

Barnsley
Joint Strategic Needs Assessment 2016
Summary Report

Produced on behalf of the Barnsley Health and Wellbeing Board

Prepared jointly by:

Barnsley Council
Barnsley Clinical Commissioning Group

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

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

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Foreword

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

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

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

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

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

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

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

I commend this new JSNA to you.

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

Introduction

What is a Joint Strategic Needs Assessment?

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

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

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

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

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

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

The production of a Joint Strategic Needs Assessment (JSNA) is a statutory duty and from 1st April 2013, through the Health and Wellbeing Board¹, both Barnsley Council and the Barnsley Clinical Commissioning Group (CCG) have an equal and explicit obligation to prepare the JSNA for Barnsley.

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

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

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

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

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

Overview

Who is involved in developing the JSNA in Barnsley?

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

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

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

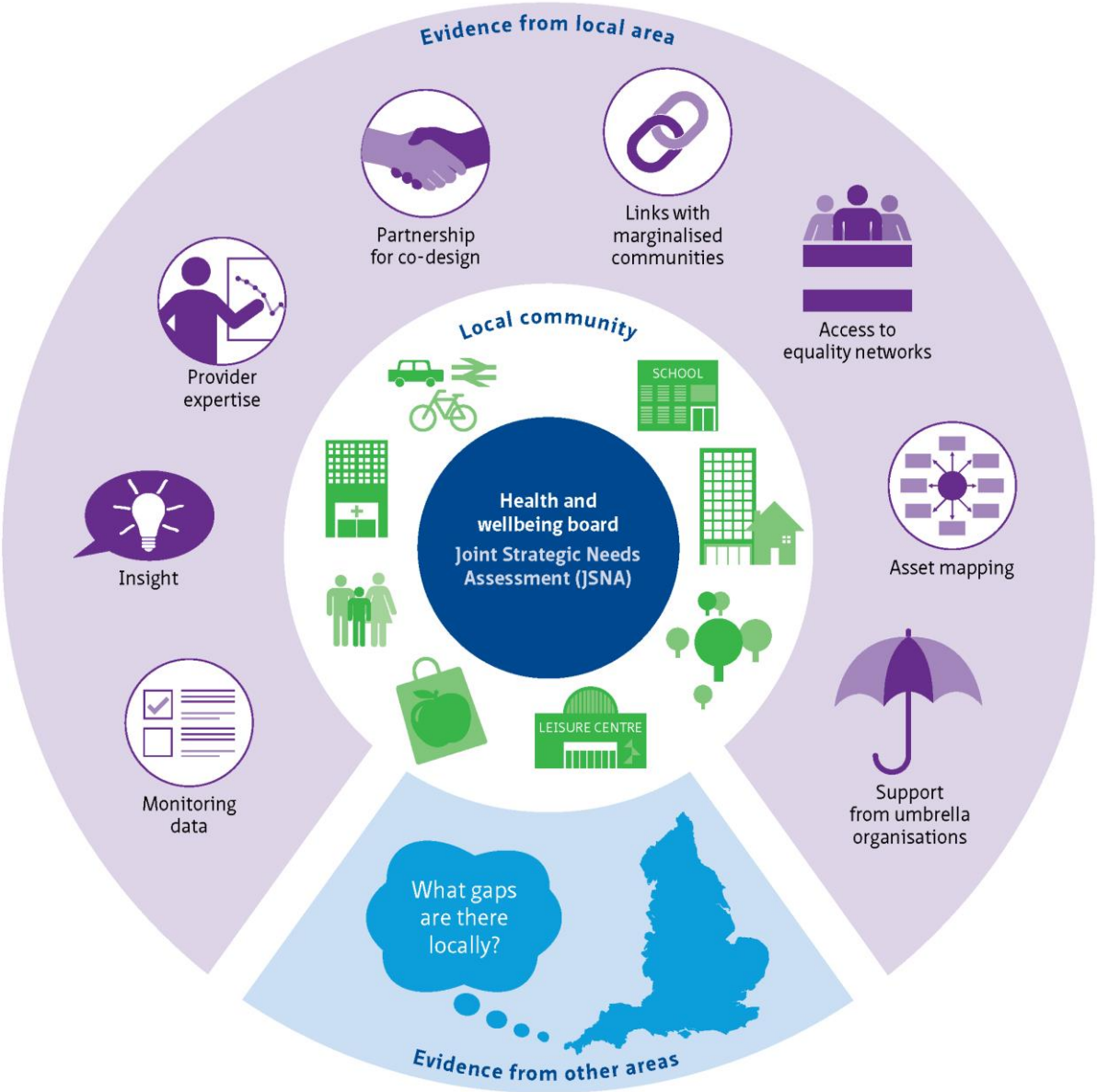
The evidence base for our JSNA is regularly reviewed and improved for the benefit of the health and wellbeing of the Barnsley population. This ensures that we can assist with service planning and reflect the changes in the population and their ever-changing needs.

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

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

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

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



Source: NHS Confederation

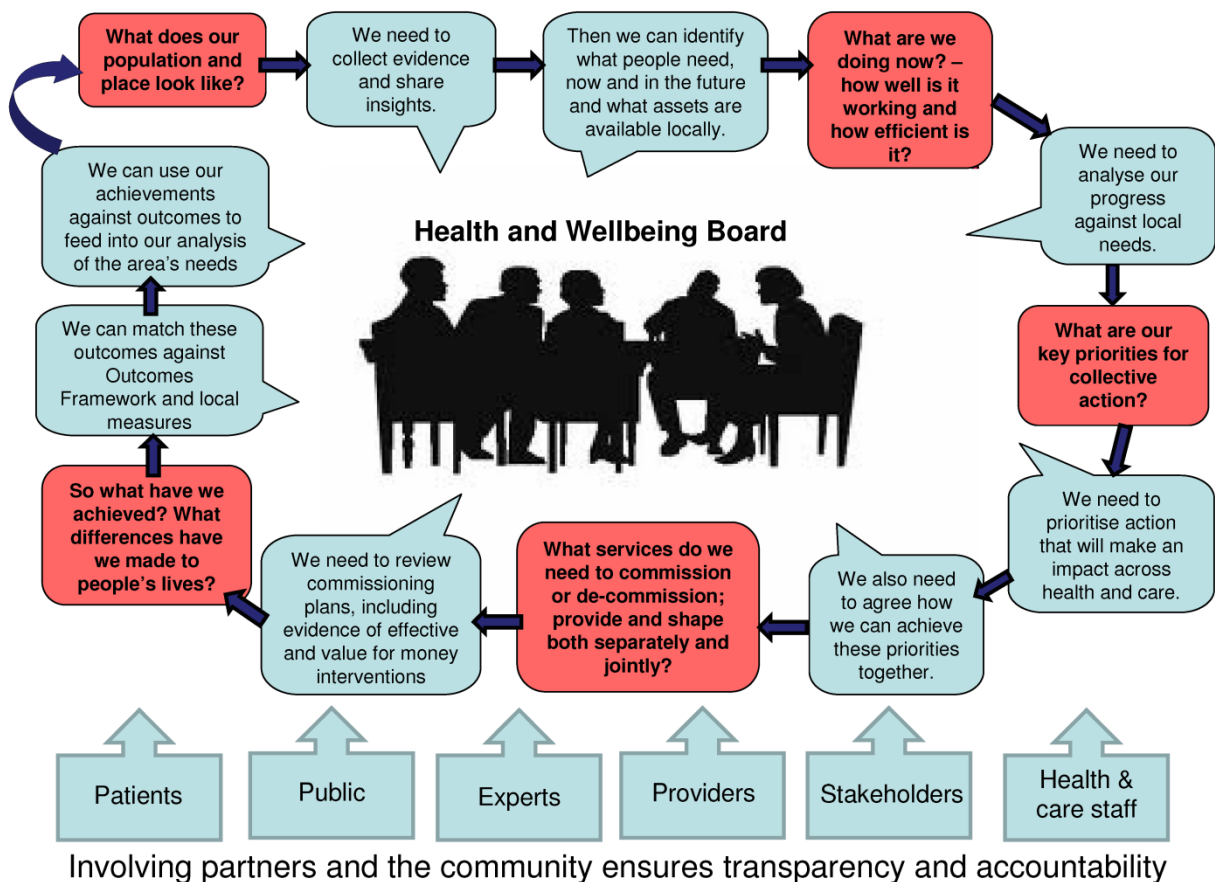
The diagram above shows how this JSNA brings together information about the local community including from schools, GPs, local transport, housing and leisure etc. The evidence about the community comes from monitoring data, customer insights, provider expertise, equality groups and asset mapping etc.

Who is the JSNA for?

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

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

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



Source: Department of Health

What does the JSNA look like in Barnsley?

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

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

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

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

The Intelligence

The population of Barnsley

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

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

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

(Source: ONS Mid-2015 Population Estimates)

Figures are rounded to nearest hundred.

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

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

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

(Source: ONS Mid-2015 Population Estimates)

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

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

Part of the net migration can be attributed to the new housing in Barnsley attracting inward migration² from more economically active people (Centre for Cities, 2015). Another part will be the number of non-British nationals. The Department for Work and Pensions (DWP) figures regarding non-British nationals that have been issued with a national insurance number (NINO), show that there were a total of 1,980 new arrivals in Barnsley during 2015³, mainly living in small pockets around the urban centre of Barnsley. Of these, 1,162 (58.7%) were from

² Inward migration is all forms of migration which involve an influx of people from a less populated area to a more populated area. Barnsley is in the top 10 for growth in Private Sector jobs (with an 8.4% increase) and for housing growth (with a 8.5% increase); both measures are based on data from 2004 to 2013. Centre for Cities, 2015

³ There are no figures available for how many 'new arrivals' stay or move on to other areas.

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

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

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

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

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

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

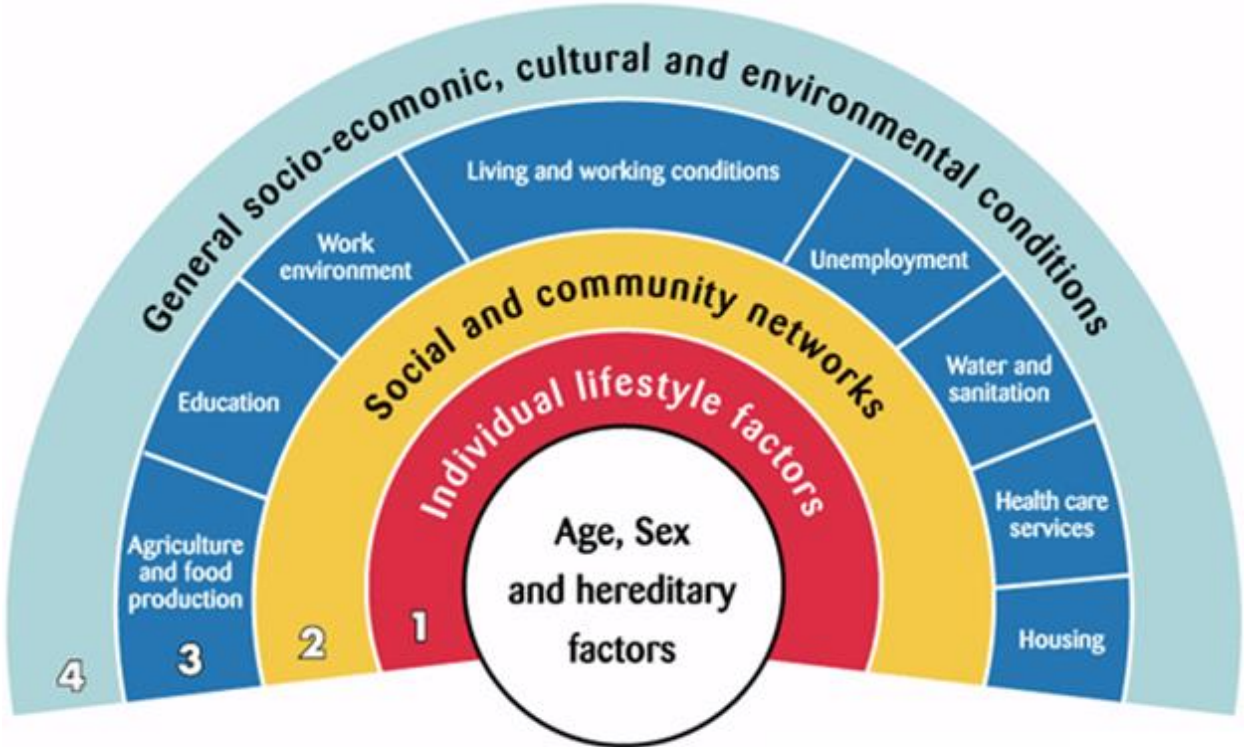
The number of carers is also difficult to estimate. The 2011 Census indicated that over 7,600 Barnsley residents were providing 50 or more hours of unpaid care each week to a friend, relative or neighbour who had a disability or health problem.

