security Agency (UKHSA), which includes information on wearing facemask and face coverings in Pharmacies. From 22 June 2022: - Pharmacy staff should continue to wear facemasks as part of personal protective equipment (PPE) required for transmission-based precautions when working in Covid-19/respiratory care pathways, and when clinically caring for suspected/confirmed Covid-19 patients. - Staff are in general not required to wear facemasks in non-clinical areas, for example, offices, social settings, unless this is their personal preference or there are specific issues raised by a local risk assessment. • **Improving access and services for disabled people, their families, and carers -** From 2005, the funding of the NHS Pharmaceutical Services has included an element to recognise the additional cost of complying with disability legislation. All pharmacies in Barnsley meet their legal responsibilities as well as standards to comply with the Equality Act 2010. Whilst we recognise there may be individual issues with some pharmacies, further improvement of access lies beyond the scope of the PNA. • **Patient representative for PNA Steering Group -** The purpose of the PNA Steering Group is to oversee and steer the production of a new Pharmaceutical Needs Assessment, in line with national directions. We have included all the relevant stakeholders that have been recommended as part of national guidance. This includes representation from Healthwatch which is an advocate for patients regarding health and social care.

	• **Widening remit for pharmacy prescriptions -** The NHS Long Term Plan sets out how patients and the public will increasingly rely on clinical care provided by pharmacy professionals. Click here to find out more.

Appendix 4. Equality Impact Assessment

Equality Impact Assessment

Pharmaceutical Needs Assessment EIA

Stage 1 Details of the proposal

Name of service **Directorate**	Pharmaceutical Needs Assessment 2022-2025 Public Health
Name of officer responsible for EIA **Name of senior sponsor**	Sohaib Akhtar Rebecca Clarke
Description / purpose of proposal	Health and Wellbeing Boards assumed statutory responsibility for publishing and keeping up to date a pharmaceutical needs assessment (PNA) from 1 April 2013. The PNA provides a comprehensive, ongoing assessment of the local need for pharmaceutical services. The National Health Service Pharmaceutical and Local Pharmaceutical Services Regulations 2013 require every HWB to publish its first PNA by 1 October 2022. The PNA informs NHS England of the need for pharmaceutical services across Barnsley. This includes decisions on applications for new pharmacy and dispensing appliance contractor premises.
Date EIA started	11/05/2022
Assessment Review date	22/07/2022

Stage 2 - About the proposal

What is being proposed?	To draft, consult on and publish a pharmaceutical needs assessment (PNA). The Health and Wellbeing Boards assumed statutory responsibility for publishing and keeping up to date a pharmaceutical needs assessment (PNA) from 1 April 2013. The PNA

	provides a comprehensive, ongoing assessment of the local need for pharmaceutical services.
Why is the proposal required?	The final version of the PNA will be utilised by NHS England when commissioning for pharmaceutical services in the borough. This will have a direct impact on the residents of Barnsley. There is a PNA information pack which determines the activity and approach the local authority must take to drafting and agreeing a PNA. Regulation 8 requires the health and wellbeing board to consult a specified range of organisations on a draft of the pharmaceutical need's assessment at least once during the process of drafting the document. They must be given a minimum period of 60 days to submit their response, beginning on the day by which they are 'served with a draft' of the document. The following organisations must be consulted: • Local Pharmaceutical Committee • Local Medical Committee • Pharmacy & Dispensing appliance contractors included in the pharmaceutical list for the area of the health and wellbeing board. • Dispensing doctors included in the dispensing doctor list for the area of the HWB • Any pharmacy contractor that holds a local pharmaceutical services contract with premises that are in the HWBs area • Healthwatch, and any other patient, consumer, or community group in the area which the health and wellbeing board believes has an interest in the provision of pharmaceutical services, • any NHS trust or NHS foundation trust in the health and wellbeing board's area, • NHS England and NHS Improvement • any neighbouring health and wellbeing board. It is also recommended that the consultation is open to members of the public.
What will this proposal mean for customers?	The primary customer base for the finished PNA is NHS England. The PNA will help to inform their decision making processes. In addition to this, consultation involved the people identified in the above box. The outcome of this consultation will enable us to ensure that the

	pharmaceutical needs of Barnsley are able to be captured and presented in the PNA. All of the above stakeholders, as well as any residents with an interest, will be able to view the public facing document to understand the general health and wellbeing of Barnsley residents as well as the pharmaceutical services provision currently available. The proposal will also allow all of these stakeholders to respond to a draft version of the Pharmaceutical Needs Assessment and allow them to make further comments and suggestions.

