Barnsley Adult Social Care Prevention Strategy

2025-2030

Promoting independence and wellbeing

2030

Barnsley – the place of possibilities.

BARNSLEY
Metropolitan Borough Council

1. Foreword

Adult Social Care plays a crucial role in supporting people to lead fulfilling and independent lives. Prevention, early engagement and early intervention are a fundamental part of keeping people well for longer, supporting them to retain their independence, and empowering people to live their lives as they choose.

Katy Calvin-Thomas
Executive Director for Place Health and Adult Social Care

This strategy outlines our commitment to preventing the need for long-term care by promoting wellbeing and independence through early intervention and proactive measures.

2. Vision and strategic objective

Our vision is to create a community where people have access to the support they need to maintain their independence and wellbeing, creating environments where people can thrive. The key objectives of this strategy are to:

- Promote independence and reduce reliance on long-term care.
- Enhance quality of life for adults through preventive measures.
- Ensure access to early intervention services.
- Foster community engagement and support networks.

Preventing the need for care and support involves proactive measures aimed at maintaining independence and promoting wellbeing, giving people better, more fulfilling lives. By focusing on early intervention, community engagement and personalised support plans, we can reduce reliance on long-term care services.

Our approach to prevention supports the delivery of three key strategies.

2.1 Barnsley 2030 strategy

In Barnsley, we want everyone to have a good life. This means everything from a quality place to call home to good physical and mental wellbeing and a sense of self-worth through diverse and secure employment opportunities. It's also about having access to the best possible local facilities in a community that values our people and our place.

In Barnsley, we want to ensure that everyone has the opportunity to learn, develop new skills and, most importantly, to achieve their personal potential.

Barnsley aims to be an exemplary place to live and a great place to do business. We want to both retain and attract new people and businesses to the area, creating an inclusive and diverse community, enriched with skills, knowledge and experiences.

We want to meet the needs of today, without compromising the needs of the future, and encourage people to connect to each other as well as to our place.

This is why our vision for 2030 is: **'Barnsley - the place of possibilities'.**

2.2 Barnsley Health and Wellbeing Strategy 2025-2030

Our vision

Living the life you want to live:
Everyone lives in a place they can call home, in communities that care, doing the things that matter most to them. When they need it, everyone receives care and support that prioritises their independence, choice and recovery.

Our Health and Wellbeing Board Strategy 2025-2030 sets out the priority themes for Barnsley. These are:

- Babies and young children have a strong bond with a caring adult, supporting their progress in reaching developmental milestones.
- Young people have creative approaches to mental health and wellbeing, supporting them to achieve their ambitions.
- Residents have access to healthy homes and active travel opportunities, supporting key building blocks of healthy and sustainable communities.
- Older people move more, enabling them to stay physically and socially active for as long as possible.

2.3 Barnsley Health and Care Plan Refresh 2022/23 - Barnsley Place Partnership

The plan sets out four key priorities, each linked to our approach to prevention:

1. **Growing our workforce**: Increase opportunities for under-represented communities, embed career pathways and provide support programmes.
2. **Joint approach to prevention**: Focus on preventing deconditioning for older people, bereavement, emotional wellbeing and resilience.

3. **Improving equity of access**: Ensure support is accessible at the right time and place, with a focus on mental health crises.
4. **Joining up care and support**: Deliver holistic, person-centred care through neighbourhood teams and develop care pathways for specific conditions.

2.4 Adult Social Care Strategy 2025 – 2030

Our Adult Social Care Strategy for Barnsley from 2025 to 2030 aims to create a community where everyone can live independently, receiving care that prioritises their choices and recovery. There are significant pressures on Adult Social Care services, including budget constraints and an ageing population, and so our focus on prevention and early intervention is strategically important.

Our strategy for commissioning is set out in our **Market Position Statement 2024-2027**. We're committed to working with our partners and the market to develop support that promotes early intervention and prevention, reduces risks of harm and prevents or delays admission into hospital or long-term residential care.

This Prevention Strategy sets out what we are doing now and what our future plans are to aspire to create environments where people can have great lives in communities where they can thrive. We aim to do this by preventing the need for care and reducing and delaying the level of care needed.

This strategy illustrates what we are doing in Barnsley, the benefits of our approach and what more we can do to prevent, delay or reduce the need for long-term support.

3. Demographics

Barnsley's industrial past has shaped our borough. We're proud of our heritage, and we know our residents are too. We take care of our local environment, and our welcoming people and communities are one of our biggest assets.

Barnsley has a population of around 244,000 people. Our population increased by 5.8% from approximately 231,200 in 2011 to around 244,600 in 2021, surpassing the growth rates of Yorkshire and the Humber (3.7%) and England (6.6%) overall.

The median age of Barnsley residents rose from 41 to 42 years, indicating an ageing population compared to the regional median of 40 years.

In Barnsley, people are entering ill health at an earlier age. Healthy life expectancy at birth for men is 52.8 years, and for women, it's 52.6 years. This makes Barnsley the area with the lowest healthy life expectancy for women in England and the second lowest for

men. These figures are significantly lower than the national averages and highlight substantial inequalities in health and wellbeing.

Employment rates for those aged 16 and over increased from 53.7% in 2011 to 54.8% in 2021, while unemployment decreased significantly from 4.7% to 2.5%.

The proportion of privately rented homes rose from 12.8% in 2011 to 17.2% in 2021, reflecting a shift in housing tenure among residents.

The percentage of residents identifying as having 'no religion' increased significantly from 24.0% in 2011 to 42.1% in 2021, while the Christian population decreased from 68.5% to 51.3%. The proportion of residents not identifying with any UK national identity also rose from 2.2% to 4.5%, showing a growing diversity in national identity perceptions.

The percentage of residents identified as disabled and 'limited a lot' fell from 13.4% in 2011 to 10.6% in 2021, indicating improved health or reporting changes.

There was a decrease in households with couples and children, with couples without children dropping from 19.8% in 2011 to 18.9% in 2021 and couples with dependent children from 19.4% to 17.7%.

In 2022/23, Barnsley had 1,164 social care users per 100,000 population aged 18 to 64 and 6,358 users per 100,000 aged 65+.

During 2022/23, there were 22,667 contacts made with Adult Social Care. 12,782 were new contacts (people not in receipt of long-term support at the time of contact).

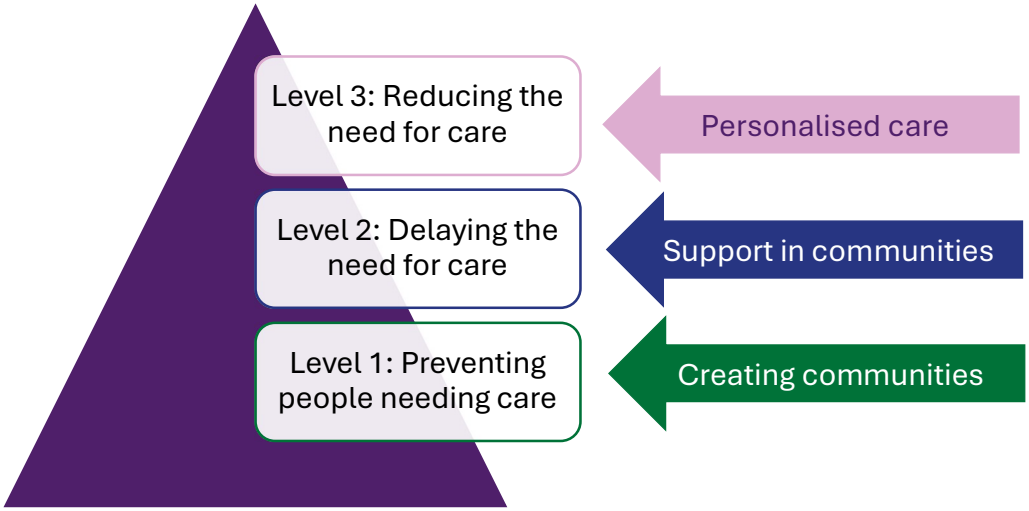
4. Legal and policy context: The Care Act 2014

The Care Act 2014 places a duty on councils to provide or arrange services that help prevent or delay people from developing care and support needs. Prevention is a core principle of the Care Act. Barnsley Council Adult Social Care is committed to adhering to these principles and ensuring their effective implementation within our community.

5. Managing demand

We manage demand by creating communities and providing and promoting community-based services that can help prevent people from needing care.

Where people need care, we offer a strength-based approach to focus on the person's strengths and capabilities rather than solely on their problems.



6. Our approach to preventing people from needing care

Level 1: Preventing people needing care

Creating communities

We are committed to providing support to people at the earliest opportunity to **prevent** problems from escalating and potentially becoming entrenched. Our approach fosters stronger resilience in residents and families, reduces the likelihood of needing more intensive interventions later and can break cycles of disadvantage.

Our approach is to **create communities** by engaging with people at all stages in their lives. We will continue to build thriving communities which have strong social connections, are inclusive to our diverse population and have shared values and goals.

