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To all Members of the

DONCASTER
HEALTH AND WELLBEING BOARD

AGENDA

Notice is given that a Meeting of the Health and Wellbeing Board is to be held as follows:

VENUE Mary Woollett Centre, Danum Road, Doncaster, DN4 5HF
DATE: Thursday, 16th March, 2017
TIME: 9.30 am

PLEASE NOTE VENUE FOR THIS MEETING

Items		Time/ Lead
1.	Welcome, introductions and apologies for absence	5 mins (Chair)
2.	Chair's Announcements.	10 mins (Chair)
3.	To consider the extent, if any, to which the public and press are to be excluded from the meeting.	1 min (Chair)
4.	Public questions. **(A period not exceeding 15 minutes for questions from members of the public.)**	15 mins (max) (Chair)

Jo Miller
Chief Executive

Issued on: Wednesday 8 March 2017

Governance Officer for this meeting: Jonathan Goodrum
01302 736709

5.	Declarations of Interest, if any.	1 min (Chair)
6.	Minutes of the Meeting of the Health and Wellbeing Board held 12th January 2017. *(Attached – pages 1 - 8)*	5 mins (Chair)
	Delivery of Health and Wellbeing Strategy	
7.	Domestic Abuse Strategy 2017-2021. *(Paper attached – pages 9 – 82)*	10 mins (Bill Hotchkiss)
8.	Quarter 3 2016-17 Performance Report. *(Paper attached – pages 83 – 106)*	25 mins (Allan Wiltshire)
9.	Black and Minority Ethnic Health Needs Assessment. *(Paper attached – pages 107 – 150)*	15 mins (Susan Hampshaw)
	Board Assurance	
10.	Health and Social Care Transformation Update/Better Care Fund Update. *(Paper attached – pages 151 – 184)*	20 mins (Jon Tomlinson/ Ailsa Leighton/ Patrick Birch)
	Developments and Risk Areas	
11.	Children and Young People's Plan 2017-20. *(Paper attached – pages 185 – 228)*	15 mins (Damian Allen/ Riana Nelson)
	Board Development	
12.	Director of Public Health Annual Report 2016. *(Paper attached – pages 229 – 286)*	10 mins (Dr Rupert Suckling)
13.	Report from the HWB Steering Group and Forward Plan. *(Paper attached – pages 287 – 294)*	10 mins (Dr Rupert Suckling)

Date/time of next meeting: Thursday, 8 June 2017 at 9.30 am in Room 007a and b - Civic Office, Doncaster.

Members of the Doncaster Health and Wellbeing Board

Chair – Cllr Pat Knight	Portfolio Holder for Health and Adult Social Care
Vice Chair - Dr David Crichton	Chair of Doncaster Clinical Commissioning Group
Cllr Glyn Jones	Portfolio Holder for Adult Social Care and Equalities
Cllr Nuala Fennelly	Portfolio Holder for Children, Young People and Schools
Councillor Cynthia Ransome	Conservative Group Representative
Kim Curry	Director of Adults, Health and Wellbeing, DMBC
Damian Allen	Director of Learning Opportunities and Skills, DMBC
Karen Curran	Head of Co-Commissioning NHS England
Peter Dale	Director of Regeneration &Environment, DMBC
Richard Parker	Interim Chief Executive of Doncaster and Bassetlaw Teaching Hospital Foundation Trust
Dr Rupert Suckling	Director of Public Health, DMBC
Jackie Pederson	Chief Officer, Doncaster Clinical Commissioning Group
Chief Superintendent Tim Innes	District Commander for Doncaster, South Yorkshire Police
Kathryn Singh	Chief Executive, RDaSH
Paul Moffat	Chief Executive, Doncaster Children's Services Trust
Steve Shore	Chair of Healthwatch Doncaster
Paul Tanney	Chief Executive, St Leger Homes of Doncaster
Steve Helps	Chief Officer, South Yorkshire Fire and Rescue
Vacant	Chief Executive, New Horizons

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DONCASTER METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY, 12TH JANUARY, 2017

A MEETING of the HEALTH AND WELLBEING BOARD was held in the DRAWING ROOM - ST CATHERINES HOUSE on THURSDAY, 12TH JANUARY, 2017, at 9.30 a.m.

PRESENT: Chair – Councillor Pat Knight, Portfolio Holder for Public Health and Wellbeing
Vice-Chair – Dr David Crichton, Chair of Doncaster Clinical Commissioning Group

Dr Rupert Suckling	Director of Public Health, Doncaster Metropolitan Borough Council, DMBC
Councillor Glyn Jones	Portfolio Holder for Adult Social Care and Equalities
Councillor Cynthia Ransome	Conservative Group Representative
Jackie Pederson	Chief Officer, Doncaster Clinical Commissioning Group
Mike Pinkerton	Chief Executive, Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Damian Allen	Director of Learning Opportunities and Skills, DMBC
Jacqueline Wilson	Director of Transformation, Doncaster Children's Services Trust, substituting for Paul Moffat
Chief Superintendent Tim Innes	District Commander for Doncaster, South Yorkshire Police
Jon Tomlinson	Interim Assistant Director Commissioning, DMBC, substituting for Kim Curry
Paul Tanney	Chief Executive, St Leger Homes of Doncaster

Also in attendance:

Allan Wiltshire, Head of Performance and Data, DMBC
Andrea Butcher, Head of Strategy and Delivery, Mental Health and Learning Disability, DCCG
Andrew Maddox, Business Development Manager Leisure Services, DMBC
Richard Parker, Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Councillor John Healey (Observer)

94 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed Paul Tanney to his first meeting of the Board following his appointment as the new Chief Executive of St Leger Homes of Doncaster. The Chair also welcomed Chief Superintendent Tim Innes, District Commander for Doncaster, to his first meeting as a Board Member.

Apologies were received from Councillor Nuala Fennelly, Kathryn Singh, Steve Helps, Paul Moffat (Jacqueline Wilson deputised), Peter Dale, Kim Curry (Jon Tomlinson deputised) and Karen Curran.

95 APPOINTMENT OF VICE-CHAIR

It was proposed by Councillor Glyn Jones and seconded by Councillor Cynthia Ransome that Dr David Crichton be appointed as Vice-Chair of the Board for the remainder of the 2016/17 Municipal Year.

Upon being put to a vote, it was unanimously

RESOLVED that Dr David Crichton be appointed as Vice-Chair of the Board for the remainder of the 2016/17 Municipal Year.

96 CHAIR'S ANNOUNCEMENTS

The Chair advised the Board that Mike Pinkerton was stepping down from his role as Chief Executive of Doncaster and Bassetlaw Hospitals NHS Foundation Trust later this month, so sadly this would be his last meeting as a member of the Health and Wellbeing Board. On behalf of the Board, the Chair expressed her sincere thanks to Mike for the significant contribution he had made to the work of the Board and wished him all the very best for the future. She added that Richard Parker, who was in attendance at today’s meeting, would be the Interim Chief Executive following Mike’s departure, so the Board would look forward to welcoming Richard as a formal Board Member at its next meeting in March.

The Chair also confirmed that, since the last meeting, Norma Wardman had tendered her resignation from the Board, due to the impending closure of Doncaster CVS. She therefore wished to place on record the Board’s thanks both to the CVS for its work in the past and to Norma for the contribution she had made as a member of the Board.

On behalf of the Board, the Chair congratulated RDaSH on receiving an overall rating of ‘good’ following a re-inspection by the Care Quality Commission.

97 PUBLIC QUESTIONS

Mr Doug Wright referred to the contents of the Sustainability and Transformation Plan (STP) at agenda item 8 (minute number 100) and stated that he was concerned over the lack of detail provided as to where the savings would come from to make up the financial shortfall of £571m that had been identified. He also stressed the importance of carrying out public consultation on the proposals. He asked whether the implementation of the STP could be temporarily halted to enable a listening exercise to be carried out between the clinicians and the public.

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Parish Councillor Stephen Platt expressed concerns over how the shortfall of £571m quoted in the STP would be met, particularly in light of the current reported problems in the NHS, such as a lack of resources, bed shortages and long waiting times for patients in hospitals and at a time when it was clear that the NHS needed more funding.

On a different subject, Parish Councillor Platt explained that Angela Curtis, who had asked a question about air pollution at the Board’s last meeting, was unable to attend
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today's meeting. He confirmed that Mrs Curtis had received a letter from Dr Rupert Suckling following the Board's meeting outlining some of the measures being taken in the Borough to tackle the problem of air pollution. Parish Cllr Platt expressed the view that these measures alone would not reduce pollution to an adequate extent and he stressed that what was needed was a change in everyone's habits and behaviours. He also suggested that air pollution should be a standing item on every HWB agenda in order that the Board could monitor progress in this area.

Parish Cllr Platt concluded by highlighting the valuable contribution that community libraries and parish councils could make in helping to publicise health awareness campaigns such as those which encouraged people to live healthier lifestyles.

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Parish Councillor Lynette Chipp asked Dr Rupert Suckling whether any progress had been made with regard to establishing an air pollution steering group, as referred to in the minutes of the Board's last meeting. In response, Dr Suckling confirmed that a meeting had been arranged with the Council's Chief Executive and Pollution Control Officers to discuss this issue with a view to moving things forward.

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Mrs Anne Gilbert referred to the STP and stated that she shared the concerns of the previous speakers regarding the financial position. She was particularly interested in how the STP would link GPs with Social Care and hoped that the presentation later in this meeting would address these points.

In thanking the members of public for their questions, the Chair explained that all of the points raised regarding the STP would be addressed under agenda item 8 (minute number 100).

98 DECLARATIONS OF INTEREST, IF ANY

There were no declarations of interest made at the meeting.

99 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 3RD NOVEMBER 2016

RESOLVED that the minutes of the Health and Wellbeing Board held on 3rd November 2016 be approved as a correct record and signed by the Chair.

100 HEALTH AND SOCIAL CARE TRANSFORMATION UPDATE - SUSTAINABILITY AND TRANSFORMATION PLAN/BETTER CARE FUND

The Board received and noted presentations by Jackie Pederson and Jon Tomlinson which provided updates on progress with the implementation of the Sustainability and Transformation Plan (STP) and the Better Care Fund (BCF).

In addressing the points raised under public questions, Jackie Pederson explained that the Doncaster Place Plan had been received by the Board at its previous meeting, and this outlined a commitment by providers to work together in new ways to provide

services for health and social care through joint commissioning and with greater integration in future. She confirmed that the Place Plan would link with the STP and that testing on this new model would commence across Doncaster soon.

In outlining the scale of the financial challenge and where the required savings were to be made, Jackie explained that if the STP proposals were successfully implemented, then it was hoped that these measures would go a long way towards making up the deficit, but she stressed that this would be a huge challenge.

With regard to public engagement in the process, Jackie confirmed that a listening exercise was due to commence in February. She explained that Healthwatch Doncaster, along with other voluntary sector organisations, would be heavily involved in the public consultation exercise on the STP and therefore suggested asking Steve Shore to report back to a future meeting of this Board on the outcome of the consultation.

During subsequent discussion, the Chair explained that Doncaster Council's Cabinet had discussed the Place Plan at length at its meeting in December 2016, but had only noted the overall direction of travel within the Plan at this stage, pending the outcome of the consultation to be held with staff, patients and the public during December and January. Following the completion of the consultation exercise, a further report would be submitted to Cabinet for further discussion.

Councillor Glyn Jones referred to a recent article which had quoted the view expressed by the Chair of the BMA that STPs, proffered as the solution to the NHS deficit, had "revealed a health service that is in fact unsustainable without urgent further investment, and with little capacity to 'transform' in any meaningful way other than by closing services on a drastic scale". Councillor Jones suggested that it would be helpful if a Due Regard Statement was produced to measure the impacts of the STP proposals. He also expressed the view that the STP was high level in terms of its content and there was little detail in the Plan to allow people to come to an informed decision about the proposals and he looked forward to seeing the results of the consultation exercise.

In response, Jackie Pederson agreed to take back to colleagues the suggestion in relation to producing a Due Regard Statement. In terms of the content of the STP, Jackie stated that it was hoped that further clarity and details on the proposals would be available soon.

Following the presentations, the Board discussed a wide range of issues that had been highlighted, including:-

- The need to consider how the STP, BCF and Place Plan would all be co-ordinated on a local level;
- Recognition that measures had to be taken to try and reduce the current levels of demand on hospitals, such as a focus on 'end of life' not meaning hospital care and, following accidents, assessing patients at home, rather than using hospitals;
- It was noted that the BCF Plan in terms of its direction of travel had been well received regionally, and it was intended that the BCF would be used to support the transformation programme and implementation of the Place Plan.

RESOLVED to receive and note the presentations on the implementation of the STP and the BCF.

101 2016-17 QUARTER 2 PERFORMANCE REPORT AND FOCUS ON MENTAL HEALTH TRANSFORMATION AND LEARNING DISABILITIES

The Board considered a report which provided the latest performance figures for the Quarter 2 period, 2016-17.

It was reported that a refreshed ‘outcomes based accountability’ (OBA) exercise was completed parallel to the refresh of the Health and Wellbeing Strategy. The five outcome areas remained and a new outcome on drugs had been introduced for 2016-17. A number of specific indicators had been identified which would measure progress towards these outcomes in 2016-17.

Further information and narrative around the performance was set out in Appendix A to the report.

The Board discussed the key points and narrative behind the latest performance figures for each outcome area in turn, as summarised below:-

Outcome 1: All Doncaster residents to have the opportunity to be a healthy weight

In response to a comment regarding the absence of data beyond 2014/15 in relation to the obesity performance indicators, Allan Wiltshire explained that this data was produced nationally and more recent performance figures were very difficult to obtain. He added that this point highlighted the need to identify ways of collecting relevant data locally.

Councillor Cynthia Ransome expressed the view that there was still much work to be done in tackling Obesity and felt that more measures were needed, such as discouraging children from visiting fast food outlets on the way home from school. Damian Allen stated that a ‘whole system’ approach was needed in order to address this issue, examining all contributing factors such as locations of fast food outlets, their opening hours and pricing of their food products. He added that a report by the Independent Commission on Education and Skills in Doncaster had identified the need to develop a ‘Healthy Schools: Healthy Workplaces’ Kitemark, recognising that health underpinned educational success, future wellbeing and economic prosperity.

Outcome 2: All people in Doncaster who use alcohol do so within safe limits

In response to a request as to whether a more detailed breakdown could be provided in relation to the data for alcohol-related attendance at A&E (Doncaster residents), such as the proportion of these that were people under the age of 18, Allan Wiltshire undertook to investigate whether this would be possible for future reports.

In reply to a question regarding the success of the trial of a Safe Haven in Doncaster Town centre during December 2016, Dr Rupert Suckling confirmed that at least 50 people had been treated who would have otherwise visited the A&E department. He added that the trial, which was still being evaluated, had received positive comments from the Police and other organisations.

With regard to the figures for alcohol related violent crime, Chief Superintendent Tim Innes confirmed that there would be a marked increase in the number of recorded crimes over the coming months, due to changes in recording methods within the police force.

Outcome 3: Families who are identified as meeting the eligibility criteria in the expanded stronger families programme see significant and sustained improvement across all identified issues

During discussion on these performance indicators, Jacqueline Wilson expressed the view that this was far too narrow a sample to enable the Board to understand the issues. She felt that broader information was required and that the Board needed to receive measures relating to outcomes rather than outputs. She added that she would aim to bring more detailed information on behalf of the Children's Services Trust next time. Dr Rupert Suckling confirmed that there would be an opportunity for the Board to re-examine the performance indicators it received at the Board's Time-out and Development session in February.

In response to a query with regard to the implementation of the Domestic Abuse Strategy 2016-20, Jacqueline Wilson stated that there were issues around governance to address and that the Strategy would be brought to the Board's next meeting.

Outcome 4: People in Doncaster with Dementia and their carers will be supported to live well. Doncaster people understand how they can reduce the risks associated with dementia and are aware of the benefits of an early diagnosis

During discussion on the upward trend of the indicators relating to the number of installations for Assistive Technology (AT) and number of AT referrals that were for people with Dementia, Members noted that there was growing recognition of the value of AT in improving the lives of people with Dementia.

Outcome 5: Improve the mental health and wellbeing of the people of Doncaster

During discussion on Indicator d) (CAMHS: % of referrals starting a treatment plan within 8 weeks) and whether it was possible to measure the impact of early help, Members noted that there might be some merit in considering the scope for introducing some impact-related indicators for this Outcome from next year.

Outcome 6: Reduce the harmful impact of drug misuse on individuals, families and communities

Dr Rupert Suckling reported that currently there were no waiting lists for drug treatment in Doncaster.

After the Board had received a short presentation by Andrea Butcher on the Mental Health Transformation and Learning Disabilities area of focus, it was

RESOLVED:-

(1) to note the performance against the key outcomes; and;

(2) to receive and note the presentation on the Mental Health Transformation and Learning Disabilities area of focus.

102 WHOLE SERVICE REVIEW - PHYSICAL ACTIVITY AND SPORT

The Board received a presentation and paper by Andrew Maddox outlining the work being carried out in relation to a whole service review of the delivery and provision of physical activity and sport.

This work would ensure that fully aligned strategies and policies were adopted by all partners at the highest level which would improve the approach to the development of sport and physical activity across the Borough. Once adopted, these key pieces of work would place Doncaster at the forefront of Physical Activity and Sport provision, enabling a step change to developing an active population to "Get Doncaster Moving".

Currently with partners the following had been commissioned:

- Stakeholder & Commissioning Project;
- Review of Doncaster Active Partnership;
- Physical Activity and Sports Strategy;
- Leisure Facility Review; and
- Playing Pitch Strategy.

During subsequent discussion, the Chair queried whether the decline in participation levels of people swimming was due to the aging pool facilities in the Borough. In response, Andrew Maddox explained that a range of factors could affect participation trends in swimming and these needed to be identified, although he added that the state of the facilities was likely to be an influence.

After Members had acknowledged the need to give physical activity and sport greater prominence and recognition when formulating strategies and policies, such as the Doncaster Place Plan, it was

RESOLVED to endorse the report and review, and agree that the Doncaster Active Partnership be formally tasked with taking forward the delivery of the review and be held accountable for its delivery.

103 REPORT FROM HWB STEERING GROUP AND FORWARD PLAN

The Board considered a report which provided an update on the work of the HWB Steering Group to deliver the Board's work programme and also provided a draft Forward Plan for future Board meetings, as set out in Appendix A to the report.

In presenting the report, Dr Rupert Suckling drew particular attention to the date of the Board's Time-out and Development Session on 9th February 2017 and asked Members to note this date in their diaries.

Dr Suckling also informed Members that the first walk of the 'Get Doncaster Walking' 2017 program would be taking place at Lakeside, Doncaster on 21st January 2017 and would be led by Paratrooper, L/Cpl Ben Parkinson MBE and everyone was welcome to come along.

RESOLVED to:

(1) note the update from the HWB Steering Group; and

(2) agree the proposed Forward Plan, as detailed in Appendix A to the report.

104 BRIEFING ON THE USE OF LICENSING POWERS TO SECURE HEALTH IMPROVEMENT (FOR INFORMATION ONLY)

The Board received and noted a briefing paper on the use of licensing powers to secure health improvement, as requested at the last meeting.

CHAIR:_______________________________ DATE:________________

Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No.
Date: 16th March 2017

Subject: 2017 – 2021 Domestic Abuse Strategy

Presented by: Bill Hotchkiss and Phil Hayden

Purpose of bringing this report to the Board

The Health and Well Being Board Members are asked to comment and endorse the content of the new Domestic Abuse Strategy 2017-2021 and discuss specifically how the Board can support the 3 key objectives:

- Communities and families no longer experience domestic abuse
- Families who are vulnerable to or experience domestic abuse are identified earlier and receive effective support to stay safe; reduce repeat victimisation and recover.
- People who use abusive behaviour are challenged and provided with effective support to change or face the consequences of their actions.

Decision	
Recommendation to Full Council	
Endorsement	X
Information	X

Implications		**Applicable Yes**
DHWB Strategy Areas of Focus	Substance Misuse (Drugs and Alcohol)	Yes
	Mental Health	Yes
	Dementia	No
	Obesity	No
	Children and Families	Yes
Joint Strategic Needs Assessment		Yes
Finance		Yes
Legal		Yes
Equalities		Yes

Other Implications (please list)	

How will this contribute to improving health and wellbeing in Doncaster?

- We know that domestic abuse isn't isolated as a single issue in families lives, in many cases it is coupled with mental ill health substance misuse and other complicating factors including the effects of poverty and disadvantage. It can happen anywhere to anyone and can take many forms from physical to emotional abuse and coercive control.

- The overall wider annual cost of Domestic Abuse in all cases for Doncaster has been independently estimated by Safe Lives to be over £122m, with the cost of support for children and young people known to children's social care, calculated at £7.5m. This represents a significant effect upon Partnership services with huge potential to reduce this impact and cost.

- There is significant and growing evidence that children are affected by Domestic Abuse, having long term implications upon their education and future relationships and indeed some go on to become perpetrators themselves. Breaking the cycle of this impact has the potential to significantly improve their health and well-being.

- Families who are vulnerable to or experience domestic abuse, can be identified earlier and receive effective support to stay safe, reduce repeat victimisation and recover. This includes working with perpetrators to enable them to change their behaviour (and where it is safe to do so) enables families to stay together.

Recommendations

The Board is asked to:-

Comment and endorse the content of the new Strategy and discuss specifically how the Board can support the 3 key objectives and strategic issues identified below :

1) Need to build community resilience, capacity and challenge cultural acceptance, expressed as the social DNA and mind-set in Doncaster
2) True joint commissioning, with shared principles across boards and commissioners to tackle DVA along with multiple needs in families
3) Long term investment to tackle DVA with whole place approach which will have wider public health benefits and support reduction of ASB
4) Challenge services to 'think' and 'work' whole family and what this means in practice, challenging the systemic issues and conflicting philosophies and approaches to practice
5) Research and evaluate the impact of silo working to develop effective multi-system and agency working to address individual needs

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Doncaster
Metropolitan Borough Council

Date: 16th March 2017

To the Chair and Members of the Health and Well Being Board

DOMESTIC ABUSE STRATEGY 2017 - 2021

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Councillor Chris McGuinness	All	Yes

EXECUTIVE SUMMARY

1. This report provides an update on the new 2017-2021 Domestic Abuse Strategy.

EXEMPT REPORT

2. This is not an exempt report

RECOMMENDATIONS

3. The Health and Well Being Board Members are asked to comment and endorse the content of the new Domestic Abuse Strategy 2017-2021 and discuss specifically how the Board can support:
   - The three key strategic outcomes (para. 10)
   - Effective development of DVA work in Doncaster including addressing the significant barriers identified through the Strategy (para. 15)

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4. This partnership Strategy reflects the co-ordinated response to domestic abuse in Doncaster, led by the Safer Stronger Doncaster Partnership (SSDP).One of the most important aspects of responding effectively to domestic abuse is that it cannot be achieved by any single agency operating in isolation.

5. Following an independent review of Domestic Abuse in Doncaster in 2012 the Partnership have made significant progress to bring partners together to tackle this important and cross cutting issue. Key achievements have included improved governance and strategic leadership, a re-commissioned service for victims, increased awareness raising and lower risk victims receiving better support through specialist caseworkers, who also work in hospitals and GP surgeries.

6. The Growing Futures programme has enabled Children and families affected by abuse to now have access to a single lead professional co-ordinating work through a whole family approach, delivering therapeutic and educational programmes to help victims and children recover.

7. A new voluntary perpetrator programme has also been established with over 490 referrals being made and 116 service users successfully completing the programme. Intervention at this level has made a difference to families affected by abuse, who now feel safer as perpetrators now have the opportunity of changing their behaviour. This successful programme is now in the early stages of being replicated across the County, based upon the innovative approach we have taken.

BACKGROUND

8. The strategy sets out the detail of how we want everyone who works with families experiencing domestic abuse to work together. It sets clear expectations and a course of action which we believe will make a difference. Bridging the gap between strategy and action is crucial to empowering and supporting people to change their lives.

9. The overall wider annual cost of Domestic Abuse in all cases for Doncaster has been independently estimated by Safe Lives to be over £122m, with the cost of support for children and young people known to children's social care, calculated at £7.5m. This represents a significant effect upon Partnership services with huge potential to reduce this impact. Reported Police incidents in Doncaster have flattened over the last three years against a continued increase in the rest of South Yorkshire. Whilst this indicates some progress has been made there remains much more to do.

10. The strategy focuses upon three key outcomes:

    - Communities and families no longer experience domestic abuse

    - Families who are vulnerable to or experience domestic abuse are identified earlier and receive effective support to stay safe; reduce repeat victimisation and recover.

    - People who use abusive behaviour are challenged and provided with effective support to change or face the consequences of their actions.

11. Our Partnerships commitment to protecting and supporting families experiencing domestic abuse recognises that we must also work with perpetrators to support them to change their behaviour, and at the same time work to change the culture of acceptance of abuse, through public awareness and so enable earlier intervention.

12. We recognise that the real experts in what works are the people who have used our services and one of the key planks of the new strategy is providing the opportunity for service users to participate in the planning, commissioning and delivery of our services. Recently a new website has been launched which has been shaped and designed with the involvement of service users.

13. Likewise we know that domestic abuse isn't isolated as a single issue in families lives, in many cases it is coupled with mental ill health substance misuse and other complicating factors including the effects of poverty and disadvantage. It can happen anywhere to anyone and can take many forms from physical to emotional abuse and coercive control.

14. Domestic abuse is everyone's business and it is essential that we work together in a coordinated way ensuring that everyone understands what domestic abuse is, knows how to respond to it and where to get support if they need it.

15. It has been put forward that the approach to Domestic Abuse is considered as one of the major change programmes as part of the Strategic Doncaster 2021 programme. This would provide governance via the Team Doncaster Partnership but feed into the SSDP, Health and Well Being Board and both the Adults and Children's Safeguarding Boards. If agreed, this suggested model of Governance firmly places Domestic Abuse within Team Doncaster's agenda. This approach would also help address some significant issues which were identified during the consultation on the strategy and are considered to be cross partner inter-related strategic issues that pose real barriers to progress being made.