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

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

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

Figure 3 – Dahlgren model



Source: Healthknowledge.org.uk

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

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

Life expectancy

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

Life expectancy at birth⁴ varies significantly across Barnsley. For men, there is a difference of 7.3 years between the ward with the highest life expectancy, which is Penistone East at 82.3 years and the ward with the lowest life expectancy, which is Dearne North at 75 years. A similar difference in life expectancy exists for women of 7.6 years. Life expectancy for women is highest in Penistone East at 86.7 years and lowest in Wombwell at 79.1 years (see ONS Life Expectancy Briefing 2012/14).

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

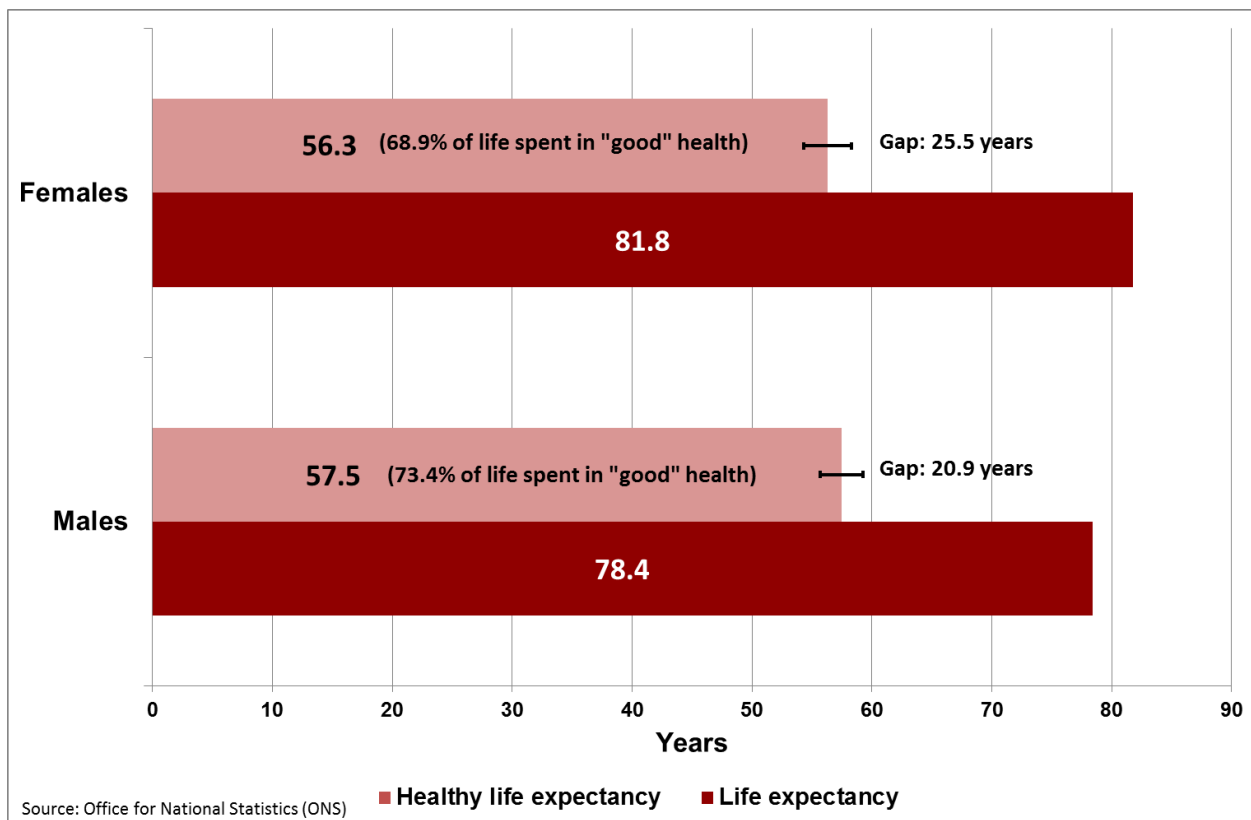
Although healthy life expectancy⁵ at birth for men in Barnsley has increased by 0.2 years from 2009/11 to 2012/14, the proportion of life spent in “good” health has decreased from 74.1% to 73.4%; this is due to life expectancy at birth increasing at a greater rate during the period. Healthy life expectancy at birth for women in Barnsley has decreased by 0.8 years from 2009/11 to 2012/14. The proportion of life spent in “good” health has also decreased from 70.6% to 68.9% (see figure 4 overleaf).

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

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

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

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



Lifestyle

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

Smoking

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

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

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

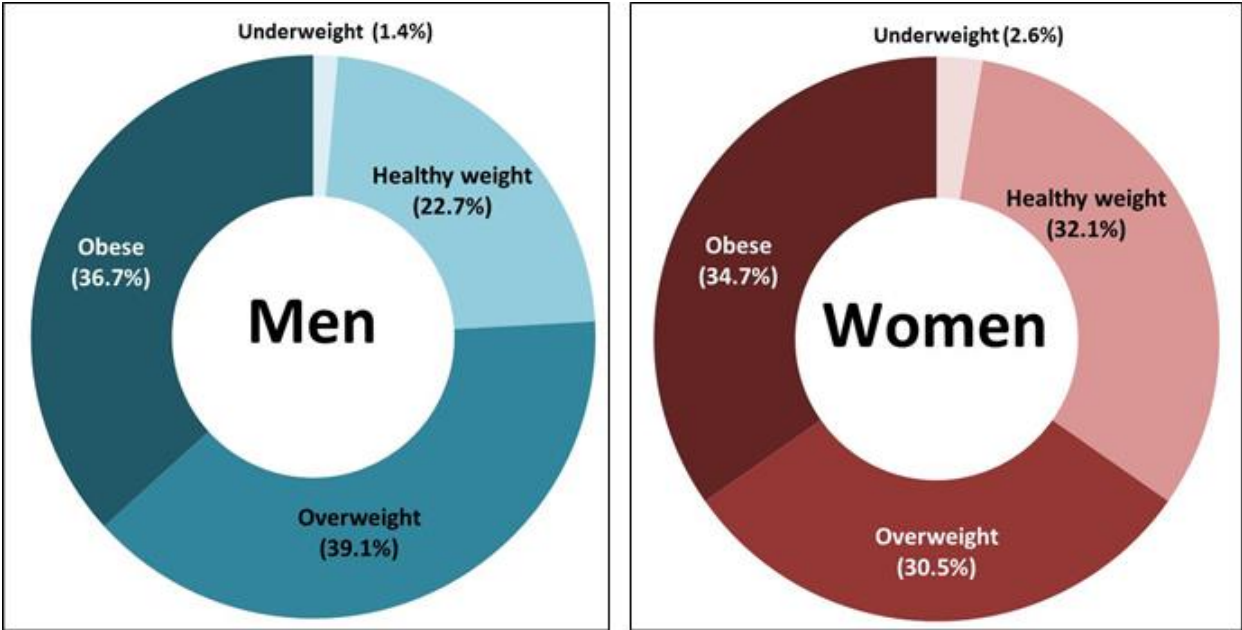
In 2015/16, the proportion of people in Barnsley setting a quit date who successfully quit smoking (38.1%) is slightly higher than the England rate (36.4%). Smoking quit rates have varied over time, but have remained above the England average (Source: NHS Digital 2016). Barnsley’s rate for smokers setting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

Healthy weight

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

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

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



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

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

This relates to all patients aged 16 or over, registered with a Barnsley GP, who have a BMI status recorded in the last 15 months. The proportion of patients who have a BMI record is around 48%. This data is available at a ward level and for different age groups. This shows that for men, the prevalence of excess weight⁶ increases with age up to 45 – 54 years old (83.6%). For women the prevalence of excess weight increases up to the age 55 – 64 years old (73.9%).

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

Active lifestyle

People who have a physically active lifestyle⁷ have a 20% – 35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Only half of adults (50.7%) in Barnsley are physically active compared to 57% in England. The rate of physical activity is increasing but a third of the Barnsley population remains inactive (34.6%). The overall proportion of residents who cycle is low but increasing. The proportion of Barnsley residents who cycle at least five times a week in 2014/15 (1.0%) has more than doubled from 2013/14 (0.4%).

Healthy eating

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

Alcohol

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

In Barnsley in 2014/15 the directly standardised rate for hospital admissions for alcohol related conditions (broad definition⁸) is 2,671 per 100,000 population. This is equivalent to 6,212 people. This is significantly higher than the England directly standardised rate of 2,139 per 100,000 population. In Barnsley, the directly standardised rate for hospital admissions for alcohol related conditions has increased from 2,001 per 100,000 in 2008/09 to 2,671 in 2014/15.

⁶ Excess weight is those who have a BMI of 25 or higher.

⁷ Active People Survey (Sport England 2015). Active is the percentage of adults achieving at least 150 minutes of physical activity per week. Inactive is the percentage of adults doing less than 30 minutes of physical activity per week. There are some people in between who are nearly active (14.7%).