This section sets out how we are doing this, with innovation and the knowledge that this really does provide better outcomes for people.

6.1 Stronger communities

Our Stronger Communities team supports the creation of communities through locality working. There are six Area Councils in Barnsley, each made up of the locally elected Councillors who support the Ward Alliances.

Ward Alliances are made up of the three elected members from that ward, along with community representatives who have put themselves forward to help improve the places they live in. They work with local Councillors to determine what the priorities are

for the area. Each Ward Alliance will develop a Ward Alliance Plan for each ward area, which helps them to measure their progress in delivering their priorities.

A map of the six areas.

The Stronger Communities Annual Report 2024-25 provides a comprehensive overview of the initiatives and achievements of the Area Councils and Ward Alliances in Barnsley over the past year.

The report emphasises the shared sense of pride in the borough and the collaborative efforts of elected members in determining priorities and commissioning services to meet community needs. They enable Barnsley residents to be healthy, safe and socially active, and live within thriving, vibrant and diverse communities.

The approach is based on the '21st Century Councillor Approach' and an Asset-Based Community Development (ABCD) model, which focuses on utilising community assets and strengths. Area Councils and Ward Alliances support micro-commissioning, community events, volunteering, early intervention and prevention projects. They facilitate local services, offer funding opportunities and build relationships with various stakeholders to coordinate local responses.

There are many examples of the great work being done to support people in our communities. **Here are some of the key achievements:**

- 17,591 volunteering opportunities supported.
- 185 new community groups.
- 1,925 new volunteers.
- 1,014 existing community groups supported.
- £613,540.30 resulting in cashable hours' worth.

- 1,119 groups supported by Area Teams.
- 2,317 adults who are benefitting from emotional and wellbeing support.
- 3,276 people supporting the environment.
- 3,881 young people benefitting from emotional and wellbeing support.
- 9,992 volunteering hours dedicated to environmental projects.
- 958 collaborations with partnering organisations.
- £6,582,488.73 in benefit gain.
- £497,235.50 in external funding gained to support social and community action.
- £274,664 of debt managed.

Case study: Stairfoot Ward - From the Heart

Who?

Ward Alliance member Lisa Hammond was inspired by her childhood experiences of visiting care homes with her mother. Even at a young age, she noticed the loneliness and isolation experienced by residents, as well as the impact of dementia.

Motivated by these memories, Lisa developed the 'From the Heart' project in 2019, aiming to visit care homes with volunteers to conduct reminiscence sessions using items from the past.

How?

The Community Development Officer worked alongside the volunteers to gain knowledge and improve their confidence. Liaising with Barnsley Libraries and Barnsley Museums, who discussed their memory box project and its use in care homes, increased their knowledge and fostered discussions on reminiscence.

The second meeting was with Public Health officials, focusing on supporting residents in care homes and improving their physical and mental health.

Results

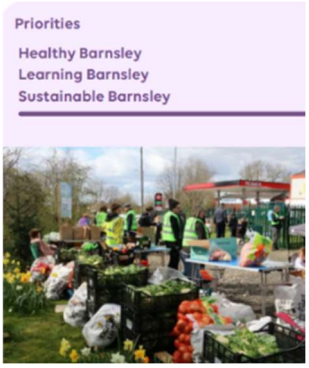
The project led to several positive outcomes:

- Volunteers gained confidence and built a network of professional relationships.
- Care staff observed an immediate improvement in residents' mood and confidence, along with reduced anxiety.
- The project helped preserve memories and support communication among residents.
- Residents experience an improved quality of life.

- Young people sent heartfelt messages to residents, demonstrating empathy and care.
- The project brought happiness and constant smiles to all involved.

“I can remember this weight”. “I used to love drinking this”. “This was always a treat to have this” while holding a modern tin with an old Carnation milk wrapper on.

Case study: Goldthorpe Railway Embankment Spring Fair



Who?

Dearne North and South Ward Alliances, Community Development Officer and the Goldthorpe Railway Embankment Group.

How?

Over the last few years, the Goldthorpe Railway Embankment Group, supported by the Dearne Area Team and the Dearne North and Dearne South Ward Alliances, have put on fairs and events at the Embankment.

These events have encouraged people to get outside, discover and enjoy the natural beauty and wildlife of the Embankment for their own mental and physical wellbeing.

This was the third year that the Spring Fair has been held in partnership with the Dearne Churches Together Group.

Results

At the event, £1,000 worth of free fruit and vegetables were given out along with recipe cards to encourage healthy eating. This was extremely popular, with all the items going within a couple of hours and a queue forming. There was also the opportunity for people to sow their own peas and beans in a small compostable pot to take home with them.

The aim of this was to encourage people to grow their own and be more sustainable, as well as for the health and economic benefits.

There was also an Easter trail for the children and families to follow, with a small, free Easter egg as a reward. Alongside this, the Spring Fair featured:

- Easter-themed crafts.
- The telling of the Easter story thanks to Dearne Churches Together.
- A decorated egg competition with prizes, which was judged by the Mayor and Mayoress of Barnsley.
- An animal petting zoo, with spring animals such as lambs, chicks and rabbits.

Other local groups, such as Dearne Kids and the Dearne Arts Festival Group, were invited to attend with a stall, such as a tombola to promote themselves and raise funds for their own activities.

All this encouraged families to attend and provided a free activity at the start of the Easter holidays for families who may be struggling financially. This was all provided for free thanks to funding from Better Barnsley Bonds.

6.2 Health on the High Street

The Health on the High Street initiative aims to bring health and wellbeing activities into the heart of Barnsley town centre. This approach includes the creation of a Community Diagnostic Centre and a health and wellbeing hub.

The Health on the High Street initiative in Barnsley helps prevent people from needing social care by addressing the wider determinants of health and wellbeing and providing integrated wrap-around care.

1. **Improved access to health services:** By placing health services in convenient locations within the town centre, the initiative makes it easier for residents to access non-emergency services. This reduces dependency on acute settings and encourages early intervention.
2. **Early prevention:** The Community Diagnostic Centre offers a range of diagnostic services, such as ultrasound, x-ray, breast screening and phlebotomy. This facility has already contributed to early prevention by reducing waiting times and increasing uptake rates for services like mammograms.
3. **Integration of care:** The health and wellbeing hub in the Alhambra will integrate wrap-around care and compatible services, addressing the wider determinants of health and wellbeing. This holistic approach helps residents manage their health more effectively and reduces the need for social care.
4. **Reducing pressure on healthcare facilities:** By encouraging residents to access non-emergency services in different locations, the initiative reduces pressure on existing healthcare facilities, including A&E services. This helps prevent the escalation of health issues that might require social care.
5. **Collaboration with preventative services:** The initiative involves collaboration with key partners, such as Barnsley Hospital, Barnsley Premier Leisure and the South West Yorkshire Partnership NHS Foundation Trust (SWYFT). This ensures joined-up working to tackle the wider determinants of health in people's lives.

6.3 Information and advice

Adult Social Care information and advice are essential. Getting this right means that people are more likely to be able to make informed choices and access the right support at the right time and place. This can make a big difference for someone and can ultimately improve their health and wellbeing. Well-informed residents can better access support, enhancing their health and wellbeing.

We have reviewed our Information, Advice and Guidance offer and implemented new and various formats for information. This can be face to face, over the telephone, within the community at Talking Points, through advocacy services and online through webpages, social media and animations. This can also be provided in alternative languages and includes the availability of easy-read documents.

We also have a dedicated online directory of information for members of the public and professionals alike. Live Well Barnsley lists 1,425 services, providing accurate information about a range of services that help people access support that can enhance their health and wellbeing. As of March 2024, Google Analytics show that the website gets on average 2,225 views a month and has on average 732 users per month.

Here are some key achievements:

- The directory responds to the increasing demand for online access to health and social care information, and is identified as forming a key part of the Adult Social Care Front Door developments around information, advice and guidance and the wider integrated care agenda.

- The directory aligns with Barnsley Council's vision of empowering people to live well and independently, as well as with the national strategy of integrating health and social care services and improving user experience and outcomes.
- The directory offers a comprehensive and up-to-date source of information on local services, covering a wide range of topics and categories. These include mental health, dementia, Autism, learning disabilities, children and young people, carers, housing, transport and leisure. The directory also includes national and regional services that are relevant to Barnsley residents.
- The directory enhances the quality and transparency of health and social care provision by allowing users to contact us for further information about services and provide feedback about their search experience. This feedback mechanism can help users make informed choices, as well as provide valuable insights for service providers and commissioners to improve their performance and responsiveness.

The directory facilitates user engagement and empowerment by allowing users to create a shortlist and save their searches to view or print, as well as being able to access links to other websites and application forms.

The directory also enables users to contact service providers directly and access further information through website links, as well as to share their views and suggestions through surveys and forums.

6.4 Talking Points

Talking to the people we support in their community offers several benefits, including enhanced understanding of individual needs, improved service delivery and increased trust and engagement.

