
FEEL GOOD BARNSLEY
Barnsley's Health & Wellbeing Strategy
2016 - 2020

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INTRODUCTION

The Health and Wellbeing Board is a formal committee of the local authority, established under the Health & Social Care Act 2012, and has a legal duty to produce a joint strategic needs assessment and a joint health and wellbeing strategy.

The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.
LOCAL GOVERNMENT ASSOCIATION

The purpose of this strategy is to set out how the Health and Wellbeing Board will drive integration in order to improve services, join up care and support people in Barnsley to better help themselves in order to help realise our collective vision:

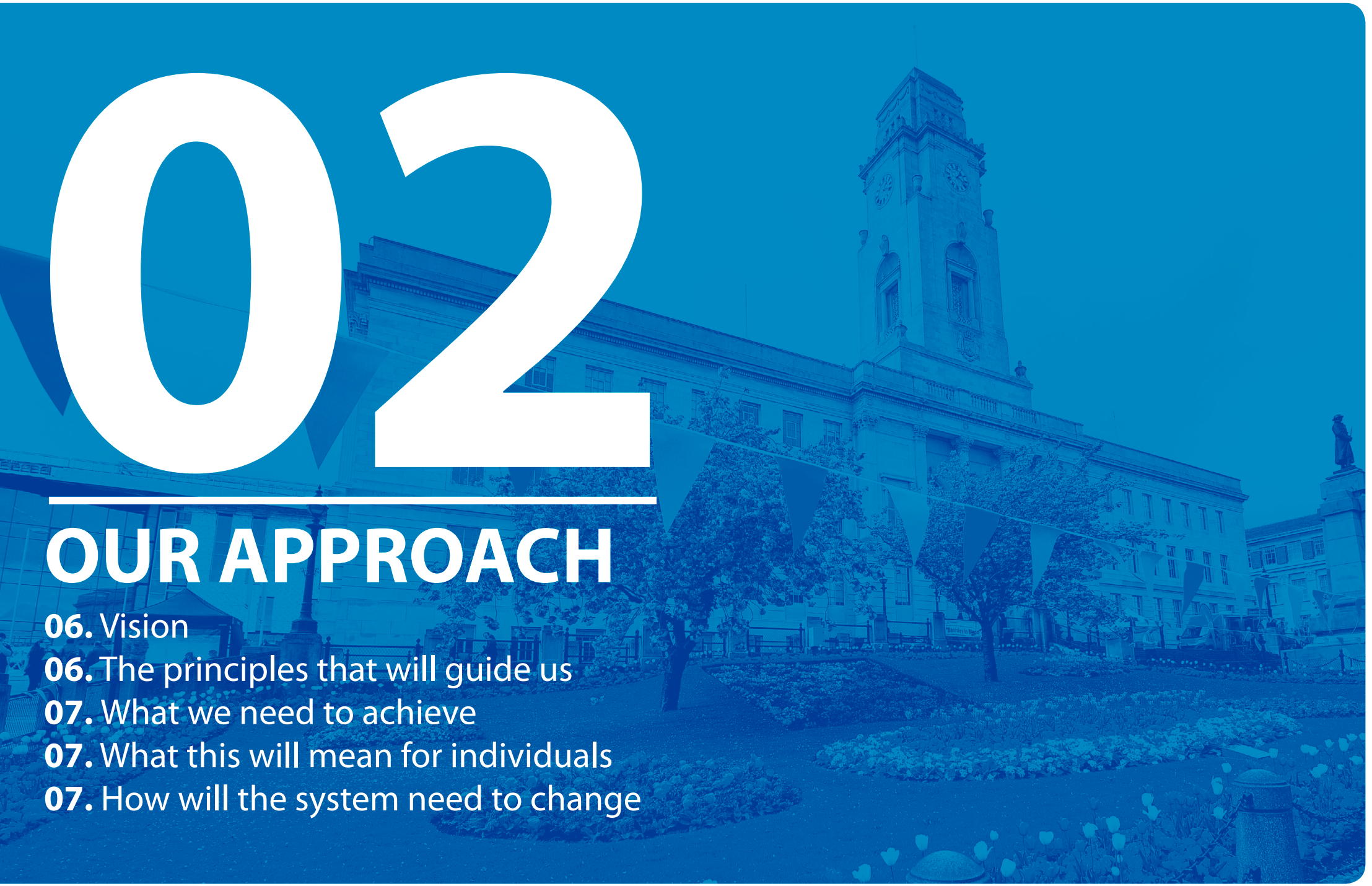
That the people of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, whoever they are and wherever they live.

This new strategy comes at a particularly important and challenging time for health and care services. As NHS England's Five Year Forward View recognises, to achieve consistently high quality care for everyone, respond to demographic change and achieve long-term financial sustainability across the health and care system, we must do things differently; we must rise to the challenge of what NHS England calls 'a radical upgrade' in prevention and integration (NHS Five Year Forward View).

Barnsley faces some significant challenges over the next few years. People are living longer but with this comes an expected rise in the number of people with one or more long term conditions. This will place extra demands on an already stretched health and care system. Health outcomes are improving within the borough but compare relatively poorly to the rest of the country, with marked life expectancy variations within the borough itself.

The Board brings together clinical, political, professional and community leaders and is therefore well placed to respond to these challenges. Our strength lies in working together to increase prevention and early help, and make sure the right system of help will be there for people when they need it most.

The Health and Wellbeing Board is accountable for making the best decisions for the whole health & care system. The Board will hold steady through the inevitable periods of change ahead. It will also ensure the system has the ability to mount a robust response to unforeseen, unpredicted, and unexpected demands so that services can continue normal operations.



02

OUR APPROACH

OUR APPROACH

Appendix 1

provides four fictional stories looking forward into the future illustrating the change we want to see.

Vision: That the people of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, whoever they are and wherever they live.

The principles that will guide us:

Focus on efficiencies and outcomes

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

Inspire & Empower

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

Connect, Collaborate & Co-produce

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

Go further, faster

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

OUR APPROACH

What we need to achieve:

Improved health and wellbeing:
Health and wellbeing is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. These 'broader determinants of health' are more important than health care services in ensuring a healthy population, and therefore this is where the Board will focus its efforts.

Reduced health inequalities:
There are marked inequalities in health which exist between Barnsley and England as a whole and within Barnsley itself, which is not acceptable. A gap also exists between people with severe mental illness, learning disabilities and autism, and the general population.
Our approach will therefore be to target our resources to achieve equality of outcomes for all.

What this will mean for individuals:

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

How will the system need to change to achieve this?

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

Appendix 2 provides an overview of the health & care system in Barnsley.

Appendix 3 provides some examples of the progress made against key actions from the previous strategy (2014 – 2016)

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EXAMPLES OF AREAS WE NEED TO IMPROVE

09. Reducing smoking
09. Improve early help for mental health
09. Join up services for older people

Examples of areas we need to improve over the course of this strategy include:

Reduce smoking

Smoking is the primary cause of preventable illness and premature death, accounting for 1355 deaths in Barnsley between 2012 – 2014. This equates to 7 double decker buses full of people dying in Barnsley as a direct result of smoking every year. Smoking is a leading cause of health inequalities and is responsible for half the difference in life expectancy between rich and poor.
Interventions having the greatest, quickest and most sustainable impact on smoking prevalence are those aimed at changing social norms and de-normalising smoking. We will therefore target our resources to tackle the availability and acceptability of smoking.

Improve early help for mental health

At least one in four of us will experience a mental health problem at some point in our life and around half of the people with lifetime mental illness experience their first symptoms by the age of fourteen. People with a diagnosed severe mental illness die up to twenty years younger than their peers in the UK, predominantly due to higher rates of poor physical health.
Mental health is everyone's business - individuals, families, employers, educators and communities all need to play their part to improve the mental health and wellbeing of the people in Barnsley. By promoting good mental health and intervening early we can help prevent mental illness from developing and support the mitigation of its effects when it does.

If we can impact these areas significantly over the next 3 years, we will have gone a long way to establishing integrated, joined up approaches as the new norm in Barnsley. Healthy life chances for generations to come will improve as a result.

Join up services for older people

Multi-morbidity, dementia and frailty are increasing, yet services are traditionally focused around single diseases and organisations. The government requires all local areas to integrate health and care services by 2020.
To do this, we need greater co-ordination between specialisms within the NHS and between primary care, secondary care and mental health services and outside the NHS with social care and the voluntary and community sector. This will enable care to become more personalised and integrated with patients having more control and choice.

The focus includes:

Dementia

In line with the current Mayor's focus on Dementia and 'the best of Barnsley', deliver an integrated pathway for dementia ensuring high quality care throughout the pathway that reflects the Prime Minister's challenge on dementia 2020.

Falls

Aligned to the work on Early Help and Prevention, develop comprehensive pathways to help to prevent, identify and minimise the impact of frailty and falls.