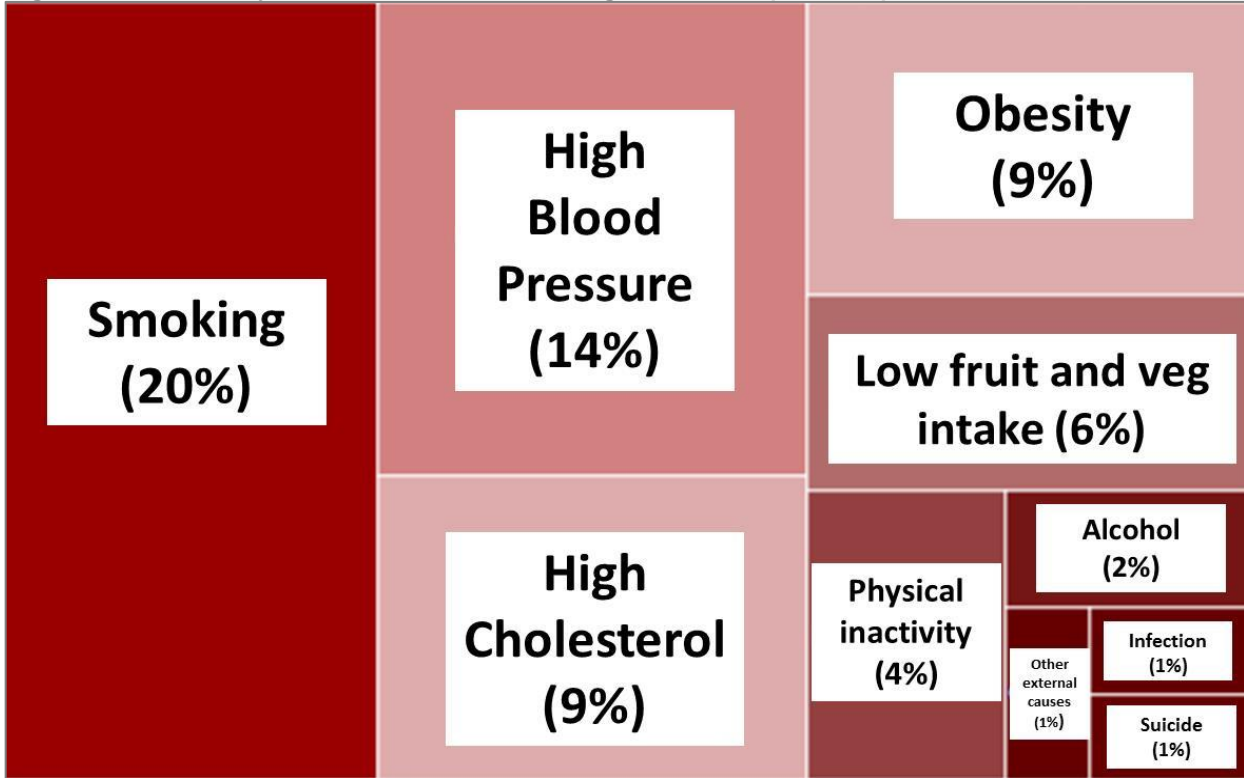
⁸ Hospital admissions for alcohol-related conditions (broad), all ages, directly age standardised rate per 100,000 population European standard population.

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

Risk factors contributing to deaths in Barnsley

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

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



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

Health services

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

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

Children and young people

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

Breastfeeding

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

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

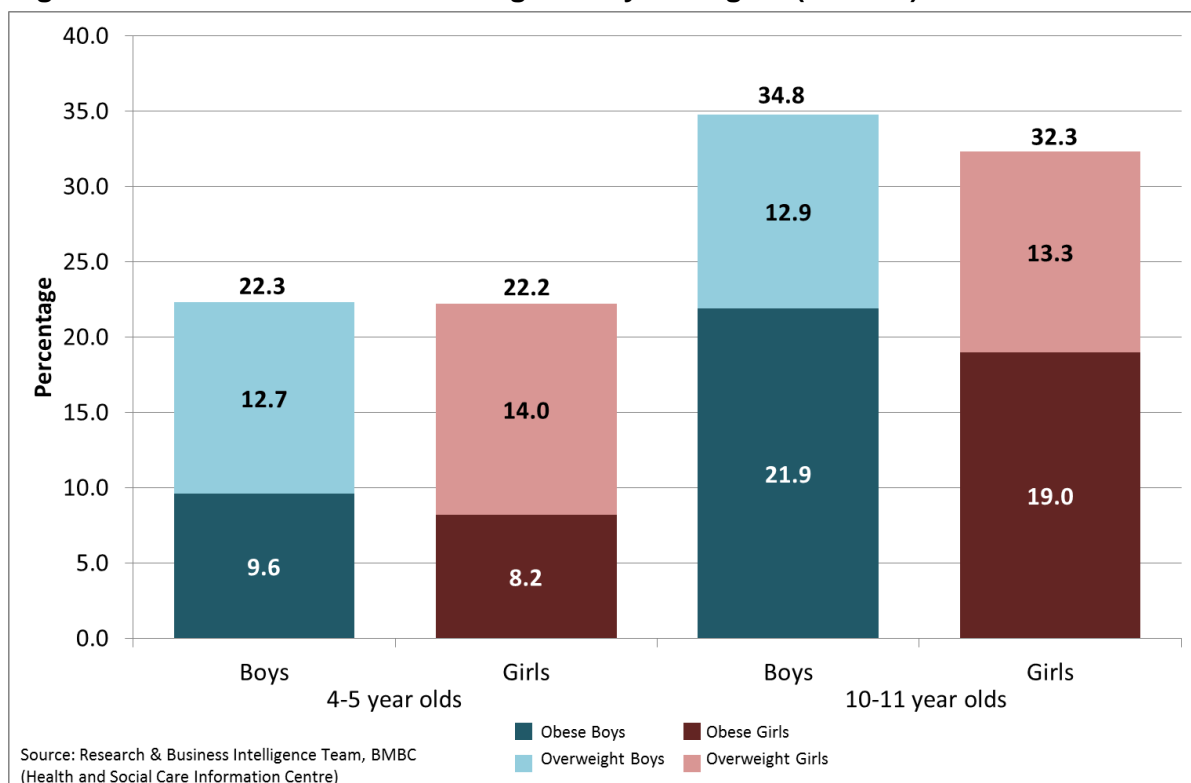
Tooth decay

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

Healthy weight in children

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

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



The following information is from the 2014 What About Youth survey⁹. The survey targets 15 year olds to ask questions relating to general health, wellbeing and behaviour.

Healthy eating

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

Active lifestyle

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

Smoking

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

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

Alcohol

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

Risky behaviour

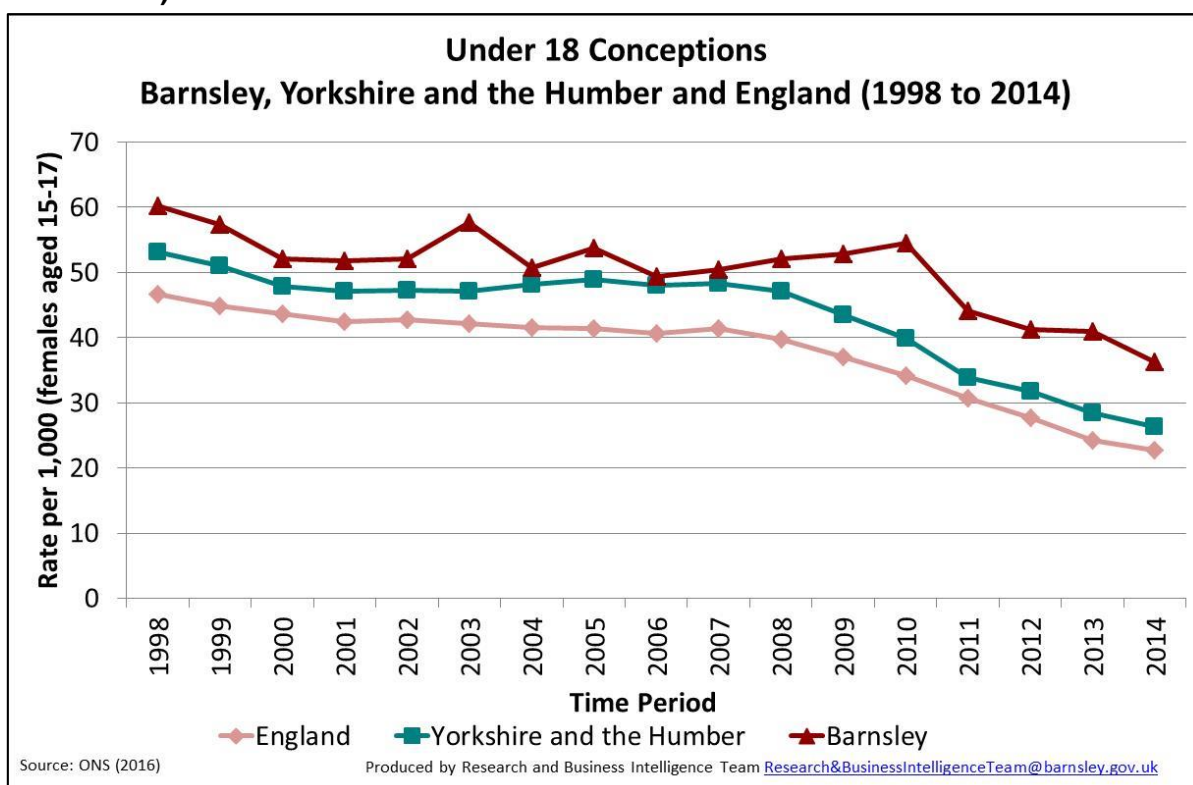
Nearly a quarter (22.5%) of young people in Barnsley undertake three or more risky behaviours (smoking, drinking alcohol, drug use, inactivity, poor diet). This is significantly higher than the England average of 15.9%. Girls (26.7%) are more likely to undertake 3 or more risky behaviours than boys (18.4%).