We piloted a new service called Talking Points which did exactly this through a collaboration with our Initial Response Team and Barnsley Libraries to improve allocation, waiting and the assessment processes. Assessments were conducted in community settings, like libraries, with support from Barnsley Libraries staff.

We learnt a lot from this approach, including adjusting appointment times for older people, prioritising geographical hotspots for carers, considering travel willingness and improving the booking system for Community Talking Points.

Here are some key achievements:

For the individual or carer:

- “It enabled me to get off my chest what is really happening instead of having to pick and choose words”.

- “Fantastic meeting today regarding care grant. It really helped stepping away from home”.

For the workforce:

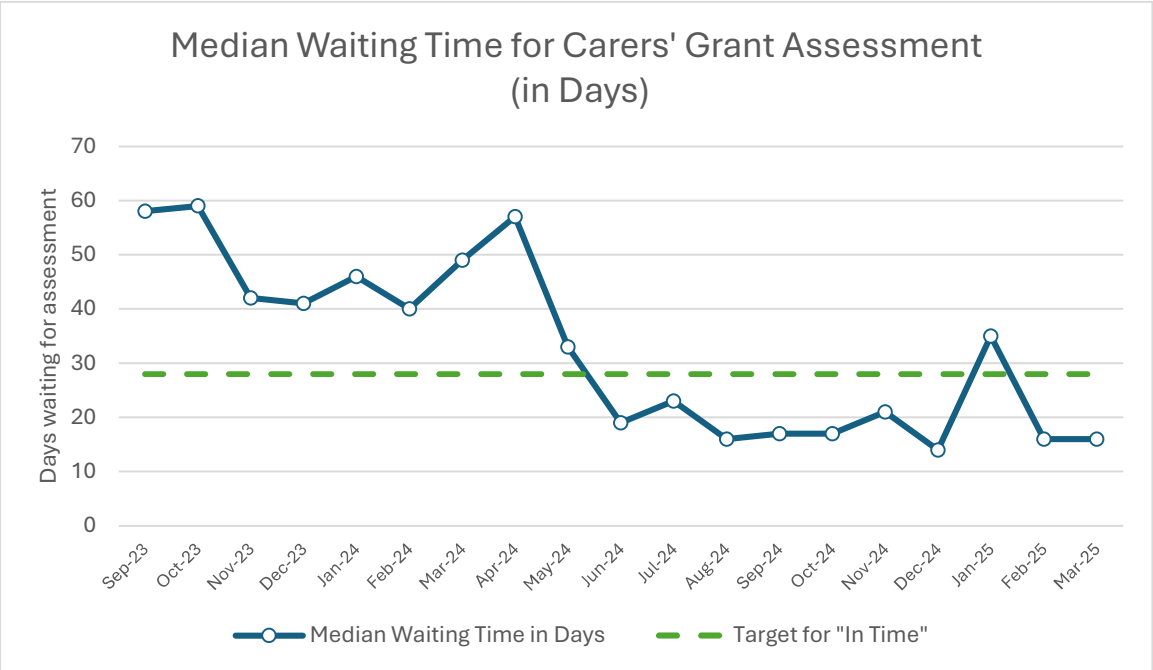
- Staff spent less time in a week travelling across the borough.
- Staff could use the time between appointments to complete documentation.
- Staff enjoyed the ability to work in a different environment.

For the organisation:

- Staff who participated returned reduced mileage claims when they were assigned to Community Talking Points.
- Reduction in unallocated tasks in team work trays.
- Fewer calls to the Contact Centre making enquiries on open referrals and more manageable team trays.
- Improved showcasing of the community services offer at local libraries.

The offer is most effectively established for unpaid carers seeking to access the Carers’ Grant. The frequency has increased since Carers’ Grants were trialled in July. In Q4 of 2024/25, there were 54 Carers’ Grant Talking Point appointments.

The introduction of Community Talking Points correlates with the improved timeliness of Carers’ Grant assessments.



Our plans include expanding Community Talking Points to new sites, advertising our offer in Barnsley Libraries and listening to participant feedback.

6.5 Social prescribing

The role of social prescribers is to help people address the social problems they are facing that impact their wellbeing. In Barnsley, social prescribers are there to listen and help, using their connections with voluntary organisations, clubs and specialised services to improve people's quality of life.

The Social Prescribing Team are known as 'Link Workers', and they take a holistic approach to people's health and wellbeing, giving people the time and space to talk and focusing on each person's definition of 'what matters to me.'

They connect people to the most appropriate and helpful community groups and statutory services which provide practical and emotional support. Link Workers also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners.

Link Workers can help people address a number of issues that can ultimately prevent them from needing care, such as feeling lonely, money worries and health and fitness.

They support people to access support services and local agencies, including GPs, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, the fire service, the Police, job centres, social care services, housing associations and voluntary, community and social enterprise organisations.

6.6 Family Hubs and Start for Life

Family Hubs deliver joined-up, early help services for children, young people and families from pre-birth up to 19 years of age (or 25 years if the young person has a disability).

They bring together practitioners from a range of universal, targeted and specialist services in each local area, including schools, health services, the Police, social care, the private and voluntary sector and some Adult Social Care services.

The services they offer vary in each area of the borough, depending on the needs of families and the wider community. These services include:

a. Preparing children for and helping them to thrive in school.

b. Helping parents and carers to develop their parenting skills.
c. Helping parents and carers to develop personal skills, access training and education, and enhance their ability to get employment.
d. Helping parents and carers to keep children safe.
e. Helping children to achieve their full potential and reduce inequalities in their health and development.
f. Supporting the development of healthy lifestyles for children.
g. Helping families to become more resilient.

Services for adults play an essential role in our early help approach, as these can impact an adult's parenting capacity and family life. Some adults have additional needs, which can negatively impact family life if they are not supported.

Family Hubs and Start for Life services offer a whole family approach, enabling coordination of the support they provide to secure better outcomes for children, young people and families with additional needs.

The Hubs are designed to support all families, regardless of their circumstances, and aim to be inclusive, welcoming families from all backgrounds, including those who may feel isolated.

They feature a wide range of activities and programmes designed to enhance family life, promote learning and foster community connections across 24 strands of support:

- Parental support
- Infant feeding
- Perinatal mental health and parent-infant relationships
- The home learning environment and early language
- Parent-carer panels
- Published ‘Start for Life’ offer
- Dispute resolution
- Debt and welfare advice
- Special education needs and disabilities (SEND)
- Mental health services (beyond Start for Life parent-infant mental health)
- Substance misuse support
- Oral health improvement
- Birth registration
- Youth services
- Intensive targeted family support services
- Stop smoking support
- Midwifery and maternity
- Early childhood education and care, including financial support for childcare

- Activities for children aged zero to five
- Domestic abuse support
- Youth justice services
- Health visiting
- Reducing parental conflict
- Family health services (before Start for Life services)

More information about their support can be found on the Family Hubs website.

Here are some key achievements:

- **Parenting support** - Parents can access workshops, one-on-one coaching and peer support groups. These sessions cover topics such as managing behaviour, fostering emotional resilience in children and creating positive routines at home.
- **Early childhood development** - For families with young children, Family Hubs offer playgroups, early learning sessions and sensory activities. These programmes are essential for promoting cognitive, social and emotional development in a nurturing environment.
- **Health and wellbeing services** - The Hubs collaborate with healthcare providers to offer health checks, breastfeeding support and guidance on nutrition and physical activity. Families can also access support and mental health services to address emotional challenges.
- **Educational and recreational clubs** - Children and young people can participate in various clubs and extracurricular activities, such as arts and crafts, sports sessions and play. These activities provide opportunities for learning, creativity and social interaction.
- **Workshops for expectant parents** - Antenatal classes and workshops are available to help expectant parents prepare for childbirth and early parenting. These sessions focus on practical skills, emotional readiness and building a support network.
- **Community events** - The Hubs organise community events that bring families together and strengthen bonds within neighbourhoods. These events are often a chance to celebrate the diversity and vibrancy of Barnsley.

Barnsley Family Hubs play a vital role in enhancing the lives of the families they serve. By reducing barriers to access and providing a comprehensive suite of services, they empower families to overcome challenges and embrace opportunities. The Hubs foster a sense of community, ensuring that families feel supported and valued.

In addition to the direct benefits to families, the Hubs contribute to the broader social fabric of Barnsley by promoting inclusivity and collaboration among community

stakeholders. They act as a bridge between families and the resources they need, creating a positive ripple effect throughout the community.

For families navigating the complexities of modern life, Barnsley Family Hubs provide a wealth of support, ensuring that every family has the opportunity to thrive as part of our Great Childhoods Ambition.

7. Our approach to delaying the need for care

Level 2: Delaying the need for care

Support in communities

Strong community support networks play a vital role in **delaying** the need for care. **Support in the communities** where we live can prevent social isolation and promote overall wellbeing. Collaborating with local organisations and volunteers helps build and sustain these networks.