Stage 3 - Preliminary screening process

Use the Preliminary screening questions (found in the guidance) to decide whether a full EIA is required
☒ Yes - EIA required (go to next section) ☐ No – EIA not required (provide rationale below including name of E&I Officer consulted with)

Stage 4 - Scoping exercise - What do we know?

Data: Generic demographics
What generic data do you know?

- Barnsley's population has been growing constantly since 2001. In Barnsley, the population size has increased by 5.8%, from around 231,200 in 2011 to 244,600 in 2021.
- Due to people living longer, the age profile of the population is changing both nationally and locally. In Barnsley there are 52,858 0–18-year-olds, 143,951 19-64 year olds and 46,532 people aged 65+.
- Barnsley's population is ageing, and the number of residents aged 65+ is projected to reach 60,800 by 2030.
- Data for Barnsley from the 2011 Census shows that 96.1% of the population were White British and 3.9% were from a Black and Minority Ethnic (BME) group.
- Barnsley is the 38th most deprived local authority of the 317 in England (IMD 2019).
- Overall, as at 31 March 2018, there were 1,276 individuals in Barnsley in receipt of one or more armed forces pension or compensation awards.
- Of these recipients 1,203 were veterans, equal to a rate of 60.7 veterans per 10,000 population (16+); lower than the regional and national rates of 68.7 and 68.3 veterans per 10,000 population (16+).
- There were 1,512 children in need episodes as at 31st March 2018 for Barnsley. (The rate of children in need at 31 March 2018 per 10,000 children was 301.3).
- There were 310 looked after children as at 31st March 2018 for Barnsley. (The rate of looked after children in Barnsley at 31 March 2018 was 62).
- The number of patients with learning disabilities as recorded on GP practice disease registers for Barnsley is 1,450 (0.5%).

Data: Service data / feedback

What equalities knowledge do you already know about the service/location/policy/contract?

Pharmaceutical provision in Barnsley is very similar to the England average. Geographical access at Area Council level is slightly better tor similar to the average for England. Likewise, the pharmacies with extended opening hours are located across the borough giving good access to pharmaceutical services on Saturdays, Sundays and late night opening. The majority of Barnsley residents live within a 1-mile radius or ten-minute drive of a pharmacy.

The majority of premises where pharmaceutical services are available allow for wheelchair access and have suitable facilities in place to provide services in private designated areas. The majority of providers of pharmaceutical services offer free home delivery service for dispensed medicine. Nearly half of pharmacies are willing to undertake consultation in the patient's home or other suitable site.

Data: Previous / similar EIA's

Has there already been an EIA on all or part of this before, or something related? If so, what were the main issues and actions it identified?

An EIA was carried out during the previous Pharmaceutical Needs Assessment (2018-2021) and no specific impact was identified.

Data: Formal consultation

What information has been gathered from formal consultation?

See Appendix 3- Results from the statutory 60-day consultation 16th May to 15th July 2022.

It states in the PNA information pack for Local Authorities that:
Whilst not required by the regulations it is strongly recommended that the views of the public are gathered. This will allow the health and wellbeing board to test some of its assumptions around how people may access services, for example, and provide useful information for the document. Similarly, it will also be necessary to gather information from those who are providing the services that is not otherwise already in the public domain.

Once the overall health needs of the population have been identified, along with those that can be met by the provision of pharmaceutical services, the pharmaceutical needs assessment will then need to identify the different needs of those who share a protected characteristic as defined in the Equality Act 2010.

A report on the consultation must be included in the final version of the document, and the steering group will need to review the responses to the consultation and agree what, if any, changes are to be made to the document. A week has been allowed in the timeline for review of the responses and production of the first draft of the consultation report which 24 will be a summary of the responses received. The steering group will need to review the responses to the consultation and agree its response to the points raised which is then to be included in the report. The steering group will also need to consider what, if any, changes needs to be made to the document as a result of the consultation. Not much time has been included in the timeline for this stage because if robust engagement has been undertaken throughout the process of drafting the document there should be no surprises from the consultation. Once the document is finalised it will then need to be signed-off by the relevant committee or the health and wellbeing board and published.

Stage 4 - Potential impact on different groups

Considering the evidence above, state the likely impact the proposal will have on people with different protected characteristics

(state if negative impact is substantial and highlight with **red text**)

Negative (and potentially positive) impacts identified will need to form part of your action plan.