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WHOLE SYSTEM ACTIONS

11. Indentification of areas of greatest need
12. Creating a healthy community
13. Making prevention everybody's business
14. Develop a communication and engagement plan
15. Deliver our 'digital road map' to improve IT

WHOLE SYSTEM CHANGE PRIORITIES

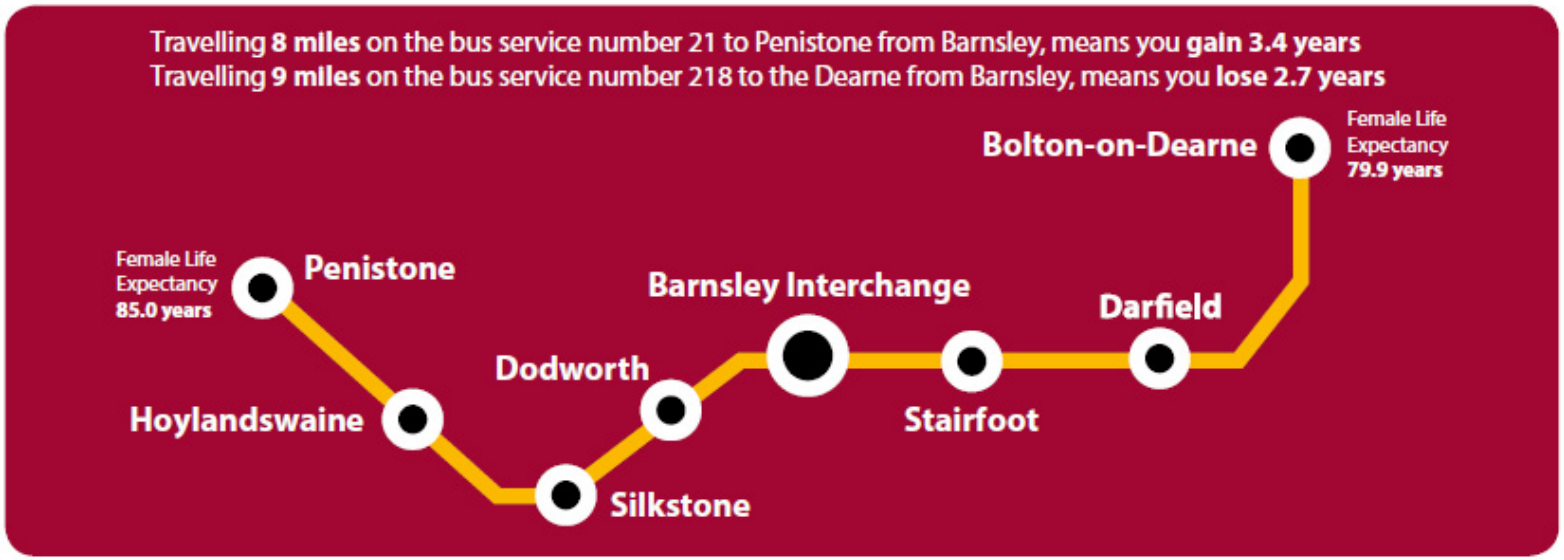
1. Focus on the areas of greatest need

There are marked differences in life expectancy and healthy life expectancy across Barnsley and therefore to make the greatest difference we need to focus our resources on the areas of greatest need.

The diagram below is one example that shows how life expectancy differs from one of the most affluent parts to one of the least affluent parts of the borough, where residents live on average six years less. For more information and data on life expectancy and healthy life expectancy across the borough, please see the Joint Strategic Needs Assessment. (The current JSNA is from 2013 and a new JSNA will be available at the end of 2016).

We will make the joint strategic needs assessment accessible and easy to understand so everyone can have a shared understanding of the health inequalities in the borough and develop a greater understanding into the areas which have the poorest health outcomes.

We will review our resources at a neighbourhood level and ensure that we have multi-agency teams that are responsive to local need. We will also collectively agree what additional resources are needed where and how this can be achieved, to make the greatest impact on health & wellbeing.



WHOLE SYSTEM CHANGE PRIORITIES

2. Build strong and resilient communities

Building strong and resilient communities means that people live in good houses, in vibrant communities, and have access to a good education and job. People are engaged in positive activities, able to access early help and support services when they need them which enable them to live a comfortable and healthy life.

The evidence shows that:

- Good housing can have a positive impact on people's physical and mental health and wellbeing.
- A good education is strongly associated with better health outcomes including life expectancy
- There is a strong association between unemployment and poor mental health
- Poverty is a key determinant of poor outcomes in health and wellbeing and is linked to numerous health problems and unhealthy life styles.

We will continue to explore prevention opportunities to get the greatest return on investment by developing new ways of working with our partners. We will work with our partners in housing to improve standards, particularly in the private rented sector; improve children's health & wellbeing by working with our family centres and the education system; increase employment opportunities, particularly for the hardest to reach groups (those with mental health, learning disabilities and care leavers) by connecting to the Local Enterprise Partnership.

In addition, our local area arrangements provide further opportunities to create healthy communities through localised commissioning. We will continue to support our 6 Area Councils to target resources based on the priorities identified by those who live there.

WHOLE SYSTEM CHANGE PRIORITIES

3. Make prevention everybody's business

The Health and Wellbeing Board will radically upgrade its focus on prevention, empowering citizens, communities and patients to improve their own health and wellbeing. We will build a broad coalition that helps all of us take healthier decisions, working with individuals and families, retailers and employers to help make the healthy choice, the easy choice.

As well as taking actions on the broader determinants of health and wellbeing, we will strengthen our advocacy role and use our local democratic and enforcement powers where appropriate to help better the health and wellbeing of Barnsley residents.

Staff from across our organisations such as fire, police, NHS and the council support thousands of people in our local community each and every day. This gives us an unparalleled opportunity to 'make every contact count' providing support to people to make positive changes to their physical and mental health and wellbeing.

The Health and Wellbeing Board is committed to giving our workforce the skills, knowledge and confidence to support people to make lifestyle behaviour changes, access early help and take control of their health and wellbeing.

We will embed the culture of behaviour change in all our workforce development, education and training plans so that providing brief advice and early help becomes the norm for all staff. Mobilising our workforce in this way will help achieve large scale change and increase the capacity to deliver improved health and wellbeing services.

WHOLE SYSTEM CHANGE PRIORITIES

4. Develop a communication and engagement plan

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

The Health and Wellbeing Board is committed to putting the voice of Barnsley people at the heart of decisions. In Barnsley we have a strong tradition of service user, carer and patient involvement through groups such as Carers and Friends Group, Learning Disabilities Forum, Older People's Forum, Patient Forums, Equality Forums and Healthwatch Barnsley. These and other forums play a key role in bringing together people's experience of health and social care in Barnsley to influence and shape local services:

We intend to develop the mechanisms to hear the voice of our communities in the Joint Strategic Needs Assessment and use the community voice to assess our progress against our priorities.

We are proud to have such an extensive reach in to our communities, where we can have ongoing conversations about what is and what isn't working, and how ,together, we can improve outcomes for our people. Openness and transparency will help bring about continuous improvement. We will ensure that the joint strategic needs assessment will be publicly available and in a user friendly format. Likewise we will report regularly on performance at local and borough wide level, in partnership with CCGs and other key stakeholders. This information can then be used by the Area Councils, individuals and voluntary and community groups to achieve creative solutions to improve and shape the health and wellbeing of their communities.

We intend to develop the mechanisms to hear the voice of our communities in the Joint Strategic Needs Assessment and use the community voice to assess our progress against our priorities.

WHOLE SYSTEM CHANGE PRIORITIES

5. Deliver our 'Digital Road Map' to improve services

People are having increasingly positive experiences of digital technology in everyday life. Whether it is through Internet banking or shopping or learning online, the use of digital technology is becoming the norm for a growing number of people

The health and care sector is way behind the commercial sector when it comes to maximising the benefits of digital technology. In Barnsley, we know from a range of engagement activities over the past few years that our communities are frustrated when communication between services and patients fails. This means that not only time and effort is wasted but this also leads to poor experiences.

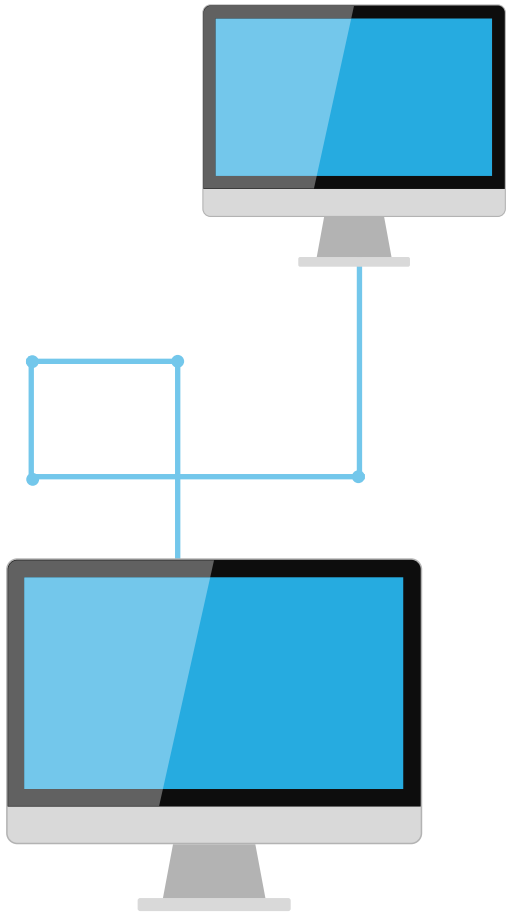
We recognise that:

- 'IT systems are a barrier to people working together'
- 'Communication between health and care teams needs to improve'
- 'We need to take a holistic view of the patient and see them as a whole'

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

Our vision in Barnsley is to:

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



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TURNING STRATEGY INTO ACTION

17. Turning strategy into action

TURNING STRATEGY INTO ACTION

This is the Health and Wellbeing strategy for Barnsley, developed by the Health and Wellbeing Board.