The Local Government Association (LGA) guidance emphasises the importance of earlier action and support in Adult Social Care to improve lives and reduce future care needs. The cost-benefit analysis shows that early interventions can save approximately £3.17 for every pound invested.[1]

Of the interventions referenced by the LGA, there is substantial work ongoing within Barnsley around:

- Falls prevention (Public Health and Assistive Living Technology)
- Employability support (Employment and Skills)
- Post-hospitalisation support (the Reablement and Reviewing teams)

7.1 Falls prevention

Falls are a major risk amongst older people and can be damaging to not only their health but also to their confidence in their environment. We are committed to reducing the number of falls in Barnsley by taking a system-wide approach and trialling innovative technologies to address the multi-factorial risks.

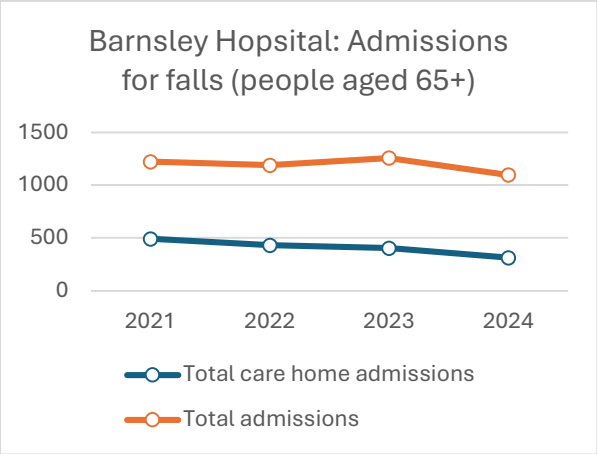
Over the past three years, we have seen a year-on-year decline in the percentage of older people's care home residents admitted for falls. Supported by the Enhanced

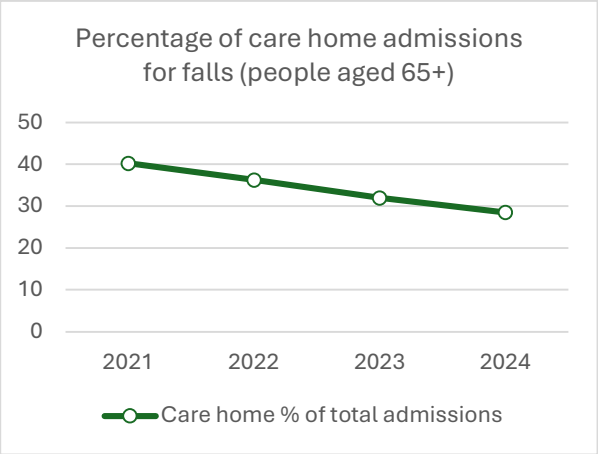
[1] Local Government Association (2024). Earlier action and support: The case for prevention in adult social care and beyond | Local Government Association

Health in Care Homes Framework, falls have become a regular point of discussion in care home multidisciplinary team meetings.

The Yorkshire Ambulance Service (YAS) provides analysis of calls for falls and conveyances to hospital.

Any data trends or issues are raised with care homes and partners, such as community matrons, to support proactive working and the prevention of future falls.





Our Assistive Living Technology (ALT) service helps Barnsley residents to live independently in their own homes. Knowing help is always available can put people's minds at ease, as well as make people feel safe.

As well as providing urgent response to service users who may need help to mobilise after a fall or assistance from YAS, the Police, Fire Service, a doctor or a nurse, ALT will also notify the appropriate health or social care partner if someone frequently alerts their monitoring centre via their alarm.

This is to check if there are underlying reasons that need a professional referral, such as a specialist falls assessment or a reassessment of social care needs.

Since December 2021, our ALT service has collaborated with YAS to respond to 999 calls, picking people up from the floor where YAS have assessed that they are not injured or only have a minor injury. By the end of March 2025, ALT had attended to 305 falls on behalf of YAS, reducing demand on ambulance crews and avoiding long lays. This is in addition to the 450+ urgent response visits for ALT service users each month.

Based on cost estimates provided by YAS nearly two years ago, ALT is saving YAS approximately £1.5 million per year compared to if the calls and response visits currently handled by ALT were instead directed to YAS.

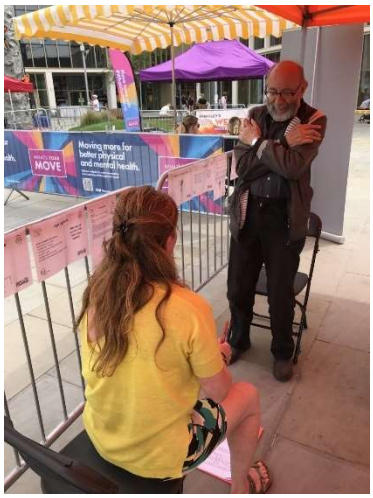
The distributed public health model also plays a role in reducing falls. For example, the Cardiovascular Disease Group works to identify people early and has developed an

award-winning campaign called How's Thi Ticker, providing free blood pressure checks across Barnsley and signposting people to relevant support services.

Barnsley Hospital has also established a Deconditioning Programme to prevent hospital-acquired deconditioning and falls, reducing the need for social care at the point of discharge. The hospital-wide campaign, called Eat, Drink, Dress, Move, is supported by multidisciplinary workforce training on having positive conversations about movement, supporting and encouraging patients to move more for themselves.

As of April 2025, over 200 staff, including medics, nurses, therapists and support workers, have attended the training.

7.1.1 Barnsley Older People Physical Activity Alliance



The Barnsley Older People Physical Activity Alliance (BOPPAA) aims to increase the provision of physical activity programmes that will improve the strength and balance of older people across Barnsley. Over 80 organisations are members of the Alliance, which provides over 211 weekly activities across the borough.

There are 20 falls management exercise classes available, with two or more in each Area Council. A survey of 126 participants found that 100% of people agreed their physical fitness had improved, and 97% said their mental wellbeing had improved.

The project includes Healthy Bones falls management exercise classes and Functional Fitness MOTs, both showing improved results.

Staff members and volunteers have been trained by Later Life Training and have been Postural Stability Instructor-trained. BOPPAA conducted MOTs during various events, including the Age Friendly Barnsley Festival.

A total of 39 MOTs were completed across these events, with participants reporting increased confidence, improved mental and physical health, and higher levels of physical activity due to BOPPAA programmes. Testimonials highlight the positive impact on older people's overall wellbeing:

"A vital service to keep us away from the GP and hospital"

"This group improves our physical, mental and social health"

"Before I started, I couldn't get up off the floor. Now, I can get down and back up"

Here are some key achievements:

Locally, the return on investment from falls prevention is substantial across the health and care system. The BOPPAA programme has brought together different stakeholders from across Barnsley to encourage more older people to maintain levels of physical activity and reduce their risk of falls.

Incident	Cost of hospital admission[2]	Cost of a six-month programme for BOPPAA per person	Potential saving
Fall and admission (no hip fracture)	£9,214.07	£544	£8,697.07
Fall and admission (with hip fracture)	£13,331.07		£12,787.07

Preventing someone from a fall-related hospital admission through physical activity can save a staggering 94% on costs. This figure increases to 96% for someone who has a hip fracture.

7.1.2 Nobi Smart Lamps

Nobi Smart Lamps are designed to enhance the safety and wellbeing of residents in care homes. They operate using electricity and Wi-Fi. They support the natural circadian rhythm of residents by detecting falls, in turn triggering alarms through the care home's central dashboard and enabling immediate help from caregivers.

Nobi lights up an out-of-bed path and shows caregivers when residents might need assistance. We are piloting the use of Nobi Smart Lamps across seven care homes, with 74 installations in bedrooms and a further 57 in bathrooms.

Here are some key achievements:

Whilst we are still in the process of evaluating the outcome of their use in Barnsley, we know that in Doncaster, their use has resulted in a reduced number of ambulance call-outs and conveyances to hospital. Nobi claims:

- They reduce falls by over 80%.
- The lamps help prevent disorientation with automatic lighting and support a natural, daily rhythm with circadian lighting.

[2] Public Health England (2018). A Return on Investment Tool. Falls Prevention Tool including tariff uplifts for 2022/23. Cost includes transfer to hospital, hospital admission, inpatient stays, follow-up.

- One in two older adults who lie on the floor for longer than an hour die within six months of the fall. Quick help is therefore a matter of life and death.

7.2 Equipment and adaptations

Equipment and adaptations are resources that help people with disabilities or those who have difficulty with everyday tasks live more independently at home.

Equipment refers to items like assistive devices and tools, while adaptations involve structural or physical changes to the home. Powers and duties under the Care Act 2014 relate to the provision of assistive technology in the home, aids, equipment and adaptations. These include a duty to provide minor adaptations up to the value of £1,000 as well as other equipment to any value.