Teenage conceptions

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

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

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



Older people

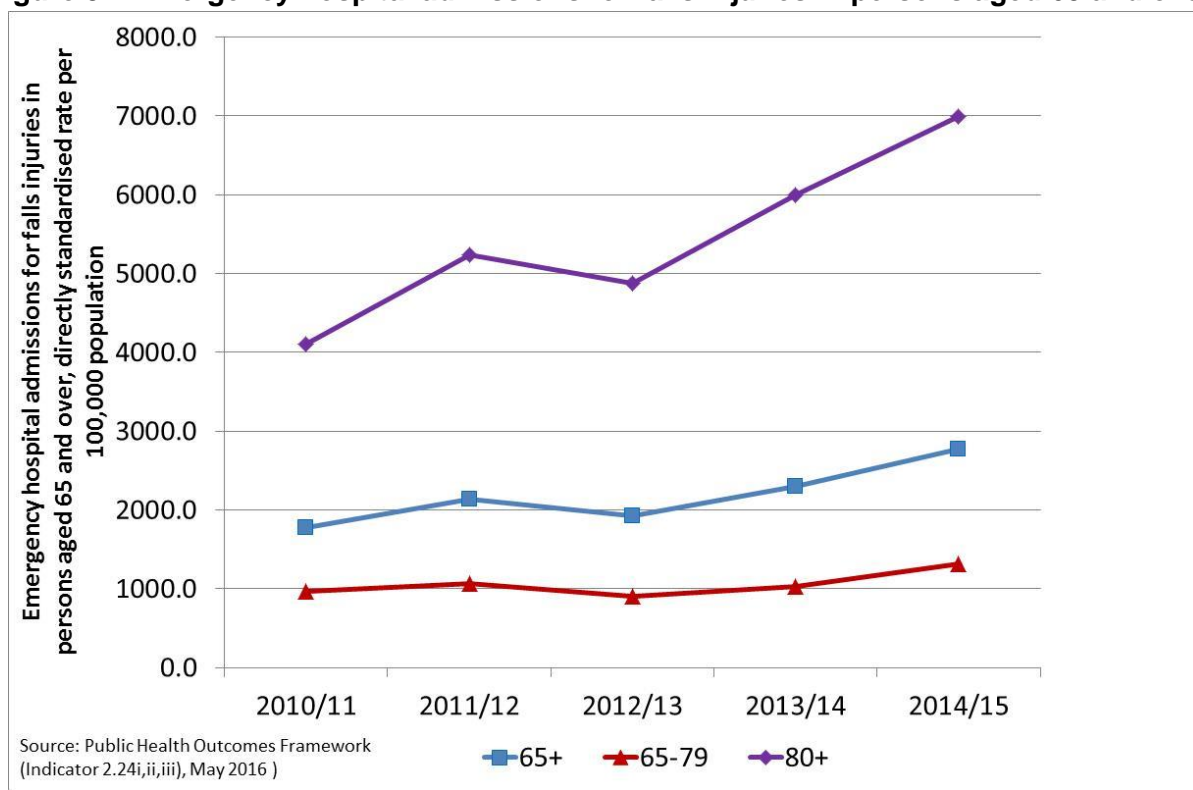
Falls

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

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

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

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



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

Dementia

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

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

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

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

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

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

Flu vaccination

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

¹¹ NHS England Living well with dementia

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf

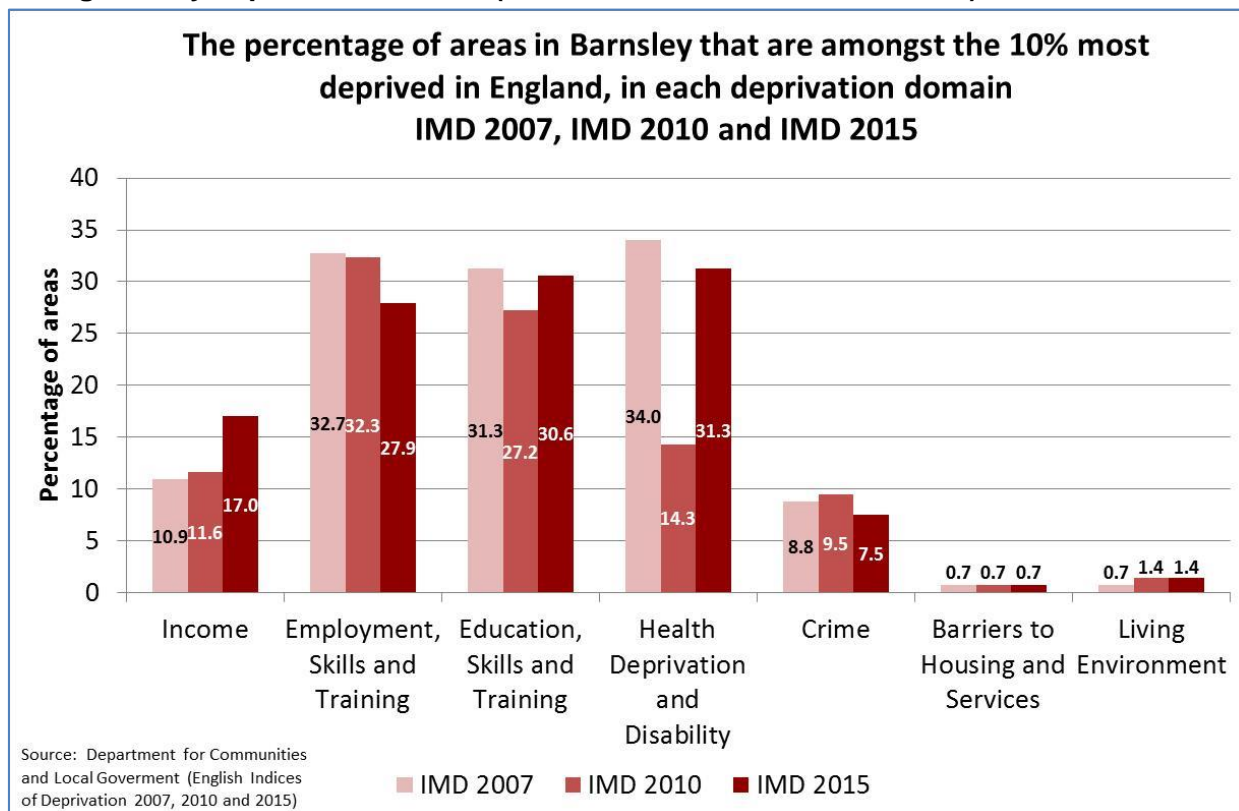
¹² Projecting Older People Population Information System 2015 <http://www.poppi.org.uk/>

¹³ Public Health England 2016

Indices of Multiple Deprivation

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

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



The IMD 2015 data shows the following:

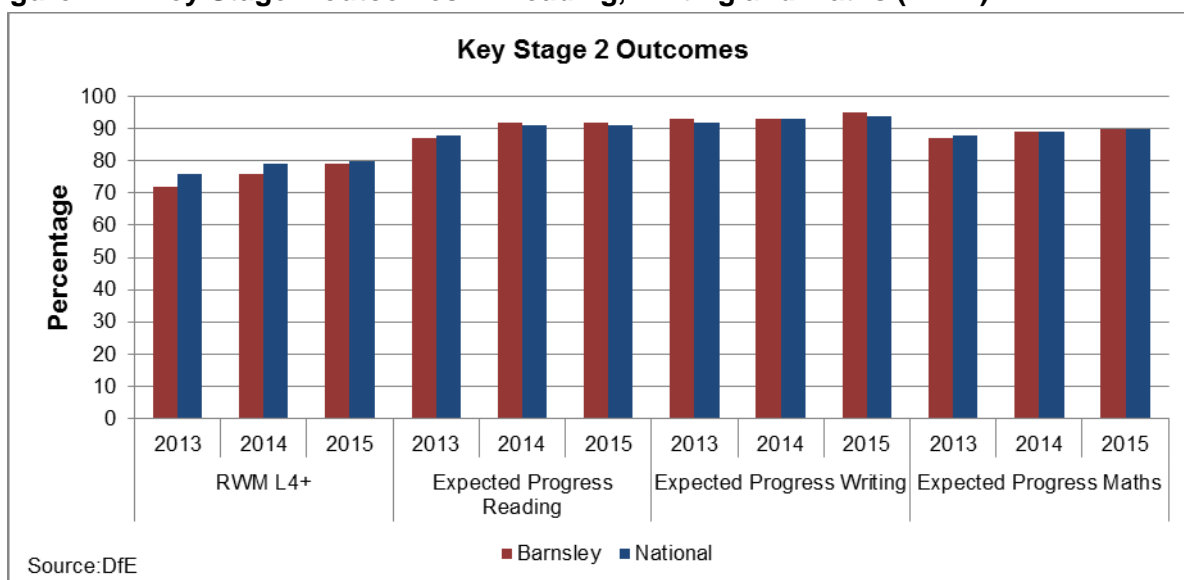
- Overall, Barnsley is ranked the 39th most deprived area in England out of 326 (where 1 is the most deprived), using the IMD 2015 rank of average score measure; a decline from IMD 2010 when it was the 47th most deprived area.
- 21.8% of areas in Barnsley are amongst the 10% most deprived in England.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

Education

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

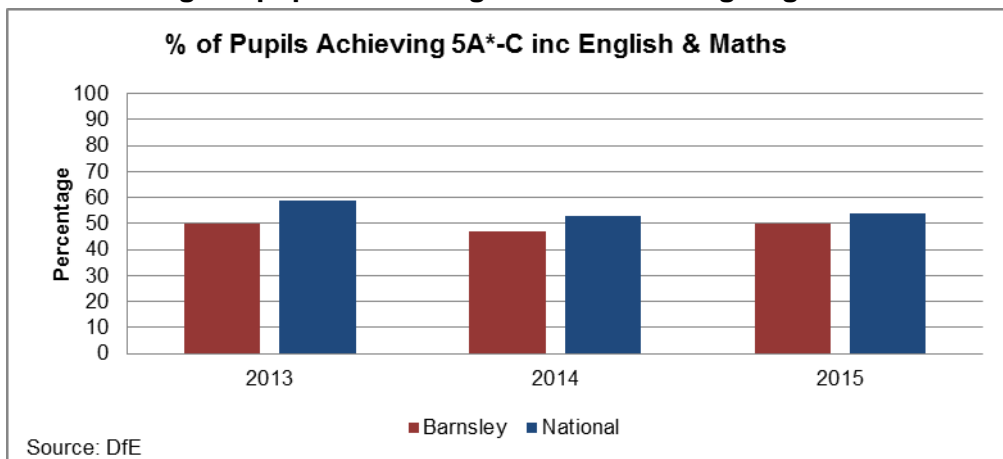
Educational attainment in Barnsley has continued to improve but has remained below the national average at all stages of education in 2015. However, since 2014, pupils between the ages of 7 and 11, made the same or more progress than pupils nationally in the individual subjects of reading, writing and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

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



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

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



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

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

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

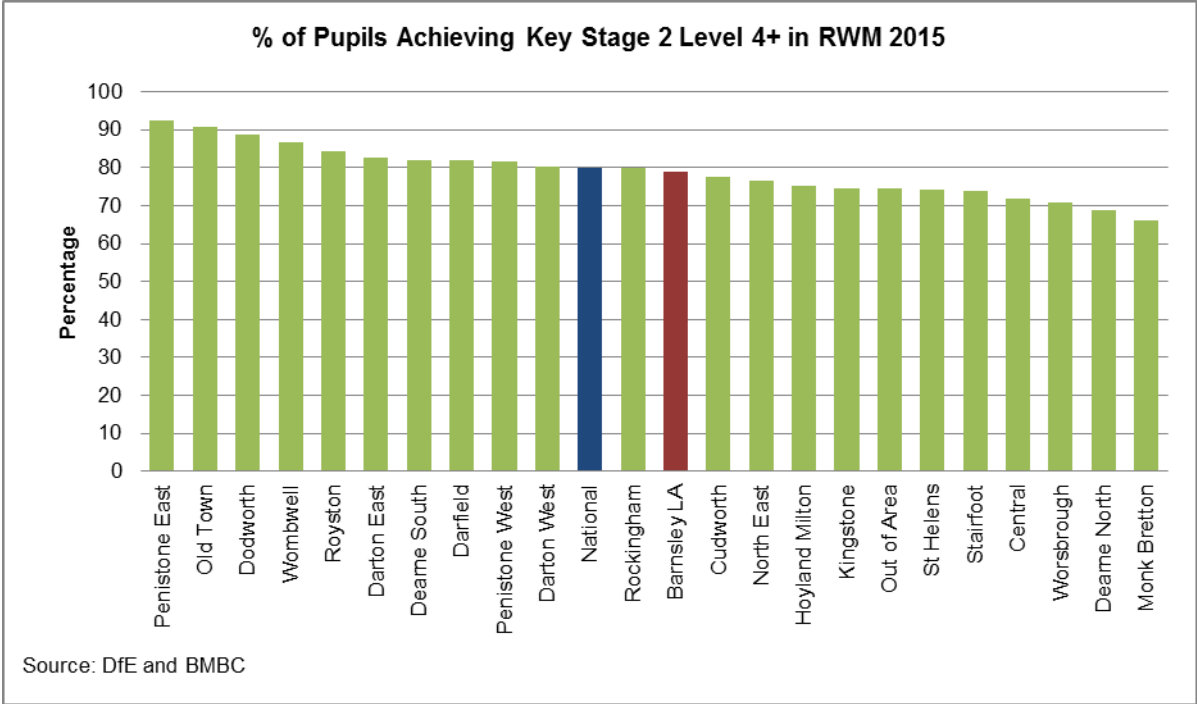
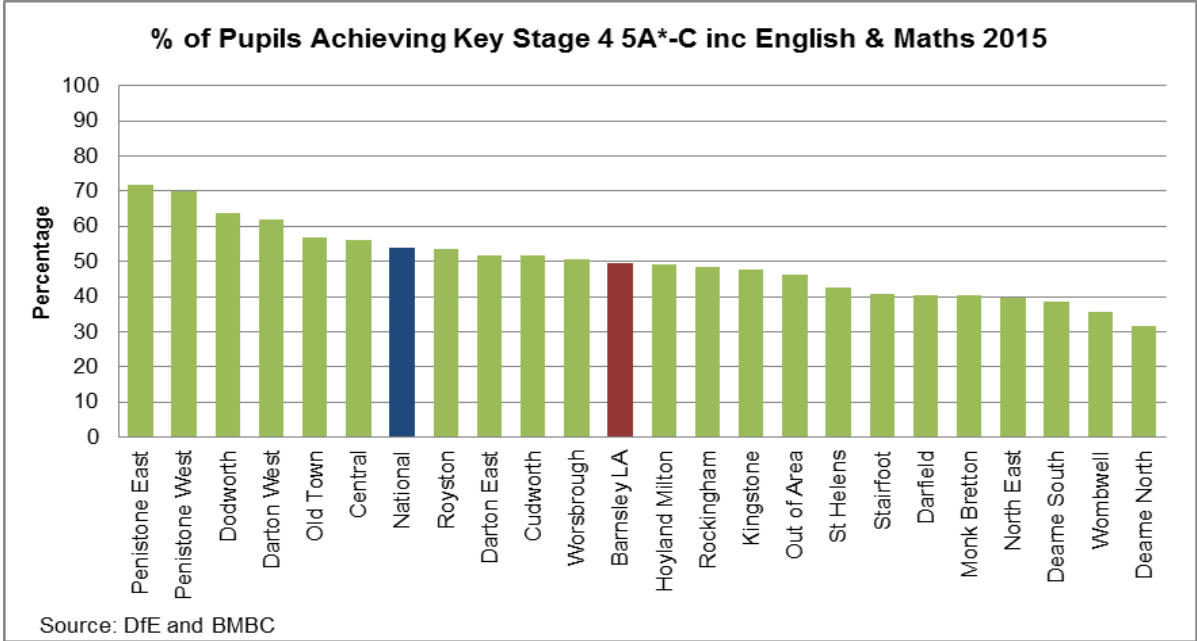


Figure 14 – Percentage of pupils achieving Key Stage 4 5A* – C including English and Maths (2015)



According to the Annual Population Survey (Jan – Dec 2015) the number of people in Barnsley aged 16 and over with no qualifications¹⁴ has increased and is now above the England average. This low level of skills is likely to have an adverse impact on the economic growth of the borough and is a cause for concern.