All partners on the Health and Wellbeing Board have agreed the strategy and will reflect it within their organisational plans and work.

Similarly, all organisations represented agree to shape their own future organisational strategies and plans in order to underpin and help deliver this joint Health and Wellbeing Strategy.

All relevant future plans will be formulated with regard to the joint strategic needs assessment (JSNA).

To outline progress in delivery, Barnsley's Health and Wellbeing Board will invite all partners to contribute to a joint annual report each year. The joint annual report will be made publicly available.

Appendix 4 provides summary information about the health and wellbeing challenges in Barnsley.

More detailed information about the health of the Barnsley population can be found in the following documents:

Public Health England's Health Profile provides a picture of health in Barnsley in 2015.

The Joint Strategic Needs Assessment (JSNA) assesses the current and future health and social care needs of the local community. The current JSNA is from 2013 and a new JSNA will be available at the end of 2016.

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APPENDICES

APPENDICES

Appendix 1 - People's Stories

It's 2015

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

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

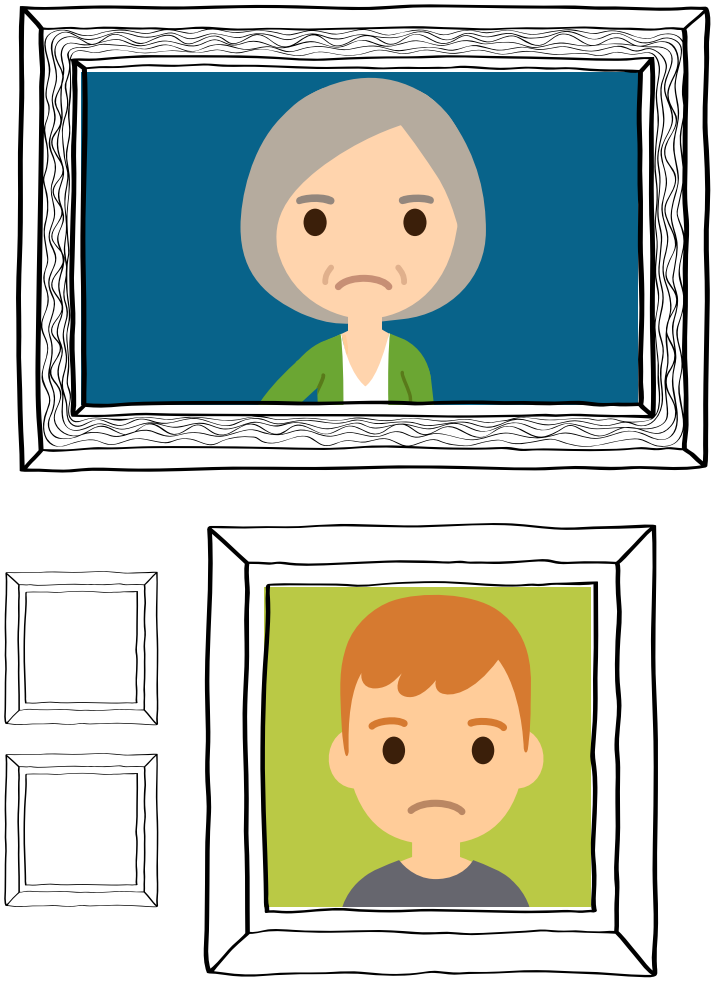
She has had to have a number of assessments, is often referred on from the people she has told her story to, has to do a lot of travelling to different services which are changed at the last minute.

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

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

This is an expensive situation for two reasons:

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



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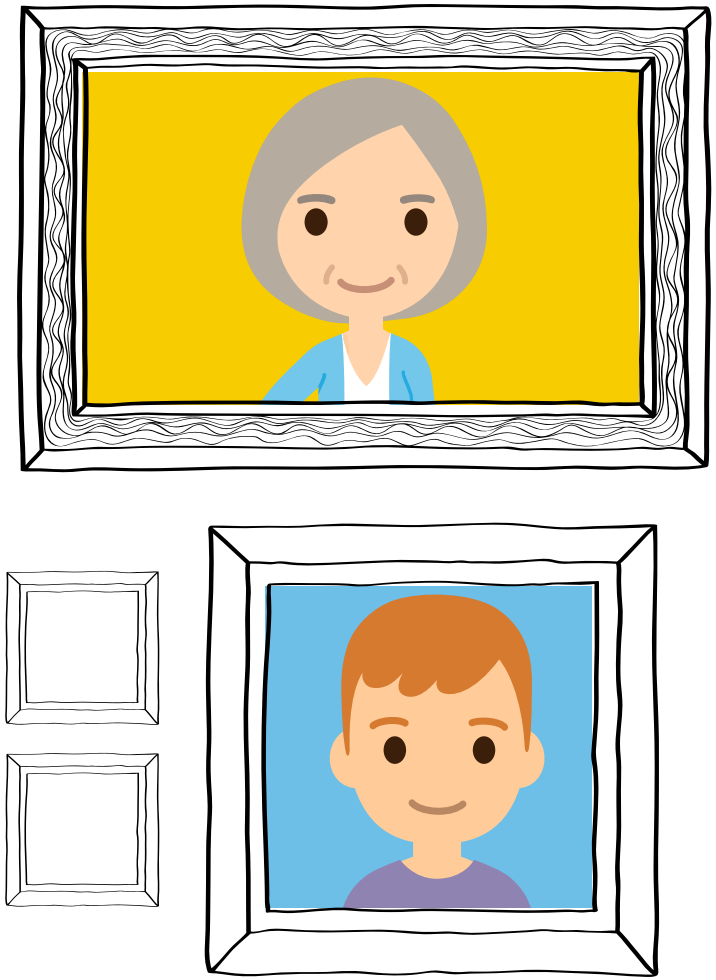
It's 2020

Mrs Brown is now 80. She is still at home despite her fears. Following a discussion with Mrs Brown and Jack, Mrs Brown was given an integrated personal budget to help her manage her health and care needs. As part of this, a single integrated care plan was developed jointly with Mrs Brown and her son Jack. Her care plan involves planned integrated health and care services, the use of assistive technology and the support from local neighbours and the local VCS. For the services Mrs Brown has chosen to buy with her personal budget, there is consistent information about quality that has been provided from regulator's report that helps them make informed choices about who provides the care.

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

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

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



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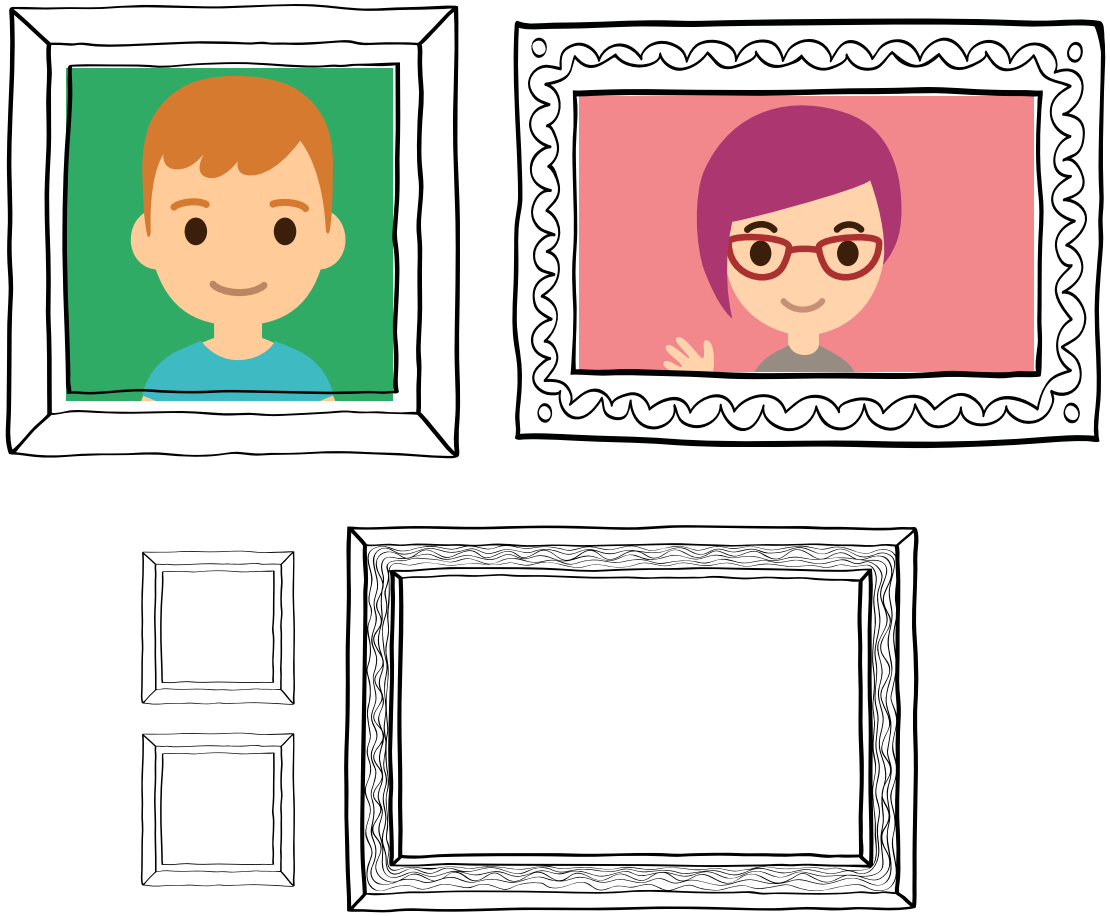
It's 2030

Mrs Brown passed away at the age of 90, at home supported by an integrated end of life plan. Her granddaughter Yasmin was born in 2015 in the same part of Barnsley. Thankfully, partners from the council, NHS, housing and education worked with the local community to develop a range of services that support Jack, Yasmin and other families to be healthy and get involved in lots of community activities – they all understand it's important to stay healthy!