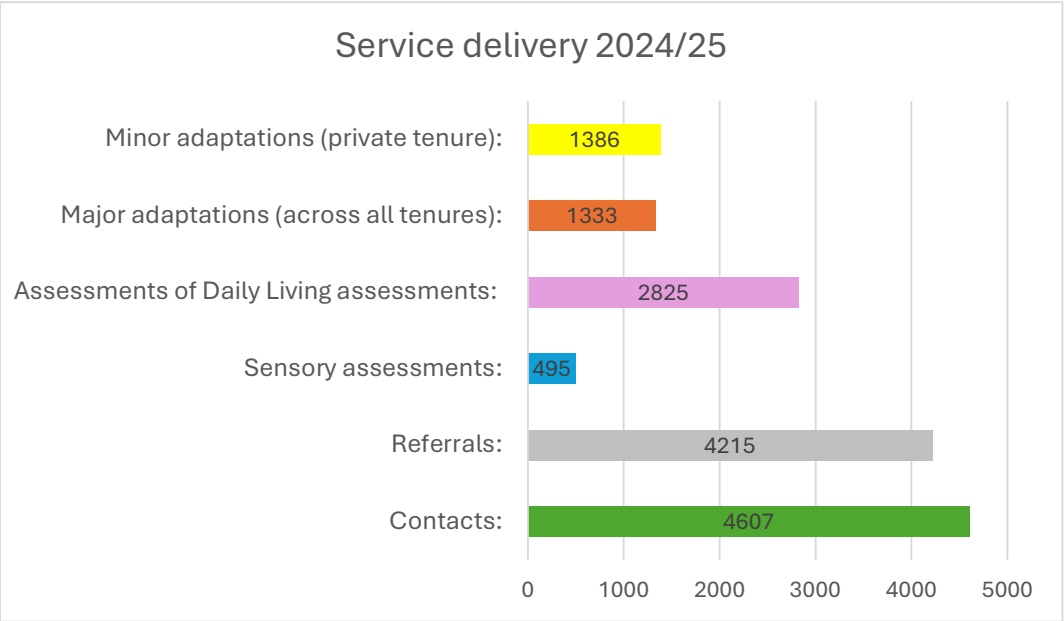
During 2025, we carried out a full-scale review of our approach to delivering the Equipment and Adaptations service. The review assessed:

- Equity across tenures **(People)**
- People's outcomes and satisfaction **(Quality)**
- Throughput **(Process efficiency and flow)**
- Value for money **(Cost)**

Our analysis has identified key areas for improvement in our current service delivery model that will positively impact people, quality, efficiency and cost.

Here are some key achievements:

In 2024/25, the current service delivery model achieved the following:



The review recommends a major transformation of our service delivery model. The objective is to redesign our service delivery to meet the timeliness targets within the existing funding envelope, essentially to do less to achieve more.

7.3 Support to unpaid carers

Support for unpaid carers is crucial because they play a vital role in providing care, often at a significant personal and financial cost.

Without support, carers may experience poorer health outcomes, social isolation and financial difficulties. Recognising and supporting unpaid carers ensures they can maintain their own health and wellbeing while also contributing to a more sustainable and effective social care system.

Our current Carers Service provision is contracted to Cloverleaf Advocacy, which coordinates support for carers across the Barnsley borough. The service provides a single point of contact for carers, coordinating and improving access to local support while building and promoting existing community assets for carers.

The outcome is to provide support, advice and training designed to improve the quality of life and wellbeing of local carers. The Carers Service team offers information and advice, drop-in support, groups, events and activities, education, benefits and financial advice, and training for unpaid carers.

Barnsley Carers Service takes a strong partnership approach, building on existing assets within Barnsley and promoting support for carers so they can continue in their caring role, look after their health and wellbeing and have a life of their own. This includes opportunities for work, training, education, leisure and social interaction.

In addition to the support Barnsley Carers Service offers, we have our Barnsley All-Age Carers Strategy, which is supported by an action plan. The strategy has set our values, vision and commitment to carers, and sets out our current priorities:

- Raising awareness to increase the identification of carers.
- Working with carers.
- Assessing carers' needs.
- Carers' health and wellbeing.
- Carer breaks.
- Helping carers stay in work.
- Young carers.
- Parent carers.

The Carers Steering Group works in partnership to ensure we have strategic links to the delivery of the Barnsley All-Age Carers Strategy.

Our Barnsley Carers Forum is the voice for people who care for a friend, relative or loved one, and is chaired by a local unpaid carer and supported by Barnsley Carers Service. The purpose of the Carers Forum is to support the commissioning, development and delivery of services for carers who live in Barnsley.

Group members bring their own lived experience, expertise and expert perspective to the forum. The group will use this expertise to positively influence carers' services for local people in Barnsley. The group acts as a voice for the people we support and local carers, influencing the development and delivery of the Barnsley All-Age Carers Strategy by having a nominated member(s) at each strategy steering group meeting.

8. Our approach to reducing the need for care

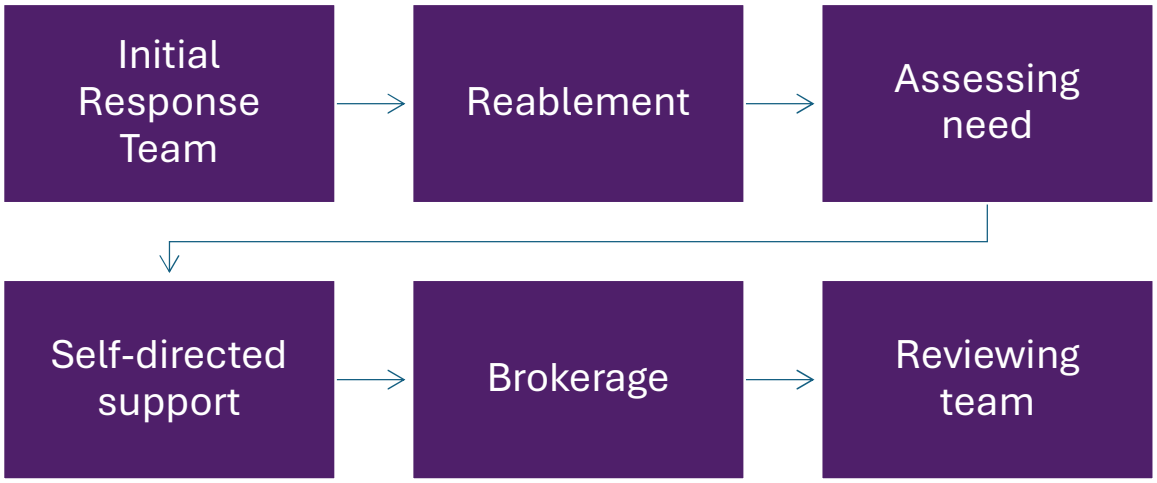
Level 3: Reducing the need for care

Personalised care

Creating **personalised support plans**, tailored to each person's strengths and preferences, ensures that care is both effective and empowering.

Collaboration with the people we support, their families and care providers is crucial in developing these personalised plans.

Prevention runs through the Adult Social Care customer journey, and every opportunity is taken to ensure the level of care a person receives is appropriate. Engagement with our teams allows their personal outcomes to be at the forefront of their care.



8.1 Our Initial Response Team

In 2024, we prioritised and implemented our Initial Response Team (IRT), where staff have responded to approximately 60 contacts per working day. Barnsley Council Adult Social Care has invested in this area, doubling the size of the team.

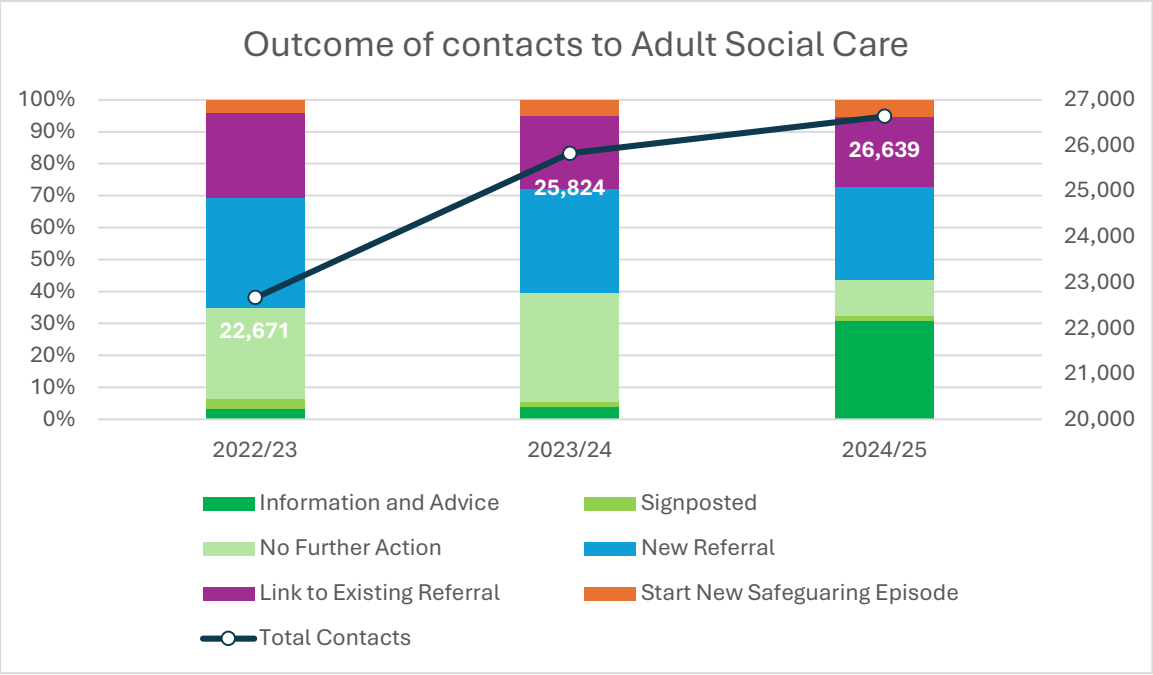
The IRT has a rapid response function, where staff prioritise welfare visits for people who may be unsafe if they are not seen or may fall into crisis. The IRT works closely with colleagues in Housing, homelessness prevention, South Yorkshire Police and other partners to ensure a coordinated, timely response.