   - Need to build community resilience, capacity and challenge cultural acceptance, expressed as the social DNA and mind-set in Doncaster
   - True joint commissioning, with shared principles across boards and commissioners to tackle DVA along with multiple needs in families
   - Long term investment to tackle DVA with whole place approach which will have wider public health benefits and support reduction of ASB
   - Challenge services to 'think' and 'work' whole family and what this means in practice, challenging the systemic issues and conflicting philosophies and approaches to practice
   - Research and evaluate the impact of silo working to develop effective multi-system and agency working to address individual needs

OPTIONS CONSIDERED

16. It was agreed by Cabinet on the 31st January 2017 that the full Strategy and Action plan should be implemented across Doncaster.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

17.

	Outcomes	Implications
	All people in Doncaster benefit from a thriving and resilient economy. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	The integrated and longer term vision if this strategy will impact upon all of the Councils key priorities. For example: • Reducing the cost of DA to the economy, to public services, young people and individuals and the community.
	People live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	Significant impact on children and young people, safeguarding serious cases. Major impact on health (A & E admissions, mental health, substance misuse and GP attendance)
	People in Doncaster benefit from a high quality built and natural environment. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	Supporting people to be in work and economically active, helping them resolve home related issues and thus facilitating them into work where appropriate. Improving community environments including reducing anti-social behaviour and levels of crime.
	All families thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	Identifying victims and perpetrators or potential perpetrators at a much earlier stage and preventing escalation of issues. The provision of therapeutic support to victims and families will significantly reduce the impact enabling families to thrive.
	Council services are modern and value for money.	The Strategy has included an examination of best practice to ensure we are using the very latest thinking to produce modern and value for money services.
	Working with our partners we will provide strong leadership and governance.	The governance arrangements proposed within the strategy will ensure effective and strong leadership of the priorities and actions.

RISKS AND ASSUMPTIONS

18. All risks and assumptions will be outlined in the detailed action plan and overseen by the relevant accountable board.

LEGAL IMPLICATIONS

19. Local Councils play a vital and central role in tackling domestic abuse.

20. The council has statutory obligations surrounding the safeguarding of children and vulnerable adults and the council may have statutory homelessness duties to some victims of domestic abuse under part vii of the housing act 1996 (as amended).

21. The decision maker must be aware of their obligations under section 149 Equality Act 2010, the Public Sector Equality Duty (PSED). It obliges public authorities, when exercising their functions, to have ‘due regard’ to the need to: Eliminate discrimination, harassment and victimization and other conduct which the Act prohibits; Advance equality of opportunity; and Foster good relations between people who share relevant protected characteristics and those who do not.

22. The relevant protected characteristics under the Equality Act are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The duty also covers marriage and civil partnerships, but only in respect of eliminating unlawful discrimination.

23. The decision maker must ensure that they have seen the due regard statement. The duty must be exercised in substance, with rigour, and with an open mind and is not a question of ticking boxes. It is for the decision-maker to decide how much weight should be given to the various factors informing the decision, including how much weight should be given to the PSED itself. The duty is a continuing one and there should be a record/audit trail of how due regard has been shown. It is not sufficient for due regard to be a “rear-guard action” following a concluded decision The decision maker must also pay regard to any countervailing factors and decide the weight to be given to these, which it is proper and reasonable to consider; budgetary pressures, economics and practical factors will often be important.

FINANCIAL IMPLICATIONS

24. Currently DMBC contribute almost £1m towards Domestic Abuse Services. This £1m is funded by a variety of sources, mainly Public Health, Police & Crime Commissioner and DMBC General Fund. There is a risk that some elements of this funding will not continue beyond 16/17 and this may impact upon DA services in the future.

25. There was an anticipated reduction in funding from the Police and Crime Commissioner to support the Domestic Abuse Perpetrator programme and therefore plans are now in place to develop a county wide programme, offsetting the local impact in Doncaster. Discussions are taking place to secure temporary funding for the current service enabling continuity of referrals and support until the new service comes on-stream.

26. A decrease in funding from Public Health may have an impact on the provision

of caseworker support to victims and the delivery of training to partners. Whilst we have secured temporary funding for 5 months, the long term funding still remains a risk, impacting upon medium and standard risk victims of abuse.

HUMAN RESOURCES IMPLICATIONS

27. On-going training for the workforce will be required to ensure staff have the knowledge and skills to identify the different forms of domestic abuse they are likely to encounter. In addition, the workforce will benefit from training to enable them to work towards changing the current culture of behaviour and acceptance of domestic abuse in Doncaster. Managers will need to work with human resources to influence and support the development and updating of policies and procedures in the workplace to ensure employers meet their duty of care for their employees' wellbeing.

28. Reductions in funding may have implications for DMBC staff and these will be considered in line with our own internal Policies.

TECHNOLOGY IMPLICATIONS

29. There are no specific technology implications at this stage.

EQUALITY IMPLICATIONS

30. A full equality impact assessment has been completed as a consequence of this strategy and all relevant considerations have been undertaken as part of this assessment.

CONSULTATION

31. There has been consultation with key agencies, services, front line workers, key stakeholders including some members and service users as part of the development of the strategy. There would need to be further consultation as the strategy is implemented.

BACKGROUND PAPERS

32. Domestic Abuse Strategy 2017 -2021 and Annual Action Plan.

REPORT AUTHOR & CONTRIBUTORS

Bill Hotchkiss, Head of Service - Community Safety
Tel: 01302 737831 Email: bill.hotchkiss@doncaster.gov.uk

Phil Hayden, Growing Futures Programme Manager DCST.
Tel 01302 734630 Email:phil.hayden@dcstrust.co.uk

Kim Curry
Director Adults Health and Well Being

DONCASTER DOMESTIC ABUSE STRATEGY

2017-2021

"Protecting and supporting victims; holding abusers to account through support and challenge; help for children and young people through prevention and recovery"

Final
March 2017

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Forward

Domestic abuse is one of the biggest challenges we face as a partnership. We know so much about the dreadful effects it has on individuals, their families and the wider community. We work hard to respond appropriately and effectively to reports of domestic abuse, and over the last three years we have significantly improved our response, and are starting to see the positive impact of the work we are doing.

But we also know that a great deal of abuse is never reported to the police or other services. We hear many families explain that abusive behaviour is perceived as normal for them. We see the evidence of abusive behaviour in relationships between young teenagers. High risk cases in Doncaster continue to be higher than average, and we have had two Domestic Homicides since our last strategy in 2012.

So three years on from our strategic review of Domestic Abuse, and the resulting strategy, I'm in no doubt that we now need to build on this, reflect on what has worked, and identify our priorities for the coming years.

Our strategy development day in October 2015 brought together all the key partners to do just that, and this new strategy for 2017-21 is the result.

Our agreed vision and philosophy of practice is to develop our whole family approach and integrated partnership working, as this is the most effective way to ensure that families receive the support and protection they need.

This strategy will detail how we want everyone who works with families who may experience domestic abuse to work together. It sets clear expectations and a course of action which we believe will make a difference. Bridging the gap between strategy and practice is crucial to empowering and supporting people to change their lives.

Our Partnership's commitment to protecting and supporting families experiencing domestic abuse recognises that we must also work with perpetrators to support them to change their behaviour, and at the same time work to change the culture of acceptance of abuse, through education and public awareness, and so enable earlier intervention.

The whole family approach is working, and we need to ensure we maximise our resources, eradicate any duplication, respond to the gaps we have identified, and improve our understanding of what works through focusing on outcomes. We recognise that the real experts in what works are the people who have experienced using the services we provide, and one of the key planks of our new strategy is that we want to provide the opportunity for service users to participate in the planning, commissioning and delivery of services.

We are committed to challenging the acceptance of abuse, recognising it is an issue across the county, nationally and internationally. There may be opportunities to work with our colleagues in a wider partnership to tackle aspects of this shared priority at a county or regional level. Equally we understand that front line services need to be accessible for our residents, and that victims are listened to and their needs responded to the first time they tell someone about their abuse.

Domestic abuse is everyone's business, and it's essential that we work together in a coordinated way ensuring that everyone understands what domestic abuse is, knows how to respond to it, and where to get support if they need it.

Likewise we know that domestic abuse isn't isolated as a single issue in family's lives, in many cases it is coupled with mental ill health, substance misuse and other complicating factors including the effects of poverty and disadvantage. However domestic abuse can happen anywhere as it has many forms from physical to emotional abuse and coercive control and can affect anyone.

Doncaster continues to go through considerable change in difficult circumstances. We recognise the competing priorities faced by agencies but never before has coming together in partnership been more important to tackle the significant issues resulting from and associated with domestic abuse. I believe we can be proud of the achievements made in recent years and this new strategy renews our dedication and commitment to working together to tackle domestic abuse.

I'm therefore delighted to commend this four year strategy as the Chair of the Safer Stronger Doncaster Partnership and the Doncaster Domestic Abuse Chief Officers' Group.

Chief Superintendent Tim Innes
Chair of Safer Stronger Doncaster Partnership

1.0 Introduction

This partnership strategy reflects the coordinated response to domestic abuse in Doncaster, led by the Safer Stronger Doncaster Partnership. One of the most important aspects of responding effectively to domestic abuse is that it cannot be achieved by any single agency operating in isolation. This strategy therefore sets out a 'call to action' and an agreed way of working with adult victims, perpetrators of domestic abuse and with any child or young person living in a household or with the consequences of domestic abuse.

Families[1] have a wide range of needs and may be experiencing a number of issues which contribute to, or initiate the domestic abuse. The response therefore needs to be tailored to the needs of individual families and may involve a range of professionals from both statutory and voluntary organisations working together. This presents a challenge of avoiding duplication, maximising the use of resources, and ensuring consistency of service. It also requires a shared vision and shared philosophy of practice.

This strategy therefore seeks to focus our commissioning arrangements and provision of services, and sets out how we will further improve our response to domestic abuse over the coming years.

Two supplementary documents which are being produced to support the delivery of the strategy and services for Domestic Abuse are:

- A financial and sustainability plan
- A workforce development plan with an agreed competency framework for practitioners

1.1 Our Strategic Vision

"In Doncaster people no longer experience Domestic Abuse"

Our vision, agreed by Partners at our Strategy Development Day (Oct 2015), is aspirational and is for a Doncaster where domestic violence and abuse is recognised as unacceptable, and people live safe and happy lives free from abuse.

Anyone experiencing domestic abuse, whether being abused, being the abuser or witnessing abuse within the home environment, has access to the support they need at the time they need it, to be safe and recover, or address their behaviour.

In fulfilling this vision families should be seen as equal partners with professionals supporting them; whether this is a rapid response to protect victims or to challenge unacceptable harmful behaviour from perpetrators.

[1] Families in the context of this strategy is anyone living with or affected by domestic abuse, which may or may not include children under the age of 18yrs old (24yrs SEND).

Children and young people have a right[2] to have their voice heard with an entitlement to information which assists them to participate and engage with services that support their needs.

We continue to work in an environment of rapid change which means that we have to constantly look at new ways of working with new models for investment, integrated commissioning and delivery of services. We have worked in an integrated way and 'think family' approach for a number of years through the MARAC, IDVA service and Domestic Abuse Caseworkers, as well as Stronger Families[3] and more recently through Growing Futures[4] to name a few.

This way of working will be strengthened through:

- the increased use of the early help assessment with support through the Early Help Hub
- better information sharing for more complex cases through the Multi-agency Safeguarding Hub (MASH) and Adult Safeguarding arrangements
- working practice focused on agreed shared outcomes

However, to make further gains and maximise the use of precious resources, we need to improve the use of our collective intelligence through:

- effective use of data,
- listening to staff working with families and in the community and also
- hearing what victims (adults and children) and perpetrators tell us.

This will enable us to understand needs more fully; provide a better understanding of families' vulnerability or behaviours and thereby target resources more effectively where they are needed most.

2.0 The National Context

2.1 Definition of Domestic Abuse

In March 2013[5] the Government announced a shared definition for domestic abuse which is

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

[2] United Nations Convention on the Rights of the Child 1989
[3] Doncaster's response to Troubled Families agenda
[4] Growing Futures is Doncaster's DfE Innovation funded project to transform mainstream social work and family support practice to support long term recovery for children from domestic abuse.
[5] https://www.gov.uk/government/publications/new-government-domestic-violence-and-abuse-definition

- psychological
- physical
- sexual
- financial
- emotional

"Controlling behaviour is defined as a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

"Coercive behaviour is defined as an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

2.2 National Research[6]

Contemporary academic research about the nature and types of domestic abuse are continually developing with evidence from practice constantly evolving and informing our knowledge and understanding. Unfortunately, there is no collective academic agreement on these typologies and the complexities of domestic abuse. This can lead to practice being determined by differing philosophy and standpoints which conflict.

Despite this, research is informing policy and in turn is reflected in Doncaster's local provision. This includes:

- Response to domestic abuse incidents taking account of multiple incidents as a potential pattern of abuse, rather than investigating single incidents in isolation
- Increased focus on teenage relationships and the support needed for young people experiencing abuse in their intimate relationships
- Teen to parent abuse which recognises that this form of abuse is likely to involve a pattern of behaviour that can include physical violence and coercive control, and a parent can find it difficult to access support tailored to their family's needs. In this situation young people are often seen as perpetrators rather than as vulnerable people, and this needs to change.
- The impact of domestic abuse on the adult victim and on children – even once they have achieved safety – is often severe and long-lasting.

[6] See 'Research references' Appendix 4

- Perpetrator services need to proactively identify risks posed by perpetrators to victims and identify other forms of behaviour that are wider than their intimate relationship, including criminal activity and abuse in the community.

Research also indicates that responses to domestic abuse need to be informed by assessment which identifies risk to victims and the type of abuse in individual families.

These are identified as:

- Intimate partner terrorism – which is mainly present in abusive relationships between heterosexual couples, and follows the gendered model of domestic abuse (i.e. a male perpetrator controlling a female victim), which leads to severe injury and chronic impact for the victim, both mentally and physically
- Violent resistance (also known as co responsive abuse) – which occurs when a victim of domestic abuse responds violently to their abuser in direct response the abuse s/he is suffering
- Situational couples' violence - where arguments escalate to aggression and physical violence, and the arguments may be attributable to or fuelled by external factors (e.g. alcohol misuse).

2.3 The National Strategy for Domestic Abuse

The national strategy *'Ending Violence against Women and Girls Strategy 2016 – 2020'*[7] although focused on women and girls, the Government is clear that abuse happens to men and boys as well, and that the definition and responses available apply regardless of gender.

Over the last five years the Government has introduced a range of new tools to support agencies to protect victims of abuse and manage perpetrators effectively, including:

- Domestic Violence Protection Notices and Orders
- Domestic Violence Disclosure Scheme (Clare's Law)
- Forced Marriage (Anti-social behaviour, Crime and Policing Act 2014)
- Female Genital Mutilation (Serious Crime Act 2015)
- Modern Slavery Act (2015)
- Controlling or coercive behaviour in intimate or familial relationships (Serious Crime Act 2015)

The key messages within the national strategy are:

[7]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/505961/VAWG_Strategy_2016-2020.pdf

- The prevalence of domestic abuse and sexual violence since 2010 has dropped and total prosecutions for VAWG offences have reached the highest levels ever recorded
- That sustained progress will only be made if national and local agencies and the community work together to prevent domestic abuse in the first place.
- The key pillars of the approach – prevention, provision of services, partnership working and pursuing perpetrators remain relevant from the 2010 strategy.
- There is a need to break the intergenerational consequences of abuse
- A need to tackle the multiple needs and disadvantage associated with, or the consequence of domestic abuse, such as substance misuse; homelessness; offending behaviour; gang involvement; prostitution or mental ill health.
- Local commissioners to deliver a secure future for rape support centres, refuge and FGM and Forced Marriage Units, whilst all services move to an early intervention and prevention approach as the norm, not only a crisis response.

2.4 Wider legislation and policy for working with families

There have been a number of legislative changes and areas of policy re-focus since our last domestic abuse strategy that are remodelling the way we think and work with adults; children and young people and with families. These include:

- The Health and Social Care Act 2012[8]
- The Care Act 2014[9]
- Children and Families Act 2014[10]
- Working Together to Safeguard Children (WTG) 2015[11]

Individually they have brought specific requirements for local delivery, for example:

- The Health and Wellbeing Board to lead the development of a local Joint Strategic Needs Assessment to understand the current and future health and social care needs of local communities (Health and Social Care Act 2012)
- Adult Safeguarding Board to lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens (The Care Act 2014)
- Confirming responsibilities on partners for inter-agency working and co-operation to safeguard and promote the welfare of children through the Local Safeguarding Children Board (WTG 2015)

2.5 What this means for our local Domestic Abuse Strategy

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[8] http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf
[9] http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted
[10] http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted
[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Collectively the national agenda has moved from a risk led approach that had the effect of focusing resources on the highest risk cases or most vulnerable victims, to an approach which now also prioritises prevention and early intervention. It seeks to meet the needs of the whole family earlier and in so doing reduce the risk of escalation and serious harm in the longer term.

It challenges partners to assess risks and concerns together recognising that multiple needs require a collective response. It also requires an understanding of the interrelationships within families and the communities and culture in which they live. The statutory duties to co-operate and to work collectively, across sectors and agencies with families are evident. There is an expectation that services for adults, children, young people and the community take a whole family integrated approach to address vulnerability; support those most at risk and challenge behaviour that impacts on positive outcomes now and into the future.

This requires partners; especially those with commissioning responsibilities, to ensure their organisational plans derive from the Joint Strategic Needs Assessment (JSNA) to provide help earlier and focus resources on evidence informed practice and research.

The key points that have informed our local strategy and action plan are:

- **Reduction of prevalence through:**
  - Early intervention by all agencies
  - Education
  - Culture change
  - Opportunities for victims to seek help safely
  - Effective perpetrator interventions
  - Assessment and response to multiple needs
- **Increased prosecutions and convictions through:**
  - Evidence led prosecutions
  - Enhanced support through the criminal justice system for victims
  - Effective use of new technologies
- **Increased reporting through:**
  - Police response
  - Confidence in criminal justice system
  - Improved understanding of violence and abuse incl. Coercive control
  - Bystander programmes[12]
- **Reduction of re-offending and breaches of orders through:**
  - Effective perpetrator interventions
  - Integrated family approach
  - Effective sanctions for breaches

[12] Bystander programmes are initiatives to empower people to challenge unacceptable behaviour and intervene safely if needed

3.0 Doncaster's Context

Domestic and sexual abuse has been a key priority for the Safer Stronger Doncaster Partnership (SSDP) since 2010. In 2012 an independent review of Doncaster Domestic Abuse Services by the NSPCC and KAFKA UK led to a new Domestic Abuse Strategy for 2012 - 2015 being launched.

In 2013 it was agreed that since not all sexual abuse occurs in the context of a relationship, it was important not to merge the two, and a stronger focus on Sexual Abuse was needed. A separate Sexual Abuse Theme Group was established, a strategic review of Sexual Violence and Abuse was carried out and a separate strategy on Sexual Violence and Abuse developed.

The Partnership have agreed in developing this new Domestic Abuse Strategy for 2017 to 2021 that a separate strategy is still required for sexual violence and abuse which maintains an equal and specific focus on these issues.

This Domestic Abuse Strategy is therefore focused on domestic abuse alone, which includes sexual abuse in intimate domestic relationships in line with the national definition.

3.1 Our Achievements

In developing this new strategy we have reviewed the work of the partners to learn what has worked and to recognise the achievements made from 2012 to 2015. Some of these achievements are illustrated through 'quotes' and feedback from service users

- **Commissioned new support services for victims** including the refuge which is consistently fully occupied, 8 dispersed housing units and floating support service which has supported 146 families.

  - ✓ "This place has helped me stand up on my own two feet"
  - ✓ "I can meet or speak with staff when I need support"
  - ✓ "The door is always open"

- **Established a new team of Domestic Abuse Caseworkers** in 2014 within the Council, working with Stronger Families service to support victims of domestic abuse who are not at high risk, including a worker based at the hospital and two working directly with GPs. Caseworkers have supported 936 clients since the team was established.

  - ✓ 'great news! the social worker has closed case. So pleased. I feel like we've got a new start and you really kept me going even when I didn't think I'd ever get to this day.'

- ✓ ‘there was nothing like this when I was being abused years ago. You just had to cope on your own. I wish I’d had someone like you to talk to.’ (clients mother)
- ✓ ‘not had a drink for a month! No way would I have gone to DDAS without you that first time.’
- ✓ ‘get keys for new house next week. Can’t believe how much difference it made you coming to housing with me.’

- **Developed and commissioned a new service to support perpetrators of abuse** to change their behaviour – Foundation4Change was established in July 2014 and has worked with 152 people to change their abusive behaviour with a 21% reduction in police call outs in respect of their clients, and 96% of service users saying they would recommend the programme.

  - ✓ the ‘effects on children’ module had been *“very emotional”* as for the first time they realised what effect their behaviour was potentially having on their children
  - ✓ *“my wife is a lot happier” and “my relationship with my child has improved so much after doing this course”.*
  - ✓ one customer specifically commented that is what they needed (to be challenged) as without that challenge they would stop making progress towards changing their thought processes.
  - ✓ One customer had gained a lot from the alcohol module, as this was a part of their life they were trying to change (they had identified alcohol abuse as a main contributing factor to their domestic abuse).

- **Delivered a multi–agency prevention and education programme** to promote the message to our communities and young people in schools that domestic abuse is not acceptable.

- **Developed and piloted an innovative programme to work with young people who are abusive to their parents.** The “Getting On” programme through joint working between the Youth Offending Service, Community Safety and Stronger Families, which is now being rolled out by the Doncaster Children’s Services Trust through Growing Futures.

- **Implemented a workforce development plan and trained 2000 staff** in all agencies to identify and respond effectively to domestic abuse

- **Established a Domestic Abuse Hub, with Police and IDVAs co-located.** Together with the police restructure we have enhanced the service for high risk victims through joint working and improved communication concerning criminal cases. This is also part of the Multi Agency Safeguarding Hub (MASH) which brings together a wider range of safeguarding professionals under one roof.

- **Restructured the South Yorkshire Police response to domestic incidents** which has streamlined the way cases are managed, from initial report, to risk assessment, investigation and prosecution of offenders.
- **Targeted the offenders most at risk of causing serious harm** and managed them proactively using an Integrated Offender Management approach through joint working with Police and Probation officers.

- **Reviewed and streamlined our Multi-agency Risk Assessment Conference** and taken over its administration from South Yorkshire Police. 631 high risk cases have been managed by the MARAC in the 12 months to 31/3/16

- **Used the new Domestic Violence Protection Notices and Orders** to enable families to stay safely in their home rather than having to leave to escape an abuser. Our Safe and Secure service, managed by St Leger Homes, provides for a quick and effective response which ensures the security of property.

3.2 What we know about domestic abuse locally

To build on these achievements we have also reviewed our data and other local intelligence to understand the current position and new baseline. We will use this baseline to improve the collection and analysis of data to measure progress and the impact of this strategy.

Full detail of the local data and intelligence available is in Appendix 2.

3.2.1 Local data and intelligence

The most accessible data for domestic abuse is through:

- Domestic Homicide Reviews (DHR)
- South Yorkshire Police recorded incidents;
- High risk cases reviewed at MARAC;
- Information available from Doncaster Children's Services Trust case management data and through Stronger Families casework.

A summary of this local intelligence highlights:

- The 4 local domestic abuse homicide reviews since 2011 tell us:

- Domestic abuse needs to be seen as a safeguarding issue by the wider workforce, who, in turn, need to be trained to ask the correct questions and respond appropriately
- The workforce needs training to identify different forms of domestic abuse
- Health practitioners need to screen for domestic abuse beyond the focus of their scheduled activity and need to recognise the links between domestic abuse, mental health and substance misuse
- Victims of domestic abuse who may not be accessing services, e.g. older victims, need to be aware how to access help and support
- The wider family and services did not recognise that men could be victims.
- In situations where couples separated the victims thought they would now be safe without recognising the potential escalation of violence and the danger they could still be in.

- Police data shows an increase in incidents since 2006/7 with a flattening trend line over the last 3 years. This is in contrast to South Yorkshire region where incidents continue to increase. This could suggest that some of the early interventions introduced through the last strategy are beginning to work.

- MARAC data over the last 3 years show:

  - The numbers of high risk cases referred are well above the average against both regional and national figures and SafeLives benchmark.
  - The number of children affected has increased to over 800 in each of the last 2 years
  - Although there has been a reduction of cases over the period the percentage of repeat cases remain higher than regional and national figures. This could be due to a greater reduction of cases overall with the number of repeat referrals being maintained.
  - The percentages of cases of victims with protective characteristics (BME; LGBT; Disability) are all below the regional and national figures and SafeLives recommended range against demographic information.
  - The number of male victims is similar to regional and national. However the number of young people referred saw a sharp increase in 2014 although this reduced last year
  - There is a disproportionately higher level of referrals from the Police than other partners against both regional and national figures.

The MARAC data would suggest that Doncaster has a far higher number of high risk cases than other areas, while also maintaining a significant number of repeat referrals of difficult cases. It could also suggest that there is a greater awareness with the public about domestic abuse through campaigns, although reported incident have reduced slightly.

The data shows that there may be a lack of understanding about intimate partner abuse and a general acceptance of cultural norms within some communities and some relationships leading to a lack of assessment and response.

Likewise risk assessment does not appear to be routine with some partners being reliant on Police to respond. This lack of routine assessment by services is a significant concern as some high risk cases could be missed with earlier interventions not deployed to support which are standard and medium risk.

- Children's Social Care data and Stronger Families information show:

    - Domestic abuse is the most frequently recorded concern being present in 39% of assessments which may be affecting 1,880 children. This has been consistent over a number of years
    - These cases also show multiple needs with a significant proportion having a range of two to four other concerns present and a number of families with five or more concern factors detailing highly complex needs.
    - These needs and concerns continue to be parental drug and alcohol misuse, mental ill-health with an increasing number with some form of learning need or disability. There is also evidence of some of these concerns identified in children and young people within the family, including abuse towards parents.
    - Families display and suffer other factors including: poverty, parental ability, housing and finance issues and poor general health and emotional wellbeing.