When Yasmin turned 15, she joined a local community group that organises activity clubs, helps people use technology to stay connected and remain independent, and provides support to local carers. Jack has told Yasmin how important these were for her grandmother.

Jack now works in social care and supports people with dementia. In his spare time Jack volunteers as an e-health community champion helping people to make use of assistive technology to support their independence.

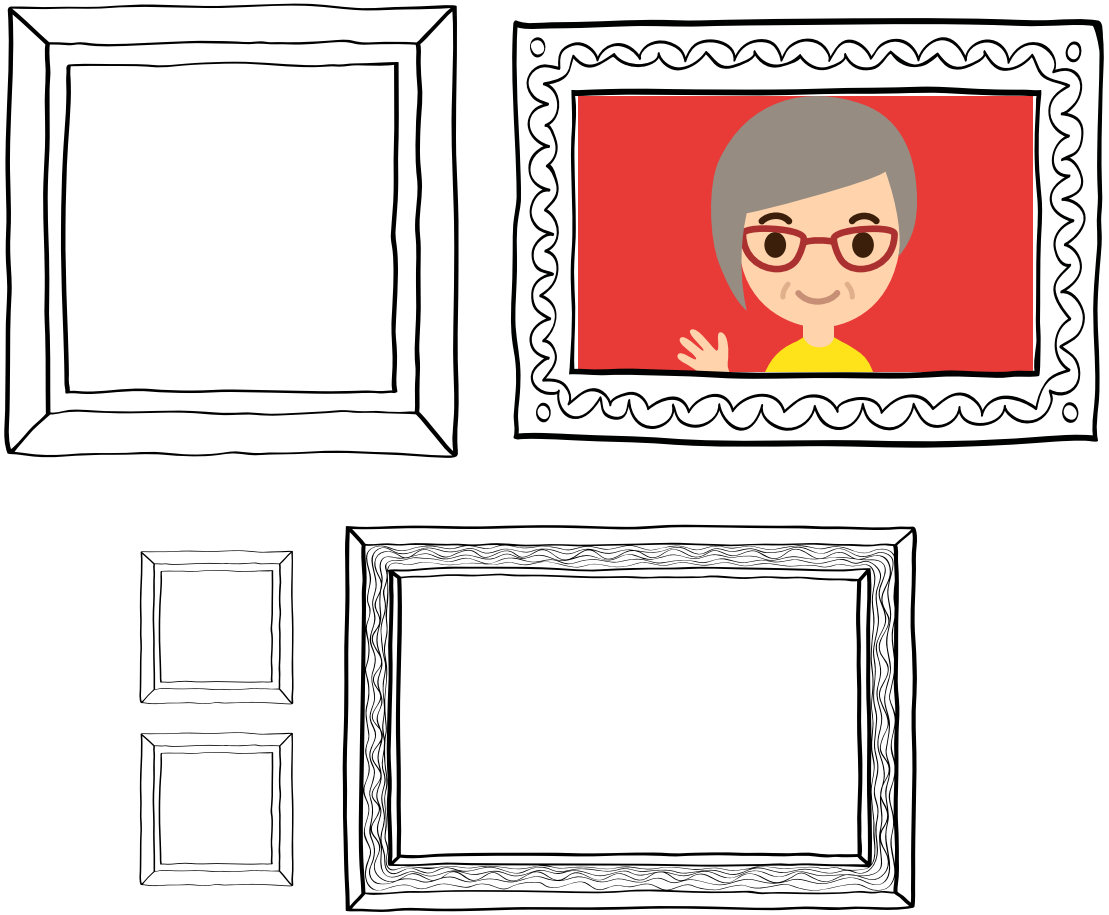


APPENDICES

It's 2100

Healthcare now uses predictive analytics to forecast future conditions so that proactive and preventative action can be taken to stay healthy. Thanks to Yasmin being active and having a healthy lifestyle, she has remained free from long-term conditions throughout her life. She rarely goes to the doctor; she uses the pharmacist for support in a lot of things. She has only had to go to hospital once when she broke her arm.

When she reached 85, Yasmin did become frail and needed some support at home. Due to a better balanced system, the local integrated health and care system was able to provide support despite the growth in demand. Yasmin remained supported at home, with people who are close to her, and lives well at home into old age.



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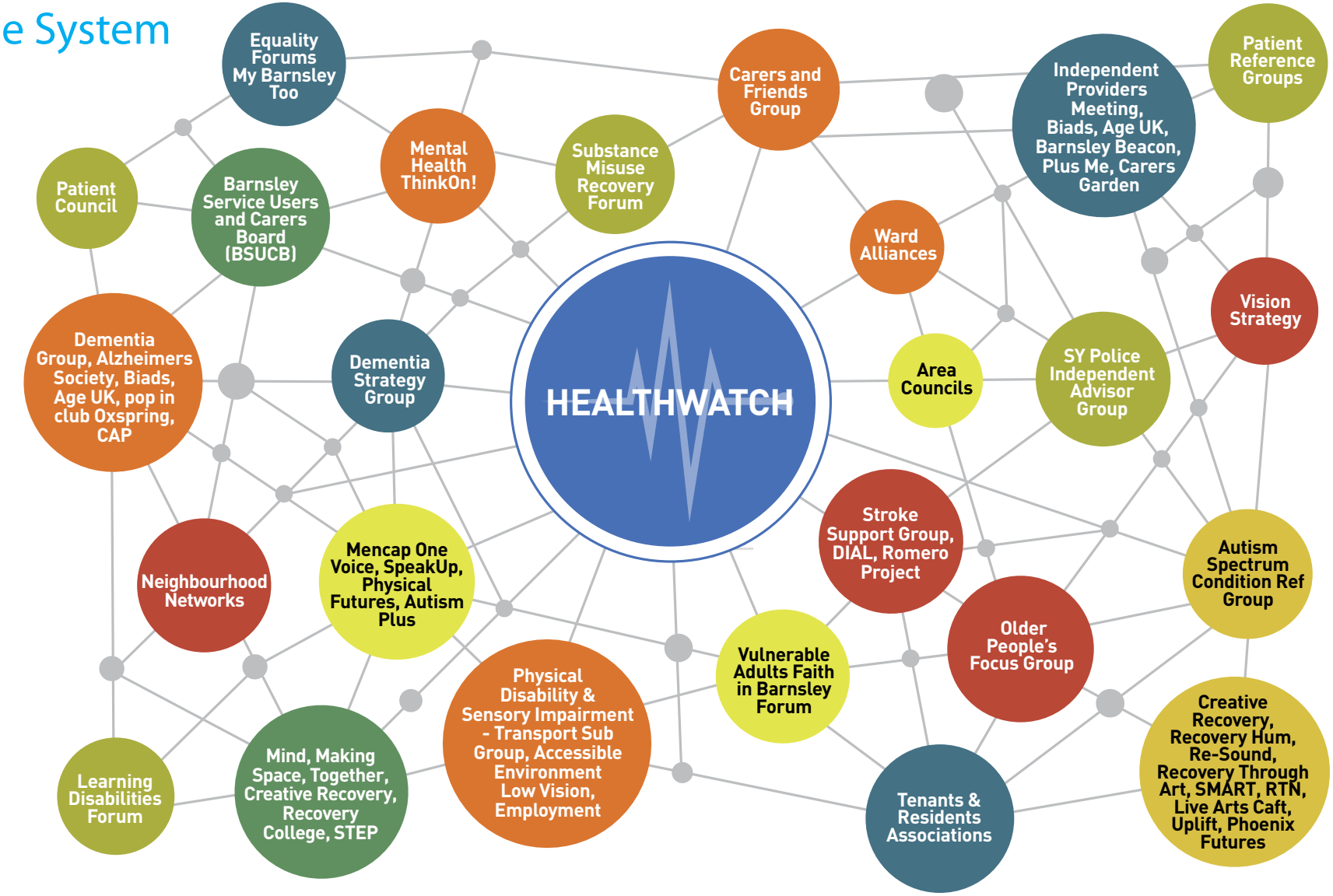
Appendix 2: The System

Networks

The responsibility to improve our health lies with us all – government, local communities and with ourselves as individuals.