This helps to keep people safe, prevent crisis and the escalation of needs.

The team takes every opportunity to direct people to appropriate community services and organisations in the community and voluntary sector before they refer the person to ongoing social care involvement.

This is reflected in the outcome of contacts into the service.

Here are some key achievements:



Despite the rising number of referrals, the introduction of the IRT has correlated with a gradual increase in the rate of referrals being resolved at the point of contact; more people with their queries answered sooner, and fewer people being sent for long-term care assessments when they do not need one.

8.2 Our approach to assessing needs

Early identification of risks and needs is essential to prevent escalation.

Our assessments identify needs and how these impact a person's wellbeing. Our aim is to focus firmly on people receiving a quality assessment at the right time for them.

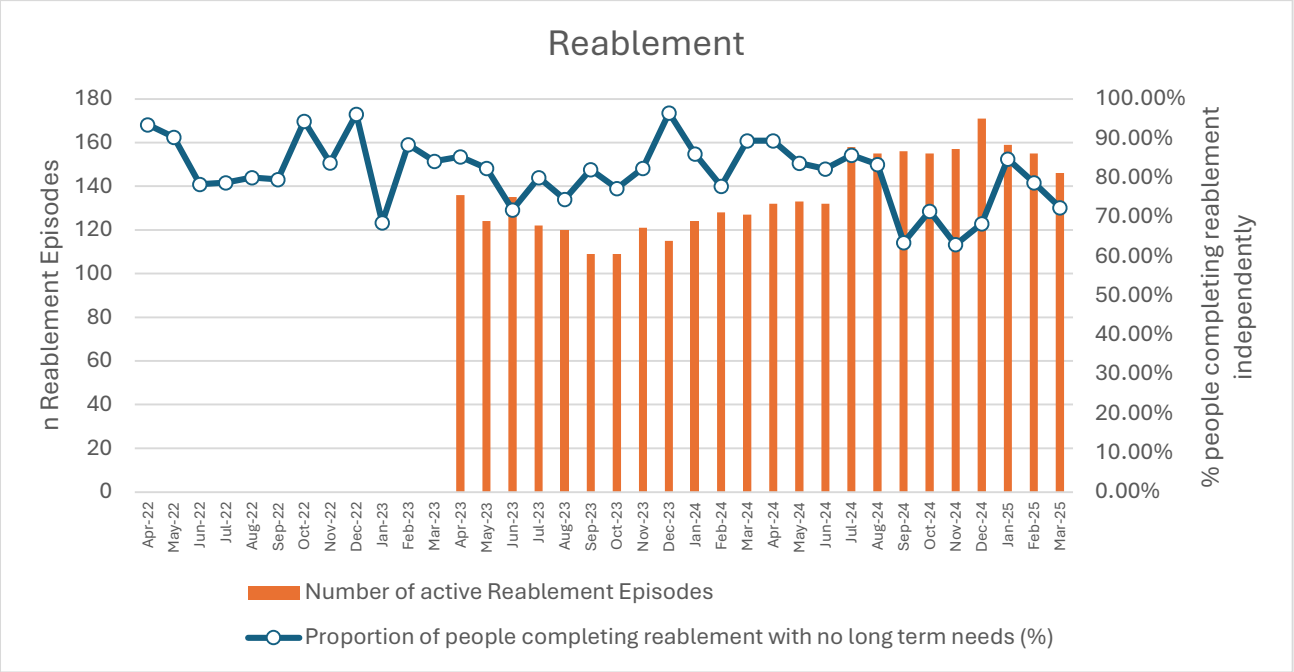
Assessments are carried out over an appropriate and reasonable timescale, considering the urgency of the situation and a person's needs. Our Waiting Well Approach ensures we deploy resources effectively.

This can often mean that people have a period of reablement first, and assessments are started when people are at their optimum level of independence.

8.3 Reablement

Barnsley's Reablement service delivers support to people after a period in hospital and those who are identified by the Initial Response Team as potential beneficiaries of reablement support. Through a maximum of six weeks' support, the service aims to reduce needs completely, supporting the person to find their full independence.

The graph below shows consistent efficacy at delivering this ambition. The graph also shows how the number of people who use the service has increased (the data is not available before April 2023).



When a person continues to need long-term support from Adult Social Care, the intended impact of reablement is to reduce the support required, empowering the people we support to maintain as much independence as they can.

8.4 Self-directed support

Self-directed support, also known as personalisation, is important because it empowers people to take control of their lives and the care they receive.

Self-directed support gives people more choice and control. It supports their human rights, promotes equality of opportunity and ensures support is tailored to meet their needs and preferences, ultimately leading to more meaningful and fulfilling lives.

We have a robust audit approach to monitor self-directed support accounts. This ensures the accounts are running well and enables people to continue having choice and control over their health and social care services through a self-directed account.

We monitor that the assessed client contributions are being paid in correctly, where eligible, to reduce the risks of debt to the person and ensure they and their carers have the correct money in the accounts to pay for the services they choose, such as employing a Personal Assistant.

Barnsley Council's Audit and Monitoring team work closely with different services, such as social work practitioners and Finance colleagues in Adult Social Care, health and Children's Services, where self-directed support has been chosen.

8.5 Brokerage

Brokerage refers to a service that helps people find and access appropriate care and support services. It involves finding suitable providers and arranging for services to be delivered, using personalised support plans. These plans are developed by our social workers with the people we support and their families.

The team in Barnsley are responsible for realising community care packages, ensuring that we comply with contractual requirements and supporting the gathering of market intelligence to inform future commissioning plans.

This has resulted in a **50% reduction** in provisioning errors, reducing the number of queries received by Financial Services and ensuring providers are paid accurately.

It has also reduced the burden on social work practitioners, allowing them to focus on their social work role.

Here are some key achievements:

Providers have reported an improved experience following the development of our new Brokerage function.

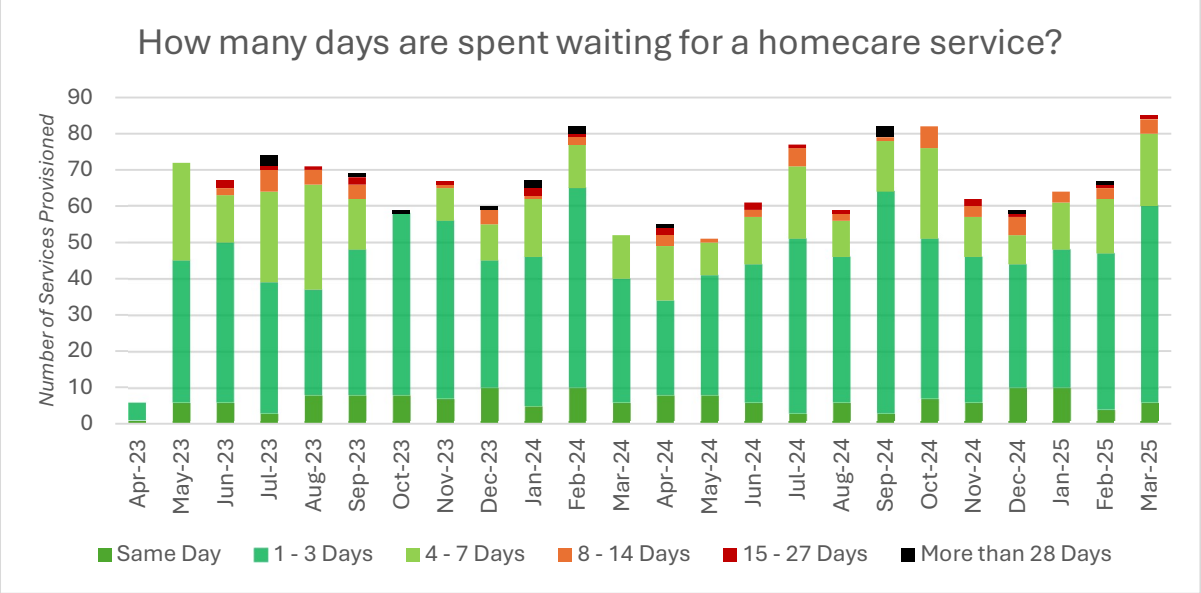
"There has been a massive improvement in the time taken to set up packages for payment.