  The finding from this data is not a surprise and shows a recurrent trend which could lead to an acceptance that this is a normal part of life for some families. It isn't normal and although protection and specialist services can do much to support families to recover in the short term there is a need for greater engagement of wider family services. This includes prevention through education and services that promote health and wellbeing.

3.2.2 What do local people say?

There are many examples of client satisfaction with some services. However, we have limited information through wider public consultation.

In summary what we do know is:

- While some adults recognise domestic abuse is a problem and unacceptable they see this as a private matter and an accepted part of life. This also extends to acceptance of aggressive behaviour in the community which in part, is fuelled by misuse of alcohol and drugs.

- In contrast although children and young people recognise domestic abuse is an aspect of many of their lives or their friends' lives, they want to change this but are not sure how to.
- Staff members delivering local services express the need to assess risk sooner and respond more effectively through collective effort with the whole family. They state there should be greater understanding of what works with individual family members including direct work with children. Many staff express a lack of confidence in working with perpetrators as well as not seeing this as their job.

3.2.3 The cost of domestic abuse

There is a real and quantifiable cost which impacts on service providers. This is in terms of the length of time and intensity of provision required to promote recovery and build resilience where domestic abuse is identified at relatively high levels of risk.

Using national figures:

- It is estimated that upwards of 27,060 of women and girls aged 15 to 59 in Doncaster have experienced an incident of abuse or sexual assault in their life.
- Estimates for Doncaster show for high risk cases to MARAC the cost to services for adults is over £13m and will exceed this by the year 2020 if the rate continues or increases
- Earlier intervention could reduce High Risk case costs by £4m if services assess need earlier and intervene
- The overall wider public cost of domestic abuse in all cases for Doncaster is estimated to be over £121 million
- The cost of support for children and young people known to children's social care is calculated at £7.5m in cases where domestic abuse is a factor, along with other factors
- In high risk cases the wider human and emotional cost for adult victims in Doncaster could be three times the cost of services

3.3 Where we are now and implications for the future

Progress has been made, but families in Doncaster continue to experience significantly higher levels of domestic abuse compared with neighbouring local authorities and against national figures and benchmarks. Domestic abuse presents at relatively high levels of concern through Children's Social Care, or referral to MARAC as high risk mainly through Police responses.

Headway has been made to identify domestic abuse earlier through the Stronger Families agenda[13] with the expanded criteria which includes domestic abuse as a concern factor for support.

[13] Stronger Families is the Doncaster response to the Government's Troubled Families programme.

We are also seeing signs of early identification through early help assessments logged through the Early Help Hub for families with children. However, this has not yet become routine practice through all services for all people.

Until 2015, most of the service responses to domestic abuse focused on either victims or perpetrators, and not the effect on children and young people in the family. Doncaster Children's Services Trust has secured £3m of DfE Innovation funding (April 2015 to Dec 2016) to address this gap in provision. This project is known as Growing Futures[14] and is developing new therapeutic practice and innovative ways of thinking and working with families alongside mainstream services. We are eager to learn from this work and look to sustain practice where this is shown to work. The aim is to address the long term harm caused by domestic abuse, which can emerge in new relationships and future generations through continued acceptance of *"that's just the way life is".*

Doncaster has also committed to working differently with perpetrators of abuse. Our last strategy introduced our innovative work with perpetrators, from the voluntary Foundation 4 Change Service, to the use of Integrated Offender Management with our highest risk offenders. We are developing this work through our focus on the whole family, and by identifying abusive behaviour earlier we can support people to change before serious harm is done. However, if perpetrators resist support they must face the consequences of their actions.

Our experience in the last two years, through our programme and whole family working show that many abusers have experienced trauma and abuse in their own lives. Therefore punitive actions alone make little difference other than entrench attitudes which continue to present in abusive behaviour in both existing relationships, including transference of behaviours to their children, or in new relationships. Our experience also shows that many families want to stay together but just want the abuse to stop.

For these reasons we are committed to supporting people who are behaving abusively to understand their life experience, appreciate what abusive behaviour is, and how it affects their partner and any children, and to learn how to change their behaviour and live without abuse.

We are committed to equality and diversity and recognise that domestic abuse has specific gender and cultural issues, as well as additional vulnerabilities for people with disabilities, or who are older or younger than the average victim profile. However we need to do more to understand and respond in specific situations, differentiating support for specific needs and circumstances. The attitude towards women and girls generally requires a specific focus and in some cases protection from physical mutilation. In addition gender and traditional roles in some

[14] Growing Futures is a partnership approach lead by Doncaster Children's Services Trust to transform practice with families to reduce emotional harm from domestic abuse and support recovery in the short and long term

communities should not maintain inherent inequality which harbours potential abuse, including forced marriage of either girls or boys.

Much of the national policy and research resonates with the local picture. A strategy to tackle domestic abuse in all its forms therefore requires a whole system and whole place approach through;

- a shared philosophy and common practice through a whole family approach
- Commissioning which requires services to co-operate with a knowledge and understanding of multiple needs and operate in a complex environment.
- direct action with the people who live and work in Doncaster on domestic abuse and on wider issues such as drugs and alcohol misuse; homelessness; anti-social behaviour; active citizenship and community well-being.

4.0 What we want to achieve and how we will do it

Our collective intelligence through national research and policy, local achievements and what we currently know has developed a clear picture of the future and objectives we want to achieve and how we need to work together to deliver them.

As partners it is essential that we share a common purpose and work towards joint outcomes that meet the needs of all victims of domestic abuse, including children and young people who suffer harm due to their experience within their family home.

This strategy sets out our strategic outcomes and outcomes, based on a whole family approach through integrated working. It also challenges us to take a whole place approach to some common issues which continue to inhibit long term and sustained change.

Our approach provides the most effective model of identifying vulnerabilities and supporting adults and children and young people who may have complex needs. We intend to make sure this happens in a safe and coordinated manner with families with both victims and perpetrators.

4.1 Strategic Outcomes and Key Objectives toward 2021

Our outcomes and objectives have been developed taking into consideration the national strategy to end domestic abuse, specifically: Preventing violence and abuse; Provision of services and Pursuing perpetrators[15]. Government's explanation of Partnership Working and our own local aspirations are threaded throughout the strategy to develop a culture of thinking and working differently to fulfil our mutual goals.

[15] Ending Violence against Women and Girls Strategy 2016-2020 (March 2016)

4.1.1 **Outcome 1 -** *Communities and families no longer accept or experience domestic abuse*

Objectives:

- Provide education to children and young people so they know abusive forms of behaviour are not acceptable and they are equipped to make healthier relationship choices in the future
- Increase the visibility and communication of domestic abuse and gender inequality with the public to challenge the social and cultural norms and attitudes that perpetuate acceptance and inequality.
- Influence and support the development of policies and procedures in all workplaces to support organisations to act responsibly for the wellbeing of their employees.
- Equip stakeholders[16] to identify and challenge the acceptance of domestic abuse and violence in families and whole communities.
- Increase confidence amongst victims including children and young people to report incidents of domestic abuse as early as possible and know their voice will be heard and responded to.

4.1.2 **Outcome 2 -** *Families who are vulnerable to or experience domestic abuse are identified earlier and receive effective support to stay safe; reduce repeat victimisation and recover.*

Objectives:

- Identify families vulnerable to domestic abuse or identify actual abuse, assess the level of risk and the impact this has, act swiftly to safeguard and protect all victims.
- Improve the quality and use of data, research and local intelligence across the partnership to inform commissioning and target resources more effectively and efficiently to address levels of need and risk.
- Provide the workforce in contact with those who may be affected by domestic abuse with the knowledge and skills to increase their understanding and identification of risks to respond to individual needs and behaviours within a family.
- Provide a range of services to support the holistic needs and recovery of victims which are appropriate to their age, gender, and ability or other circumstances (e.g. physical, legal, cultural, social, or emotional wellbeing).
- Improve the response to victims from professionals so they are effectively supported and protected from the first time they seek help, extending this to their family to promote resilience and recovery
- Ensure an effective and efficient multi agency response through MARAC for those victims who are at greatest risk and in need of immediate protection, but offers choice to support short and longer term recovery.

4.1.3 **Outcome 3 -** *People who use abusive behaviour are challenged and provided with effective support to change or face the consequences of their actions.*

[16] Stakeholders are defined as any person living or working in Doncaster

Objectives:

- Identify abusers at an earlier stage in their offending behaviour so they understand the consequences of their actions before they come into contact with the criminal justice system and are motivated and supported to change their behaviour
- Utilise the various Criminal and Civil Justice options including new legislation (coercive control) to protect the safety of victims, bring offenders to justice, and protect children and young adults in need of care and protection.
- Build on the Integrated Offender Management Approach and improve working practice between MARAC and MAPPA to manage risk, disrupt offending behaviour and ensure that offenders including serial perpetrators face the consequences of their actions

Our outcomes and objectives are clear with specific actions to address these in the 2016/2017 action plan. This action plan will be reviewed annually along with the performance scorecard to measure progress (Appendix 3).

5.0 Our Finances and Resources

We have a clear understanding of the services we expect to focus on the immediate response to risk from perpetrators and the short and longer term recovery for victims. We also know the universal[17] services that we expect to have awareness of abuse and respond appropriately following assessment.

The first diagram shows the focus of core funded mainstream services, along with other local support when domestic abuse is suspected or identified at whatever level of risk. It should be noted that each service at whatever level will work together as part of a team with the family to address individual needs and behaviours. All services will maintain a focus on the rights of families to access universal services such as schools, health services and community services, while providing any targeted or specialist intervention or support.

The second diagram details additional services which are currently available but have short term funding. The ambition is to move away from short term funding so these additional targeted and specialist services become mainstream.

[17] Universal Services are those who support basic needs or requirements to live a happy, healthy, sociable and prosperous life. They include education, health and community services.

Core funded mainstream services and other local support

Focus and specialism in Domestic Abuse

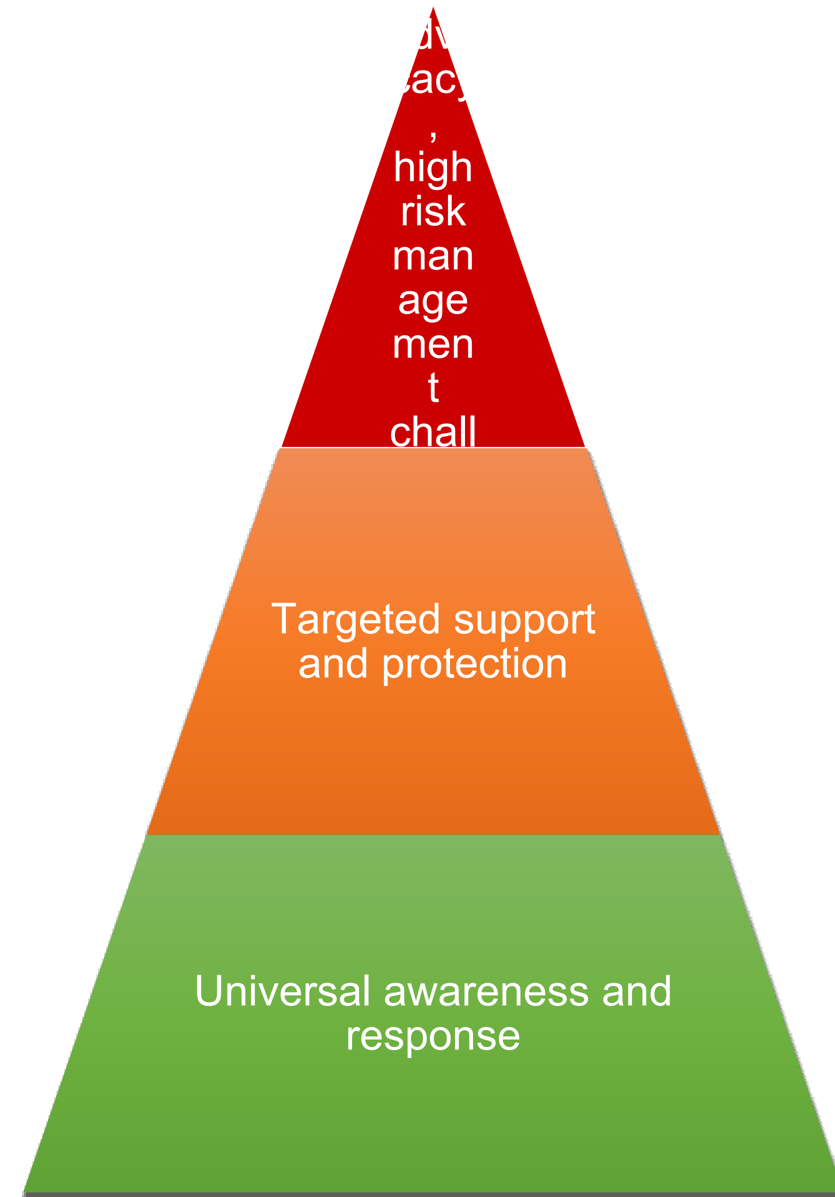
- Strategic Lead and MARAC management
- IDVA core service
- Public Protection Unit (SYP)
- Courts and Crown Prosecution Service
- National Probation Service
- South Yorkshire Community Rehabilitation Company
- Prison Service
- Solicitors and legal services
- Security to homes for Safety (St Leger Homes)

Focus on vulnerability or negative behaviours

- Children's Social Care and Adult Social Care
- Family Support Services
- Acute Health Services
- Adult mental health services and drug and alcohol services
- CAMHS and Project 3 (universal but includes targetted services for young people e.g. substance misuse)
- Special educational needs or disability services
- Youth Offending Service
- CAFCASS
- Local Policing (SYP)

Focus on universal needs

- Midwifery, Health visiting, school nursing, GP's and Dentists
- Nurseries / Schools/ FE colleges and Universities
- Older people support and care providers
- Adult and community education providers
- Community services e.g. libraries, leisure facilities, environmental
- Youth and play providers
- Community Suport Teams
- Families Information Service and IAG services
- Housing providers and local landlords
- General public



Additional Domestic Abuse Services (Individually funded)

Direct work with families Key: W = women; G&B – girls and boys; YP = young people	**Adult victims**	**Perpetrators**	**Children and Young People**
Independent Domestic Violence Advisor additional capacity (DMBC) specialist workers who support 'high risk' victims/survivors of domestic abuse	x		
Domestic Abuse Case Workers (DMBC) supporting medium/standard risk victims. Some work with couples on healthy relationships	x		
Young Persons Violence Adviser (DMBC)	x		x (YP)
Domestic Abuse Navigators (DCST) specialist work with the whole family to support victim and child recovery and challenge perpetrators to support change in behaviour	x	x	x
Refuge and floating Support (Riverside)	x		x
Foundation UK - Custody suite support and Working Towards Change & Foundation for Change programmes		x	
Changing lives (victim programmes)	x (W)		x (G&B)
Specialist Mental Health and Drug and Alcohol Workers (DCST & ADS)	x	x	x
Domestic Abuse help line (Riverside)	x	x	x

In addition there are:

- services which are independently funded and delivered by the voluntary and community sector; private organisations; not for profit organisations and charities
- programmes that have domestic abuse as criteria or focus for support e.g. Stronger Families Programme (funded until 2020 subject to performance)

6.0 Governance and how partners will work together

6.1 Governance of the Strategy

This Strategy is owned by the Safer Stronger Doncaster Partnership (SSDP) on behalf of Team Doncaster. The SSDP Board has the strategic lead for Domestic Abuse, including conducting domestic homicide reviews, MARAC, contracting support services and partnership working at strategic and operational levels, including collaboration with service users.

This Strategy and the annual delivery plans will be led collectively by the Domestic Abuse Chief Officer Group holding lead officers and partner agencies to account for its implementation and for the impact of service delivery (Appendix 4).

The Domestic Abuse Theme Group will be tasked by the Chief Officer Group (COG) to support the delivery of the strategy and to produce bi-monthly performance reports which the COG will monitor and report directly to the SSDP

6.2 Working with other Strategic Boards

The Chief Officer Group do not intend to replicate the work undertaken by other Boards but this strategy does provide the context and approach from which commissioning and service delivery should be driven for Domestic Abuse and where there are multiple needs. This approach supports the priorities of a number of other Strategic Boards with the intention to maximise impact through joint leadership.

Health and Well Being Board	Theme 3 – Area of Focus on Families[18] The Stronger Families Programme is delivered – one of the six eligibility criteria is Domestic Abuse Agencies identify families, assessing them holistically, monitoring progress against identified needs, working with whole families and implementing the 5 family intervention principles through a lead professional model
Children and Families Board	Doncaster Children, Young People & Families Plan 2011 – 2016[19] Outcome 1: Children and young people are healthy and have a sense of wellbeing Outcome 3: Children and young people are free (and feel free) from harm

[18] Doncaster Health and Wellbeing Strategy 2016-2021
[19] Interim Plan 2015 – 2016

Children Safeguarding Board	Strategic Priority 3 Doncaster has effective arrangements for responding to key safeguarding risks.... promoting early identification & support to prevent escalation of risk to keep children safe
Adult Safeguarding Board	Strategic Objective 3[20] Key deliverable 3.1 Develop a Safeguarding Adults Preventative Strategy that outlines Doncaster's approach to preventing adults at risk from abuse
Enterprising Doncaster Board.	Significant impact on business through lost time due to impact of Domestic Abuse (DA). Contributing to changing the culture, getting businesses to adopt a DA policy for their staff. Getting the message out that DA is not acceptable.

At times the Domestic Abuse Chief Officer Group will identify complex problems or poor outcomes within the arena of Domestic Abuse and related issues. Under these circumstances there will be discussion between the Chair/s of relevant Boards to agree how this work will be progressed under a joint agreement. This will be determined by their respective priorities and responsibilities or statutory duties. This may result in joint commissioning arrangements but will be led by one strategic board to avoid confusion or duplication of effort

Bi-monthly performance reports and outcomes of any reviews will also be circulated to other Boards for information and comment and to ensure Domestic Abuse is aligned with any specific priorities and work programmes across Doncaster.

6.3 Individual Partner responsibility and accountability

The SSDP through the Chief Officer Group will provide leadership to improve the outcomes and well-being of adult victims, children and young people affected by domestic abuse; alongside challenging and holding to account perpetrators of abuse.

However, it is the responsibility of individual partners to evidence the work they do to improve performance and measure the impact of their service provision through their own governance or contractual arrangements.

In the majority of circumstances partners are able to achieve this through the intelligence and analysis available through the JSNA and JSIA, in addition to their own service level information to respond to presenting needs.

[20] Doncaster Safeguarding Adults Partnership Board Strategic Objectives 2013-16 – Revised 10.6.14

Individual partners will therefore continue to focus on specific key performance areas for which they are responsible, but agree to work to common objectives and approach through this strategy.

The agreed ways of working and guiding principles to support this work are detailed in section 6.4

6.4 A Common approach and philosophy of practice

In addition to the objectives detailed in section 4.1 is a philosophy of practice and model of working that needs to be embedded across Doncaster for both direct work with families and as a partnership.

6.4.1 Whole Family and Integrated Working

A whole family approach and integrated working provide the most effective model of identifying vulnerabilities and supporting families who need help or protection.

There is strong evidence that practice which promotes a 'think family' approach is effective in promoting health and wellbeing and helps tackle some of the most complex problems in family life. However this includes domestic abuse even if the perpetrator has left the family home, but remains in contact with the victim or children, or moves on to a new relationship and family. This need to be undertaken in a manner that does not escalate risk or collude with perpetrators.

Whole family and integrated working are inextricably linked as one worker[21]; even if they take a holistic view of a family's needs is unlikely to make an impact and sustained improvement if other agencies do not work with them to achieve shared outcomes.

The key ingredients to achieving a successful whole family approach are when services for adults and children, where children are involved, share a common purpose and share information; there are clear lines of accountability but have shared assessments; and multi-agency working takes account of all the family's needs

In addition, tailoring evidence based services to the diverse and different needs of individual family members, with the support from a lead practitioner[22] who builds trust and empowers them to take control provides the best chance of success.

Families should also have multiple access points for help and support and every worker in Doncaster irrespective of which agency or organisation they work for across children's and adults' or services for the community should have the

[21] Workers are defined as any person paid to work with adults or children in any capacity from universal to specialist services. This includes staff from public or private organisations or the VCS.
[22] A Lead Practitioner is any worker from the range of practitioners who are in contact with a family and are best placed to co-ordinate services around a particular child/young person or adults needs.

opportunity to identify and assess the risk of domestic abuse. Doncaster will capitalise on these assets across the partnership to strengthen our joined up support.

6.4.*2 Shared Principles*

The following guiding principles and agreed ways of working have been developed to support a risk led approach and longer term recovery.

1) Listen to the voice of adult victims and child or young person to understand their journey and life experience to engaging them in the design and delivery of services they need.
2) Whole family working through knowledge and understanding of their holistic needs and the community in which they live.
3) Strengths based approach to working with families and communities recognising their skills, knowledge and experience when developing action plans.
4) Early intervention and prevention approaches to working that respond more quickly to risks, vulnerability and prevent escalation
5) Focus and emphasis on reducing the impact of parental / adult vulnerabilities and behaviour to promote better outcomes and safeguard children and young people
6) Involve the workforce and individual workers in understanding needs and issues of working with adult victims, children and young people and perpetrators to inform practice and service delivery
7) Deliver evidence and research based practice that is focused on outcomes and learning from what works including innovative practice.
8) Joint commissioning through pool budgets or shared resources to understand needs, support planning, deliver services and measure impact.

6.5 Partnership response to complex issues, poor outcomes or performance

As a partnership we know that a strong collaborative approach is vital to seeing sustained impact on domestic abuse. We need to understand some problems in more depth and formulate a joint response. Many indicators are linked together and therefore a focus on one alone will have no real impact in the longer term if the root causes are not commonly understood and addressed in combination.

For this reason the Chief Officer Group will concentrate its efforts by identify each year one or two priorities for a 'deep dive' review on which to target its combined resources. This will follow an annual review of the outcomes through the action plan or performance scorecard which could lead to a focus on:

- a specific outcome area; or
- a focus on a combination of indicators, or

- a theme that promotes a culture of working that leads to sustained and consistent practice across a number of organisations

6.5.1 How priorities will be identified for 'Deep Dive' review

It is vital that all partners understand the complexity of some issues and challenges of delivering on some outcomes. It is therefore important that the decision making of any 'deep dive' reviews to address some issues are open and transparent and inclusive of all partners. It is important that the focus is on the issue or poor outcome rather than individual partners and therefore the method and practice should reflect this approach.

Collectively the Chief Officer Group will identify annually one or two key issues that they want to address which could be identified through data or other intelligence. There will be a clear rationale why this is important and what the outcome of the review is seeking to achieve.

Any decision for a deep dive review will take account of, but not be limited to:

- Strategic fit – national, regional or Borough wide
- Impact on the population
- Long term trend or future impact of a poor outcome
- Resource implications
- Agency and named lead

The practice of reviews will take account of the guiding principles and agreed ways of working in Section 6.4.2. A methodology will be agreed appropriate to the type of review. The partnership has used Outcome Based Accountability (OBA) to date where data can be used to project trend.

7.0 How Partners will measure progress and success

The Partnership agrees that tackling Domestic Abuse is a shared priority for all agencies and in order to achieve value for money, it is important that we quality assure the work we do both in terms of the individual service user's experience, but also the overall effectiveness of services. We are innovative in our approach and look forward to the Government's publication of the National Statement of Expectations, against which we can benchmark our provision.

In support of this there are a number of different ways the partnership will measure progress and the impact of the strategy.

7.1 Annual Action Plan

This Strategy has an action plan to progress the objectives and work towards the outcomes detailed in section 4.1. This will be reviewed throughout the year by the Chief Officer Group with an annual report detailing progress and the impact this has made. This annual review will determine the following years plan.

Where there is concern over progress in an area of practice or outcome the partnership may decide on a 'deep dive' review to understand the issue in more detail and help overcome any challenges or barriers identified.

7.2 Progress of Performance Indicators

Annually the partnership will formally review the Performance Scorecard (Appendix 3) to monitor improvement. This review may identify areas where improvement has slowed or the trend causes concern. The partnership will discuss with the lead partner who has responsibility for these specific indicators their plans for improvement with the intention to provide support to change the current or trend position.

It may be that the partnership identifies this area of work for 'Deep Dive' review

7.3 How services work together and have confidence in their work

Section 6.4 identifies how partners will work together and although it is not for the partnership to monitor individual partner's performance beyond agreed scorecard indicators the Chief Officer Group will use some key measures to understand how partners are working together. Initially these will be:

1. An increase in Early Help Assessments and Stronger Families eligibility – use and impact for domestic abuse.
2. Increase in the percentage of referrals to MARAC from other partners using the current baseline of 23%
3. Increase in access and take up of training across partners to work with:
   a) children and young people suffering domestic abuse and
   b) working with perpetrators

The partnership may identify further measures in coming years. Where measures identify concerns for the Chief Officer Group this could lead to a 'Deep Dive' review to support and overcome any challenges that partners face, both individually and collectively.

7.0 Annual Action Plan 2017/2018

Attached as appendicies

9.0 Abbreviations

SYP	South Yorkshire Police
DAC	Domestic Abuse Caseworker
CAMHS	Child and Adolescent Mental Health Services
CAFCASS	Children and Family Court Advisory and Support Service
FE College	Further Educational College
IAG	Information, Advice and Guidance
DMBC	Doncaster Metropolitan Borough Council
DCST	Doncaster Children's Service Trust
ADS	Adult Drug Service
SSDP	Safer Stronger Doncaster Partnership
MARAC	Multi-agency Risk Assessment Conference
IDVA	Independent Domestic Violence Advocate
COG	Chief Officer Group
DA	Domestic Abuse
JSNA	Joint Strategic Needs Assessment
JSIA	Joint Strategic Intelligence Assessment
OBA	Outcome Based Accountability
MASH	Multi-agency Safeguarding Hub
FGM	Female Genital Mutilation
VAWG	Violence Against Women and Girls
DHR	Domestic Homicide Review
NSPCC	National Society for the Protection and Prevention of Cruelty to Children.
KAFKA	Kafka Brigade UK & Ireland Limited
DDAS	Doncaster Drug and Alcohol Services
LGBT	Lesbian, Gay, Bisexual and Transgender
BME	Black and Minority ethnic
DFE	Department of Education

MAPPA	Multi agency Public Protection Arrangement

10.0 Appendices

Appendix 1	References to Research
Appendix 2	What we know about Domestic Abuse locally
Appendix 3	Doncaster Partner Agency Performance Scorecard
Appendix 4	Domestic Abuse Chief Officer Group Members
Appendix 5	Growing Futures cost estimate references

References to Research Appendix 1

- http://www.safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf
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What we know about domestic abuse locally

Appendix 2

1.0 Data and local Intelligence

Currently the information available to the partnership relating to domestic abuse is data from South Yorkshire Police; the Multi Agency Risk Assessment Conferences (MARAC) and Doncaster Children's Services Trust for children known to children's social care. This data is a useful and important baseline for this new strategy which will be used to measure progress over the next 4 years.