PUBLIC HEALTH OUTCOMES FRAMEWORK

In Barnsley we have many organisations, individuals, community groups and partnerships that make up the 'Health & Wellbeing Network' in Barnsley.



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PARTNERSHIP NETWORK

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Strategies & Plans

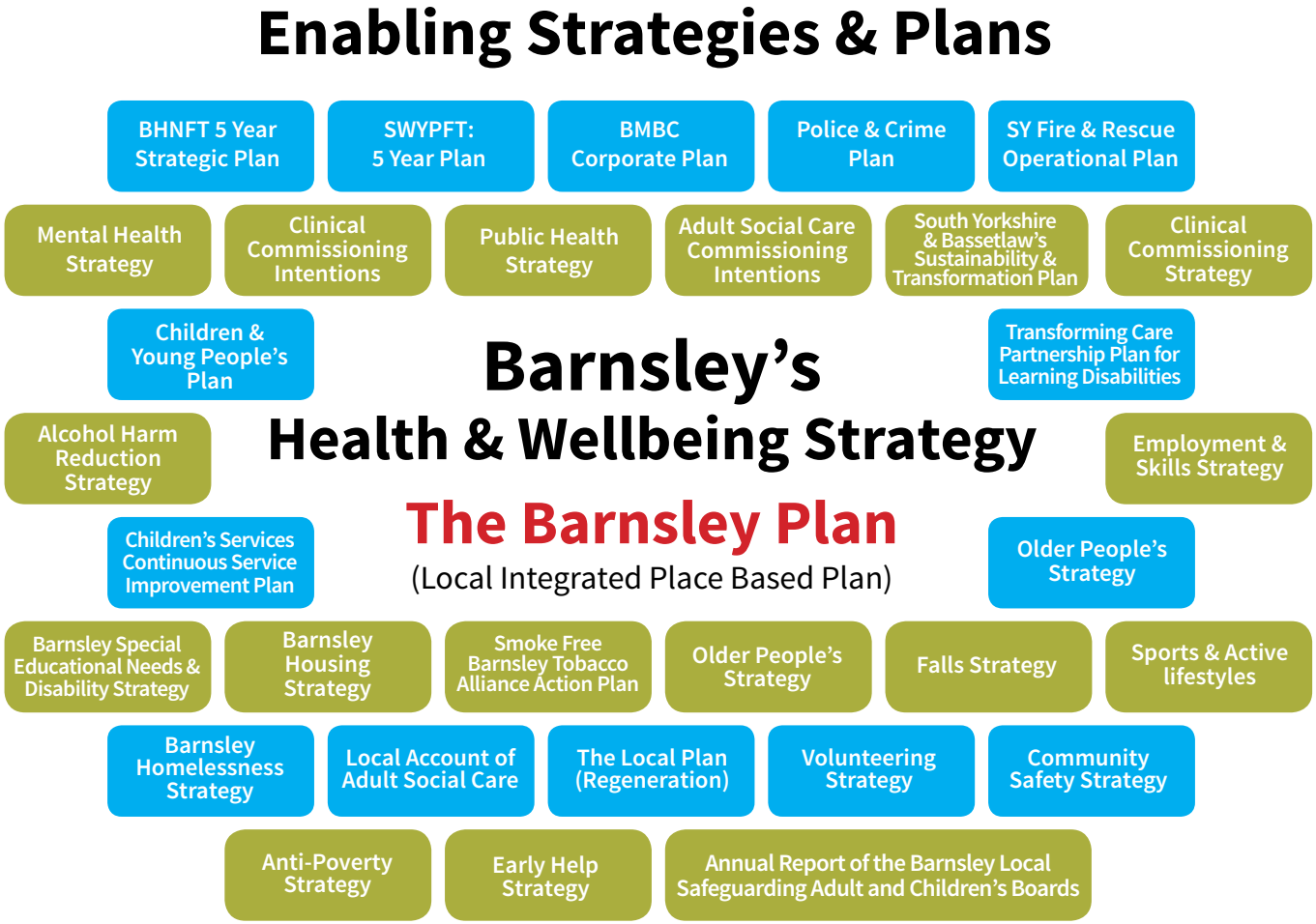
These networks work together to shape and deliver a number of strategies which collectively spell out our approach to improving Health and Wellbeing in Barnsley:

There are many linkages between and across the different boards and groups; strategies and plans and collectively they are responsible for contributing to making this strategy a reality.

For more information on each of these strategies and plans, please click on to the relevant link.

From across all of these plans and strategies, the Health and Wellbeing Board has agreed to focus on a number of priority programmes that will make the biggest impact on health and wellbeing. Details of these priorities may be found in the Barnsley Local Integrated Place Based Plan. This Plan complements and reflects the commitments set out in the Health and Wellbeing Strategy..

The **Barnsley Plan** complements and reflects the commitments set out in this strategy.



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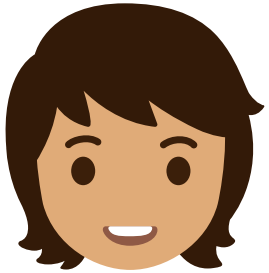
Appendix 3: Progress to Date

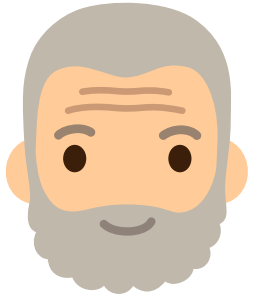
Communities:

The Stronger Communities Partnership is now established as a system wide partnership working to develop strong and resilient communities. The partnership is focussed on improving early help and prevention and tackling areas such as poverty. Our Area Councils and Ward Alliances have worked hard at developing community based solutions to wellbeing and create a strong foundation for the future.



Children & Young People:

A Local Transformation Plan (LTP) for children and young people's mental health and wellbeing has been developed and funding received from NHS England for 5 years, ending in March 2020. 'Improving Social and Emotional Mental Health and Resilience in Young People' is part of the work programme where primary school staff are trained in the 'Thrive Approach'. This is an evidence based whole school approach to enhance teachers' awareness of the social and emotional wellbeing among young people.



Adult Social Care:

A new operating model in adult social care services has now been implemented. The model has fundamentally changed how the service responds to its customers and the services it offers. Evidence shows that these changes have had a positive impact with more customers taking control over their care and support and an increased uptake of reablement with sustained outcomes. The service has been recognised nationally as 1 of 8 shortlisted finalists for the Local Government Chronicle Awards, under the business transformation category.

RightCare Barnsley:

A telephone based care coordination centre providing a brokerage service for Healthcare Professionals seeking a care solution. The aim of RightCare Barnsley is to facilitate the provision of the right care, at the right time, in the right setting, for the benefit of the public and patients. This service has been recognised nationally and has recently won a Health Service Journal Award.

Appendix 4 - Our Health and Wellbeing

Demographic Profile

The latest data from the 2011 Census, 97.9% of the Barnsley resident population were from a white ethnic background, 0.7% of mixed group, 0.7% Asian or Asian British, 0.5% were Black/ African/ Caribbean or Black British with 0.2% other

	Age (years)	Barnsley	Yorkshire & Humber	England
2013	0-15	43,491	1,071,422	10,857,103
	16-64	149,405	3,394,714	34,351,400
	65 +	42,861	935,822	9,305,179
	All Ages	235,757	5,337,711	53,865,817
2014	0-15	43,763	1,012,862	10,303,556
	16-64	150,064	3,389,620	34,475,354
	65+	44,016	957,545	9,537,708
	All Ages	237,843	5,360,027	54,316,618

Life Expectancy and Healthy Life Expectancy

Life Expectancy is the average number of years a person would expect to live and Healthy Life Expectancy is the average number of years a person would expect to live in 'very good' or 'good' health, based on how individuals perceive their general health, taking account of the quality as well as the length of life. Both measures are published by the Office for National Statistics (ONS) and are important for population health.

In 2012 to 2014, life expectancy for a new born baby boy born in Barnsley was 78.4 years and for a new born baby girl, the figure was 81.8 years. However, data for healthy life expectancy shows that a boy born in Barnsley could expect to experience 57.5 years in either 'very good' or 'good' health and a girl born in Barnsley could experience 56.3 years in 'very good' or 'good' health. Of particular concern is the healthy life expectancy data for females in Barnsley which is ranked in the bottom five local authorities in England.

On average, people in our Borough are living for the last 20 years of their life in ill health. Many will have multiple long term conditions and will need help in managing their health.