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

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

Lack of digital skills

A lack of digital skills seems to compound other inequality issues and as the digital divide increases, it gets harder for people to catch up as technology moves so quickly. For individuals, digital skills are linked to boosting productivity in work and helping to improve the chances of unemployed people to find jobs¹⁵. Digital skills can also assist with success in education and work, reducing social isolation, saving money, claiming benefits and accessing services. On an economic level, digital skills contribute to a vibrant economy and a skilled and confident workforce. Barnsley and other Northern towns and cities seem to suffer an exodus of the technologically skilled, which will in the long term negatively impact on our economy.¹⁶

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

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

The Barnsley Skills and Employment Strategy¹⁷ seeks to address three priority areas that will create more and better jobs in Barnsley in the next 4 years:

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

¹⁵ The economic impact of Basic Digital Skills and inclusion in the UK. A report for Tinder Foundation and GO ON UK. Nov 2015 http://www.tinderfoundation.org/sites/default/files/research-publications/the_economic_impact_of_digital_skills_and_inclusion_in_the_uk_final_v2.pdf

¹⁶ Northern Powerhouse project threatened by 'brain drain': <https://www.ft.com/content/7b730442-0196-11e6-ac98-3c15a1aa2e62>

¹⁷ Barnsley Skills and Employment Strategy: More and Better Jobs (2016-2020)

Benefits

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

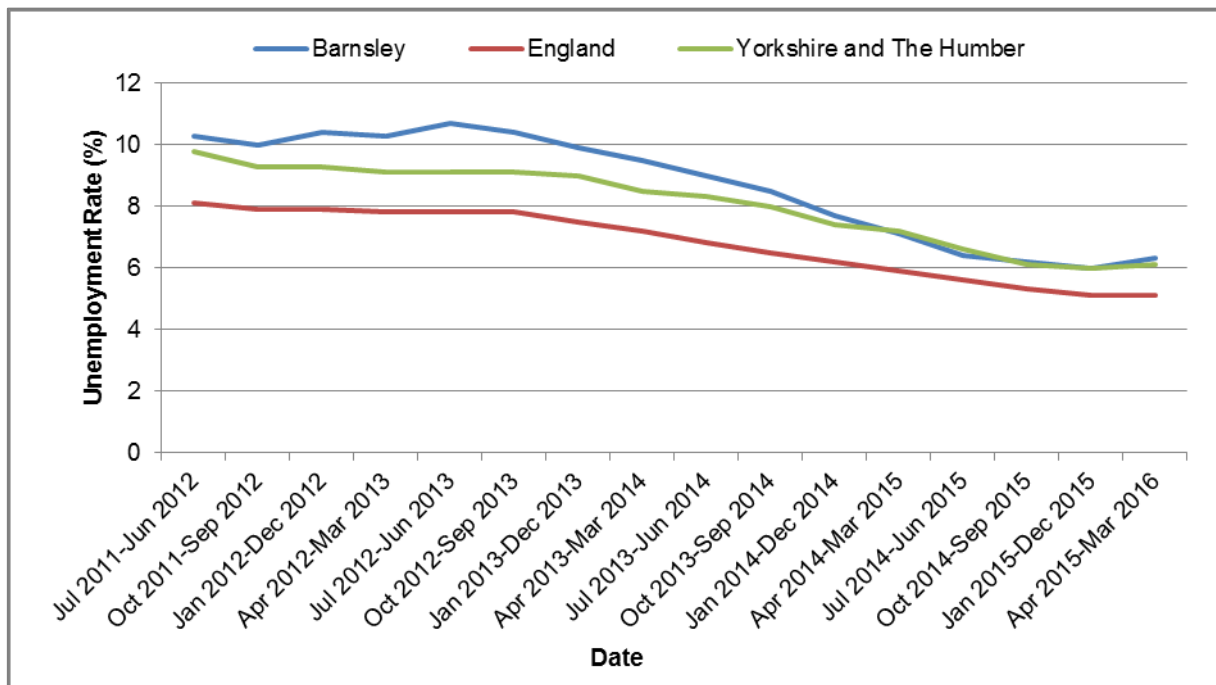
Worklessness

The rate of unemployment¹⁸ has been reducing steadily from the period of July 2012-June 2013, to the latest 12 month period from a high of 10.7% to 6.3%. In actual terms, the 6.3% estimate of unemployment in Barnsley amounts to 7,400 people.

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

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

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



Source: Annual Population Survey 2016

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

During the period April 2015-March 2016, 35,600 people in Barnsley were economically inactive¹⁹. Of those that are economically inactive, the reason that contributed to the largest proportion was 'long-term sick or disabled' which accounts for 37.4%, followed by those that are 'looking after home or family' which accounts for 22.8%.

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

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

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

There continues to be a mismatch in the local economy between the skills of the local labour supply and the demands of local business²⁰. The latest job density rate²¹ of 0.58 indicates that the borough is failing to maintain an adequate number of jobs in the local economy to support the indigenous working age population. Whilst the rate is improving (it's at its highest level since 2005) it lags behind the regional rate of 0.77 and the national of 0.82.

National research shows²² that people's employment conditions have the strongest impact on the risk of poverty and recurrent poverty. Figure 16 overleaf shows the factors that keep people in the low pay/no-pay cycles.

¹⁹ Economic inactivity is people not in employment who have not been seeking work within the last 4 weeks and/or are unable to start work within the next 2 weeks.

²⁰ Barnsley Skills and Employment Strategy: More and Better Jobs (2016-2020)

²¹ Job density is the number of jobs per resident of working age. For example, a job density of 1.0 would mean that there is one job for every resident of working age in the population. Barnsley Labour Market Profile, Jobs Density. ONS. 2014, Nomis, 2016.

²² Cycles of Poverty, Unemployment and Low Pay. Joseph Rowntree Foundation, 2010. <https://www.jrf.org.uk/report/cycles-poverty-unemployment-and-low-pay>

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



Source: Joseph Rowntree Foundation, 2010

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

Working Age Client Group (WACG)

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

Disability and work

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

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

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

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

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

Jobseeker's Allowance and Tax Credits

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

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

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

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

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

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

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

Disability Living Allowance – children

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

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

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

²³ <http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/adhdhyperkineticdisorder.aspx>

Carers Allowance

Carers Allowance (CA) is for people who care for another person for 35 or more hours per week. The cared-for person must be in receipt of a benefit for their disability/illness at a rate indicating that they would need additional personal support. Caring for someone can have implications for the carer's physical and mental health. People providing high levels of care are twice as likely to be permanently sick or disabled and 625,000 people in England have health problems because of their caring responsibilities²⁴.

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

Further reading on benefits

Barnsley Skills and Employment Strategy (2016 – 2020)

<https://www.barnsley.gov.uk/media/3063/employment-and-skills-strategy.pdf>

Labour Market Profiles at ward level

<https://www.nomisweb.co.uk/reports/lmp/ward2011/1946157120/report.aspx>

Labour Market Profiles at borough level

<https://www.nomisweb.co.uk/reports/lmp/la/1946157120/report.aspx>

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

Housing

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

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

It is estimated that the demand for housing for vulnerable people²⁵ will be an additional 3,070 units and 28 bed-spaces by 2030 (Peter Fletcher Associates Ltd, 2015).

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

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

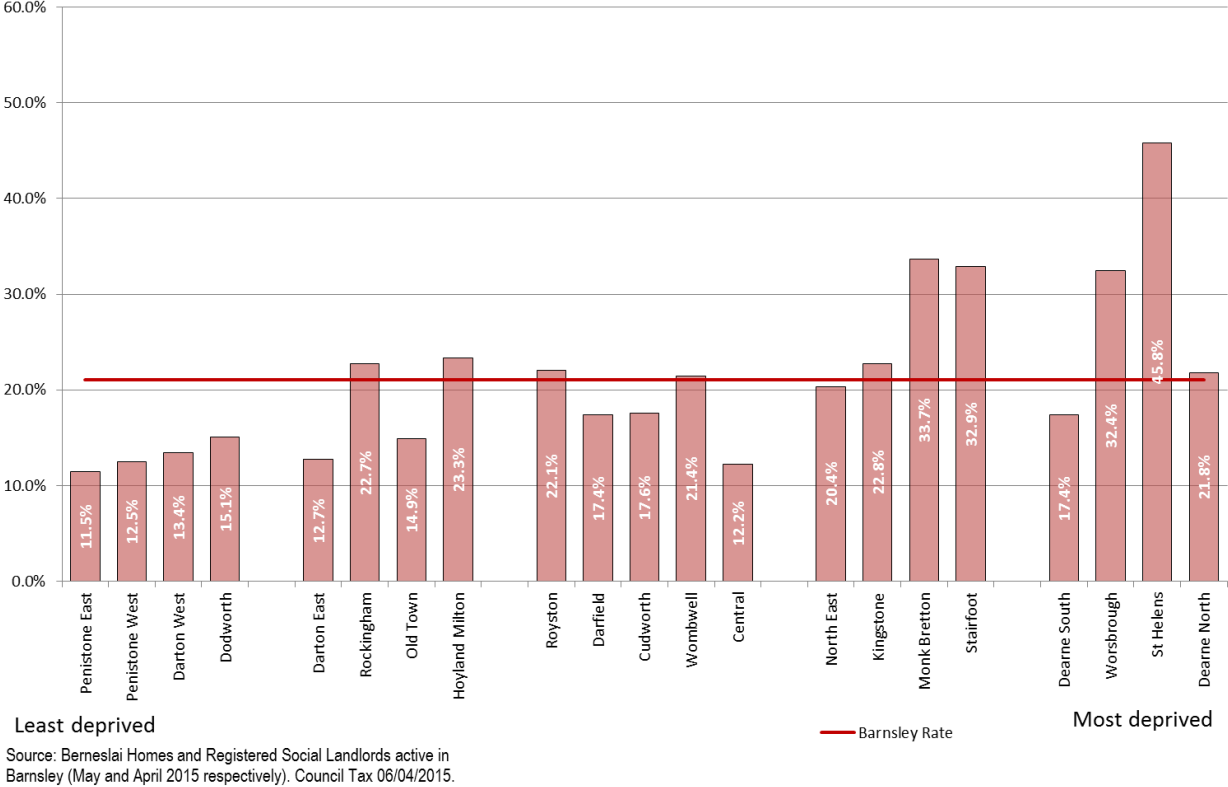
So what does bad housing mean for our children? Evidence from Shelter (2013) states:

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

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

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

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

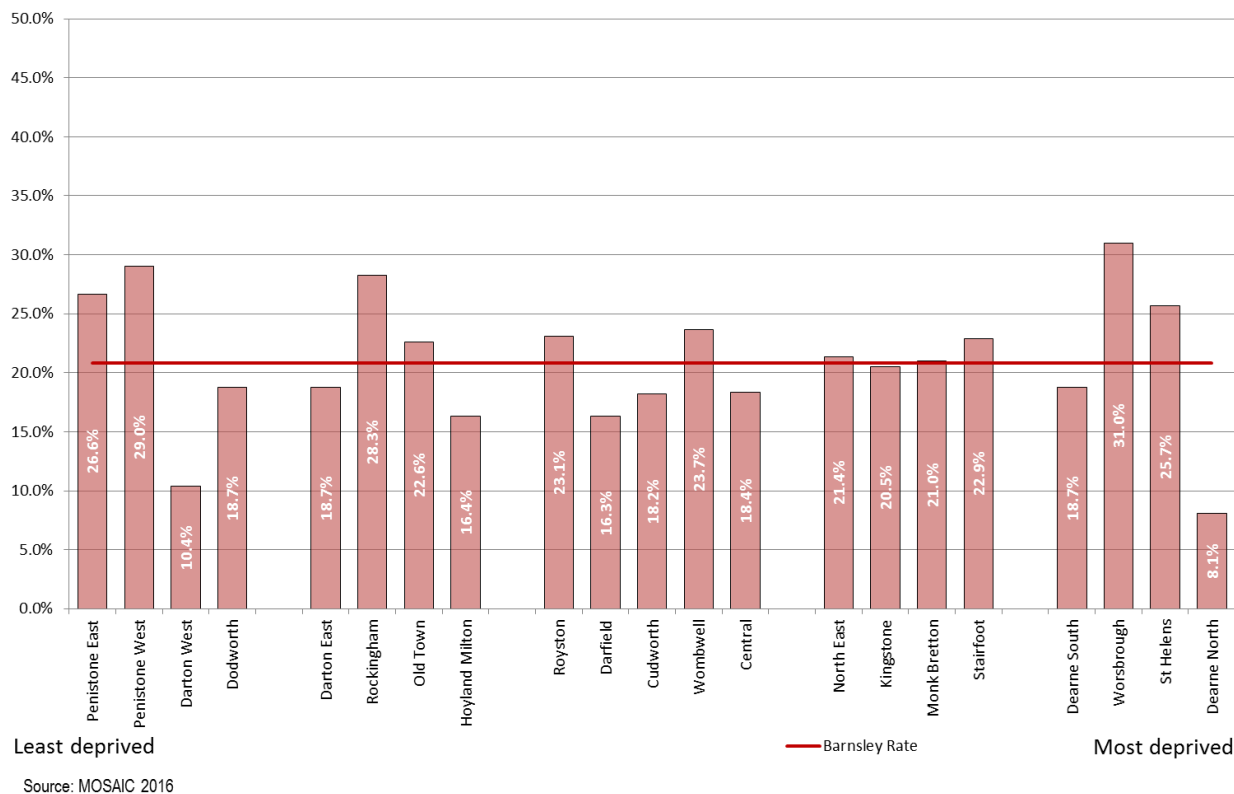


Notes: The accommodation above ranges from a room to a house. Council Tax data excludes Band 'U'.

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

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

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



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

Further reading on housing

DCLG Housing Stats

<https://www.gov.uk/government/organisations/department-for-communities-and-local-government/about/statistics>

BMBC Housing Strategy 2014-2033

https://www2.barnsley.gov.uk/media/3824981/bmbc_housing_strategy_2014_final.pdf

BMBC Strategic Housing Market Assessment 2014 (Arc4, 2014)

https://www2.barnsley.gov.uk/media/3824978/barnsley_shma_2014_update_final_report.pdf

BMBC Energy Strategy 2015-25

https://www2.barnsley.gov.uk/media/3838552/bmbc_energy_strategy.pdf

Poverty

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

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

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

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

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

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

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

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

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

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

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

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

Fuel poverty

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

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

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

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

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

Long term conditions

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

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

The number of people with three or more long-term conditions is predicted to rise nationally from 1.9 million in 2008 to 2.9 million in 2018.²⁹ Multimorbidity is more common among deprived populations, especially those that include a mental health problem. Some people living in deprived areas will have multiple health problems 10 – 15 years earlier than people living in more affluent areas.

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

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

²⁷ NHS England <https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

²⁸ Quoted by Kings Fund <https://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/long-term-conditions-multi-morbidity>

²⁹ Quoted by Kings Fund <https://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/long-term-conditions-multi-morbidity>

³⁰ Quoted by Kings Fund https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

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

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

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

	Number of People known to Primary Care diagnosed with a condition, (Quality Outcomes Framework (QOF) register)			Predicted Prevalence (expected number)			Gap between predicted Prevalence & Barnsley QOF Registers
	Number	% of Population		Number	% of Population		
	Barnsley	Barnsley	England	Barnsley	Barnsley	England	
Obesity (age 18+)	29,806	14.6	9.5				
Diabetes (age 17+)	14,921	7.2	6.5	17,480	8.9	8.6	2,559 ³¹
Diabetes³² (age 17+)				21,124	9.8	9.5	
Non-Diabetic Hyperglycaemia				24,093	11.6	11.2	
Cardiovascular Disease:							
Hypertension	40,211	15.7	13.8	65,576	25.8	23.6	25,365 ³³
Coronary Heart Disease	11,687	4.6	3.2				
Atrial Fibrillation	4,639	1.8	1.7	6,202	2.5	2.4	1,563 ³⁴
Heart Failure	2,284	0.9	0.8				
Peripheral Arterial Disease	2,598	1.0	0.6				
Stroke and TIA	5,279	2.1	1.7				

³¹ Source of prediction model: National Cardiovascular Intelligence Network, Public Health England

³² Diabetes – predicted prevalence in 2030

³³ Source of prediction model: National Cardiovascular Intelligence Network, Public Health England

³⁴ Source of prediction model: National Cardiovascular Intelligence Network, Public Health England

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

Burden of Disease

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

³⁵ Source of prediction model: Age 16+, National Cardiovascular Intelligence Network, PHE

³⁶ Source of prediction model: 2011, APHO

³⁷ Source of prediction model: All ages, CFAS II and AS2014, NHSE

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

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



Source: Public Health England

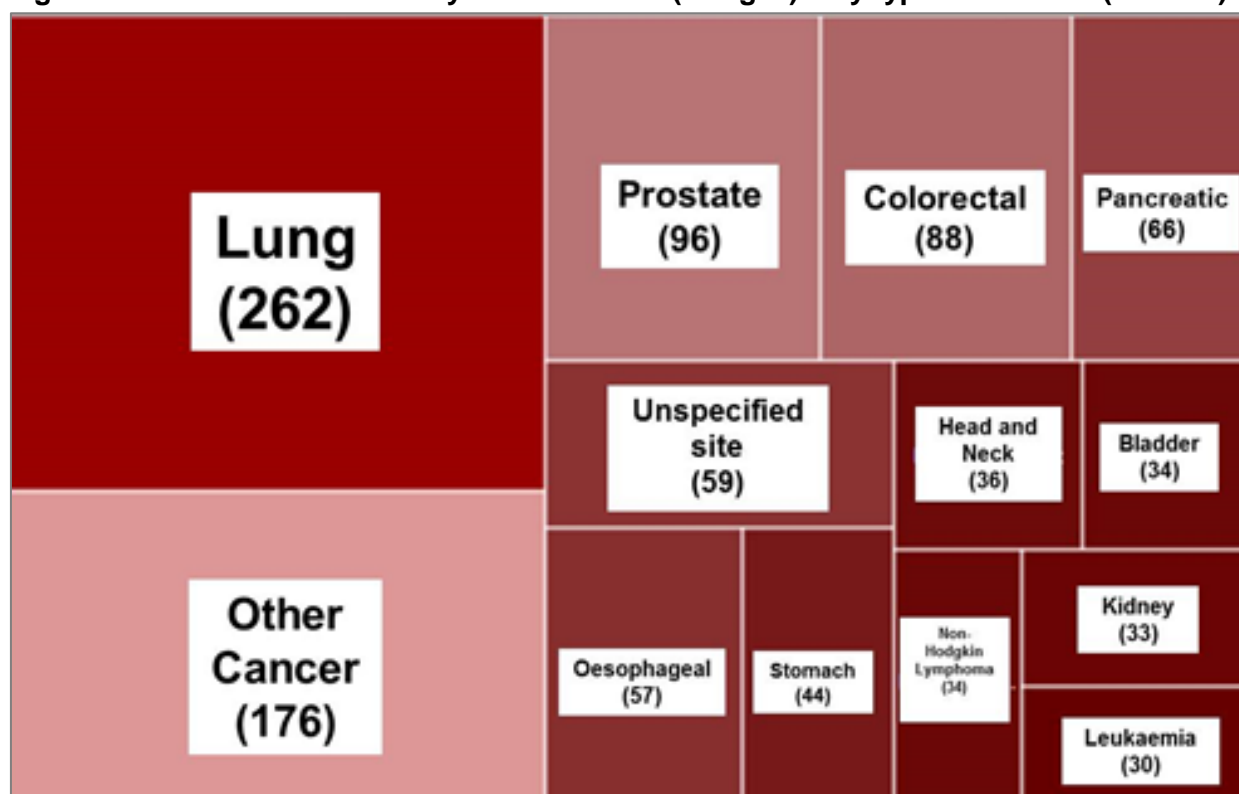
Cancer

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

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

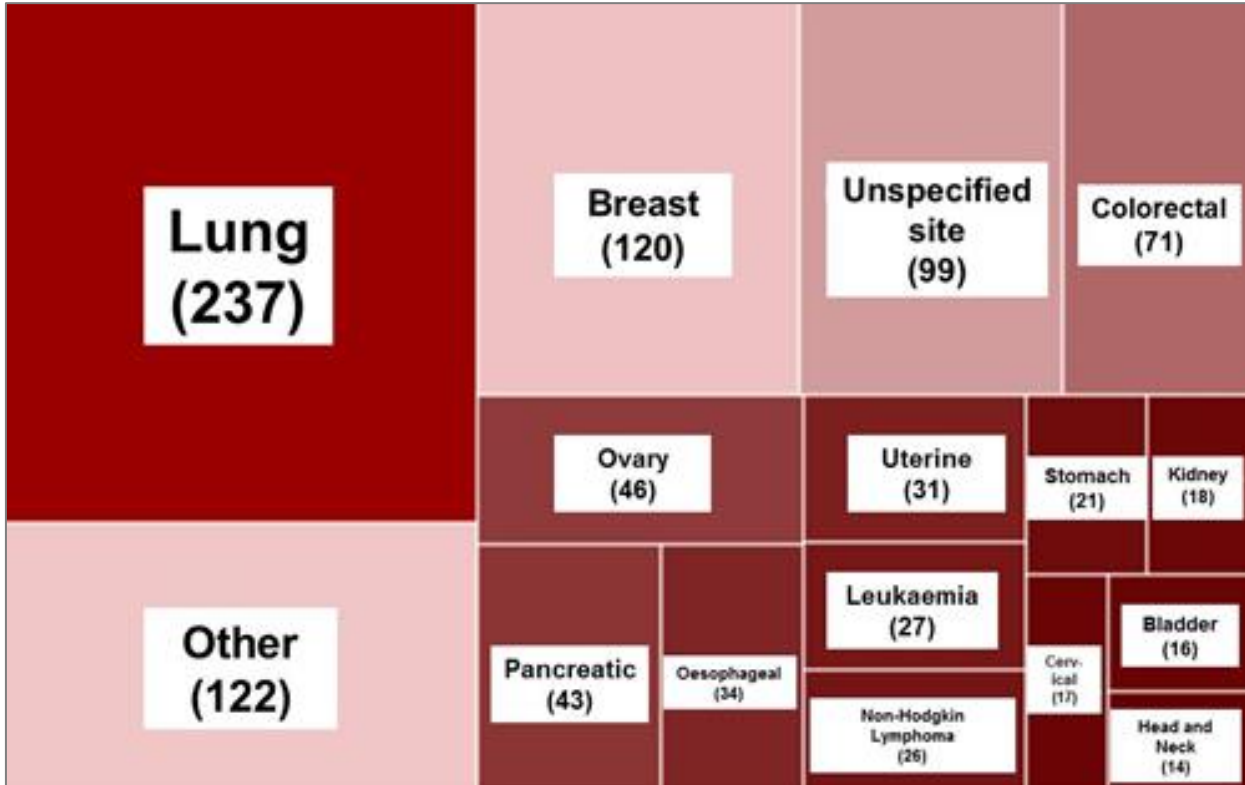
Lung cancer is responsible for the greatest proportion of cancer deaths in Barnsley (25.8% of all men and 25.1% of all women). Figure 19 below and figure 20 overleaf show the number of deaths by type of cancer for Barnsley men and women.