1.1 *South Yorkshire Police data*[23]

Police data shows over the last 3 years a flattening trend line (Figure 1). This is in contrast to South Yorkshire region where incidents continue to increase (Figure 2).

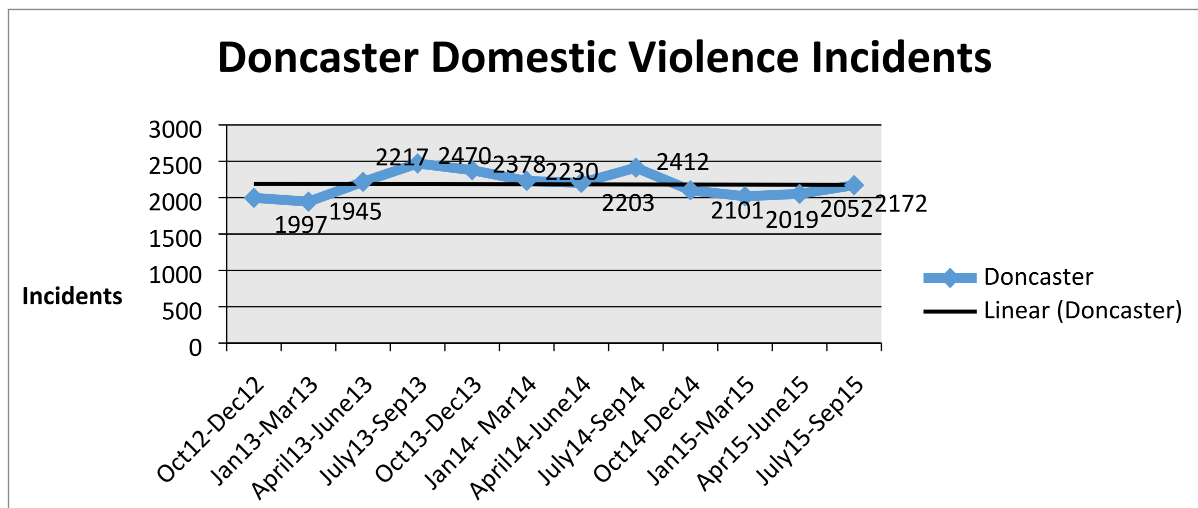


Figure 1

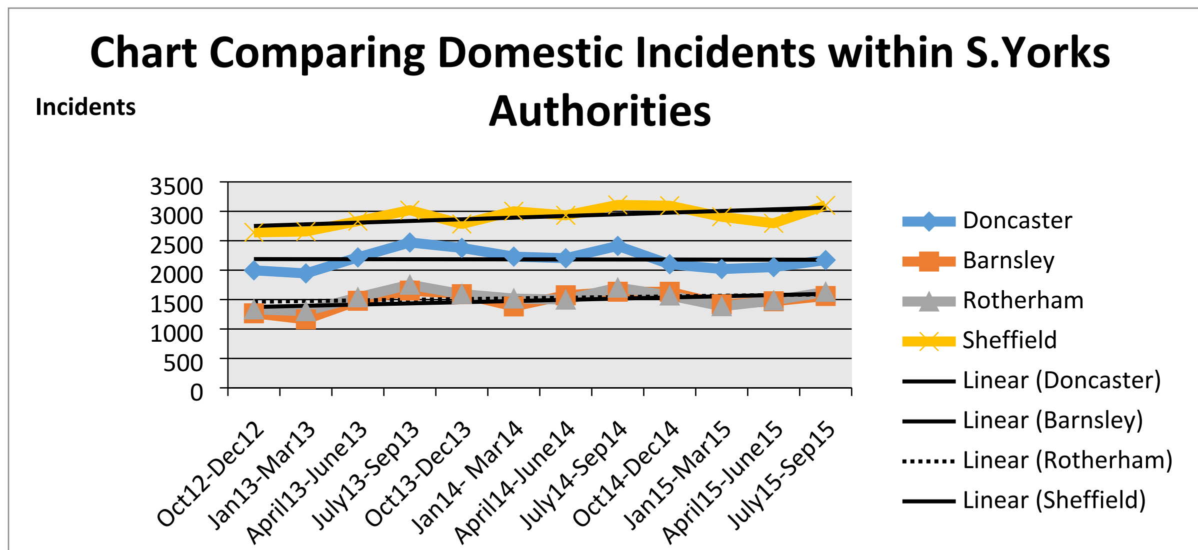


Figure 2

[23] SYP data Oct 2012 to Sept 2015

A review of previous year's data prior to the introduction of new intervention services and practice show a year on year increase in Doncaster with a greater rate of increase than our neighbouring authorities (Figure 3).

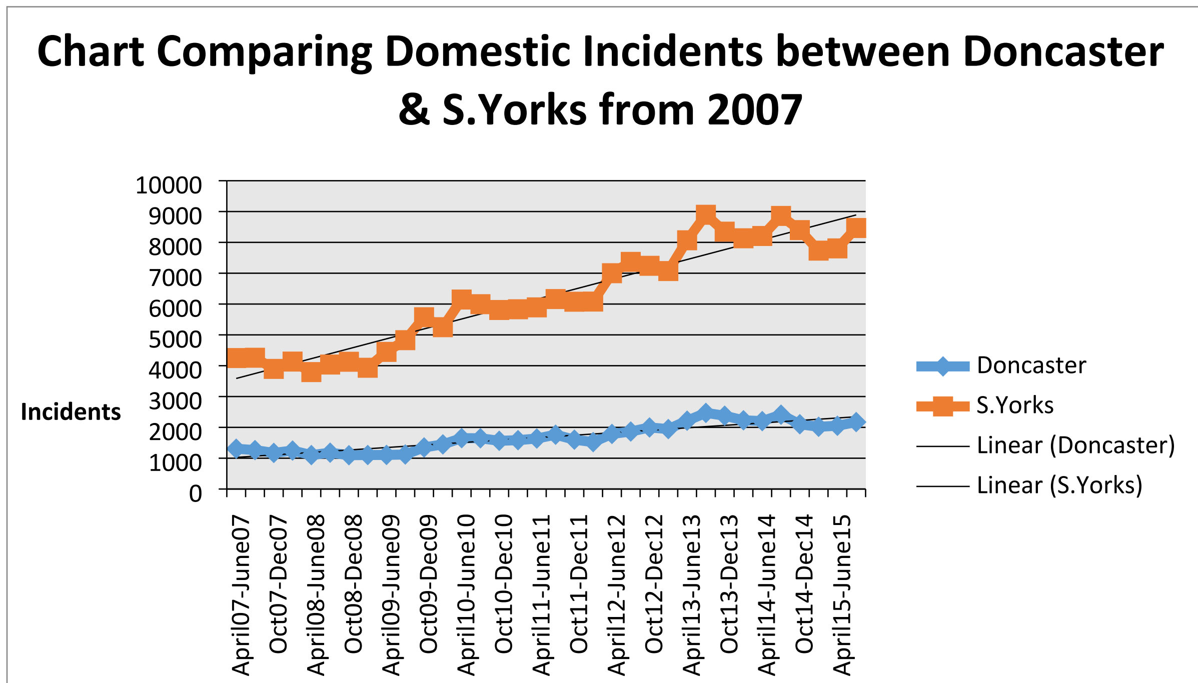


Figure 3

1.2 *Multi Agency Risk Assessment Conferences (MARAC) data*[24]

Analysis of this data in Figure 4 shows:

- The number of cases discussed at MARAC in Doncaster is high with an average 169 more victim cases discussed per annum above the 500 recommended by SafeLives[25]
- This equates to a 3 year average of 54 cases for every 10,000 population against a South Yorkshire Police (SYP) Force area population of 43/10,000; SafeLives recommended 39/10,000 and national average of 30/10,000
- In the cases at discussed the numbers of children in these households peaked in 2014 at 890 from 652 in 2013 and although this has reduced in 2015 remained at over 800 children
- The SafeLives recommended range of repeat cases at MARAC is 28% to 40%. In Doncaster repeat cases are at the top of this range with a 3 year average of 39% against a SYP average of 31% and nationally 25%. In 2015 the repeat cases peaked at 43%.

[24] MARAC data Jan 2013 to Dec 2015
[25] SafeLives are a national charity dedicated to ending domestic abuse

- In the 3 groups identified of victims with protected characteristics[26] (BME; LGBT; Disability), Doncaster's figures are all below the SafeLives recommended; SYP and national levels
- The number of male victims referred to MARAC over the 3 years, is similar to SYP and national figures and was within the lower range of 4% to 10% recommended by SafeLives for 2013 and 2014, although this dropped to 3.80% in 2015.
- Victims aged 16-17 years old referred to MARAC have increased since 2013 from 5 to 8 in 2015 although there was a peak of 19 in 2014

[26] Equality Act 2010

MARAC Data (January 2013 to December 2015)

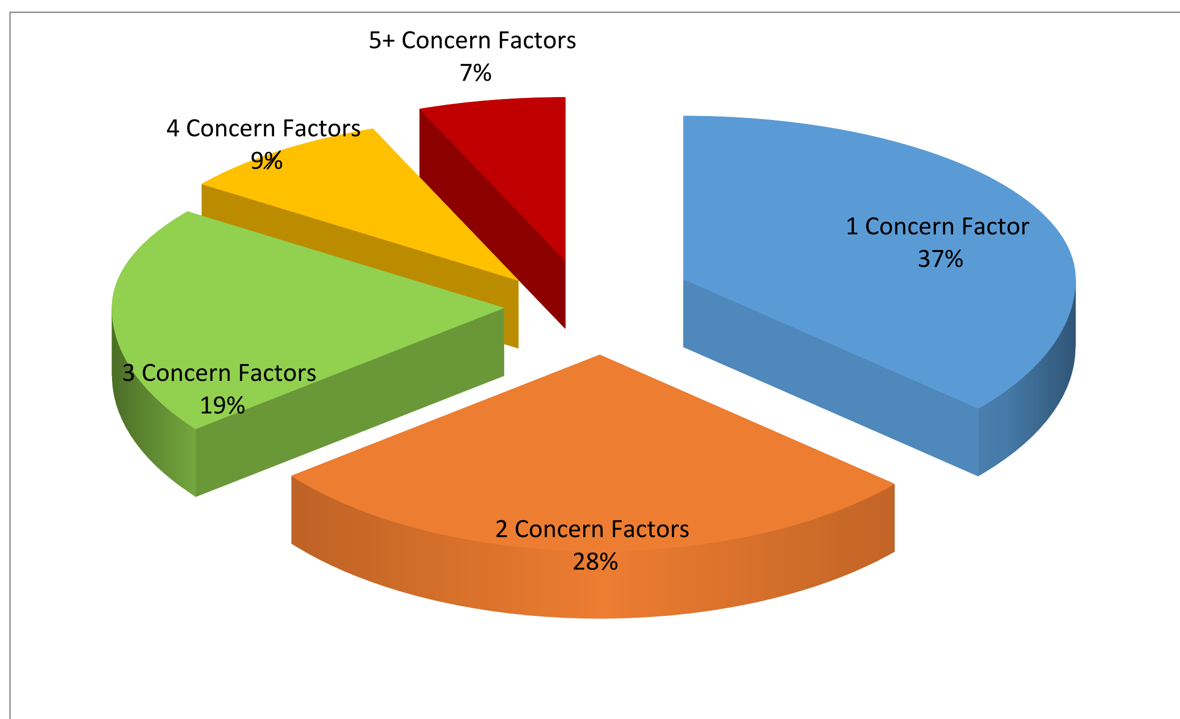
Indicator	National figure 3 year ave.	Most similar force group 3 year ave.	SafeLives recommends	Police force area 3 year ave.	Doncaster			
					3 year ave.	2013	2014	2015
Cases discussed	74045	16572	-	2377	669	631	746	631
Recommended cases	98683	10283	N/A	2240	500	500	500	500
Cases per 10,000 population	30	39	40	43	54	51	60	51
Children in household	94438	22131	N/A	2787	782	652	890	804
Year on year change in cases	12%	6%	N/A	7%	11%	26%	23%	-15%
Repeat cases	25%	27%	28% - 40%	31%	39%	35%	38%	43%
BME	15%	10%	12%	11%	8%	7.60%	6.60%	9.00%
LGBT	1%	1%	5%+	1%	1%	0.60%	1.10%	0.60%
Disability	4%	3%	17%	1%	0%	1.10%	0.30%	0.00%
Males	4%	5%	4% - 10%	4%	5%	5.50%	4.60%	3.80%
Victims aged 16-17	914	277	-	47	11	5	19	8
Cases where victims aged 16-17	1%	2%	-	3%	3%	4.50%	2.60%	1.30%
Police referrals	62%	66%	60% - 75%	66%	82%	84%	86%	77%
Referrals from partner agencies	38%	34%	25% - 40%	34%	18%	16%	14%	23%

Figure 4

1.3 Children's Social Care data[27]

An analysis of assessments carried out by Doncaster Children's Trust presents a picture of the kinds of multiple and complex needs that often accompany each other for families in need of support.

The chart shows the proportion of families with 1 or more concern factor from 4,859 Child and Family Assessments recorded. 40% of these assessments are still open cases within Children's Social Care.



Of all child and family assessments completed (4,859) by Doncaster Children's Services Trust Workers in 2015/16 Parental Domestic Violence was the most frequently recorded concern factor in 39% (1,880) of these. Of these,

- 28% (532) also had a concern factor of parental alcohol misuse
- 31% (592) also had a concern factor of parental mental health
- 25% (471) also had a concern factor of parental drugs misuse
- 2% (30) also had a concern factor of a learning disability

The next most frequent was parental mental health which featured in 22% (1,108) of all initial assessments completed. Of these,

- 50% (555) also had a concern factor of parental domestic violence
- 27% (294) also had a concern factor of parental alcohol misuse
- 27% (294) also had a concern factor of parental drugs misuse
- 5% (51) also had a concern factor of a learning disability

[27] DCST data April 2015 to March 2016

1.4 Doncaster Stronger Families Programme

The Stronger Families Programme has domestic abuse as one of the 6 criteria for eligibility for support. An analysis of services working with these families' shows a much wider range of needs present in the families. Below is a list of additional issues affecting families which need to be planned when responding to need.

- Engagement with universal services
- Emotional Wellbeing
- Housing
- Finance
- Health
- Employment and training
- Parenting ability
- Children's behaviour at home and progress in school or nursery
- Safeguarding

It is clear that families who suffer domestic abuse suffer both in the short and longer term with a number families having multiple factors present which impact on parenting or carer capacity and family functioning.

2.0 Consultation and what people say

2.1 What some adults and children and young people say

A significant part of delivering this strategy is through earlier intervention and supporting the development of healthier relationships for future generations to come. There is currently no significant local data or research to understand what children and young people think is a healthy relationship or their attitude to domestic abuse. The only research available which asks children and young people in Doncaster their opinion is through the health and wellbeing survey[28] which explores their health beliefs and behaviours. Although this is a valuable survey and offers some insight to sexual relationships, conclusions relating to healthy relationships or potentially abusive relationships cannot be drawn

Through the Growing Futures Innovation programme four focus groups were convened by OPCIT Research[29]. Two of these focus groups were with young people to understand their current understanding of domestic abuse. Participants were aware of domestic abuse, with some living in households and experiencing it first-hand. In contract to the 2 adult focus group participants who felt domestic abuse in a relationship was a private matter, young people said that it was unacceptable, although they didn't know what to do about it.

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[28] The Doncaster Children and Young People's Health and Welling survey 2015 (Primary and Secondary age pupil reports)

[29] OPCIT Research are Growing Futures DfE funded external evaluators

In response to young people's OPCIT Research have been commissioned to work with Club Doncaster Foundation to research with young people why domestic abuse is spatially acute in the area and what young people want to do about this. Results from this research will be available in December 2016 and will be used to inform this strategy

2.2 What Domestic Abuse and Family Services say…

In developing this strategy, we have consulted with stakeholders working with adults, children and young people who have been affected by domestic abuse. It is clear they want us to:

- Speed up the identification of domestic abuse and ensure victims and their families receive earlier help
- Provide proactive support to the whole family in the round, not just individual family members in isolation – ensuring that the right intervention from the right professional is available, including perpetrators of abuse.
- Understand and meet the needs of victims of domestic abuse, working towards long term recovery and independence
- Ensure better evaluation of what works to make families safe, and keep them safe
- Listen to victims experiencing abuse, learning from their experiences and capture the full costs of late intervention

3.0 The financial cost of domestic abuse

There is a very real cost which impacts on service providers in terms of the length and intensity of provision required to promote recovery and build resilience where domestic abuse is identified at relatively high levels of risk.

To estimate the costs for Doncaster we have used national figures to calculate the actual and potential implications for partners and families.

Doncaster's Population[30]	***304,185***
• Women and girls age 15 to 59 years	approx. 90,200
• National figures estimate that 30% of women and girls will have experienced an incident of abuse or sexual assault, each year In Doncaster this could be.	27,060
• Estimates for actual domestic abuse[31] based on population figures for each year in Doncaster this could be	9,38 4

[30] ONS estimated residential population mid 2014
[31] http:/crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence072.htm

	Estimated costs[32]	By 2020 estimates (inflation at 2.9% per year BoE)
Victim costs per person (physical and mental health; criminal justice and others incl. Housing, employment and civil legal)[33] • High Risk • Medium and Standard Risk	 £20,000 £13,100	 £22,425 £15,585
MARAC cases (High Risk) 3 year ave. [34] 669@ £20,000 =	£13,380,000	£15,002,325
All other Cases 8,715 @ 13,900 =	£121,138,500	£135,823,275
Children's Social Care costs[35] and numbers of children[36] per category where domestic abuse is a concern factor with other needs:		
Children in Need 329 @ £3,243	£1,066,947	£1,120,294
Child Protection Plan 202 @ £4,270	£862,540	£905,667
Children in Care 93 @ £59,984	£5,578,512	£5,857,437
Total	£7,507,999	£7,883,398

Frequently, victims of domestic abuse who receive support after a number of attempts to access services are likely to display mental health and other complicating factors which impact on their other relationships, including any children in the family. National estimates calculate the human and emotional costs for adult victims to be 3 times the cost of services.

[32] See 'Cost Estimates and references' section for detail
[33] SafeLives Saving Lives, Saving Money – MARAC and high risk domestic abuse,
[34] Doncaster MARAC data Yrs. Jan 13 to Dec 2015
[35] Growing Futures Innovation Bid March 2015 with inflationary increase
[36] DCST March 2016

SAMPLE

Key Measure

Awareness and rate of Domestic Abuse across Doncaster	Lead Agency	Lead Officer	Report Frequency	Target	Target Date	Baseline Source	RAG
Number of professionals accessed Domestic Abuse training	DMBC Community Safety	Sandra Norburn	Quarterly				
Number of professionals accessed Domestic Abuse awareness sessions	DMBC Community Safety	Sandra Norburn	Quarterly				
Number of young people accessed the Domestic Abuse Advocacy Programme	DMBC Community Safety	Sandra Norburn	Quarterly				
Number of children and young people accessed the Domestic Abuse awareness sessions through PSHE	Public Health	Steve Presley	Quarterly				
Number of cases reviewed by MARAC	South Yorkshire Police	Karen Taylor	Quarterly	Reduce to 500		SYP	
Number of children in cases reviewed by MARAC	South Yorkshire Police	Karen Taylor	Quarterly			SYP	
Number of repeat cases reviewed by MARAC	South Yorkshire Police	Karen Taylor	Quarterly	Reduce by 25%, to 236		SYP	
% of repeat cases reviewed by MARAC	South Yorkshire Police	Karen Taylor	Quarterly	Reduce by 25%, to 30%		SYP	
The rate of repeat victimisation of domestic abuse across the borough	South Yorkshire Police	Karen Taylor	Quarterly			SYP	
Number of victims / families in refuge accommodation	Riverside		Quarterly				
Total number of all domestic incidents non-crime and crime	South Yorkshire Police	Karen Taylor	Quarterly			SYP	
% of domestic incidents non-crime & crime where there have been children present	South Yorkshire Police	Karen Taylor	Quarterly			SYP	
Number of domestic incidents non-crime	South Yorkshire Police	Karen Taylor	Quarterly			SYP	
Number of domestic incidents crime	South Yorkshire Police	Karen Taylor	Quarterly			SYP	

Key Measure

MARAC referrals	Lead Agency	Lead Officer	Report Frequency	Target	Target Date	Baseline Source	RAG
MARAC referrals from South Yorkshire Police	South Yorkshire Police	Karen Taylor	Quarterly			SYP	
MARAC referrals from A&E	South Yorkshire Police	Karen Taylor	Quarterly				
MARAC referrals from RDaSH	South Yorkshire Police	Karen Taylor	Quarterly				
MARAC referrals from GP's	South Yorkshire Police	Karen Taylor	Quarterly				
MARAC referrals from Adult Mental Health Service	South Yorkshire Police	Karen Taylor	Quarterly				
MARAC referrals from Housing	South Yorkshire Police	Karen Taylor	Quarterly				
MARAC referrals from Children's Social Care	South Yorkshire Police	Karen Taylor	Quarterly				
MARAC referrals from Community Local Authority Early Help Services including Stronger Families	South Yorkshire Police	Karen Taylor	Quarterly				
MARAC referrals from other agencies	South Yorkshire Police	Karen Taylor	Quarterly			SYP	
Referrals & Domestic Abuse Cases	**Lead Agency**	**Lead Officer**	**Report Frequency**	**Target**	**Target Date**	**Baseline Source**	**RAG**
Number of restraining orders	South Yorkshire Police		Quarterly				
Number of DVPN issued	South Yorkshire Police		Quarterly				
Number of DVPO issued	South Yorkshire Police		Quarterly				
Referrals & Domestic Abuse Cases	**Lead Agency**	**Lead Officer**	**Report Frequency**	**Target**	**Target Date**	**Baseline Source**	**RAG**
Number of referrals received (IDVA'S)	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
% of referrals received with children *(IDVA'S)*	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
% of repeat referrals from previous year *(IDVA'S)*	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
% of repeat referrals received with children *(IDVA'S)*	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
% of 'repeat repeat' referrals (IDVA'S)	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	

	Measure	Owner	Lead	Frequency	Target		Source	Status
	% of 'repeat repeat' referrals received with children (IDVA'S)	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
	Number of referrals received (DAC's)	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
	% of referrals received with children (DAC's)	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
	% of repeat referrals (DAC's)	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
	% of repeat referrals received with children (DAC's)	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
	% of 'repeat repeat' referrals (DAC's)	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
	% of 'repeat repeat' referrals received with children (DAC's)	DMBC Community Safety	Sandra Norburn	Quarterly			DMBC	
	% of referrals in Referral & Response where Domestic Abuse is a factor	Doncaster Children's Services Trust	Claire Harris	Quarterly	Reduce by 30%, to 42%		DCSTLL	
	% of 'repeat' referrals in Referral & Response in the last 12 months	Doncaster Children's Services Trust	Claire Harris	Quarterly	Reduce by 30%, to 21%		DCSTLL	
	% of 'repeat' referrals in Referral & Response in the last 12 months where Domestic Abuse is a factor	Doncaster Children's Services Trust	Claire Harris	Quarterly	Reduce by 30%, to 20.8%		DCSTLL	
	Total Number of Children in Need	Doncaster Children's Services Trust	Claire Harris	Quarterly	Reduce by 135, to 1,219		DCSTLL	
	% of Children in Need where there is a Single Assessment and Domestic Abuse is a factor	Doncaster Children's Services Trust	Claire Harris	Quarterly	Reduce by 10%, to 40.3%		DCSTLL	
	Total Number of Children on Protection Plan	Doncaster Children's Services Trust	Claire Harris	Quarterly			DCSTLL	
	% of Children on Protection where there is a Single Assessment and Domestic Abuse is a factor	Doncaster Children's Services Trust	Claire Harris	Quarterly			DCSTLL	
	Total Number of Children Looked After	Doncaster Children's Services Trust	Claire Harris	Quarterly	Reduce by 5 to 15, to 474 to 484		DCSTLL	
	% of Children Looked After where there is a single assessment and Domestic Abuse is a factor	Doncaster Children's Services Trust	Claire Harris	Quarterly	Reduce by 1% to 3%, to 37.7% to 38.5%		DCSTLL	