	Gender	Barnsley (%)	Yorkshire & Humber (%)	England (%)
Life expectancy (years)	Male	78.4	78.7	79.5
	Female	81.8	82.4	83.2
Healthy life expectancy (years)	Male	57.5	61.4	63.4
	Female	56.3	61.8	64.0

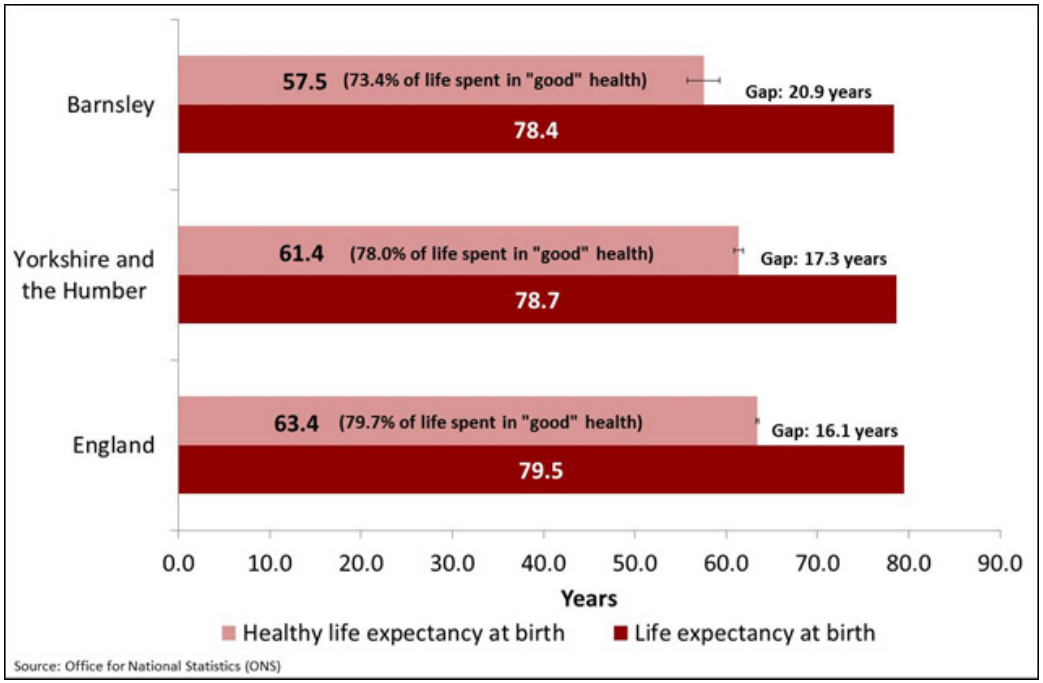
Source: Public Health Outcomes Framework (Feb 2016)

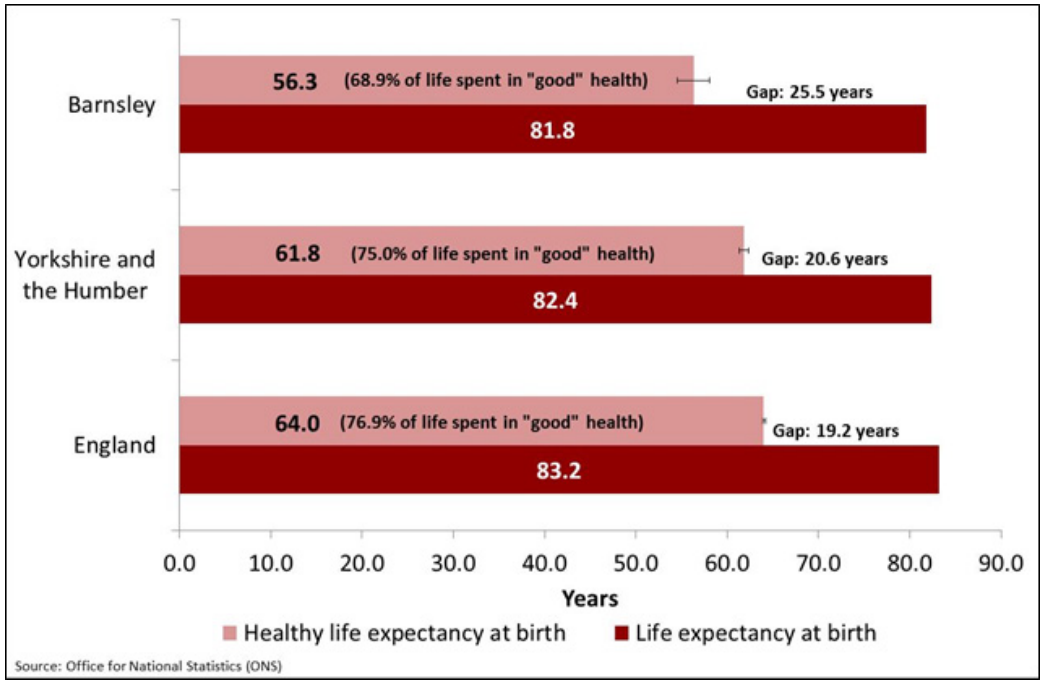
Life expectancy at birth, healthy life expectancy at birth, for males and females in Barnsley compared with Yorkshire and the Humber and England (2012-14)

Life Expectancy and Healthy Life Expectancy

Life expectancy at birth, healthy life expectancy at birth and the proportion of life spent in "good" health for men in Barnsley, compared with Yorkshire and the Humber and England (2012-2014)

Life expectancy at birth, healthy life expectancy at birth and the proportion of life spent in "good" health for women in Barnsley, compared with Yorkshire and the Humber and England (2012-2014