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



Source: Primary Care Mortality Database

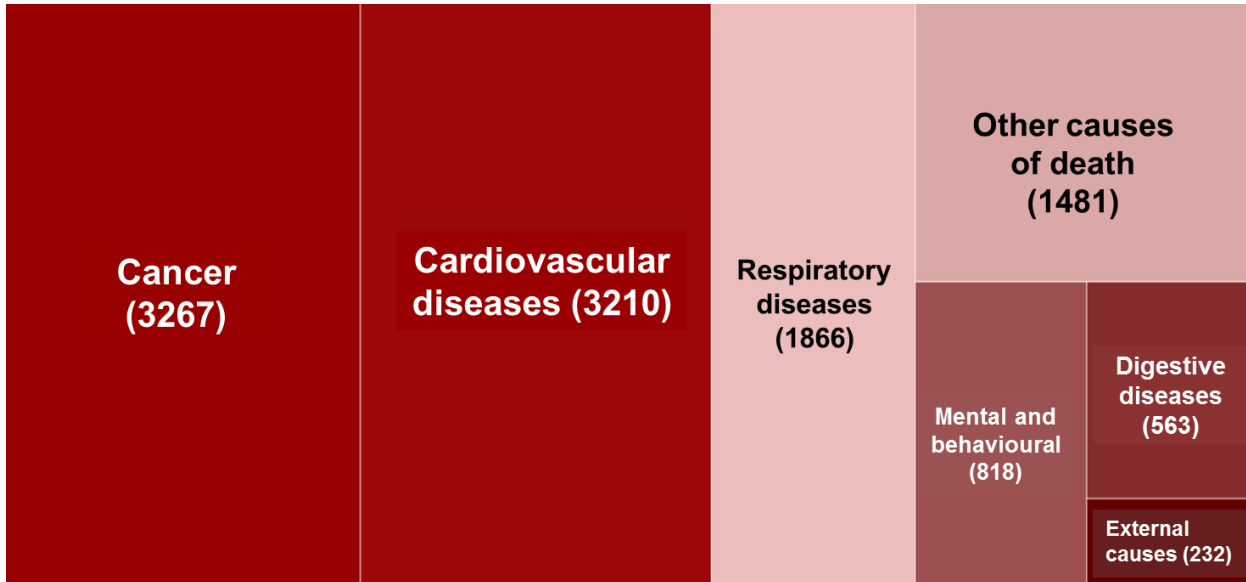
Figure 20 – Number of deaths by Cancer – women (all ages) – by types of Cancer (2012/14)



Source: Primary Care Mortality Database

Mortality

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



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

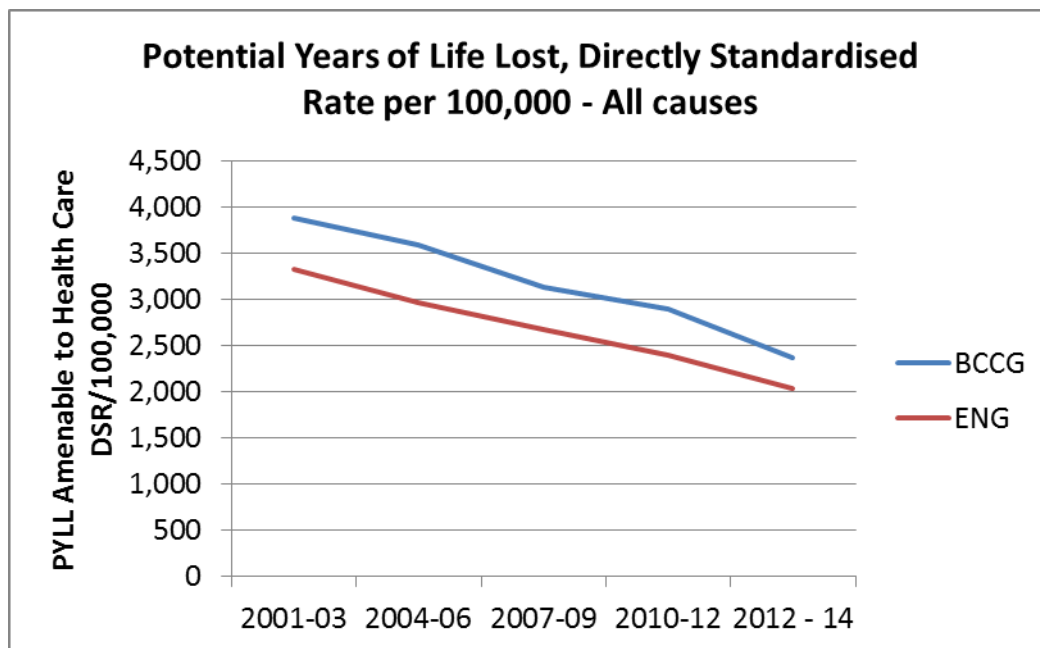
There were 11,437 deaths in Barnsley between 2010 and 2014. As shown in figure 21, the main causes of death were cancer, cardiovascular and respiratory diseases.

Potential Years of Life Lost

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

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

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



Source: Public Health England 2014

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

Cancer mortality aged under 75 years

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

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

Cardiovascular disease mortality aged under 75 years

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

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

Respiratory disease mortality aged under 75 years

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

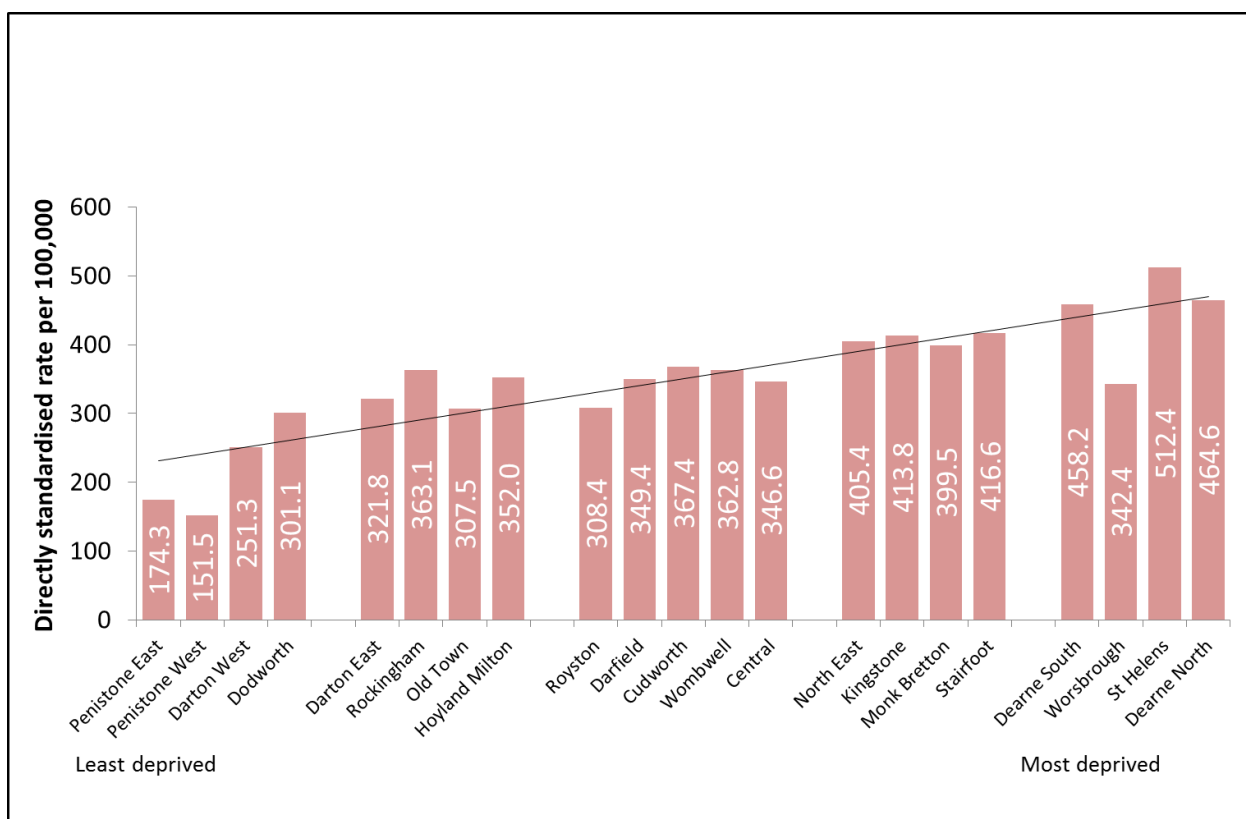
There are differences in respiratory disease mortality within Barnsley. Within the Barnsley wards in 2010/14, St Helens ward has the highest respiratory disease mortality rate at 75.7 and Penistone West the lowest rate at 19.4 (persons), a difference of 56.3(per 100,000 population).

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

Smoking attributable mortality

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

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



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

Alcohol Related Mortality

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

Suicide

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

Excess winter deaths³⁸

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

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

Wellbeing and mental health

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

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

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

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

³⁸ Office for National Statistics (ONS) standard method defines the winter period as December to March, and compares the number of deaths that occurred in this winter period with the average number of deaths occurring in the preceding August to November and the following April to July

³⁹ NHEngland. The Five Year Forward View For Mental Health, 2016

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

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

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

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

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

Barnsley's 2012/13 rate for premature (under 75) mortality in adults with serious mental illnesses is 1,329.3 per 100,000. This is slightly higher than the England rate of 1,318.9 per 100,000, but not significantly higher. The rate has increased since 2009/10 from 1,273.5 to 1,329.3 in 2012/13.

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

For further details, see the mental health in Barnsley profile

Minority Groups

Black and Minority Ethnic Communities

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

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

Lesbian, Gay, Bisexual and Transgender (LGBT)

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

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

Gypsy Travellers

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

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

Asylum Seekers

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

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

Sensory Impairment

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

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

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

Carers

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

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

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

Feedback highlighted:

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

Adult Social Care Survey

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

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

The key findings are:

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

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

Health surveys

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

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

What are the potential issues for Barnsley in the future?