% of Children referred to Early Help where Domestic Abuse is a presenting issue	Doncaster Children's Services Trust	Claire Harris	Quarterly			DCST EHM	
Perpetrator Outcomes	**Lead Agency**	**Lead Officer**	**Report Frequency**	**Target**	**Target Date**	**Baseline Source**	**RAG**
Number of restraining orders issued to perpetrators	South Yorkshire Police		Quarterly				
Number of DVPN issued to perpetrators	South Yorkshire Police		Quarterly				
Number of DVPO issued to perpetrators	South Yorkshire Police		Quarterly				
Number of perpetrators referred to 'Foundation for Change' for programme	Foundation for Change	Nikeisha Bragger	Quarterly				
% of repeat referrals referred for 'Foundation for Change' for programme	Foundation for Change	Nikeisha Bragger	Quarterly				
% of referred perpetrators accessing 'Foundation for Change' for programme	Foundation for Change	Nikeisha Bragger	Quarterly				
% of referred perpetrators completed 'Foundation for Change' for programme	Foundation for Change	Nikeisha Bragger	Quarterly				
Number of perpetrators referred to 'Community Rehab Team' for 'Building Better Relationships' programme	Community Rehab Team	Joan Cox	Quarterly				
% of repeat referrals referred for 'Building Better Relationships' programme	Community Rehab Team	Joan Cox	Quarterly				
% of referred perpetrators accessing 'Community Rehab Team' for 'Building Better Relationships' programme	Community Rehab Team	Joan Cox	Quarterly				
% of referred perpetrators completed 'Community Rehab Team' for 'Building Better Relationships' programme	Community Rehab Team	Joan Cox	Quarterly				
Number of perpetrators referred to 'Community Rehab Team' for 'Respectful Relations' programme	Community Rehab Team	Joan Cox	Quarterly				
% of repeat referrals referred for 'Respectful Relationships' programme	Community Rehab Team	Joan Cox	Quarterly				
% of referred perpetrators accessing 'Community Rehab Team' for 'Respectful Relations' programme	Community Rehab Team	Joan Cox	Quarterly				
% of referred perpetrators completed 'Community Rehab Team' for 'Respectful Relations' programme	Community Rehab Team	Joan Cox	Quarterly				
Perpetrator & Victim Profiles	**Lead Agency**	**Lead Officer**	**Report Frequency**	**Target**	**Target Date**	**Baseline Source**	**RAG**

	Indicator	Organisation	Lead	Frequency	Target		Source	RAG
	Number of Perpetrators causing harm aged 17 and below referred to MARAC	South Yorkshire Police	Karen Taylor	Quarterly			SYP	
	% of victims referred to MARAC aged 16-18	South Yorkshire Police	Karen Taylor	Quarterly	Reduce to 2.1%		SYP	
	% of male victims referred to MARAC	South Yorkshire Police	Karen Taylor	Quarterly	Recommendation 4 - 10%		SYP	
	% of BME victims referred to MARAC	South Yorkshire Police	Karen Taylor	Quarterly	Recommendation 12%		SYP	
	% of LGBT victims referred to MARAC	South Yorkshire Police	Karen Taylor	Quarterly	Recommendation 5%+		SYP	
	% of victims with a disability referred to MARAC	South Yorkshire Police	Karen Taylor	Quarterly	Recommendation 17%		SYP	
	% of victims with mental or physical ill health referred to MARAC	South Yorkshire Police		Quarterly				

Domestic Abuse Chief Officer Group Members

Appendix 4

Name	Designation	Agency
Chief Supt Tim Innes	Chair	South Yorkshire Police
Markye Turvey	Deputy Director	Community Rehabilitation Company (CRC)
Andrew Russell	Chief Nurse	Doncaster CCG
Helen Conroy	Head of Service	Public Health
Suzannah Cookson	Head of Quality and Designated Nurse for Safeguarding and LAC	Doncaster CCG
Sarah Sansoa	Commissioning Manager	DMBC Commissioning
Karen Johnson	Assistant Director	DMBC Communities
Bill Hotchkiss	Head of Service	DMBC Community Safety
Sandra Norburn	Dom and Sexual Abuse Theme Lead	DMBC Community Safety
Sarah Mainwaring	Head of Probation	National Probation Service (NPS)
Jackie Wilson	Director of Quality Performance and Innovation	Doncaster Children's Services Trust (DCST)
Phil Hayden	Programme Manager Growing Futures	Doncaster Children's Services Trust (DCST)
Riana Nelson	Assistant Director	DMBC Children's Commissioning

Growing Futures Cost estimate references Appendix 5

1. £2,832 (2010) or **£3,243** (2014) [3.4% average inflation per year over the period] (Holmes L, McDermid S, Soper J, Sempik J and Ward H, (2010*) 'Extension of the cost calculator to include cost calculations for all children in need'*, Centre for Child and Family Research (CCFR), Loughborough University)

2. £3,728 (2010) or **£4,270** (2014) [3.4% average inflation per year over the period] (Holmes L, McDermid S, Soper J, Sempik J and Ward H, (2010*) 'Extension of the cost calculator to include cost calculations for all children in need'*, Centre for Child and Family Research (CCFR), Loughborough University)

3. £36,524 (13/14 Children's Services Estimates England, Chartered Institute of Public Finance and Accounting). These costs can often be much higher e.g. a standard residential placement costs £2,100 - £4,450 p.w. or £109,200 - £231,400 p.a. in Doncaster the actual cost is **£59,984**

4. *SFR36_2013_LA Tables*

5. Berridge D., Biehal N., Henry L.(2012) *Living in Children's residential homes*, DfE

6. *Children's Homes data pack* (2014), DfE

7. Walby S (2009), *'The Cost of Domestic Violence: Up-date 2009'* Lancaster University)

8. SafeLives Saving Lives, Saving Money – MARAC and high risk domestic abuse 2015 http://www.caada.org.uk/policy-evidence/policy-and-research-library

9. Smith, K., Osborne, S., Lau, I., & Britton, A. (2012). *Homicides, firearm offences and intimate partner violence 2010/ 2011: Supplementary volume 2 to Crime in England and Wales.* London.)

10. Bank of England Inflation Calculator is used throughout the report to adjust costs for inflation.

Domestic Abuse Strategy Annual Action Plan 2017/2018

RAG Rating Guide

Red	Action date passed and not complete, or Action not expected to be complete in time with significant impact on the work
Amber	Action not started but in timescale, or Slow progress with some impact on the work but expected to be complete within timescale.
Green	Action complete, or Action expected to be complete within timescale with no adverse impact on the work

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Overview of Strategic Outcomes and Key Objectives

Outcome 1:	**Communities and families no longer accept or experience domestic abuse**	**Principle Lead from COG**
1.1	Provide education to children and young people so they know abusive forms of behaviour are not acceptable and they are equipped to make healthier relationship choices in the future	Bill Hotchkiss Doncaster Metropolitan Borough Council
1.2	Increase the visibility and communication of domestic abuse and gender inequality with the public to challenge the social and cultural norms and attitudes that perpetuate acceptance and inequality .	
1.3	Influence and support the development of policies and procedures in all workplaces to support organisations to act responsibly for the wellbeing of their employees.	
1.4	Equip stakeholders[1] to identify and challenge the acceptance of domestic abuse and violence in families and whole communities.	
1.5	Increase confidence amongst victims including children and young people to report incidents of domestic abuse as early as possible and know their voice will be heard and responded to.	

Outcome 2:	**Families who are vulnerable to or experience domestic abuse are identified earlier and receive effective support to stay safe; reduce repeat victimisation and recover**	**Principle Lead from COG**
2.1	Identify families vulnerable to domestic abuse or identify actual abuse, assess the level of risk and the impact this has, act swiftly to safeguard and protect all victims.	Jackie Wilson Doncaster Children's Services Trust
2.2	Improve the quality and use of data, research and local intelligence across the partnership to inform commissioning and target resources more effectively and efficiently to address levels of need and risk.	
2.3	Provide the workforce in contact with those who may be affected by domestic abuse with the knowledge and skills to increase their understanding and identification of risks to respond to individual needs and behaviours within a family.	
2.4	Provide a range of services to support the holistic needs and recovery of victims which are appropriate to their age, gender, and ability or other circumstances (e.g. physical, legal, cultural, social, or emotional wellbeing).	
2.5	Improve the response to victims from professionals so they are effectively supported and protected from the first time they seek help, extending this to their family to promote resilience and recovery	
2.6	Ensure an effective and efficient multi agency response through MARAC for those victims who are at greatest risk and in need of immediate protection, but offers choice to support short and longer term recovery.	

Outcome 3:	**People who use abusive behaviour are challenged and provided with effective support to change.**	**Principle Lead from COG**
3.1	Identify abusers at an earlier stage in their offending behaviour so they understand the consequences of their actions before they come into contact with the criminal justice system and are motivated and supported to change their behaviour	Nat Shaw South Yorkshire Police
3.2	Utilise the various Criminal and Civil Justice options including new legislation (coercive control) to protect the safety of victims, bring offenders to justice, and protect children and young adults in need of care and protection.	
3.3	Build on the Integrated Offender Management Approach and improve working practice between MARAC and MAPPA to manage risk, disrupt offending behaviour and ensure that offenders including serial perpetrators face the consequences of their actions	

[1] Stakeholders are defined as any person living or working in Doncaster

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1.1	*Provide education to children and young people so they know abusive forms of behaviour are not acceptable and they are equipped to make healthier relationship choices in the future*

EXPECTED OUTCOMES FROM ACTIONS

- **Attitudinal and behavioural changes in children and young people with reduced abusive activity**
- **Schools and colleges use PSHE to promote positive relationship to children and young people**
- **Young people aged 13+ access specialist support when they experience abuse in their intimate relationships**
- **Communities are supported to challenge the cultural acceptance of domestic abuse**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
1.1.1	Produce toolkit for staff in schools, colleges, youth centres etc. to use to teach about healthy relationships	Liz Close Jayne Vose	Jan 2017	Toolkit developed and disseminated for use Delivery of sessions in schools and colleges Design format for feedback and evaluation of sessions Review delivery	Records of delivery and feedback from schools	**COMPLETED**	
1.1.2	Deliver awareness sessions for the services into schools Provide specialist support for young people 13+ experiencing relationship abuse (YPVA) and.	Sandra Norburn	From May 2016	Programme of awareness sessions planned and delivered to range of secondary schools Records of YP 13-19 receiving support from YPVA /IDVA	Feedback from students and teachers Number and proportional increase from Safelives baseline of YP supported Client satisfaction surveys		
1.1.3	Deliver the Getting On Programme to tackle Teen to Parent abuse	Cherryl Henry-Leach	From May 2016	Delivery of programme to further cohorts.	Numbers and Evaluations from participants		
1.1.4	Investigate possible development of mobile phone app to track behaviour based on content of Getting On, for families to self-monitor behaviour	Julie Grant	From June 2016	Feasibility work - completed Funding stream identified Procurement of app provider App developed and launched, accessed by Public	Number of downloads Tracking of app usage User feedback		
1.1.5	Involve young people in the development of local bystander programmes in colleges	Amy Booth Sandra Norburn Liz Close Doncaster College Doncaster	Jan 2017	Establishment of MA task and finish group to develop project plan	???		

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		Foundation Cherryl Henry-Leach					
1.1.6	Involve adults in the local bystander programmes in the community	TBC	April 2017	Establishment of MA task and finish group to develop project plan			

1.2	***Increase the visibility and communication of domestic abuse and gender inequality with the public to challenge the social and cultural norms and attitudes that perpetuate acceptance and inequality.***

EXPECTED OUTCOMES FROM ACTIONS

- **Increase in members of public accessing promotional and awareness activity**
- **Increase awareness of what domestic abuse is and support available**
- **Increased requests for service provision and support**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
1.2.1	Develop a communications strategy that keeps domestic abuse in the public arena and gives clear messages that Doncaster will not tolerate domestic abuse and that our residents can live safe and happy lives free from abuse	TBC	Jan 2017	Comms officer resource agreed Comms strategy agreed Comms evaluation and impact measures developed	Report on activity and feedback		
1.2.2	Raise awareness of domestic abuse across Doncaster - fully utilise social media as well as traditional media channels, and targeted messages to specific groups at specific times of the year so they are relevant to those receiving them.	TBC	2016-17	Routinely questioning of all people contacting support services where they heard about the service Collate answers to identify successful media channels Align with YPVA activity	Feedback and evaluation of delivered targeted campaigns		
1.2.3	Identify a key DA champion and also engage and upskill our Elected Members who are the eyes and ears of residents in the community, so that our key messages are reinforced on the ground.	Bill Hotchkiss	Jan 2017	Key DA champion confirmed Arrange and deliver annual domestic abuse seminars for elected members Elected members complete E Learning	Feedback and evaluation of delivered targeted campaigns Report on numbers of elected members who have completed training		
1.2.4	Fully utilise community networks and wider services (e.g. licenced premises, gyms, pharmacies, GP Practices, Community Centres, etc.) and businesses to proactively work with us and promote our messages about	Liz Close Pat Hagan	Jan 2017	Work with community based team to arrange promotional activity.	Feedback and evaluation of delivered activity As part of comms strategy all activity to be monitored and		

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	healthy relationships				evaluated		

1.3	***Influence and support the development of policies and procedures in all workplaces to support organisations to act responsibly for the wellbeing of their employees.***

EXPECTED OUTCOMES FROM ACTIONS

- **Increase in employers recognising that domestic abuse is an issue that affects their business delivery and is an occupational health issue for their workforce**
- **All local employers adopt a domestic abuse HR policy or, where they are a small employer, adopt best practice principles to support their workforce**
- **More employees accessing support through their employment**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
1.3.1	Promote model DA policy for employers to adopt, targeting large and public sector employers in year 1.	Lead officer to be identified from Enterprise Doncaster	By Sept 2017	All SSDP Partners agencies adopt DA policy for staff	Develop simple evaluation process for employers to monitor impact of policy on their staff		
1.3.2	Engage with large private sector employers to adopt DA policy in year 2	Lead officer to be identified from Enterprise Doncaster	By Sept 2018	Employers adopt policy on DA	As above		
1.3.3	Engage with Business Doncaster and Chamber of Commerce to promote adoption of DA policy by other employers – year 3	Lead officer to be identified from Enterprise Doncaster Chamber of Commerce	By Sept 2018	Employers adopt policy on DA Employers approach CSP for advice and support to improve their support to workforce	As Above		
1.3.4	Commissioners and contracting services across the Partnership to require provider organisations to have employee DA policies and to train their staff appropriately	TBC	Feb 2017				

1.4	***Equip stakeholders[2] to identify and challenge the acceptance of domestic abuse and violence in families and whole communities.***

EXPECTED OUTCOMES FROM ACTIONS

- **Increased stake holder confidence in their ability to challenge acceptance of domestic abuse**
- **Reduction of tolerance of domestic abuse in families and communities**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
1.4.1	Deliver targeted multi agency training on Challenging Abusive Behaviour on rolling programme from April 2016	Sandra Norburn	From April 2016	Training sessions delivered	Number of delegates trained Evaluation averages		

[2] Stakeholders are defined as any person living or working in Doncaster

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					Survey of delegates re impact on practice		
1.4.2	Develop other training products, including E Learning, to ensure key messages are widely promoted.	Sandra Norburn	By Feb 2017	Refreshed workforce development plan in place	Number of delegates trained Evaluation averages Survey of delegates re impact on practice		
1.4.3	Utilise new technology, including the new website and possible mobile app to make information easily accessible	Sandra Norburn	By Jan 2017	Copy produced for website	Hits on website and downloads of app. Service user feedback Staff feedback		

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1.5	***Increase confidence amongst victims including children and young people to report incidents of domestic abuse as early as possible and know their voice will be heard and responded to.***

EXPECTED OUTCOMES FROM ACTIONS

- **Increased awareness of what domestic abuse is and support available**
- **Increased requests for service provision and support**
- **Increased customer satisfaction with support received**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
1.5.1	Capture the views of service users to inform commissioning and service development.	Matt Cridge	By Jan 2017	Standard system for gathering service user feedback across agencies developed	Feedback collated for outcomes measurement		
1.5.3	Engage with non-abusive men by implementing the White Ribbon Campaign Local Authority Accreditation Action Plan.	Sandra Norburn	From Sept 2016	White Ribbon Accreditation achieved			
1.5.4	Ensure support services are accessible to anyone affected, including men, people from minority groups and those with protected characteristics under the Equality Act.	Catherine Needham	By Jan 2017	Due Regard Statement completed and aligned with comms activity Through task and finish group, undertake review of support services and develop equality action plan to ensure compliance with Equalities Duty	**action completed**		**Green**

2.1	***Identify families vulnerable to domestic abuse or identify actual abuse, assess the level of risk and the impact this has, act swiftly to safeguard and protect all victims.***

EXPECTED OUTCOMES FROM ACTIONS

- **Increased awareness of what domestic abuse is and support available**
- **Increased requests for service provision and support**
- **Earlier intervention in cases of domestic abuse and intimate partner abuse for young people that is risk led but aligns with vulnerability**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
2.1.1	Staff in all agencies trained to Ask, Assess and Act on domestic abuse as appropriate to their level of responsibility and role.	Sandra Norburn	End Jan 2017	Partnership Competency Framework on DA agreed Reporting process agreed for agencies.	Staff Trained Evaluation scores Evidence of learning from PDR/1:1 processes.		
2.1.2	Relevant workers in all agencies trained to Risk Assess using DASH RA tool and Young Persons Risk Assessment	Sandra Norburn Cherryl Henry-Leach	Jan 2017	All relevant workers (identified in Comp framework) have been trained to risk assess using DASH Develop and deliver training session regarding YP intimate partner abuse	Training records Referrals to MARAC Training records Referrals to MARAC		
2.1.3	Develop and promote the referral pathway to the YPVA to ensure intimate partner abuse between 13 - 18 is identified and response risk led and aligns with child safeguarding activity	YPVA/Sandra Norburn/ DCST	Sept 2017	Networker events held with all service providers who come into contact with young people aged 13 – 24	Increased referrals to MARAC where CYP is 16/17		
2.1.4	Review support offered to CYP where intimate partner abuse is identified aligns MARAC process with safeguarding processes	Sandra Norburn/Cherryl Henry-Leach/LSCB	Feb 2017	Referral pathway clarified and disseminated	Increased multi agency meetings for 13 – 18 year olds		
2.1.5	Develop joint protocol between, CSP, safeguarding adults and DCST to ensure funding for families without recourse who are experiencing DVA, inc forced marriages and “honour” abuse in line with statutory guidance	CSP/Adult safeguarding/ Cherryl Henry-Leach	Feb 2017	Joint protocol developed and disseminated Joint funding of cases until UKBA confirm benefits have been fast tracked HR assessments will be informed by other assessments (i.e. DASH, s17 and s47)	Increased service user satisfaction Increased referrals to UKBA Increased numbers of HR assessments where DVA is a feature		
2.1.6	Develop existing training so CCB is reflected within the training and that, in line with care act 2014, impact of CCB on mental capacity is recognised, identified and aligns with DVA pathways	CSP/Adult safeguarding	Feb 2017	Workforce equipped to recognise CCB and responds appropriately with DVA aligned with safeguarding of vulnerable adults	Increased referrals to DA support inc MARAC/IDVA Increased adult safeguarding activity where		

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					DVA is a feature for vulnerable adults defined by Care Act		
2.1.7	Develop a multi agency standard assessment process to address risk and the wider needs of the family through the adoption of Signs of Safety.	DCST	Jan 2017	New assessment tool agreed.			
2.1.8	Develop our collective understanding of protection powers through training so that they are used wherever possible to contribute to the safety of victims and children	DCST	Jan 2017	Review use of protection powers in various agencies and monitor use and effectiveness			

2.2	***Improve the quality and use of data, research and local intelligence across the partnership to inform commissioning and target resources more effectively and efficiently to address levels of need and risk.***

EXPECTED OUTCOMES FROM ACTIONS

- **Commissioning activity is strategically informed**
- **Commissioning activity is jointly resourced**
- **Service provision responds to data trends, emerging best practice and DHR/SCR findings both locally and nationally whilst reflecting whole family, strengths based approach to domestic abuse**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
2.2.1	Work with partners to bring data together to identify extent of DVA and service user satisfaction	COG	June 2017	Performance analyst identified Improved quality and range of performance data Development of victim satisfaction multi agency data base Accurate problem profile of domestic abuse developed and disseminated Victim satisfaction profile developed and disseminated			
2.2.2	Transfer Doncaster Council DA service to Eclipse system to improve reporting, and efficiency, and facilitate information sharing	Sandra Norburn	Jan 2017	Reports to SSDP & COG using new dataset and Performance framework			
2.2.3	Develop standard report format bringing together quantitative and qualitative datasets. Reports to be presented to DA Theme Group and highlights/exceptions reported to COG/SSDP		Feb 2017	Commissioning activity informed by both data trends and evidence of successes and need, as well as learning from formal reviews such as DHRs /SCRs Impact of changes in			

				practice following DHR action plans implementation.			
2.2.4	Adopt as appropriate, the findings of our external evaluation of our local voluntary perpetrator programme, provided by Foundation 4 change, which is being undertaken by Sheffield School of Health and Related Research, in addition to recent national research undertaken through the Mirabelle Project.	Commissioners	Jan 2017 March 2017	Draft Evaluation report completed Re-commissioning exercise completed			
2.2.5	Review our indicators so our Outcome Based Accountability (OBA) methodology reflects the work being undertaken DVA features in our Health and Well Being strategy	Sandra Norburn	Jan 2017	Outcome Based Accountability (OBA) methodology reflects the work being undertaken DVA features in our Health and Well Being strategy			
2.2.6	Adopt as appropriate, the findings of our external evaluation of Growing Futures programme being undertaken by UCLAN and Opicit	DCST	Jan 2017	Whole Family approach for DVA embedded as local philosophy of practice			
2..2.7	(Re) Commission services with contracts of up to five years		Jan 2017 March 2017	Commissioning plan agreed Tendering process commenced	Progress tracked through Workforce development plan		
2.4.5	Invest in early intervention as well as crisis response in order to identify domestic abuse as early as possible, and provide effective early intervention to minimise harm, prevent escalation and safeguard our most vulnerable	DCST	Feb 2017	Commissioning plan for specialist services agreed which provides balance across the risk levels. Universal services ensuring early intervention.			

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2.3 ***Provide the workforce in contact with those who may be affected by domestic abuse with the knowledge and skills to increase their understanding and identification of risks to respond to individual needs and behaviours within a family.***

EXPECTED OUTCOMES FROM ACTIONS

- **Domestic abuse is responded to from first point of contact with victim or as soon as it is identified as a feature in the case**
- **Reduction, in the long term, reduction in crisis intervention in high risk situations, and an increase in earlier intervention**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
2.3.1	QA current DVA training to be sure that CCB and needs of workforce are embedded	TBC	Feb 2017	Increased and consistent awareness of CCB across multi agency workforce			
2.3.2	Offer a progressive programme of skills based training and	Sandra Norburn	Jan 2017	New Training and Development plan agreed	Report against Workforce development		

	development opportunities for all staff working with families who may be affected by domestic abuse	Phil Hayden Cherryl Henry-Leach Shabnim Ali	Jan 2017 Jan 2017	Early Help Service equiped and responding to DVA in line with best practice DVA linked in to adults workforce dev plan	strategy.		
2.3.3	In line with the Care Act 2014 make use of legislation to ensure effective safeguarding whilst holding perpetrators to account		Jan 2017				
2.3.4	Utilise the various Criminal and Civil Justice options including new legislation (coercive control) to protect the safety of victims, bring offenders to justice, and protect children and young adults in need of care and protection.		Jan 2017				

2.4	***Provide a range of services to support the holistic needs and recovery of victims which are appropriate to their age, gender, and ability or other circumstances (e.g. physical, legal, cultural, social, or emotional wellbeing).***						
EXPECTED OUTCOMES FROM ACTIONS							
• **Mainstreamed service provision that is not short term, ring fenced and/or time limited** • **All services promote whole family working approaches to domestic abuse** • **The Partnership's workforce is skilled and confident to provide holistic support to victims of domestic abuse** • **Victims of domestic abuse can access a range of support options that will increase their resilience and empowerment over time**							
Action No.	**Key Action**	**Lead Officer**	**Timescale**	**Milestones**	**Measure(s)**	**Quarterly Progress Update**	**RAG Rating**
2.4.1	Undertake an audit of all domestic abuse and family support provision to avoid duplication of service provision	Phil Hayden DCST	Audit completed	April 2016	Using OBA methodology for all services we will monitor agreed indicators and report to SSDP/COG on outcomes		
2.4.2	Agree a pooled budget across the partnership for provision of appropriate support services to meet the needs of all victims of domestic abuse, their children and the perpetrators	Jackie Wilson Phil Hayden Bill Hotchkiss	Jan 2017 (urgent as current funding streams expiring)	Pooled budget agreed and funding plan in place			
2.4.3	Mainstream specialist services that demonstrate evidence of success		Jan 2017	Specialist services are mainstreamed DMBC DA Service achieved leading lights accreditation			
2.4.4	Provide targeted support to children and young people, which	Liz Close		Education toolkit project completed			

	is sensitive and appropriate to their needs that links to the current Growing Futures activity	DCST	Jan 2017	DANs mainstreamed Refocus of Family Support Services			
2.4.5	Develop and provide talking therapies to support all adult victims regardless of gender, that links with mental health and substance misuse		Jan 2017	Commissioned services providing therapeutic support to adult victims Victims of domestic abuse reducing dependence of substances, including alcohol	Progress tracked through workforce development plan Outcomes star measures Service user feedback		
2.4.6	Provide a range of 1-1 interventions and group work programmes that promote and sustain effective change	Changing Lives	Jan 2017	Caseload of young people Reports from YPVA to DA theme group			
2.4.7	Develop the "Getting On" programme so that all parents living with teen to parent abuse can access support and young people being abusive can address their behaviour.	DCST	Jan 2017		Rolling programme of delivery in place.		