Protected characteristic	Negative '–'	Positive '+'	No impact	Don't know	Details
Sex			✓		No specific negative impacts identified from this PNA.
Age			✓		The PNA identifies good provision of services for all ages. No specific negative impacts identified from this PNA. Older people may have a higher prevalence of illness and take regular medicines. Pharmacy staff can support people to live

					independently by supporting optimisation of use of medicines, support with ordering, re-ordering medicines, home delivery and appropriate provision of multi-compartment compliance aids and other interventions such as reminder charts to help people to take their medicines.
Disabled *Learning disability, Physical disability, Sensory Impairment, Deaf People ,invisible illness, Mental Health etc*			✓		The majority of community pharmacies allow for wheelchair access, however, where there aren't accessibility measures, pharmacies also provide home delivery services in these instances. No specific negative impacts identified in from this PNA. When patients are managing their own medication but need some support, pharmacists must comply with the Equality Act 2010. Where the patient is assessed as having a long term physical or mental health condition that affects their ability to carry out everyday activities, such as managing their medication, the pharmacy contract includes funding for reasonable adjustments to the packaging or instructions that will support them in self-care. The first step should be a review to ensure that the number of medications and doses are reduced to a minimum. If further support is needed, then compliance aids might include multi-compartment compliance aids, large print labels, easy to open containers, medication reminder alarms/charts, eye dropper or inhaler aids.
Race			✓		No specific negative impacts identified from this PNA.
Religion & Belief			✓		No specific negative impacts identified from this PNA.
Sexual orientation			✓		No specific impact has been identified from this PNA.
Gender Reassignment			✓		No specific impact has been identified from this PNA.
Marriage / civil partnership		N/A	✓		No specific impact has been identified from this PNA.
Pregnancy / maternity			✓		No specific negative impacts identified from this PNA. Community pharmacies can provide an important source of advice for minor ailments for conditions which commonly occur in pregnancy. For women planning pregnancy, access to a community pharmacy for advice can also be important.

Other groups you may want to consider					
	Negative	Positive	No impact	Don't know	Details
Ex services			✓		No specific impact has been identified from this PNA.
Lower socio-economic			✓		No specific impact has been identified from this PNA.
Other …					

Stage 5 – Action plan

To improve your knowledge about the equality impact . . .

Actions could include: community engagement with affected groups, analysis of performance data, service equality monitoring, stakeholder focus group etc.

Action we will take:	Lead Officer	Completion date
To share the PNA consultation with council networks and equality forums.	Sohaib Akhtar	16/05/2022
To ensure members of the public can access the survey, allow hardcopy versions on request and easy read option for those who have language barriers.	Sohaib Akhtar	16/05/2022

To improve or mitigate the equality impact . . .

Actions could include: altering the policy to protect affected group, limiting scope of proposed change, reviewing actual impact in future, phasing-in changes over period of time, monitor service provider performance indicators, etc.

Action we will take:	Lead Officer	Completion date
To ensure a summary of the consultation feedback is included in the final PNA report including the steering group response.	Sohaib Akhtar	31/10/2022
To ensure the final version of the PNA is easily accessible on the council website and shared with equality forums.	Sohaib Akhtar	31/10/2022

Stage 6 – Assessment findings

Please summarise how different protected groups are likely to be affected

Summary of equality impact	The PNA has taken into account accessibility of pharmaceutical services in Barnsley as outlined in the statutory guidance https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack In general, the majority of providers of pharmaceutical services have made suitable adjustments to ensure everyone has equal access to pharmaceutical services. The Equality Act 2010, sets out a framework which requires providers of goods and services to ensure that they do not discriminate against a person for reasons relating to a protected characteristic. It is expected that pharmacies will provide an equitable service to everyone regardless of sex, age, race, disability, religion or belief, sexual orientation, gender reassignment, marriage or civil partnership, pregnancy or maternity. Similarly, it is also expected the pharmacies makes reasonable adjustments, to enable disabled people who face barriers to accessing their services to do so equitably.
Summary of next steps	To ensure a summary of the consultation feedback is included in the final PNA report including the steering group response. To ensure the final version of the PNA is easily accessible on the council website and shared with equality forums.

Signature (officer responsible for EIA) Date	S. Akhtar (22/07/2022)

**** EIA now complete ****

Stage 7 – Assessment Review

(This is the post implementation review of the EIA based on date in Stage 1 if applicable) **What information did you obtain and what does that tell us about equality of outcomes for different groups?**
N/A