Population Projections

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

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

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

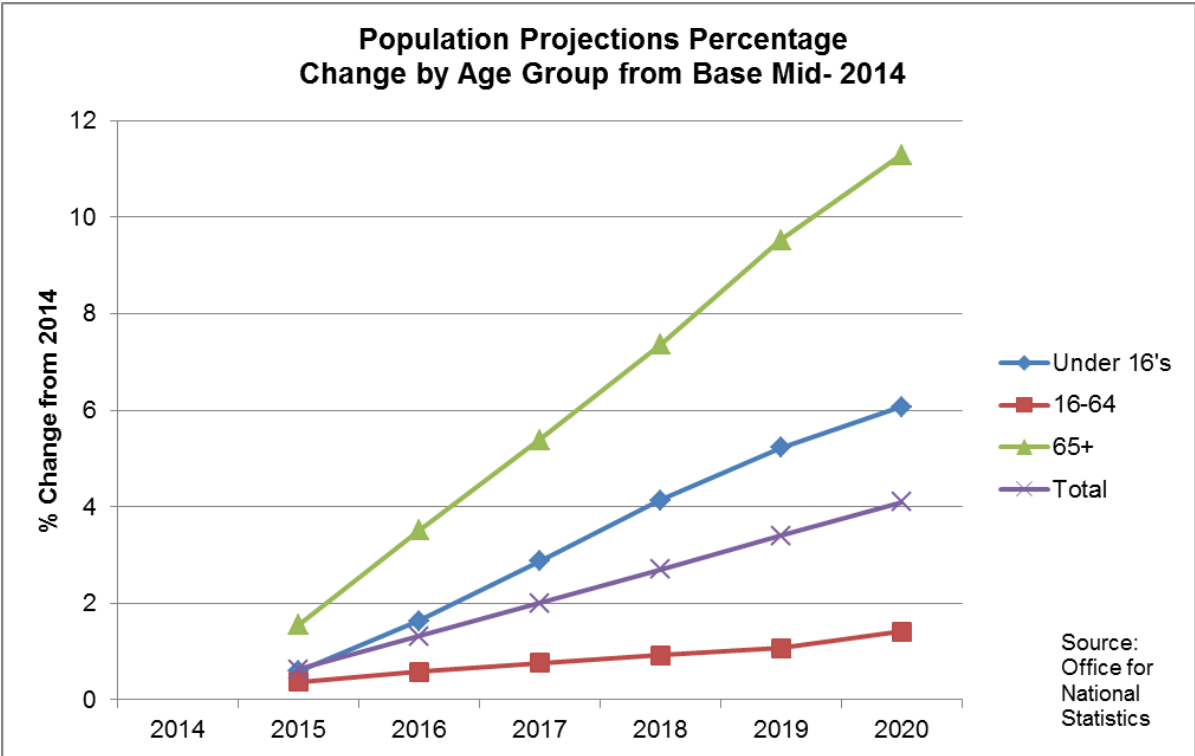


Figure 24 illustrates how the Barnsley population is predicted to grow by age group. The largest and most rapid change is relating to those aged 65 years and over.

Housing Projections

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

New Builds

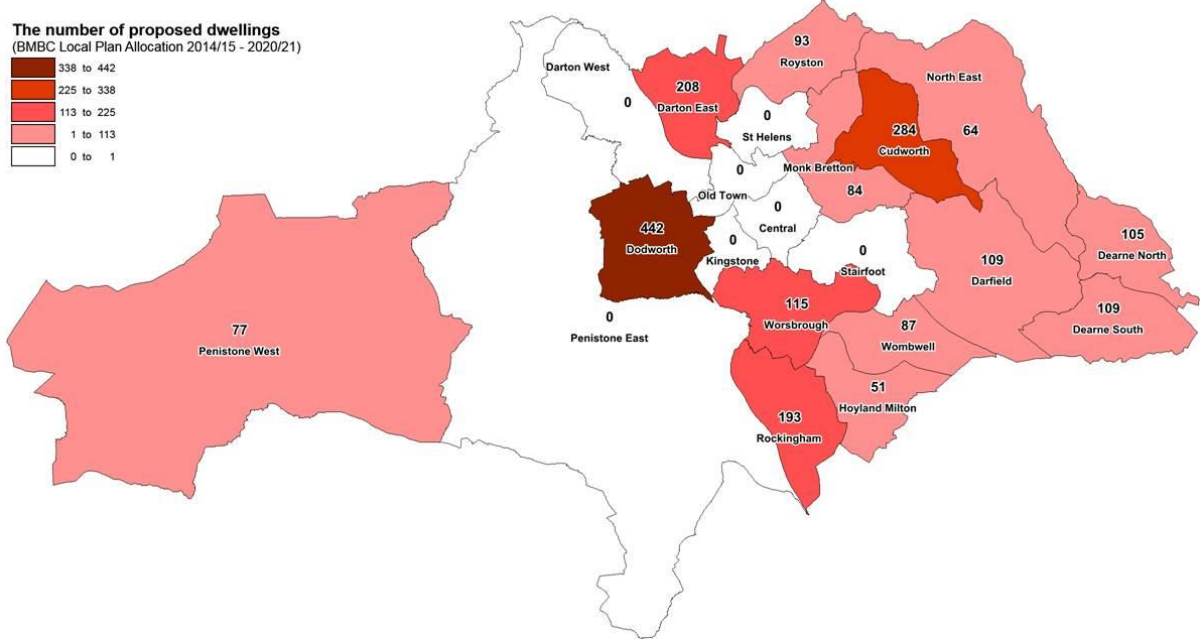
According to the Local Plan allocations, there are 14,790 dwellings proposed for the period of 2014/15 to 2032/33. In addition to this, there are also a number of sites with planning permission which amounts to a further 6,100 potential dwellings.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

Health and Care Projections

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

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

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

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

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

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

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

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

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

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

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

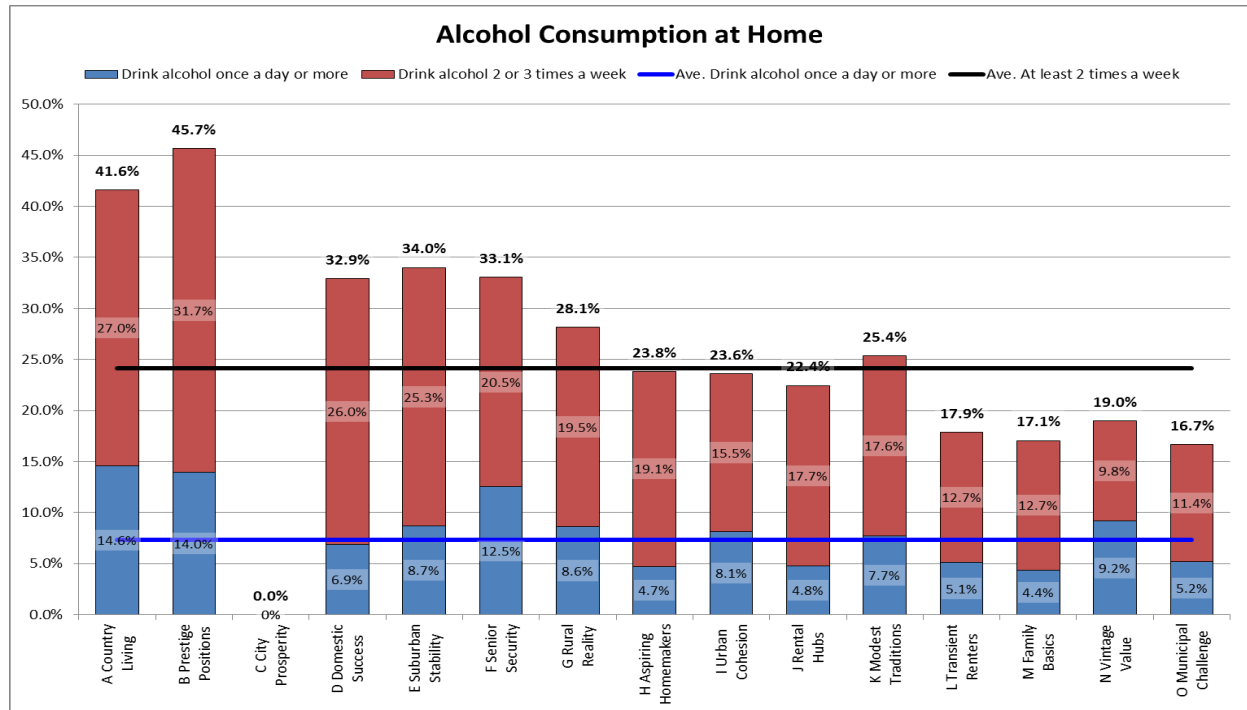
Customer insight data helps to widen the knowledge we already have about the health and wellbeing of Barnsley residents.

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

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

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

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



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

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

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

Healthwatch Barnsley

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

Be Well Barnsley

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

Public Health – Wider Determinants of Health

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

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

Police

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

Communities

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

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

Housing

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

Fire Service

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

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

NHS Barnsley Clinical Commissioning Group (BCCG)

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

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

Digital

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

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

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

What are we intending to do in the future?

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

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

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

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

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

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

Key priorities for the JSNA over the coming year are:

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

Appendices

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

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

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

Glossary

TERM	DEFINITION
APB	Anti-poverty Board.
Asset Mapping	A list of assets (land and buildings) owned or managed by community organisations. These assets can cover a wide spectrum and include community centres, sports facilities, affordable housing and libraries. (Not all land and buildings are community assets). Community assets in the context of this document can also include community organisations/groups and volunteers who may be able to provide a service within their local community.
Clinical Senate	Clinical Senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent.
CSJ	Centre for Social Justice.
DCLG	Department for Communities and Local Government
DEFRA	Department for Environment Food and Rural Affairs
Determinants (of health)	The range of personal, social, economic, and environmental factors that influence health status are known as determinants of health. Determinants of health fall under several broad categories (e.g. education, housing).
DFE	Department for Education
DWP	Department for Work and Pensions
Economically Inactive	<i>“People not in employment who have not been seeking work within the last four weeks and/or are unable to start work within the next two weeks”.</i> (Source: ONS). This includes students, disabled people, the long-term sick, unpaid carers and those who retire early.
EPC/SAP rating	An Energy Performance Certificate (EPC) shows the energy current and potential energy rating of a property, known as a ‘SAP rating’. A ‘ SAP ’ rating stands for S tandard A ssessment P rocedure and is the governments recommended system for producing a home energy rating.
FCT	Family and Childcare Trust.
Fuel Poverty	In the UK, fuel poverty is defined by the Warm Homes and Energy Conservation Act as: “a person is to be regarded as living “in fuel poverty” if he/she is a member of a household living on a lower income in a home which cannot be kept warm at reasonable cost”. The UK Government definition of ‘Low Income High Costs’ is “a household is considered to be fuel poor if: <ul style="list-style-type: none"> • they have required fuel costs that are above average (the national median level) • were they to spend that amount, they would be left with a

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

References

Document	Link
Active People Survey (Sport England 2015)	https://www.sportengland.org/research/about-our-research/what-is-the-active-people-survey/
Age UK Risk of Loneliness index 2016	http://data.ageuk.org.uk/loneliness-maps/england-2016/barnsley/
Annual Population Survey 2016	
Arc4 (2014), Barnsley Strategic Housing Market Assessment. 2014	https://www2.barnsley.gov.uk/media/3553720/barnsley_shma_2014_update_final_report.pdf
BMBC Barnsley Skills and Employment Strategy: More and Better Jobs (2016 – 2020)	https://www.barnsley.gov.uk/media/3063/employment-and-skills-strategy.pdf
BMBC Corporate Plan	https://www.barnsley.gov.uk/media/1574/corporate-plan-2015-18.pdf
BMBC Energy Strategy 2015 - 2025	https://www2.barnsley.gov.uk/media/3838552/bmbc_energy_strategy.pdf
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