2.5	***Improve the response to victims from professionals so they are effectively supported and protected from the first time they seek help, extending this to their family to promote resilience and recovery***

EXPECTED OUTCOMES FROM ACTIONS

- **All vulnerable adults an CYP in need of protection are supported and safeguarded from the first point of them accessing help**
- **Increase in victims reporting DVA**
- **Increased victim confidence and resilience**
- **Increased victim satisfaction with support received**
- **Reduction of repeat victims (in the long term)**
- **Civil Justice options are fully utilised**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
2.5.1	Getting it right first time, ensuring accessibility of service, regardless of risk level, for all victims through provision of high quality helpline service supported by effective triage.	Sandra Norburn Cherryl Henry-Leach	Jan 2017	Case pathways reviewed Referral routes promote seamless service provision			
2.5.2	All IDVAs receive MacKenzie friend training	Sandra Norburn	Jan 2017	Victims not eligible for Civil Funding supported to obtain Civil Court orders (e.g. NMOs)	Number of cases supported through court process		
2.5.3	Pilot a Housing Officer within the Domestic Abuse Hub, who can provide immediate advice and support in relation to housing issues to both service users and staff of the police and IDVA service	St Leger Homes	Sept 2016	Housing officer collocated in DA hub.		**COMPLETED**	
2.5.4	Continue development of getting on so that a referral pathway for teen to parent	Cherryl Henry-Leach Emma Palframan/YOS	Sept 2016	Suitability criteria for "Getting On" developed that identifies risk level	Increase in appropriate referrals to "Getting On"	**COMPLETED**	

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	abuse is developed and support available to both parent and abusive teen whilst waiting for allocation on "Getting On"			at point of referral to programme and at commencement of programme and support required through pre-course activity Risk reduction recorded when families commence "Getting On" "Getting On Program developed to support girls who abusing their parents	Risk Assessment and MARAC data Increase in girls supported through program		
2.5.5	Improve responses where domestic abuse is a feature along- side no recourse to public funding	Cherryl Henry-Leach Sandra Norburn Amanda Hannigan Pauline Turner	Jan 2017	Develop local pathway and joint funding agreement where adults and children are included, so HRA assessment aligns with and is informed by with all other assessments required Disseminate pathway to local partnership	Number of cases supported		
2.5.6	Provide a whole age approach to victims of domestic abuse that recognises and appropriately responds to the impacts of coercive control in line with the Care Act 2014	Amanda Hannigan	Jan 2017	Increased numbers of referrals to adult social care progressed to strategy and investigation	Number of strategy meetings		

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2.6	***Ensure an effective and efficient multi agency response through MARAC for those victims who are at greatest risk and in need of immediate protection, but offers choice to support short and longer term recovery.***

EXPECTED OUTCOMES FROM ACTIONS

- **Robust and proactive MARAC provision to victims facing the highest risk of harm**
- **Reduction in domestic homicide**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
2.6.1	MARAC Accreditation process	Sandra Norburn	Jan 2017	Accreditation process successfully completed	Accreditation awarded	**COMPLETED**	
2.6.2	IDVA service – Leading lights accredited	Sandra Norburn	Jan 2017	Accreditation process successfully completed	Accreditation awarded	**COMPLETED**	
2.6.3	Undertake review of Repeat cases at MARAC to ensure effective risk management	Sandra Norburn	July 2016	Review completed	Report to DA Theme group and COG of results of review.	**COMPLETED**	
2.6.4	Continue to provide an effective Multi Agency Risk Assessment Conference for the highest risk cases and to provide specialist	Sandra Norburn SYP	Jan 2017	Ensure risk assessment processes are consistent across agencies	Report to DA Theme group and COG results of		

	support to victims combined with robust offender management	MARAC Coord		Dip sampling of MARAC referrals and address any inconsistency Monitor MARAC referrals Annual review of repeat MARAC cases undertaken MARAC hearing appropriate cases	reviews.		

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3.1	Identify abusers at an earlier stage in their offending behaviour so they understand the consequences of their actions before they come into contact with the criminal justice system

EXPECTED OUTCOMES FROM ACTIONS

- **Identify abusers at an earlier stage in their offending behaviour so they understand the consequences of their actions before they come into contact with the criminal justice system**
- **Provide a range of 1-1 interventions and group work programmes that promote and sustain effective change**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
3.1.1	Provide support and encourage motivation for perpetrators to change their behaviour from an earlier stage in their offending activity – where possible, before they come into contact with criminal justice agencies.	F4C/SYP	Jan 2017	Increased SYP referrals to F4C	Reports through commissioning activity		
3.1.2	Continue to offer the opportunity for perpetrators to receive support to recognise that they are behaving abusively	Bill Hotchkiss	Jan 2017	Perpetrator support continued beyond Dec 2016 (and mainstreamed in longer term)			
3.1.3	Provide a range of 1-1 interventions and group work programmes that promote and sustain effective change	CSP/NPS/CRC	Jan 2017	Wider range of interventions available to perpetrators			

3.2	Utilise the various Criminal and Civil Justice options including new legislation (coercive control) to protect the safety of victims, bring offenders to justice, and protect children and young adults in need of care and protection.

EXPECTED OUTCOMES FROM ACTIONS

- **Utilise the various Criminal and Civil Justice options including new legislation (coercive control) to protect the safety of victims, bring offenders to justice, and protect children and young adults in need of care**
- **Where possible, offenders are brought to justice, with offending activity disrupted/monitored**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
3.2.1	Improve information pathways between MARAC and MAPPA and develop local protocol based on MAPPA guidance, improve working practice between MARAC and MAPPA so risk is managed and perpetrators held to account	DI Hockley Sandra Norburn	Feb 2017	License conditions address concerns shared by MARAC			
3.2.2	Identify serial perpetrators of DVA and disrupt their offending	DI Hockley	Feb 2017				
3.2.3	Prosecute where possible, utilising all new DVA legislation, inc. the new offence of CCB	Det Supt Nat Shaw	Jan 2017	All first responding police officers trained in DA Matters (or equivalent training package) All police officers trained to recognise all forms of DVA beyond physical			

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				Milestones (continued)			
				abuse (e.g. stalking, CCB) and undertake appropriate risk reduction activity Increased confidence in reporting to SYP by victims of DVA Increased prosecutions for DVA, and CCB Increased numbers of restraining orders imposed both after conviction and trial Increased numbers of DVPO's Increased numbers of DA Disclosures			

3.3	Build on the Integrated Offender Management Approach and improve working practice between MARAC and MAPPA to manage risk, disrupt offending behaviour and ensure that offenders including serial perpetrators face the consequences of their actions

EXPECTED OUTCOMES FROM ACTIONS

- **Build on the Integrated Offender Management Approach, improve working practice between MARAC and MAPPA so risk is managed, seeking to disrupt offending behaviour and ensure that offenders including serial perpetrators face the consequences of their actions**

Action No.	Key Action	Lead Officer	Timescale	Milestones	Measure(s)	Quarterly Progress Update	RAG Rating
3.3.1	Continue to build on the Integrated Offender Management Approach to manage risk, disrupt offending behaviour and ensure that offenders face the consequences of their actions	Supt Nat Shaw	Jan 2017				

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Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Date: 16 March 2017

Subject: 2016-17 Q3 Performance Report

Presented by: Allan Wiltshire

Purpose of bringing this report to the Board	
Regular performance reports on the priorities set out in the Health and Well-being strategy will provide assurance that progress is being made and the board are made aware of any risks or barriers to improvement in key areas.	
Decision	NA
Recommendation to Full Council	NA
Endorsement	Y
Information	Y

Implications		**Applicable Yes/No**
DHWB Strategy Areas of Focus	Alcohol	Y
	Mental Health & Dementia	Y
	Obesity	Y
	Family	Y
	Personal Responsibility	Y
Joint Strategic Needs Assessment		Y
Finance		N
Legal		N
Equalities		Y
Other Implications (please list)		N

How will this contribute to improving health and wellbeing in Doncaster?
Good quality performance management arrangements ensure that priorities are achieved and good quality services delivered to the residents of Doncaster. Also this report should highlight progress against the key health and well-being priorities identified as priorities in Doncaster.

Recommendations
The Board is asked to:- a) Note the performance against the key outcomes b) Agree what area of focus the Board would wish to have further information in Q4 2016-17

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Doncaster
Metropolitan Borough Council

Date: 16 March 2017

To the Chair and Members of the HEALTH & WELL BEING BOARD

PERFORMANCE REPORT Q3 2016-17

EXECUTIVE SUMMARY

1. A refreshed 'outcomes based accountability' (OBA) exercise was completed parallel to the refresh in the Health and Well-being strategy. The five outcome areas remain and a new outcome on drugs has been introduced for 2016-17. A number of specific indicators have been identified which will measure our progress towards these outcomes in 2016-17. The 6 outcomes are;

- Outcome 1: All Doncaster residents to have the opportunity to be a healthy weight
- Outcome 2: All people in Doncaster who use alcohol do so within safe limits
- Outcome 3: Families who are identified as meeting the eligibility criteria in the expanded Stronger families programme see significant and sustained improvement across all identified issues.
- Outcome 4: People in Doncaster with dementia and their carers will be supported to live well. Doncaster people understand how they can reduce the risks associated with dementia and are aware of the benefits of an early diagnosis
- Outcome 5: Improve the mental health and well-being of the people of Doncaster ensures a focus is put on preventive services and the promotion of well-being for people of all age's access to effective services and promotes sustained recovery.
- Outcome 6: Reduce the harmful impact of drug misuse on individuals, families and communities

2. Further information and narrative around the performance is available in **Appendix A**.

EXEMPT REPORT

3. NA

RECOMMENDATIONS

4. The Board is asked to:-
   a) Note the performance against the key outcomes
   b) Agree what area of focus the Board would wish to have further information in Q4 2016-17

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

5. Good Performance Management arrangements of the priorities set out in the Health and well-being strategy will ensure services improve and peoples experience in the health and well-being system is positive.

BACKGROUND

6. The Health and Well Being Board have chosen to use Outcomes Based Accountability (OBA) to support the delivery of improvement against the key priorities in the health and well-being strategy. ***Appendix A*** sets out the five outcomes and the main *indicators* associated with each. The OBA methodology moves away from targets for the whole population indicators and this is reflected in this report, instead the trend and direction of travel is the key success criteria.

7. We have introduced a basic forecast into some of the indicators contained within Appendix A which should help the board to assess if the direction of travel is acceptable and if not seek to understand the options and implications of such a trend. The forecast is a linear forecast and only used if there is an acceptable amount of data to base a forecast on. Furthermore if there have been any significant deviation within the period that may impact on the validity of a linear trend a forecast has not been made.

8. As agreed with the board in Q1 2015-16 a short presentation on one of the areas of focus will be provided at each quarterly performance update. The Board will need to decide which area of focus should be invited for Q3 2016-17.

9. Changes as suggested in the Q2 report included a rationalisation of measures and clear expectations on when impacts might take place are iterative and improvements should be seen as each report is presented. Furthermore the discussion to update outcome 3 (families) to be broader than the stronger families programme will be incorporated into the Q4 report update; this will allow an update of the 2016-17 year and act as a springboard for refresh in 2017-18.

OPTIONS CONSIDERED

10. NA

REASONS FOR RECOMMENDED OPTION

11. NA

IMPACT ON THE COUNCIL'S KEY OUTCOMES

12.

Outcome	**Implications**
All people in Doncaster benefit from a thriving and resilient economy. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	
People live safe, healthy, active and independent lives. *Mayoral Priority:* Safeguarding our Communities *Mayoral Priority:* Bringing down the cost of living	Reduce Obesity. Reduce Substance Misuse Dementia Mental Health
People in Doncaster benefit from a high quality built and natural environment. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	
All families thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	Stronger Families Programme

Council services are modern and value for money.	
Working with our partners we will provide strong leadership and governance.	

RISKS AND ASSUMPTIONS

13. NA

LEGAL IMPLICATIONS

14. There are no specific legal implications for this report.

FINANCIAL IMPLICATIONS

15. Any financial implications will be associated with specific indicator improvement and will be associated with separate reports as appropriate.

EQUALITY IMPLICATIONS

16. There are no specific Equalities implications associated with this report. However specific programmes or projects aimed at improving performance and changing services will need to have a comprehensive analysis detailing the impacts on protected groups.

CONSULTATION

17. This report has significant implications in terms of the following:

Procurement		Crime & Disorder	
Human Resources		Human Rights & Equalities	
Buildings, Land and Occupiers		Environment & Sustainability	
ICT		Capital Programme	

BACKGROUND PAPERS

18. NA

REPORT AUTHOR & CONTRIBUTORS

Allan Wiltshire
Head of Policy and Partnerships
01302 862307
Allan.wiltshire@doncaster.gov.uk

Dr. Rupert Suckling
Director of Public Health

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Doncaster Health & Well Being Board

Performance Report

Q3 2016-17

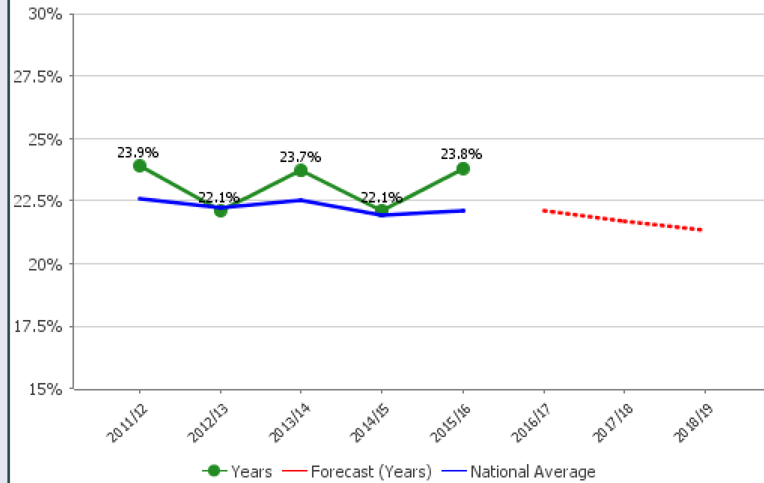
Appendix A

*Values below 5 have been rounded to 0 or 5
** If performance is outside of a control limit the text [Beyond Control Limit Q3 2016-17] will be used.

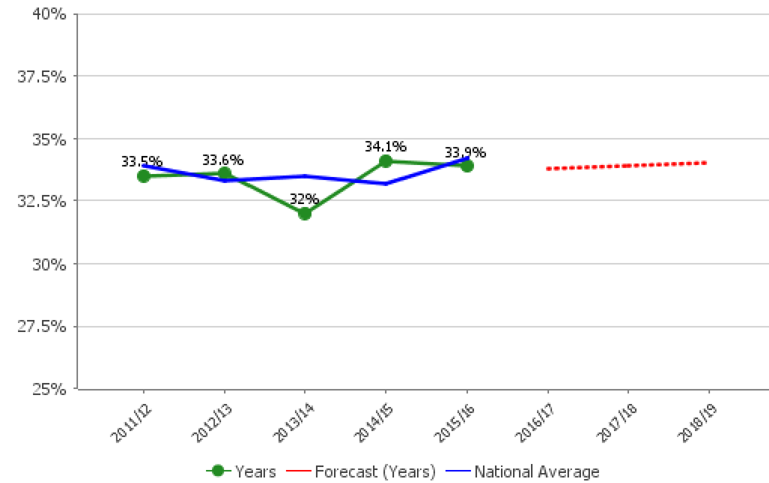
OUTCOME 1	All Doncaster residents to have the opportunity to be a healthy weight

INDICATORS

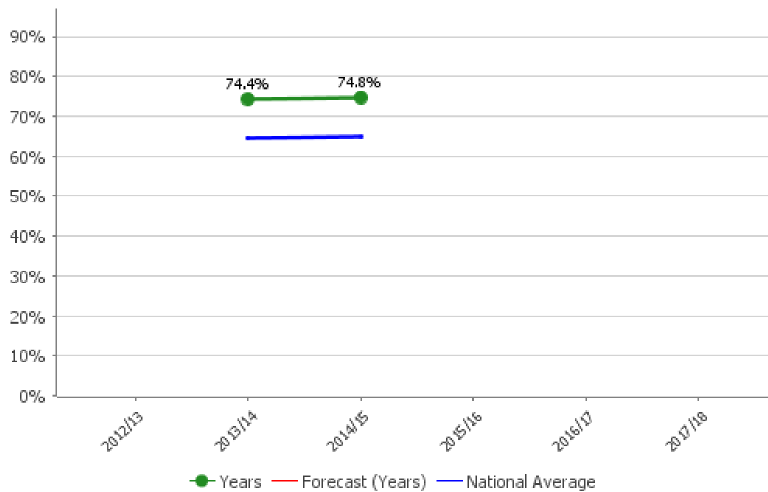
a) % of Children that are classified as overweight or Obese (Aged 4/5)



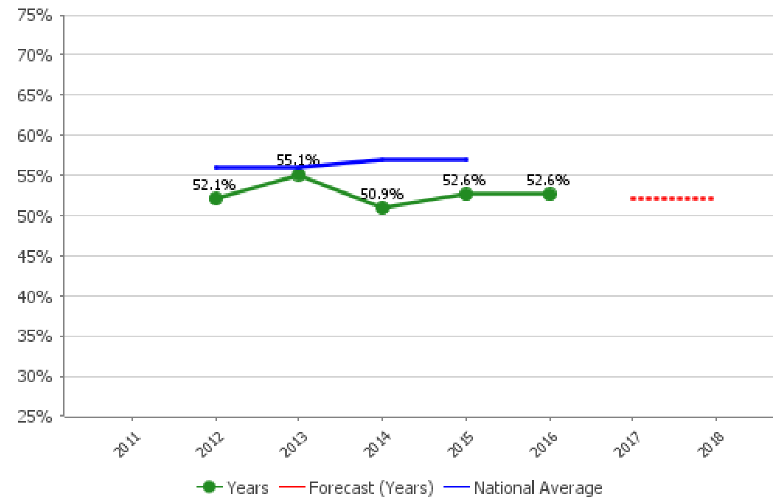
b) % of Children that are classified as overweight or Obese (Aged 10/11)

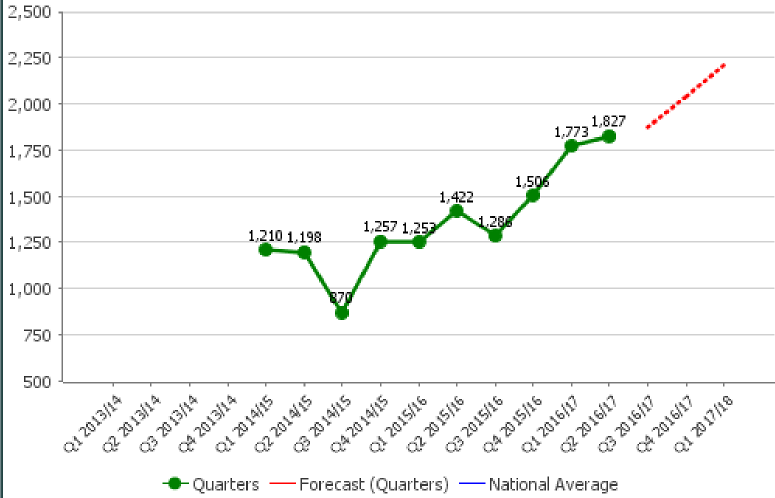


c) % of Adults Overweight or Obese



d) % of adults achieving at least 150 minutes of physical activity per week



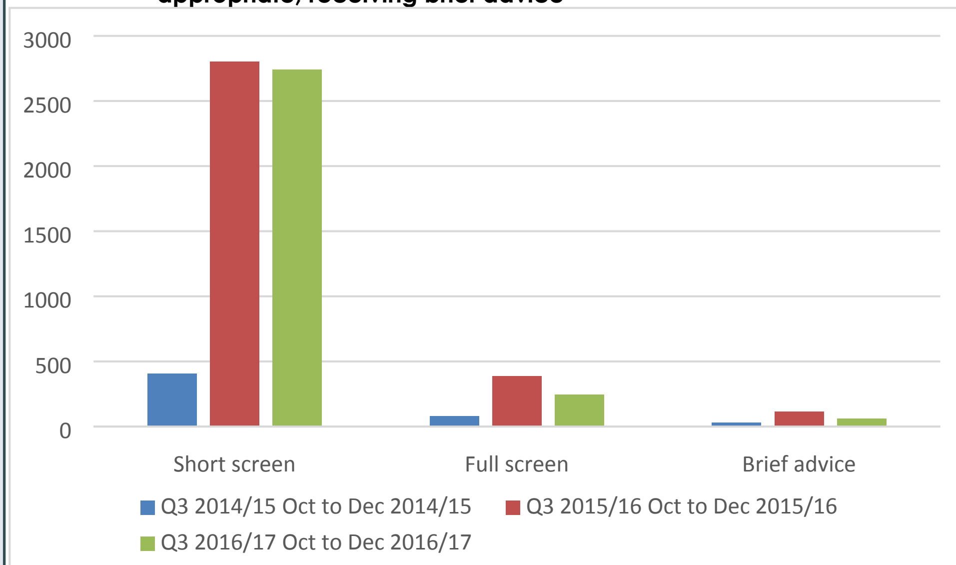
	e) Number of people participating at DCLT Leisure Centres per 1000 population (includes multiple visits)
	
STORY BEHIND THE BASELINE	NCMP data for 2015/16 is now available. For Doncaster we have seen a slight increase in overweight and obese children at reception from 22.2% in 2104/15 to 23.9% in 2015/16. There was a slight decrease in overweight and obese children at Year 6, a drop from 34% in 2014/15 to 33.7% in 2015/16. The local research study conducted by a PH Registrar around NCMP trends over the last 9 years is now completed and the findings are available . Key findings indicate a significant increase in overweight and obese children between reception and year 6 suggesting primary school aged children should be targeted for obesity intervention initiatives. Findings also demonstrate children from more deprived areas to be more likely to be overweight and obese as is reflected in nationally reported data. A new accreditation scheme has been developed for educational settings based on the previously DH led Healthy Schools criteria. Settings will be required to produce evidence of positive steps taken towards supporting and promoting the health and wellbeing of pupils to gain accreditation. Specific sections on healthy eating and physical activity are included. The scheme will be open to all settings accepting children from ages 2 and up. The scheme is currently being piloted with settings and will be launched in the New Year. Tier 3 Weight management service for children has now ended (Sept) and is being effectively managed by the provider. Signposting information is being developed to provide alternative options within the wider community for the public via health professionals. The Food plan was disseminated to key professionals and stakeholders as an online resource. The first meeting of an **Obesity Alliance t**ook place in Q2 and the following work streams were agreed for further consideration and which would have the greatest impact: **Food/Families/Physical activity and social media.** A whole system and family approach was agreed as a priority. Social media and good news stories would be key to a social movement and culture change around weight management**.** Actions agreed included: reviewing local data compared to national data ; health and well-being of workforce; asset mapping and stock take of current activity including childhood obesity; collective stories and mapping on food (Top 10 tips), physical activity (usage of parks and green spaces) and weight management;

	reviewing membership in terms of planning and Communications representation. The next meeting will take place in Q3 and a work plan will be produced. Local research undertaken by Masters students around **food banks and food takeaways** are now completed. Policy briefs and recommendations are now available on request. The findings from these studies will be incorporated into the Healthy Weight plan and recommendations will be fed back to the Obesity Alliance. The second quarter of 2016/17 sees Total visits to all DCLT facilities was 548,075 compared to the same period in 2015 this represents up 19% increase. Health and Fitness membership sales continue to be strong and every venue under the portfolio has achieved the sales and retention targets for the quarter. Total members are 16'657 which is 76% of target. Aquatic sales are also strong with current occupancy levels across the portfolio at 91%, translating to 6,753 young people attending swimming lessons.	
ACTION PLAN	**What we will achieve in 2016-17**	**What we will do next period**
	1. Public Health are working in collaboration to address healthy food options; the work around proximity of takeaways and healthy food choices is underway and results will be provided when available. Two research studies are being undertaken around food takeaways and food banks. 2. Physical activity proxy measures through discount promotions are being explored. 3. The One You Campaign has been launched and a walking campaign is to be launched in September 2016. 4. NCMP data analysis. 5. Ongoing work around the development of health policies into the local plan.	1. Look at the findings of the NCMP data - 2015/16 data to identify any key trends and feed into the Children Young People and Families operational plan and Healthy Doncaster group 2. Launch new healthy educational settings accreditation criteria including sections on healthy eating and physical activity 3. Embark on research project to rate implementation of obesity prevention guidance in junior schools 4. Review and refresh Doncaster Infant Feeding Guidelines 5. Provide signposting information to GPs and allied professionals 6. Develop a Healthy Weight plan for Doncaster and an obesity map 7. Incorporate findings and recommendations from the food research studies 8. Look at models elsewhere including Sustainable food cities and research around the food environment 9. Build on the work already established with the local plan, food policy and PA initiatives 10. Input at Healthy Weight regional meetings including obesity pathway indicators and whole system approaches; part of CLARHC and Leeds Beckett Park studies around Whole system approaches

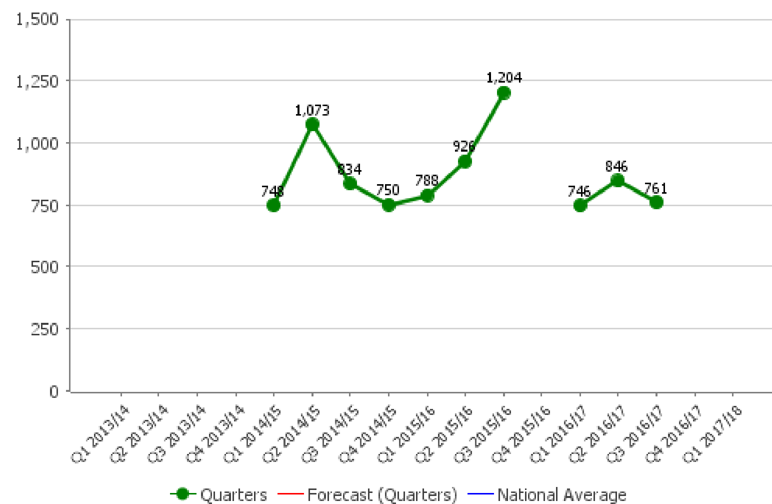
OUTCOME 2	All people in Doncaster who use alcohol do so within safe limits

INDICATORS

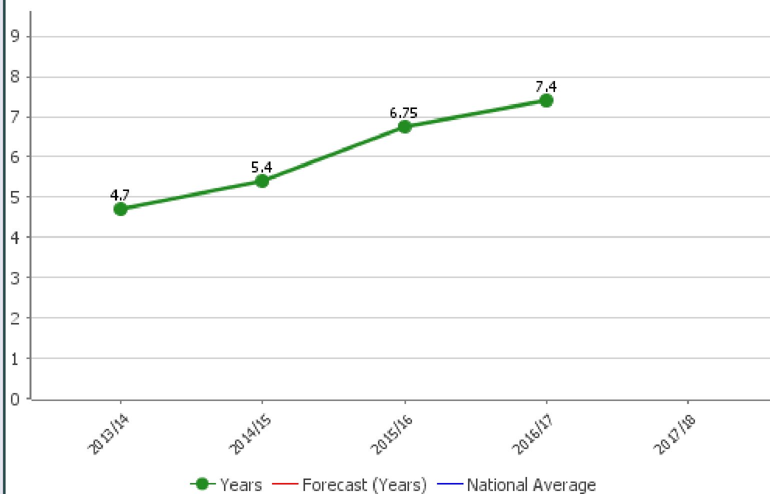
a)Numbers of people being screened for alcohol use and, where appropriate, receiving brief advice