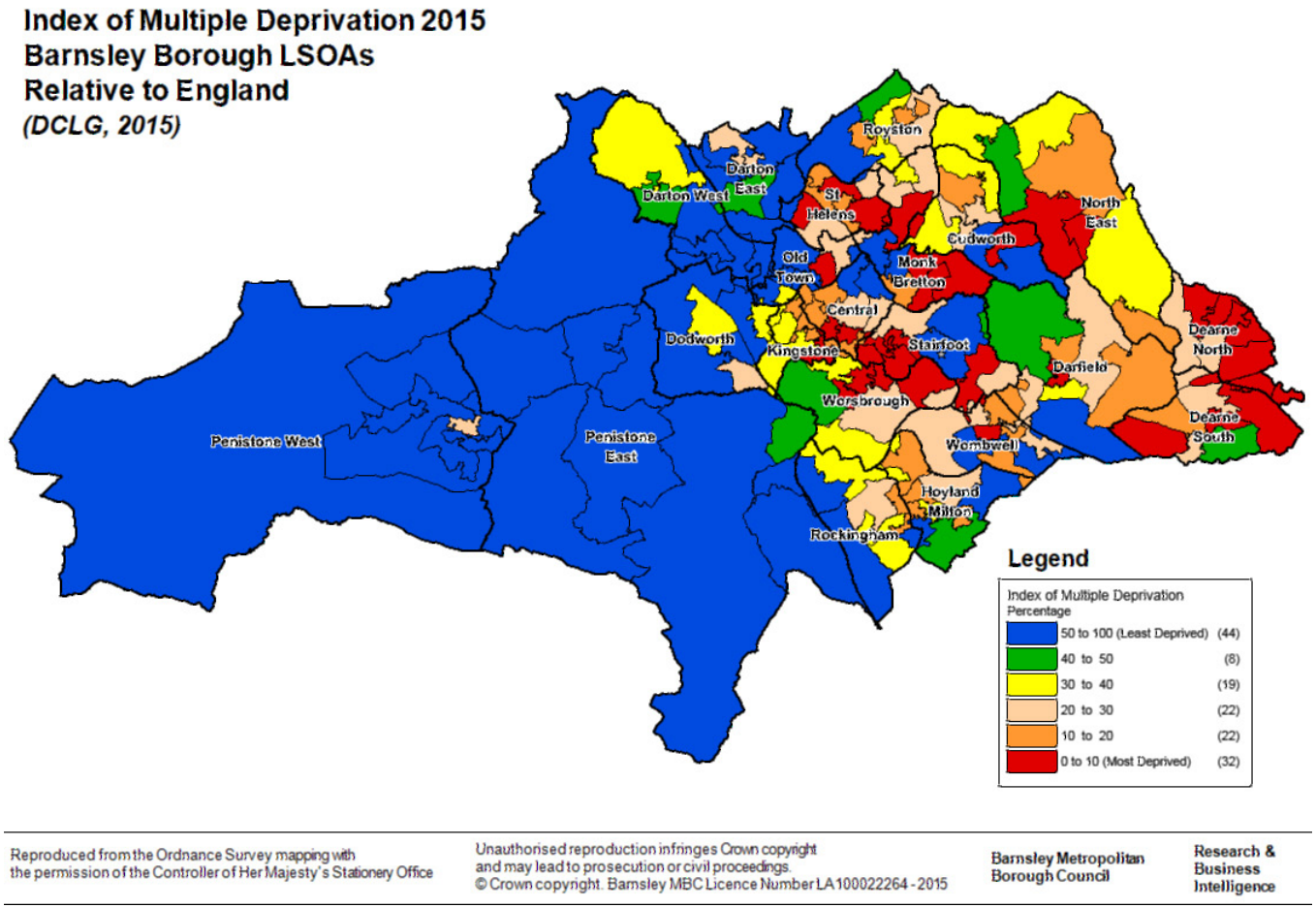




Health Inequalities

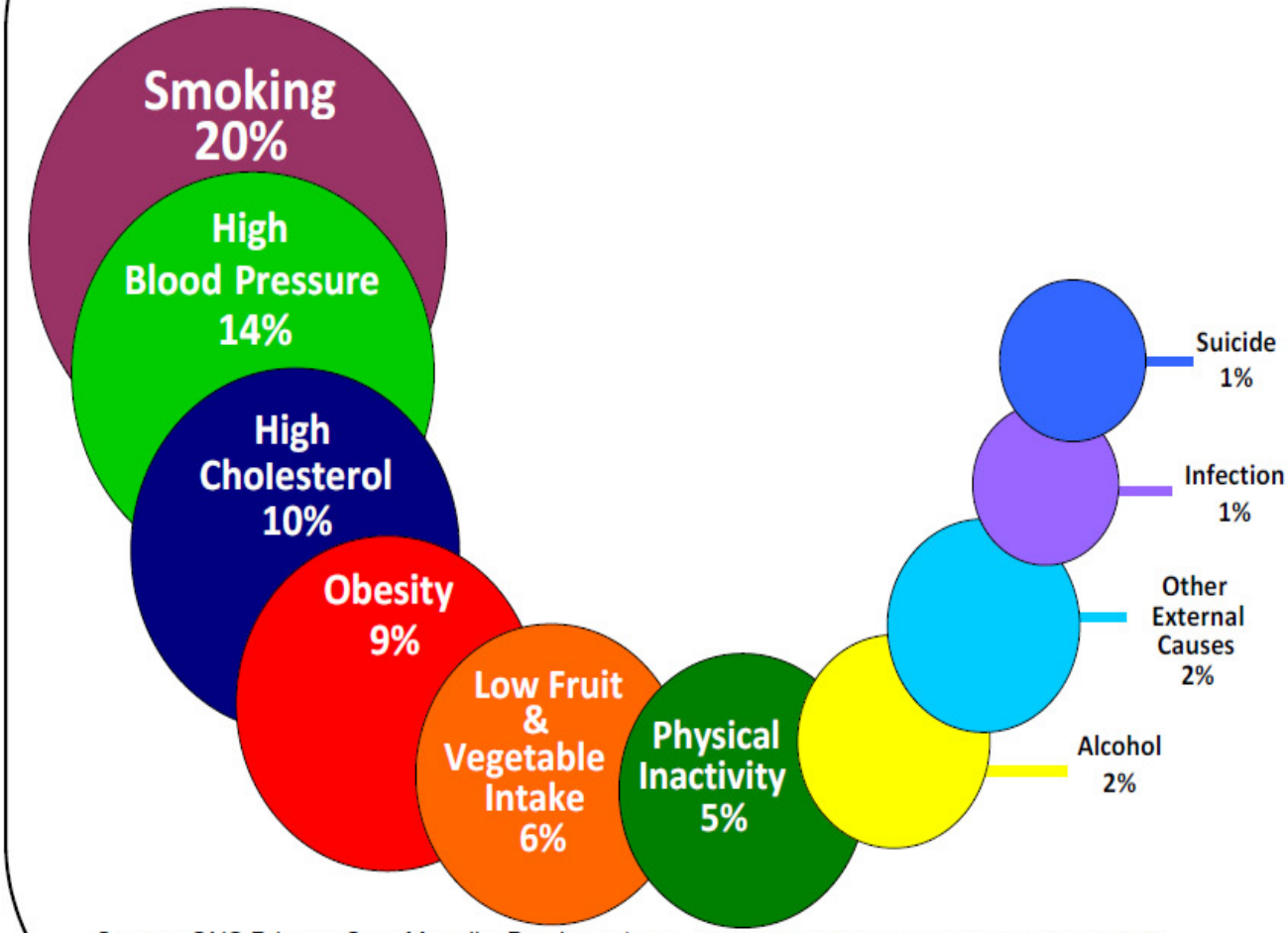
Deprivation is a key factor affecting life expectancy and healthy life expectancy and in 2015 Barnsley was ranked the 39th most deprived Borough out of 326 local authorities. There are great variations in deprivation within Barnsley itself. Good housing, education and employment are strongly associated with better health outcomes including mental health and life expectancy.

People with severe mental health conditions or learning disabilities can expect to live 15 – 20 years less than the average person.



APPENDICES

Risk factors contributing to deaths in Barnsley 2011-2013:



- A large proportion of deaths can be attributed to modifiable lifestyle factors.
- The leading risk factor for death in Barnsley is smoking, which contributed to 1 in 5 deaths in 2011-13.
- After smoking, high blood pressure and high cholesterol together contributed to 24% of deaths in Barnsley in 2011-13.

Source: ONS Primary Care Mortality Database (2011-13); The World Health Report 2002 (WHO: Geneva, 2003); Statistics in Smoking, The Information Centre, 2006.

Please see technical note on page 9.

APPENDICES

Learning Disabilities Within The Population

The tables on this page show the number and percentage of people in Barnsley with a learning disability who currently or are predicted to have a learning disability, categorised by age group:

These predictions are based on prevalence rates which are reflected in a report by the University of Lancaster's Institute for Health Research, entitled 'Estimating Future Need/Demand for Support for Adults With Learning Disabilities in England' (June 2014). The data in the Institute for Health Research's report is based on an estimate of prevalence across the national population. Prediction rates have been applied to Office for National Statistics (ONS) population projections for people aged 65 and over in the years 2011 and 2021 and linear trends projected to give the estimated number of people who are predicted to have a mild, moderate or severe learning disability, up to the year 2020.

Predictions of the number of people with a learning disability, by age

Age Group	2014	2015	2016	2017	2018
People aged 18-24	525	528	519	511	500
People aged 25-34	737	742	754	764	772
People aged 35-44	719	707	691	686	684
People aged 45-54	832	840	848	847	839
People aged 55-64	665	674	686	700	716
People aged 65-74	534	543	553	568	574
People aged 75-84	282	287	291	295	303
People aged 85+	95	99	103	107	111
Total population aged 18-64	**3.479**	**3,492**	**3,499**	**3,509**	**3,511**
Total population aged 65+	**911**	**929**	**947**	**970**	**988**

(Figures may not sum due to rounding. Source: Pansi.org.uk and Poppi.org.uk (September 2016)

Predictions of the number of people with a learning disability, for 2011 and 2021

Age Range	% in 2011	% by 2021
15-19	2.77	2.67
20-24	2.69	2.71
25-29	2.49	2.49
30-34	2.49	2.49
35-39	2.45	2.46
40-44	2.45	2.47
45-49	2.28	2.31
50-54	2.37	2.39
55-59	2.33	2.32
60-64	2.2	2.22
65-69	2.01	2.02
70-74	2.34	2.33
75-79	2.07	2.08
80+	1.89	1.93

(Source: Pansi.org.uk and Poppi.org.uk (September 2016)

Physical Disability Within The Population

The following tables show the number of people, categorised by age group , who currently or are predicted to have a moderate or serious physical disability in Barnsley, during the period 2014-2018.

Moderate Physical Disabilities

Age Group	2014	2015	2016	2017	2018
18-24	795	799	787	775	758
25-34	1,243	1,252	1,273	1,289	1,302
35-44	1,641	1,613	1,574	1,562	1,557
45-54	3,463	3,492	3,521	3,511	3,473
55-64	4,366	4,425	4,500	4,589	4,693
Total population aged 18-64	**11,508**	**11,581**	**11,654**	**11,727**	**11,783**

(Figures may not sum due to rounding. Source: Pansi.org.uk and Poppi.org.uk (September 2016)

Severe Physical Disabilities

Age Group	2014	2015	2016	2017	2018
18-24	155	156	154	151	148
25-34	118	119	121	123	124
35-44	498	490	478	474	473
45-54	964	972	980	977	967
55-64	1,699	1,723	1,752	1,786	1,827
Total population aged 18-64	**3,435**	**3,459**	**3,484**	**3,512**	**3,538**

Source: Pansi.org.uk and Poppi.org.uk (September 2016)

Mental Health Of The Population

Examples of Mental Disorder

Common mental disorders (CMDs) are mental conditions that cause marked emotional distress to the individual and which interfere with daily function, but do not usually affect insight or cognition. Such disorders can comprise different types of depression and anxiety, including obsessive compulsive disorder.
Information gathered by the Health and Social Care Information Centre, in 2009, based on a national, household survey, suggests that 19.7% of women and 12.5% of men surveyed, met the diagnostic criteria for at least one CMD.
Personality disorders can be long standing, ingrained distortions of personality which interfere with the ability to make and sustain relationships. Antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance.
ASPD can be characterised by a disregard for and violation of the rights of others. People with ASPD can display a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. BPD is characterised by high levels of personal or emotional instability associated with significant impairment. People with BPD can possess severe difficulties in sustaining relationships, with self harm or suicidal behaviour often being a characteristic.
Psychoses are disorders which produce disturbances in thinking and perception which can be severe enough to distort the perception of reality. The main types of psychoses are schizophrenia and affective psychosis, such as bi-polar disorder.
Research suggests that the main age group affected at national level by such disorders, is the 35-44 years age group.
Psychiatric co-morbidity in which individuals meet the diagnostic criteria for two or more psychiatric disorders, is known to be associated with the increased severity of symptoms, longer duration, greater functional disability and increased use of mental health services. This can include the most common mental disorders, notably anxiety and depressive disorders, as well as psychotic disorder and anti-social and borderline personality disorders, such as eating disorders, post traumatic stress disorder and attention deficit hyperactivity disorder. The above research suggests that there was no significant variation in the number of identified conditions between men and women.
The table, below, is based upon ONS population projections, concerning the percentage of people aged between 18-64, in the Borough, who are predicted to experience and require support for a disorder, up to 2030.