I have a good working relationship with all the Brokerage officers, and we communicate, either by phone or email."

"In summary, the Brokerage Team is a pleasure to work with."

"The Brokerage Team getting involved was one of the best things that has happened."

By creating the Brokerage team, we have been able to collect more information about how long people wait once a homecare package has been identified as necessary by social work practitioners.



This graph shows that demand for community services fluctuates, yet our Brokerage team are always on hand to offer timely support, helping people find a provider to accept their package of care.

Each month, at least 50 homecare packages are sourced by the Brokerage Team, and March 2025 saw the most packages sourced in one month (85).

Despite rises and falls in the number of care packages that need to be sourced, the work of our Brokerage team is fast and effective. Since April 2023, over 70% of homecare packages have been sourced within three days, and 94% of packages have been sourced within a week.

The supported living numbers are much smaller, and this can often take longer because of complexity and the need to match people to the right environment.

The Brokerage team were able to secure support for three people in under 14 days. Another case, which took 64 days, related to complex mental health needs and alcohol misuse.

The specialised skills of the Brokerage team ensure that people get the support they need quickly and are not left waiting for social care support.

8.5.1 Our contracts

Our contracts for care and support are based on an ethos of enabling people and maximising their independence.

Our current contract for homecare includes a requirement that:

'People are supported to maintain maximum independence in their own homes and local communities. They are involved in day-to-day decisions about their care or level of support offered, taking greater control of their life.'

8.6 Nutrition and hydration

It has been estimated that malnutrition-related issues cost 15% of the national health and social care budget. In many cases, malnutrition and dehydration are preventable and treatable. They are not a natural consequence of ageing.

Barnsley's A&E data indicates that care home residents are twice as likely to be at risk of malnutrition than the general population on admission to hospital.

Barnsley Hospital NHS Foundation Trust: Malnutrition Universal Screening Tool, over 65s admissions data for 2024

	High risk	Medium risk	Total admissions	Number of admissions with high and medium risk
Non-care home admission	1,509	766	31,884	7.1%
Care home admission	370	86	2,807	16.2%

Our Quality team has been collaborating with the South West Yorkshire Partnership NHS Foundation Trust's Dietetics service to systematically deliver training to prevent dehydration and implement the malnutrition triangle in care homes.

Eating and drinking are basic needs and fundamental to our overall health and wellbeing. For many older people, low mood, loneliness and isolation can affect their inclination to eat and drink.

Recognising that it should be everyone's responsibility to encourage and support older people to be nourished and hydrated, a project is being developed to expand malnutrition screening in the community.

The multi-agency project will report to Barnsley's Ageing Well Board as part of the proactive and anticipatory care workstream.

8.7 Extra Care housing

Extra Care housing, also known as assisted living, provides a combination of independent living with on-site care and support services.

Residents have their own, self-contained apartments but also have access to 24/7 support for things like personal care, meal preparation and assistance with daily tasks. It's a good option for older adults who want to maintain their independence while having access to support when needed.

We have four Extra Care schemes in Barnsley. Each offers a range of facilities that keep residents active and living in a safe and secure environment, access to on-site support, flexible care options and opportunities for social interaction.

8.8 Use of digital technology

Digital tools allow for more personalised and proactive care by providing real-time updates, enabling remote monitoring of health conditions and facilitating timely interventions. They can empower people to manage their daily routines more independently, promoting self-sufficiency and a greater sense of control.

Here are some ways we have used digital technology to support some of our most vulnerable residents:

- We have helped our social care providers to implement Digital Social Care Record Systems (DSCR's). DSCR's enable easy, secure information sharing, reduce admin time and improve care record quality. In Barnsley, 81% of providers now use a DSCR, exceeding the Department for Health and Social Care's national target of 80%.
- Adult Social Care staff now have access to the Yorkshire and Humber Shared Care Record viewer. This tool offers a near real-time view of someone's health

and social care record from various organisations across Yorkshire and the Humber, facilitating coordinated care across different settings. The system is continuously being developed to enhance its capabilities by providing additional data items and information about an individual's health and care record.

8.8.1 Innovation and research

To support people living with dementia and their carers, we undertook a research project with the University of Huddersfield, South West Yorkshire Partnership NHS Foundation Trust's Memory Service and South Yorkshire Police.

GPS devices were given to people living with dementia to prevent them from going missing in the community and resulting in an admission to hospital and care.

180 GPS trackers were issued. South Yorkshire Police then recorded the number of people missing with dementia and the number of missing hours.

Here are some key achievements:

Since issuing GPS devices, we have had three people missing in Barnsley, and all three had GPS trackers. It took relatives working with the Police only three hours in total to retrieve their loved ones, compared to the below for the same time period:

- 221.14 hours for twelve people in Doncaster.
- 385.9 hours for 21 people in Rotherham.
- 275 hours for 32 people in Sheffield.

None of these people had GPS devices. Finding a person quickly reduces the need for them to require health or social care interventions.

In partnership with Age UK Barnsley, we funded the purchase of 1,000 digital fobs to support people living with dementia and their carers.

As part of implementing the Herbert Protocol, and following the GPS project, the fobs are being distributed by South Yorkshire Police. Since September 2024, 90 have been issued to Barnsley residents by Police Community Support Officers.

9. Our plans for further opportunities to embed our preventative approach

We will continue to make improvements that work toward further opportunities to embed our preventative approach. Some of these will be about small, incremental changes to enhance systems, processes and services.

Others will be much larger and ambitious, supporting our approach to Enabling Barnsley. We will continue to learn and adapt to achieve excellence.

9.1 Neighbourhood Networks

Neighbourhood Networks are community-based initiatives that focus on supporting people, particularly older adults and those with specific needs, to live independently and actively participate in their local communities. They offer a range of services, activities and social connections to promote wellbeing, health and social inclusion.

Neighbourhood Networks can prevent social care needs by fostering community connections, reducing isolation and improving overall wellbeing, ultimately leading to greater independence and self-sufficiency.

They achieve this by connecting people to local resources, activities and social opportunities which can help prevent or delay the need for formal social care services.

Neighbourhood Networks focus on supporting mental and physical health, wellbeing, activities and social networks for older people, with positive outcomes for residents and alignment with local and national health and social care policies.

They also ensure we have equitable provision of services and resources, aiming to improve access for minority groups and those facing barriers

Barnsley has an excellent platform on which to build stronger Neighbourhood Networks with health and social care. The six Area Councils, as outlined in section 7.1, provide an opportunity and a platform for geographical Neighbourhood Networks. We will explore opportunities to plan services across this type of geographical network.

9.2 Embedding physical activity in health and social care

Barnsley is in the top ten least active places in England, as well as having the lowest healthy life expectancy for women.

As a population, we do not move enough for good physical or mental health. The promotion and use of physical activity as a tool to prevent poor health, manage health conditions or recover from injury is widely underused.

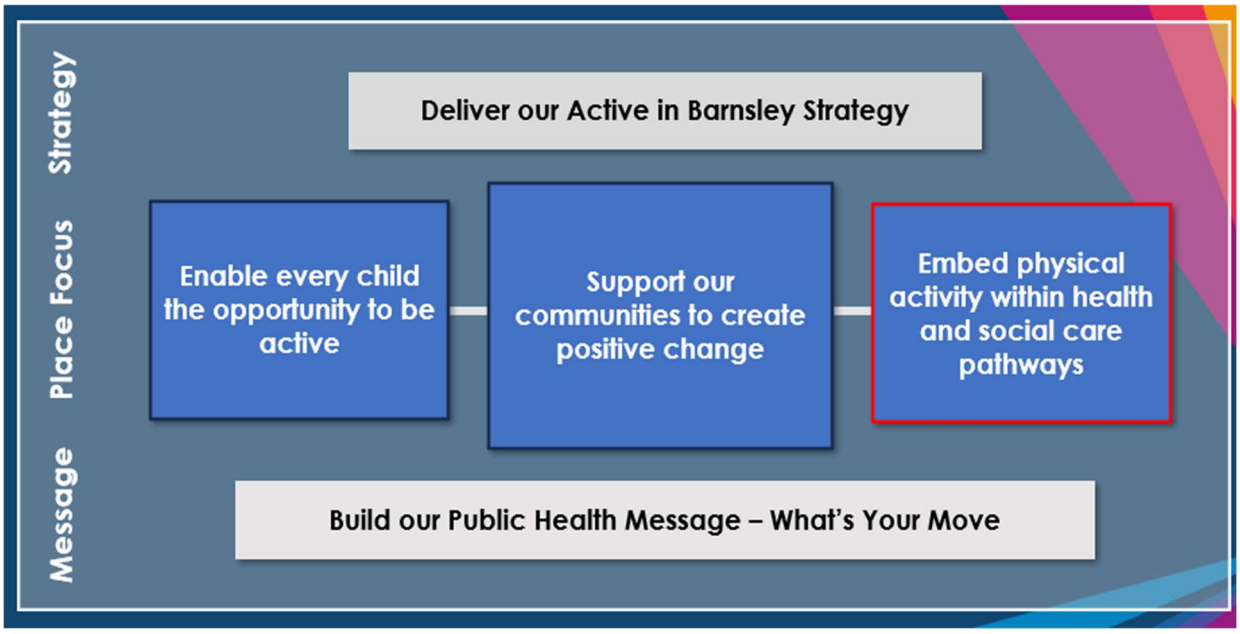
The Active in Barnsley Partnership has become an official partner of Sport England. This partnership will support Barnsley residents to move more, ultimately preventing, delaying and reducing the need for social care.