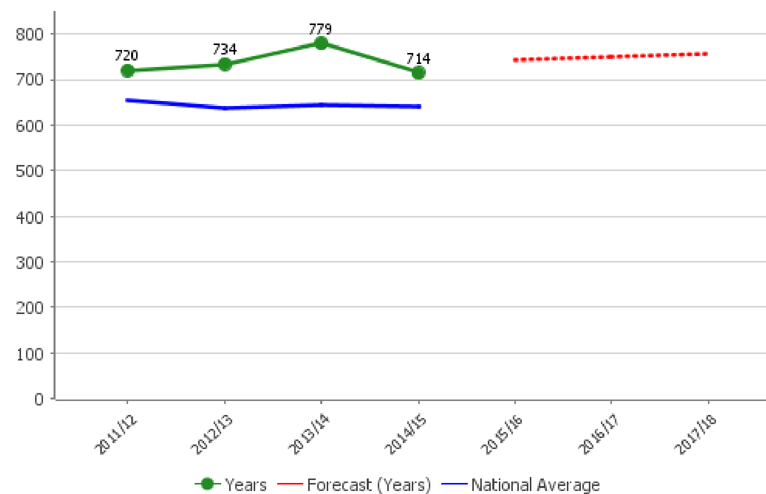
b) Alcohol-related attendance at A&E (Doncaster Residents)



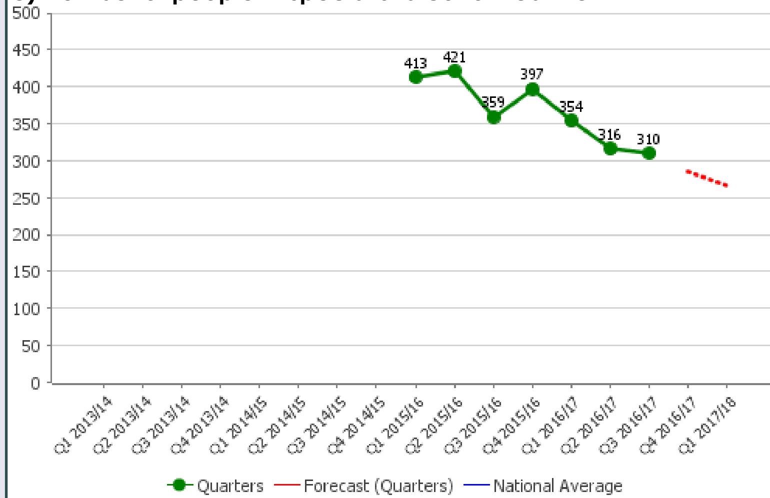
c) Alcohol-related violent crime per 1000 pop (2016/17 YTD Only)
[Beyond Control Limit Q3 2016-17]



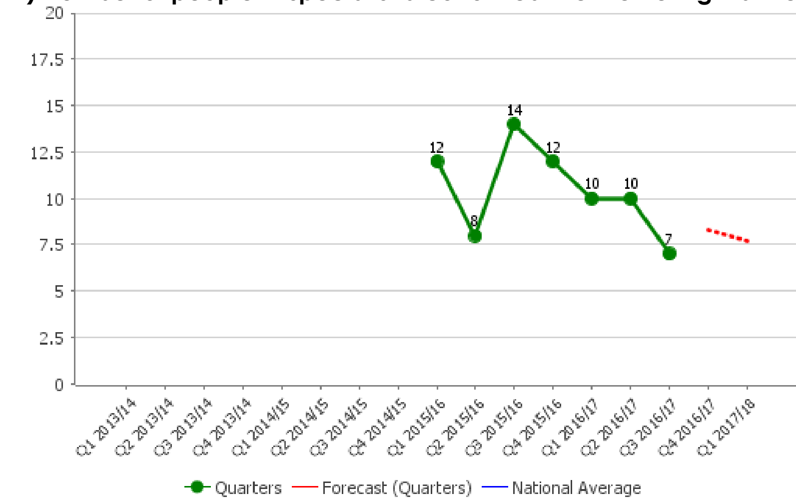
d) Alcohol related admissions to hospital



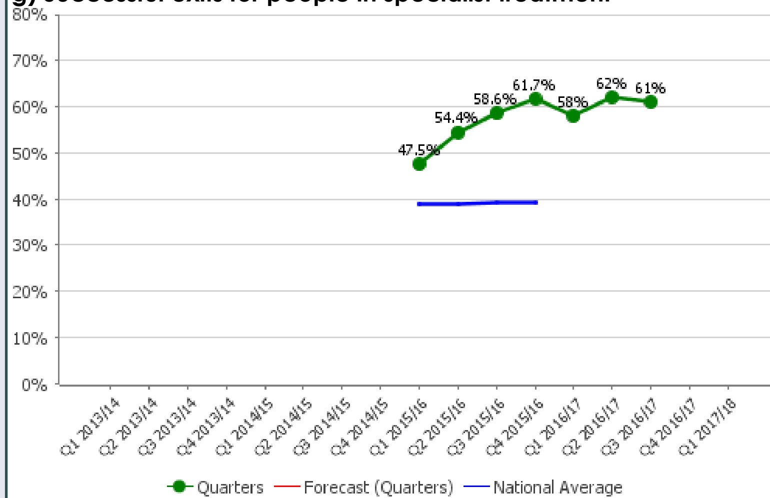
e) Number of people in specialist alcohol treatment



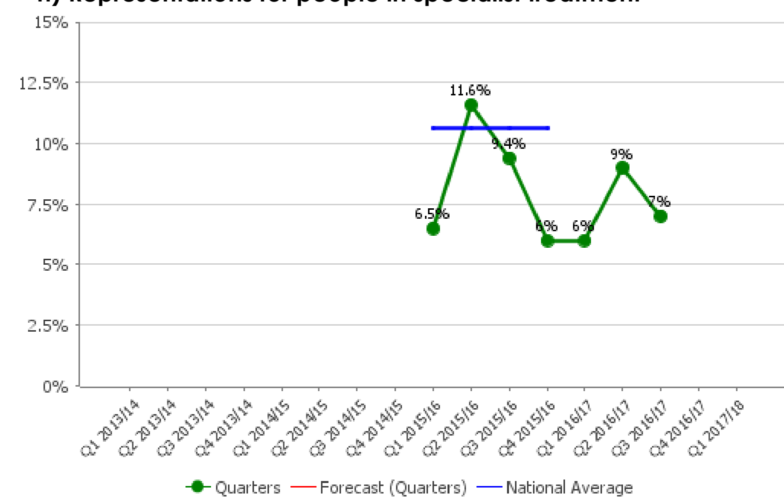
f) Number of people in specialist alcohol treatment entering via the CJS



g) Successful exits for people in specialist treatment



h) Representations for people in specialist treatment

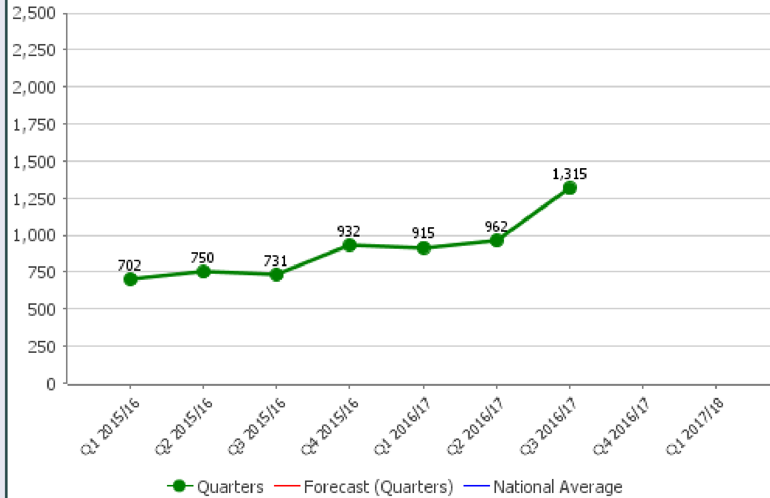
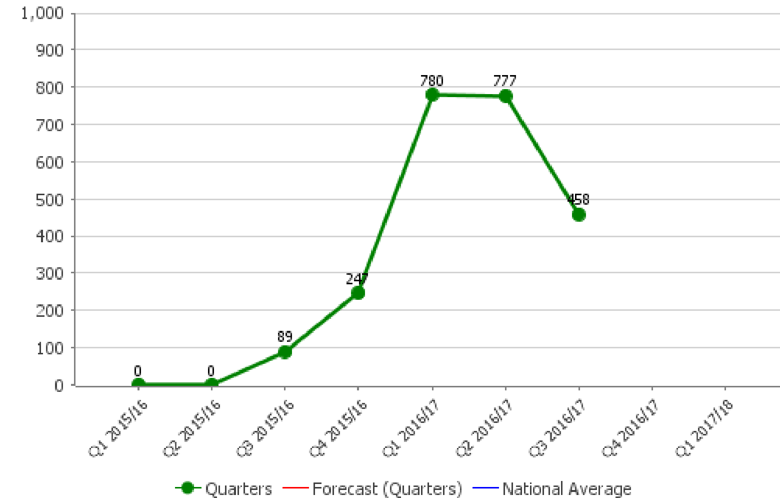
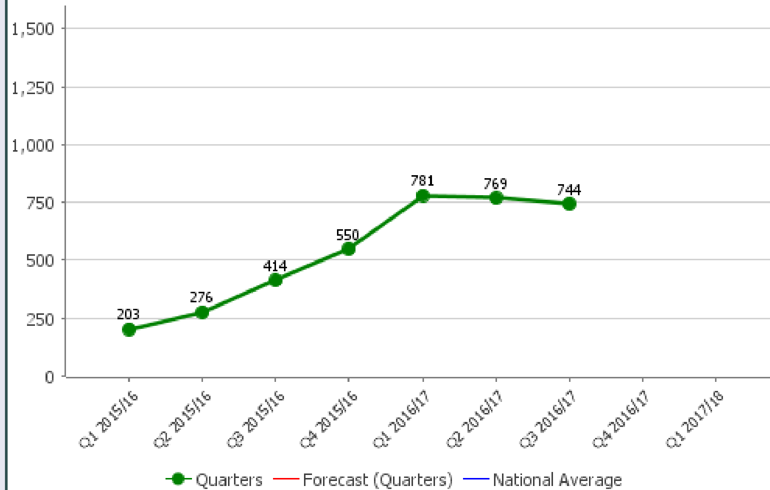
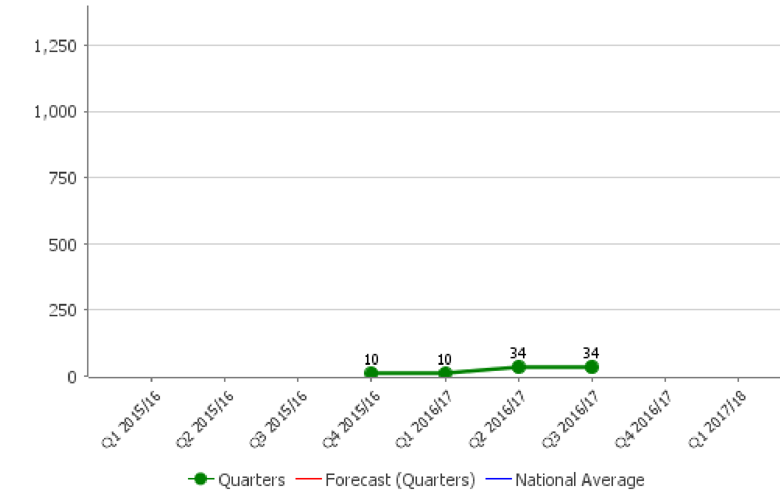


STORY BEHIND THE BASELINE

Indicator a – Information Provided by ASPIRE September -December data only. Aspire is now managing the contracts directly and there has been an increase in activity. It is planned that through liaison with the LMC more practices will sign up.
Indicator b - Significant difference in data reported due to change in data source (CCG to DRI). Q2 16/17 data received from CCG instead of directly from DRI
Indicator c –At present, there is no definition of alcohol-related violence within the National Crime Recording Standard (NCRS) or Home Office Counting Rules (HOCR), although there is guidance within the National Standard for Incident Recording (NSIR). (Latest available data) Alcohol-related crime has increased significantly from a low in 2012/13. The Joint Strategic Intelligence Assessment notes this increase citing increases in Town Centre violence and

	recorded domestic abuse, but also discrepancies in the recording process. **Indicator d** –. Latest data available. Alcohol-related admissions increased up to 2013/14 and were consistently above England. The rate for 2014/15 appears to decrease sharply though this requires further investigation. These admissions are primarily linked to cancer, unintentional injuries and mental/behavioural disorders. Doncaster is significantly worse than England average **Measure e** –Numbers in specialist treatment have reduced by approx. 60 people since April 2016. There are estimated to be approx 5,600 dependent drinkers in Doncaster therefore the aim is to increase the number of people accessing services. Aspire have been alerted to this apparent decrease. **Measure f** –Numbers entering via the criminal justice system are low and the aim is to increase the numbers entering via this pathway (as a benchmark the Probation Service historically targeted 80 service users per year). This decrease may be a result of changes in the CJS, reducing the number of Alcohol Treatment Requirements (ATRs) issued by Magistrates (e.g. less use of alcohol conditional cautions, the reorganisation of probation into the National Probation Service and Community Rehabilitation Companies). **Measure g** - successful exits stood at 60% in September 2016, which is above the local target (36%) and above the national rate for England (39%). The aim is to maintain this performance through the mobilisation of the new service. **Measure h** - re-presentations (people who exit successfully but return to services within 6 months) stood at 9% in September 2016, which is better performance than the national figure of 10.6%. Re-presentations were declining prior to the gap in data linked to the national system, however the aim is to improve this performance. When interpreting the data, it is important to bear in mind that some people may relapse and do not represent to the service.

	What we will achieve in 2016-17	What we will do next period
ACTION PLAN	1. Work with GP practices to expand and improve screening and interventions from this year to next, delivered via RDASH/Aspire subcontract. 2. Learn from the evaluation the Community Alcohol Partnership (CAP) in Askern, Campsall and Norton. The model was expanded to Conisbrough and Denaby in November 2015. 3. Make greater use of campaigns to raise public awareness and influence attitudes to alcohol in the population. Fixed national dates include Alcohol Awareness Week and Dry January while local campaigns will likely include topics such as alcohol and cancer, alcohol in pregnancy, alcohol and older people and the link between alcohol and house fires. 4. Improve the referral pathway between hospitals and the treatment system and enhance the identification and support to people repeatedly attending A&E or admitted to wards. Alcohol Concern defines these as 'Blue Light' clients - people who become vulnerable and isolated so that emergency services are their only source of support.. 5. Increase public and professional awareness re alcohol and older people through partnership with services which work with older people. A leaflet and poster campaign has been produced and distributed across Doncaster highlighting the increasing issue. 6. Deliver a 'safe haven' piloted for a year between December 2016 through to end of September 2017	1. Monthly monitoring of exits and representations. 2. Continuing to monitor and screening and brief interventions through GP practices contracted via RDASH. 3. Delivering public awareness campaigns and planning for the year. 4. Look at ways to Increase screening of alcohol identifying high-risk drinkers to access alcohol services earlier 5. Promotion of 'age well drink wiser' highlighting alcohol and older people 6. A leaflet specifically for dependent drinkers called 'Dying for a drink' has been produced and distributed to A&E and DRI, custody suite and other areas 7. Public Health leading led on the delivery of a Safe Haven in Doncaster Town Centre on Saturday nights to 'treat' people with alcohol related issues/harm to alleviate pressure on emergency services and DRI and vulnerability to crime on the 10th of December and subsequent Fridays 16th and 23rd. It is anticipated that the next Safe Haven will take place on Sunday the 16th of April (Easter Sunday), May bank holiday and consecutive Saturday's between July and September. 8. Assisting the Town Centre Management and the Mayor with working to address the homelessness, begging and ASB as part of the complex lives/blue light initiative.

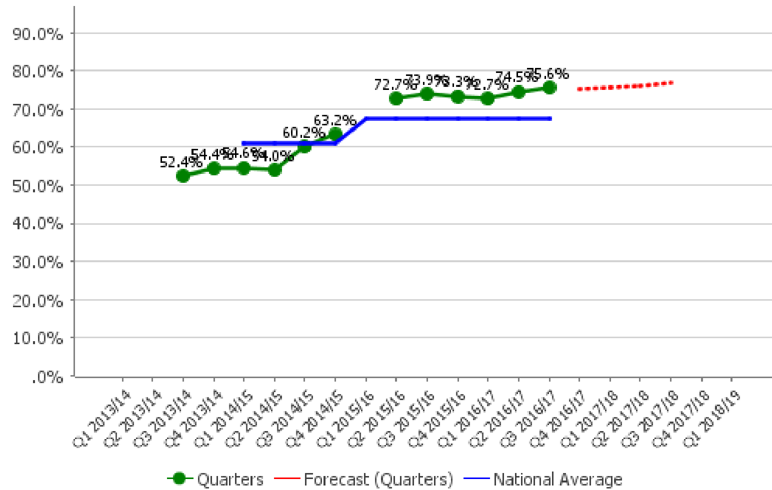
OUTCOME 3	**Families who are identified as meeting the eligibility criteria in the expanded Stronger families programme see significant and sustained improvement across all identified issues.** **[To Be Refreshed to Include Wider Early Help in Q4]**
INDICATORS	**a) Number of Families Identified as part of the Phase 2 Stronger Families Programme**  **b) Number of families achieving positive outcomes through the Stronger Families Programme**  **c) Number of Families Engaged in the Expanded Stronger Families Programme**  **d) Number of family claims made to DCLG through the Expanded Stronger Families Programme** 

STORY BEHIND THE BASELINE	Our current total of identified and validated families is 1315. During Quarter 3 our focus has been on strengthening the process of identifying families via the Early Help Hub, historical only approximately 50% of cases screened at the hub are being identified as Stronger Families. We are working on improving this with partners in the Early Help Hub. During Q3 we have also been horizon scanning as part of the on-going service transformation activity for the programme which has highlighted further work to gather families who are eligible from across the Team Doncaster Partnership. We have now defined what needs to take place to gather details of eligible families which will have an impact on our outturn and we expect that this activity will continue throughout Q4 and the resulting performance results at the end of that period. We are not planning to do another data identification process at the moment as we are consolidating the current families we have and this process in its self has inherent issues. We are currently engaged and working with 744 families who meet 2 or more of the eligibility criteria which is below the accumulative Q3 target. There has been a small decline in the number of families currently being worked due to expected reasons like, moved out of area, no longer family unit, no longer at address, no longer eligible. We expect the target for the remainder of the year to be met by existing eligible families who are yet to be engaged with and families being identified and assessed through the Early Help Hub and Social Care (DCST). The next claim results will be reported in Quarter 4 2016/17. While Claims may only be made for sustained and significant progress against all assessed outcomes, or, continuous employment, progress against individual outcomes has been made by many families. This total represents counts of individual progress against outcomes and not individual families. Therefore a family can be counted under more than one outcome so this does not relate to 458 individual families. The latest progress is: Outcome 1 (Crime & ASB): 71 Outcome 2 (Children Attending School): 52 Outcome 3 (Children Needing Help): 101 Outcome 4 (Worklessness & Financial Exclusion): 131 Outcome 5 (Domestic Violence): 37 Outcome 6 (Health): 66 There were no further claims processed during Quarter 3 however the preparation for claims has continued throughout Quarter 3. The next claim is in January 2017 and the final claim opportunity is March 2017 and results will be reported in Q4 2016/17.

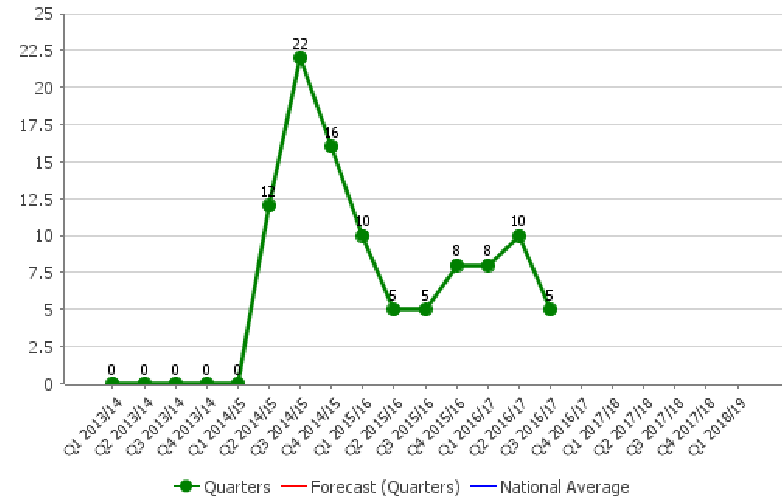
	What we will achieve in 2015-16	What we will do next period
ACTION PLAN	1. To identify as many families who meet the criteria as we can 2. Implement the case management system to allow for easier case management , tracking and progress reporting 3. Commission services needed by families following evaluation of the SF programme. 4. Train multi-agency staff in working with families, ‘early help’ assessment and case management system inputting.	1. Expand the measures and remit of the area of focus to Early Help for families 2. Prepare for January 2017 claims 3. Train staff in Signs if Safety processes 4. Review areas to be commissioned / where there are gaps.

OUTCOME 4	**People in Doncaster with dementia and their carers will be supported to live well. Doncaster people understand how they can reduce the risks associated with dementia and are aware of the benefits of an early diagnosis**
INDICATORS	

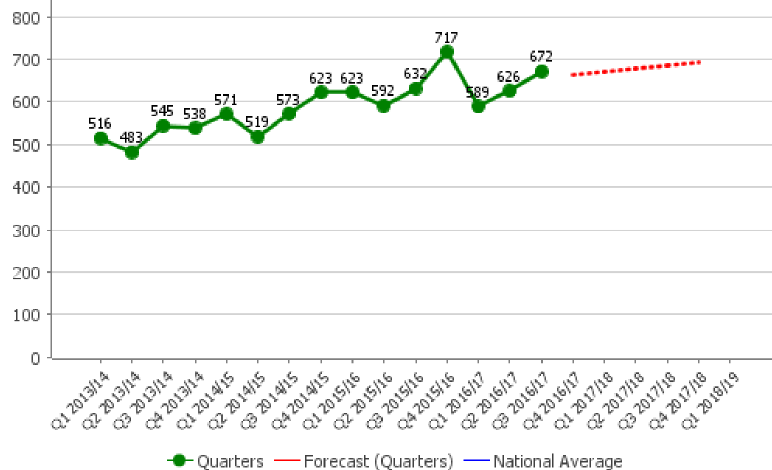
a) Dementia Diagnosis Rate (%)



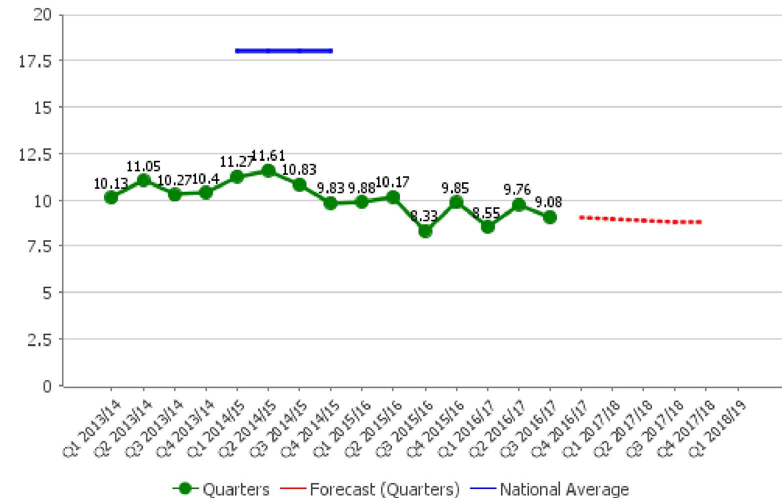
b) Number of 4hr RDaSH Emergency responses for people with dementia



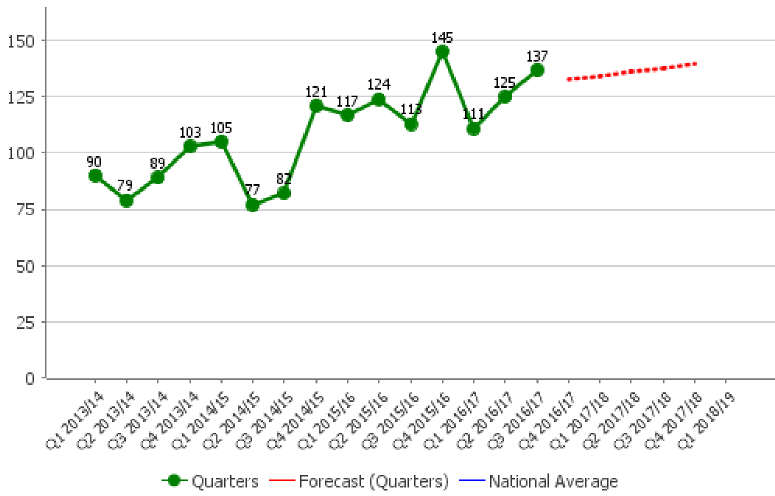
c) Reduce the number of Hospital Admissions (DRI) for people with dementia