Summary	% Male	% Female
Common mental disorders	12.5	19.7
Borderline personality disorder	0.3	0.6
Anti social personality disorder	0.6	0.1
Psychotic disorder	0.3	0.5
Two or more psychotic disorders	6.9	7.5

Source: Pansi.org.uk and Poppi.org.uk (September 2016)
No projections are currently available concerning child mental health.

APPENDICES

Impact of Poor Health on Educational Attainment and Access to Skills and the Labour Market

Being in work provides purpose, promotes independence and is a factor in preventing physical and mental health conditions. Over a third of adults in Barnsley who are of working age, are affected by worklessness. Of these, 11,500 or 37% have a long term health condition which prevents them from working, compared to 21% at national level (NOMIS – 2015). The main health condition which is preventing Employment Support Allowance (ESA) claimants from working in Barnsley, is a mental or behavioural disorder. The percentage of such people amounts to 46% of workless people in the Borough and is comparable both to the Regional Average and National Average of 47% and 47.6% respectively.

Impact of Poor Housing on Health and Wellbeing

It is widely felt that poor housing can affect a child's ability to learn at school and study at home. Homeless children are two to three times more likely to be absent from school than other children due to the disruption caused by moving into and between temporary accommodation. Children residing in unfit or overcrowded homes can miss school more frequently as a result of the greater risk of illness and infection.

Overcrowding can be linked to delayed cognitive development whilst homelessness can impact on the development of communication skills. Homeless children are more likely to suffer from behavioural problems, such as aggression, hyperactivity and impulsivity as well as other factors which can compromise academic achievement, together with relationships with both peers and teachers. These factors can detrimentally impact upon the life chances of disadvantaged young people, later in the life course.

APPENDICES

Prevalence of Dementia

Diagnosed Dementia

Current data (2014/15) shows that of the 250,893 people registered with a GP practice in Barnsley, 1,904 have been given a diagnosis of dementia, resulting in a prevalence rate of 0.8%. This is slightly higher than the National Average of 0.7% and slightly lower than area team and commissioning rates of 0.8%.

Undiagnosed Dementia

Based on current data, Barnsley has 1,057 patients with dementia which has been undiagnosed (35.9%). Barnsley's diagnosis rate of 64.1% is higher than the National Average of 60.8%.
The following table sets out the percentage of people in Barnsley with either, mild, moderate or severe dementia, as at March 2015:

Mild		Moderate		Severe	
Nos.	%	Nos.	%	Nos.	%
1,628	55.3	956	32.5	358	12.2

(Source: NHS England Dementia Prevalence Calendar)

Projected Changes in the Prevalence of Dementia

Current predictions estimate that, by 2030, there will be an additional 1,810 people suffering from dementia in Barnsley (850 men and 960 women). The steepest rise, in both genders, is likely to be in the 90+ age group whilst the smallest changes are forecasted to be in the 65-69 age group, for both genders.

There is likely to be minimal change in the percentage of males and females predicted to have dementia in each age band at each five yearly interval between 2015 and 2030. This is due to the anticipated increase in the population in each age band. However, in those aged over 65 the prevalence of dementia is likely to be higher among females.

Early Onset Dementia

Of those, currently predicted to have early onset dementia by 2030, there is likely to be a minimal increase among people aged between 30 and 64. Prevalence is likely to be higher within the 50-64 age band with early onset dementia, higher among males than females in this age band.

Falls Among Those Aged 65 and Over

The proportion of people aged 65 and over is predicted to increase by 38% by 2030 which equates to the National Average for such an increase. The increase will be higher among the older age groups within this category with the 85-89 age group set to increase by 79% from 3,300, during 2014, to 5,900 in 2030 and the number of people aged over 90 from 1,700 in 2014 to 3,600 in 2030.

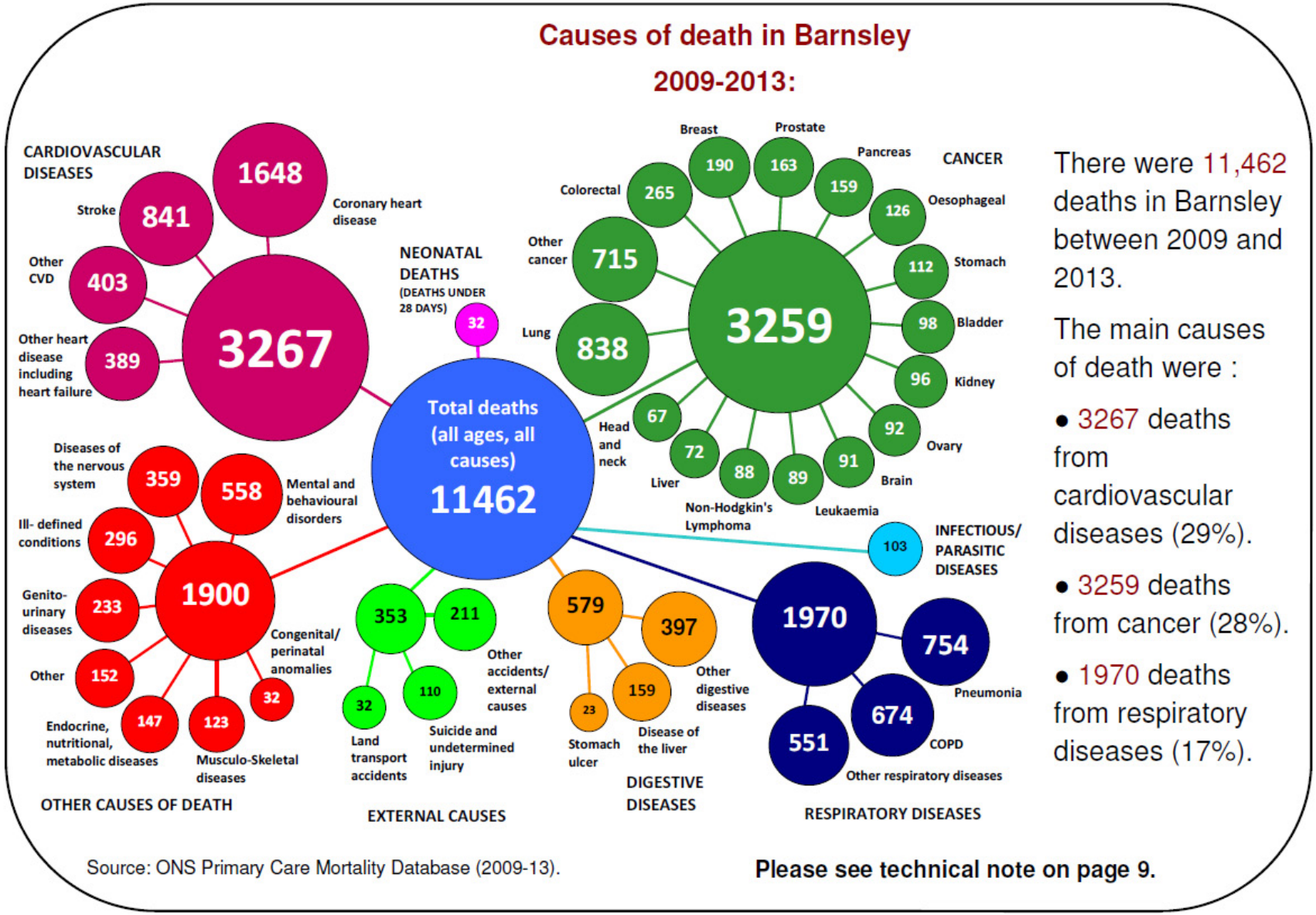
Hip Fractures Among People Aged 65 and Over

In both the 65+ and 80+ age groups the number of falls recorded during 2013/14 was slightly higher than in 2010/11.
Hip fractures are more prevalent among females within both the 65+ and 80+ age groups and whilst incidences within the 65-79 age group are notably lower than the National Average, the number among the 80+ age group is higher than the National Average.

Emergency Hospital Admissions For Falls Among People Aged 65 and Over

In Barnsley, the rate of admission for falls injuries among people aged 65+ is the eighth highest out of 16 statistically comparable neighbours and is significantly higher than the National Average. Whilst the number among those aged 65-79 is the fourth lowest it is also higher than the National Average. Admissions for fall injuries, within the 80 and over age group, is the seventh highest among the 16 statistically comparable neighbours and is also significantly higher than the National Average.
In both the 65+ and 65-79 age groups, the admission rate for falls injuries is significantly higher among females and is a reflection of the admission rate both in this Region and nationally. Whilst the admission rate among men aged 65-79 is lower in Barnsley than the National and Regional Average, it is higher among men aged 80+ in the Borough.

APPENDICES



There were 11,462 deaths in Barnsley between 2009 and 2013.

The main causes of death were :

- 3267 deaths from cardiovascular diseases (29%).
- 3259 deaths from cancer (28%).
- 1970 deaths from respiratory diseases (17%).

Source: ONS Primary Care Mortality Database (2009-13).

Please see technical note on page 9.