The Barnsley 2030 Board has adopted the **'Big Idea – Transforming Communities through Moving More'** as a Healthy Barnsley-endorsed priority project.

With support from Sport England, the ambition is to directly support 20,000 people to move more for improved physical and mental wellbeing, with many more people benefiting indirectly through wider systemic change.

The three priority areas for this project are to:

- Enable every child the opportunity to be active.
- Support our communities to create positive change.
- Embed physical activity within health and social care pathways.



To embed physical activity within health and social care pathways, we will:

- Recognise physical activity and movement across health and care partners as an asset to preventing, delaying and reducing the need for care.
- Recognise that physical activity will support the reduction of health inequalities, prevent ill health and is key to the proactive management of chronic diseases and long-term conditions.
- Weave in physical activity as part of any work we undertake, collaboratively across and between system partners, through to smaller-scale projects as part of our strengths-based approach to Adult Social Care.
- Acknowledge that the promotion of physical activity is everyone's responsibility, and links to all health and care teams across Barnsley
- Recognise the huge positive impact physical activity can have on people, including social, economic, health and wellbeing benefits, hence the importance of really pushing and promoting physical activity in all we do.

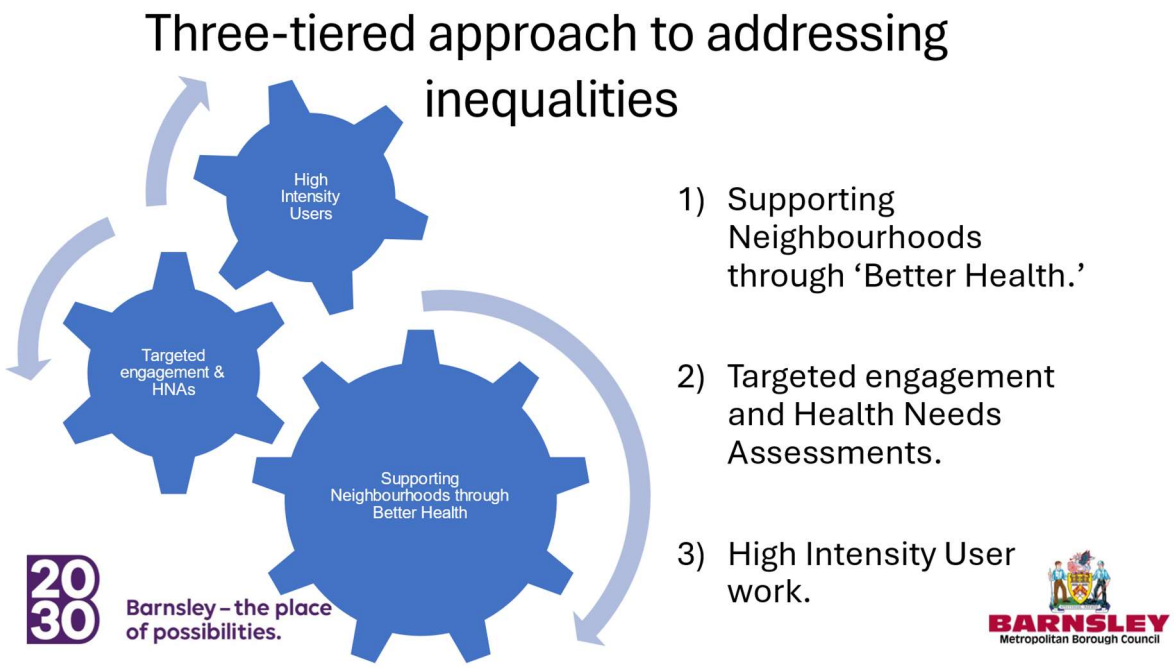
- Make sure decisions are made with people and communities, not to them. We will hear from patients and the people we support, actively listening and, most importantly, acting on what we hear.

9.3 Core20+5

Core20+5 is a national health approach to address health inequalities, focusing on specific populations and clinical areas.

It aims to reduce disparities in healthcare access, experience and outcomes, particularly for the most deprived populations and those with additional vulnerabilities.

Barnsley Council has been given health funding to implement Core20+5. We aim to address health inequalities in Barnsley through a three-tier approach:



Asset-Based Community Development and co-production are at the heart of each tier. Communities will be empowered to design and deliver a range of interventions which address health inequalities and enable people to live longer, healthier lives.

This approach will focus on improving outcomes for the most vulnerable and deprived communities first.

The funding for these initiatives totals £480,000 per annum, divided into:

- £245,000 for Supporting Neighbourhoods.
- £122,500 for Health Needs Assessments and hyper-local engagement.

- £112,500 for ‘high intensity users’.

Each of these areas will involve collaborative working with partners across the health and care system, voluntary and community sector organisations and residents.

Metrics for outcome monitoring include the impact of interventions, patient stories and cost savings. The overall goal is to build a foundation for long-lasting improvements in health outcomes and access across Barnsley.

A healthier population can reduce the overall burden of disease and the need for extensive social care services. Improved health can lead to increased independence, reduced hospital admissions and a better quality of life for our residents, ultimately benefiting both the individual and the social care system.

9.4 Home First model

A Home First model aims to prioritise and support patients returning to their homes after hospital stays or those who require care at home rather than in a hospital setting. It's a collaborative approach involving health and social care professionals, focused on providing the necessary support and resources for people to recover and maintain their independence at home.

The key features of a Home First model are:

- **Prioritising home**
  The core principle is to make returning home the default pathway for patients.
- **Short-term care**
  This model often includes short-term support and reablement services, helping people regain skills and independence in their own home.
- **Integrated teams**
  Health and social care professionals work together as a single team to coordinate care and ensure seamless transitions.
- **Community support**
  The focus is on providing the necessary resources and support within the community to help people maintain their independence and wellbeing.
- **Assessment and planning**
  Assessments are conducted in the patient's home to determine their needs and develop a care plan.
- **Reduced hospital stays**
  By providing care at home, the model aims to reduce unnecessary hospital admissions and shorten hospital stays.
- **Improved patient outcomes**

Recovering at home can lead to improved patient outcomes, such as increased independence, reduced risk of deconditioning and infection, and a sense of continuity with their usual routine.

- **Improved patient wellbeing**
  Staying at home can reduce stress, anxiety and the risk of infections often associated with hospital stays.
- **Reduced healthcare costs**
  By reducing hospital stays, the model can lead to cost savings for the health and care system.
- **Enhanced independence**
  Home-based care can help patients regain or maintain their independence, allowing them to live a more fulfilling life.
- **Improved patient flow**
  By facilitating timely and effective discharges, the model can help reduce delays in hospital care and improve overall patient flow.

There are key elements of the Home First model that are already being delivered in Barnsley. However, we want to strengthen its coordination, and importantly, we want to ensure that the voluntary sector plays a key role.

We know that the voluntary sector often acts as a safety net for those who may fall outside of public sector support. This sector can provide various services and support, including direct support, offering services like home visits, companionship, befriending and respite care, or even providing temporary accommodation in certain cases.

Voluntary organisations can promote the benefits of Home First and advocate for changes in policies or practices to better support people and their families.

They can facilitate community connections and create opportunities for people to participate in social activities and build relationships.

Voluntary organisations often work in partnership with other sectors, including public and private, to ensure that a range of services are available to meet people's needs.

In essence, the voluntary sector provides essential fill-in services and support, helping to ensure that people who choose or need to live at home can do so safely, independently, and with a good quality of life.

9.5 Research culture

We are working across directorates to develop the strategic direction of the council's research. Our vision is:

Building a research culture together to ensure the best outcomes for our residents. Our decision-making is evidence-based, knowledge is shared, and research contributes to making Barnsley the place of possibilities.

We have already secured external research funding to build capacity within the Council for research and are working with colleagues to increase this external investment towards research. We are working to build capacity, processes and a strong research culture across our teams to achieve our vision.

10 Conclusion

By focusing on prevention, early intervention and community engagement, we aim to enhance the quality of life for adults and reduce the need for long-term care.

This strategy represents our commitment to fostering a supportive environment where people can thrive independently.