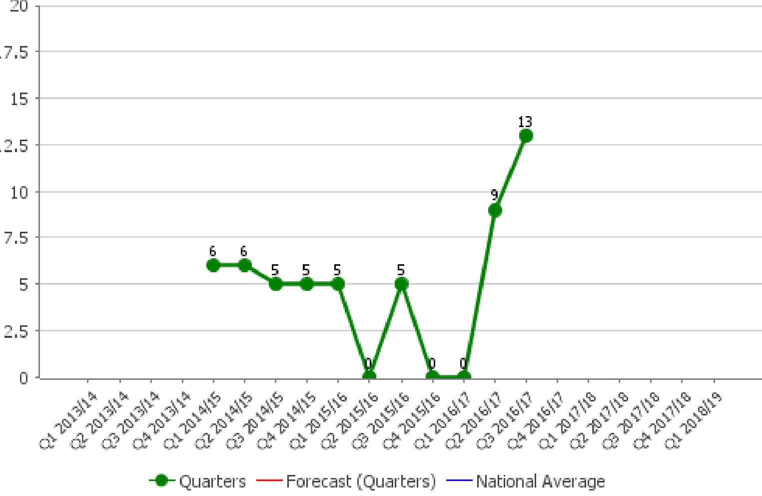
d) Length of stay of people with Dementia in an acute setting (average days)



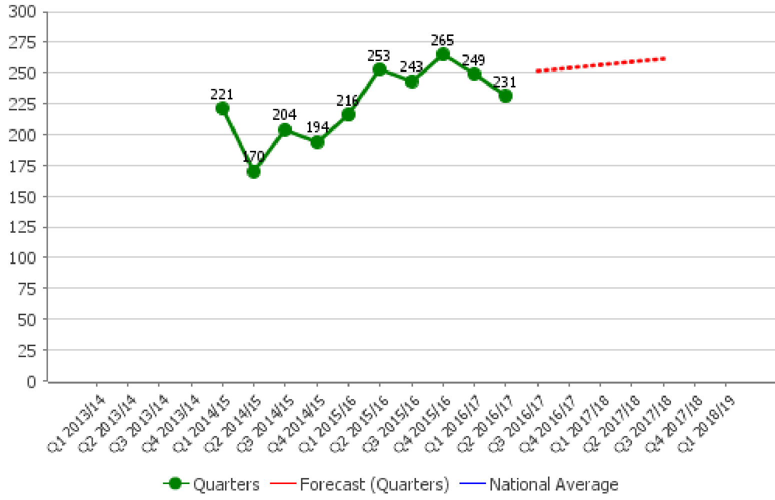
e) Hospital re-admissions within 30 days (DRI) for people with Dementia



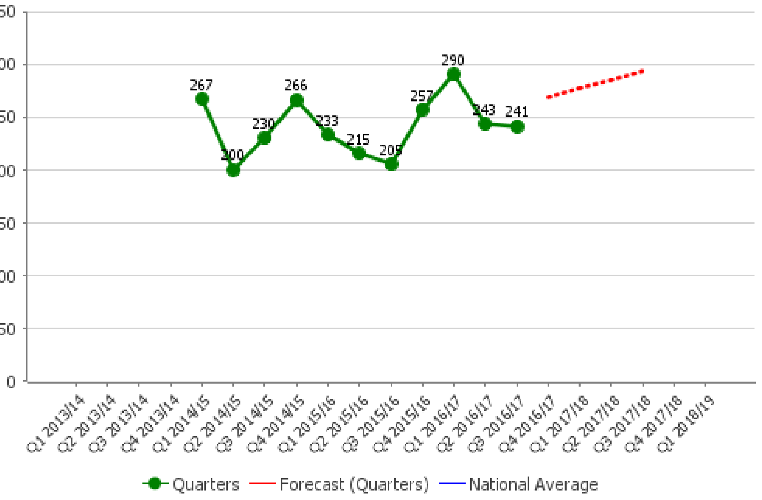
f) Number of patients having any delayed discharges at RDaSH
[Beyond Control Limit Q3 2016-17]



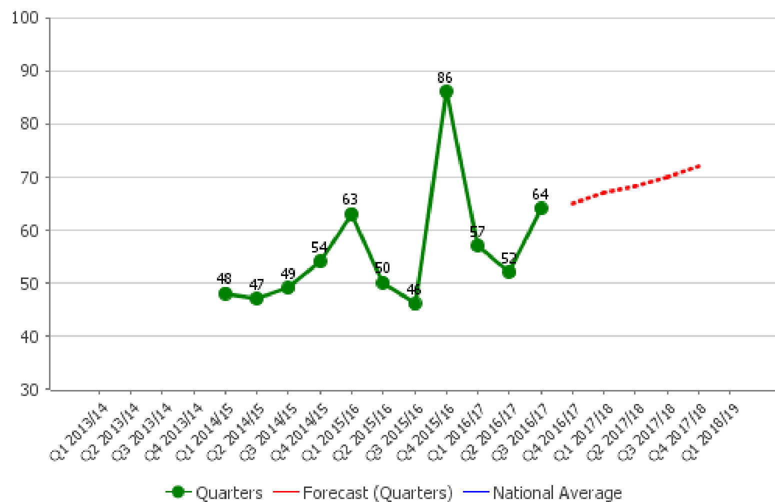
g) Attendances at A&E for people with dementia



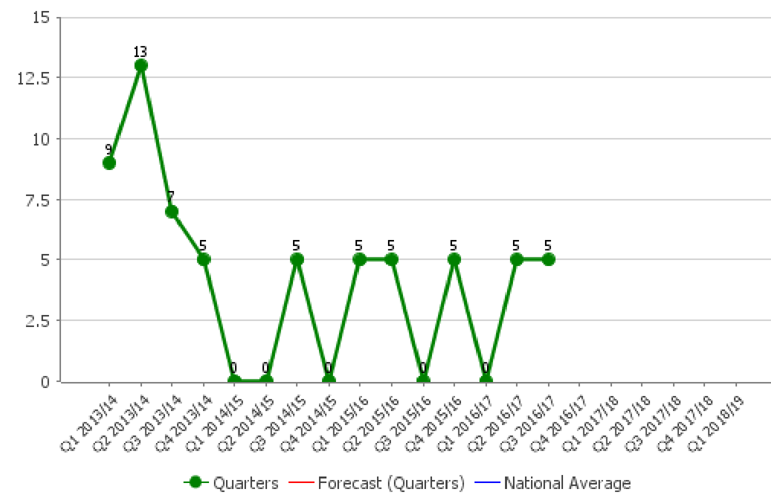
h) Number of people with dementia being admitted from care homes to DRI



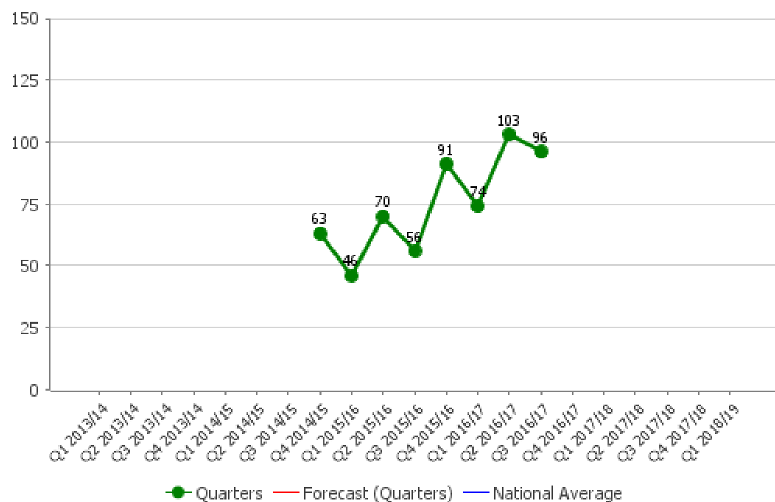
i) Number of Hospital deaths for patients with dementia



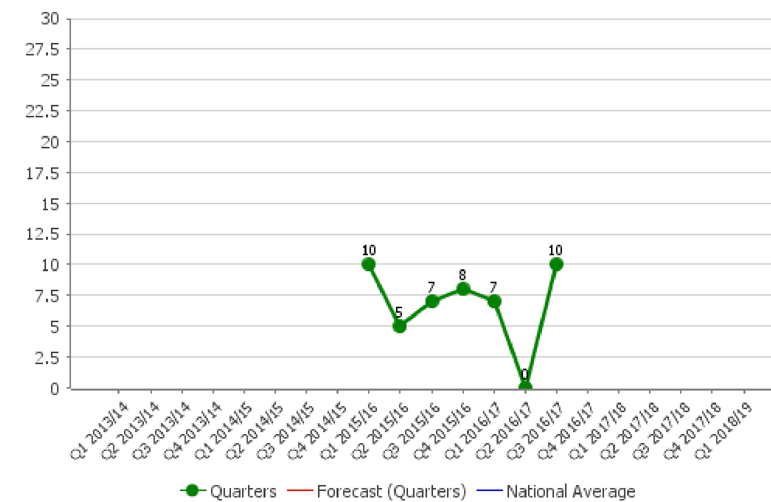
j) Unplanned episodes of Respite for people with Dementia



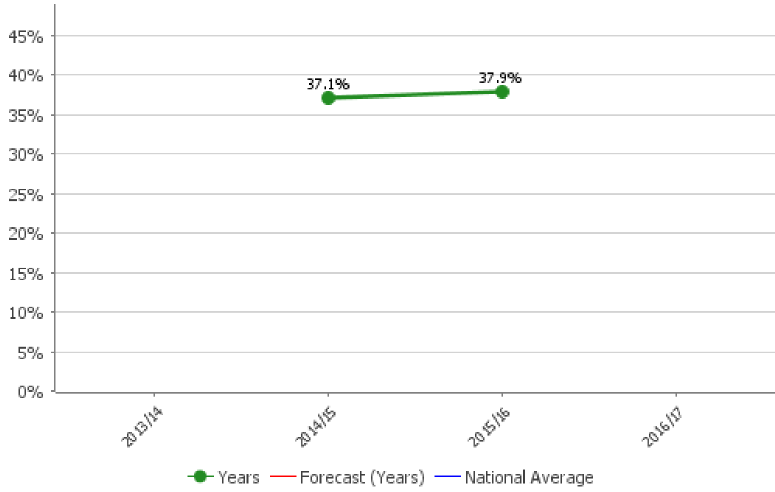
k) Number of installations for Assistive Technology that are for people with Dementia



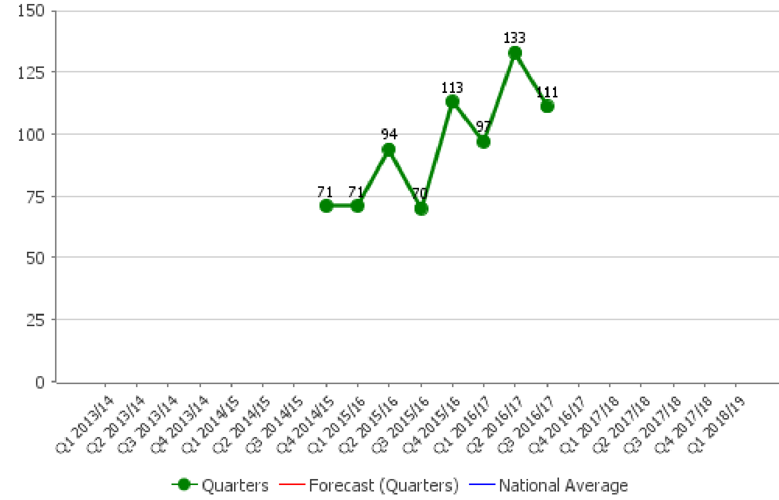
l) Number of safeguarding referrals involving people with a PSR of Memory & Cognition



M) Proportion of People who access social care services and have a PSR of Memory Support & cognition living at home



N) The number of Assistive Technology referrals (telecare) that are for people with Dementia



STORY BEHIND THE BASELINE

The measures capture the strategic direction of improving diagnosis rates, reducing inequalities and supporting people to live well with dementia by preventing crisis and helping people to be in control of their lives. Doncaster's dementia diagnosis rate is now well over the national ambition of 67%. Having a diagnostic rate of 75.6% leaves an unknown gap of around 914 people over the age of 65 and around 1040 people in total. By being able to identify people with dementia results in 2 key outcomes; firstly it enables people with dementia and their carers to access the right services and support and secondly assists commissioners to identify more accurately activity in the health and social care system so improvements can be made. The delays from RDaSH increased and reasons in the main are a result of delay in agreeing care packages.

ACTION PLAN

What we will achieve in 2016-17	What we will do next period
For 2016/17 the action plan will address the 5 Key Areas of Focus as presented in Dementia Strategy for Doncaster, Getting There, launched in March 2015. These are: • Raising Awareness and reducing stigma – Information, Advice and Signposting, • Assessment and Treatment, • Peri and Post Diagnostic Support, • Care Homes • End of Life.	1. Finalise the 'Admiral pilot' evaluation which is being independently completed by Sheffield Hallam University. 2. Agree with partners the strategic direction for dementia post March 2017 (post strategy)

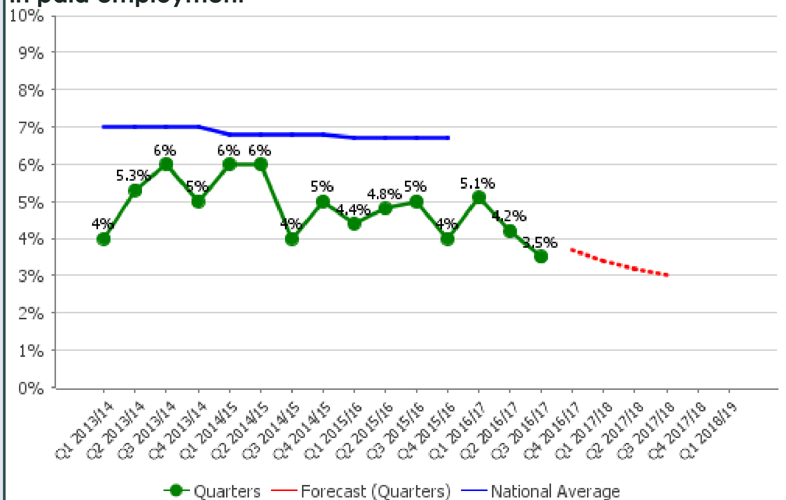
	This will ensure we build on the success of 2015/16 but also address identified gaps and areas for improvement. This year the people of Doncaster will be able 1. to access reliable and consistent dementia information and support in a timely manner; 2. there will be reduced variance in assessment and treatment pathways ensuring every referral receives an equal, timely and effective response; 3. there will be an integrated and co-ordinated support pathway/service for people with dementia and their carers/families before and after diagnosis; more people will live at home with dementia and be in control of their life/care, delaying the need for possible residential care ; 4. when people with dementia need residential care they receive high quality care locally 5. People with dementia will die with dignity and in a place of choice through planned empowerment.	

OUTCOME 5

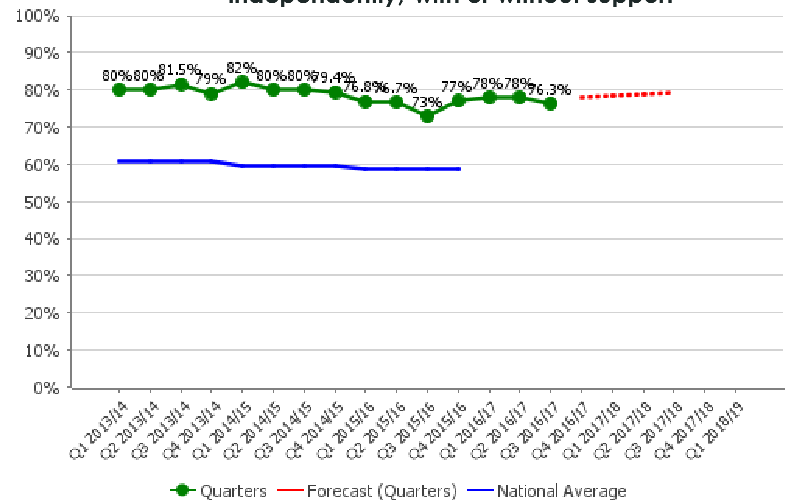
Improve the mental health and well-being of the people of Doncaster ensures a focus is put on preventive services and the promotion of well-being for people of all age's access to effective services and promote sustained recovery.

INDICATORS

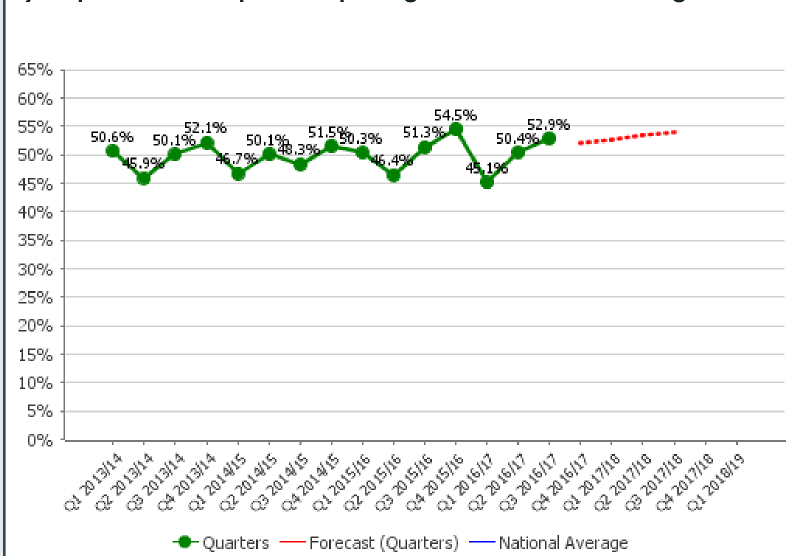
a)Proportion of adults in contact with secondary mental health services in paid employment



b) Proportion of adults in contact with secondary mental health services living independently, with or without support

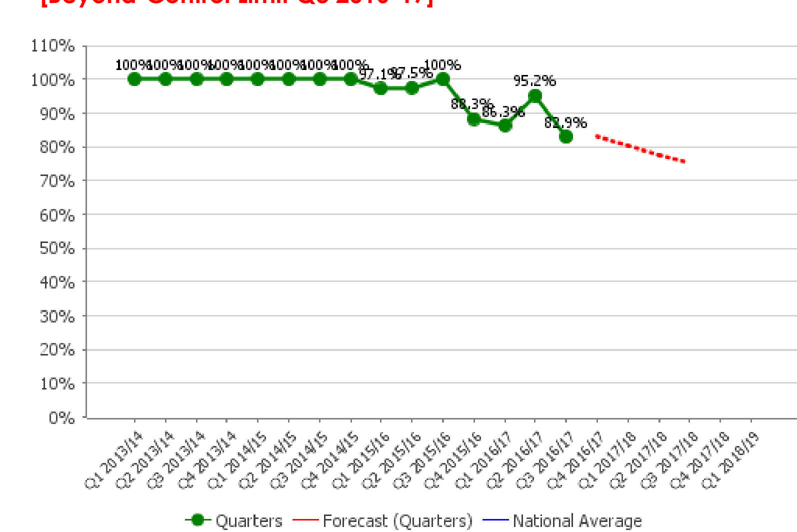


c) Proportion of People Completing Treatment and Moving to Recovery



d) CAMHS: % of referrals starting a treatment plan within 8 weeks

[Beyond Control Limit Q3 2016-17]



<table>
<tr><td>STORY BEHIND THE BASELINE</td><td colspan="2">There is a slight upward trend for both the proportion of adults in secondary mental health accessing paid employment and also the proportion living independently, with or without support. The Paid employment measure is below the national and regional averages and has been so for some time. The proportion of people living independently is consistently better than the national average.

The proportion of people completing treatment and moving to recovery has decreased this quarter and the lowest recorded in the past two years but this is not statistically significant this period.

RDASH, the main provider, are currently completing an audit of care plans around the advice given to patients in connection with employment. This will allow a greater quality marker on the support provided and also opportunities for work experience/unpaid work. The results of this should be available during Q3 to the early part of Q4.

In regards the IAPT recovery rate measure a meeting with the provider, lead Commissioner and Performance Team was held in August and an action plan developed. One of the main reasons for under performance has been identified as increasingly complex patients being referred into the service, some of whom would be more appropriately treated in other settings. Further meetings have been held monthly to review these actions and their impacts.

The measure for non-urgent CAMHS referrals has been affected by the capacity of the service in 2016/17 and also increased referrals. The service is now working to resolve this issue through increased staffing. The service is currently extending the weekend sessions as required. Staff are being transferred between clinical pathways and the service is exploring the use of appropriate agency staff to provide additional support with the current referral demands.</td></tr>
<tr><td rowspan="2">ACTION PLAN</td><td>What we will achieve in 2016-17</td><td>What we will do next period</td></tr>
<tr><td>Continue to implement the recommendations of the Mental Health Review and by doing so, support the delivery of the National Mental Health Agenda:

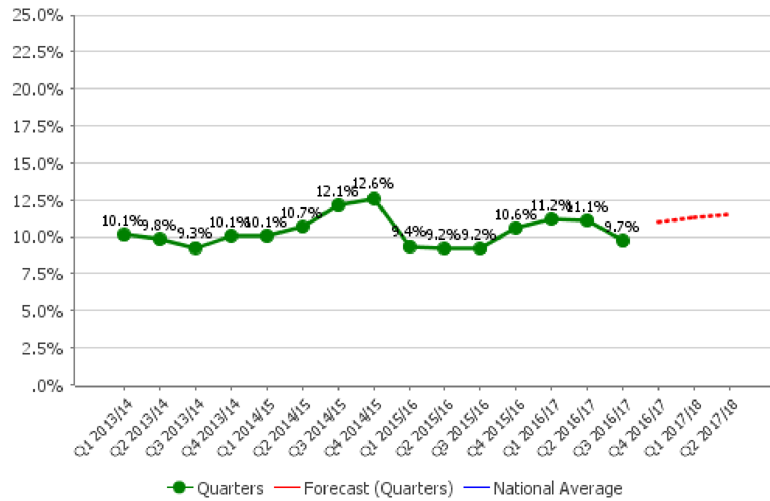
Continue the development and implementation of the Mental Health Development. Programme and pathway redesigns – 3 year development programme (currently in year two) and deliver the principles of the 5 Year Forward View for Mental Health and the National Suicide Prevention Strategy

a. Crisis and acute care pathway
b. Secondary Care & Community Teams
i. Personality Disorder
ii. Perinatal Mental Health
iii. Eating Disorders
iv Attention Deficit Hyperactivity Disorder

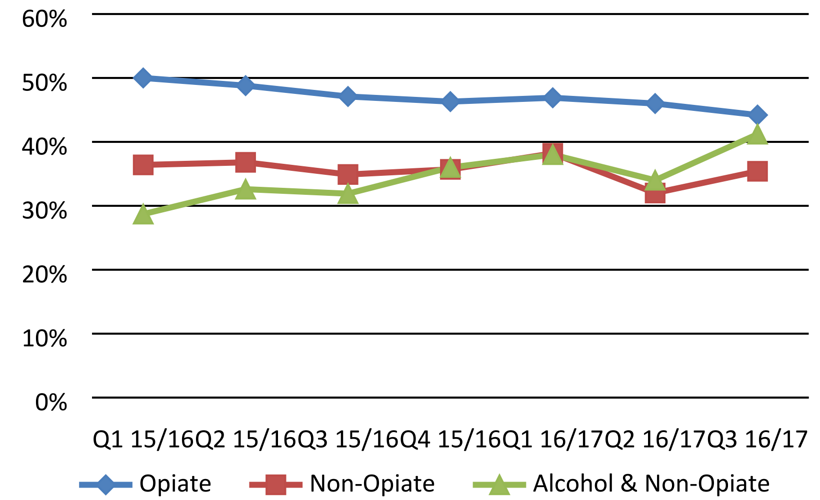
1. Collaborate with Public Health to ensure that the Joint Strategic Needs Assessment has a strong focus on mental health and physical wellbeing.
2. Implement the local Crisis Care Concordat Action Plan with regular progress reports to the Health & Wellbeing Board</td><td>1. Present the Summary Progress Report on the Doncaster Crisis Care Concordat Action Plan to the Health & Wellbeing Board
2. Redesign of the Eating Disorders pathway which will be combined with the new children's planning guidance for improving access for young adults to rapidly access Eating Disorder services locally
3. Redesign of the Attention Deficit Disorder pathway for young people in transition to adult secondary care services and support general practice to manage people in the community who have ADHD
4. The National Guidance for improved Access to Early Intervention in Psychosis has been published and Doncaster CCG will be working with RDASH to improve access response to 2 weeks from referral.
5. Support the development of a Psychiatric Liaison Service between RDASH and DBHFT.</td></tr>
</table>

OUTCOME 6	Reduce the harmful impact of drug misuse on individuals, families and communities.
INDICATORS	a) Proportion of all in treatment, who successfully completed drug treatment and did not re-present within 6 months (Opiate & Non Opiate); b) The proportion of clients in treatment who live with children; c) Number of People in Treatment (Opiate and Non Opiate); d) Re-presentations to drug Treatment

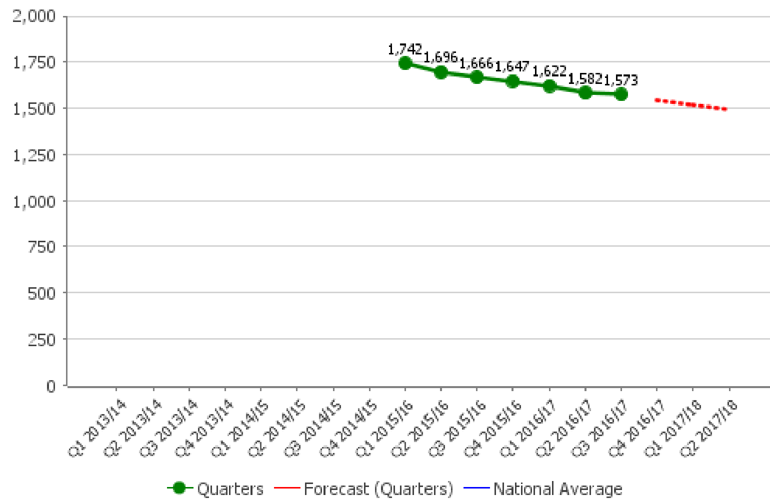
a) Proportion of all in treatment, who successfully completed drug treatment and did not re-present within 6 months (Opiate & Non Opiate)



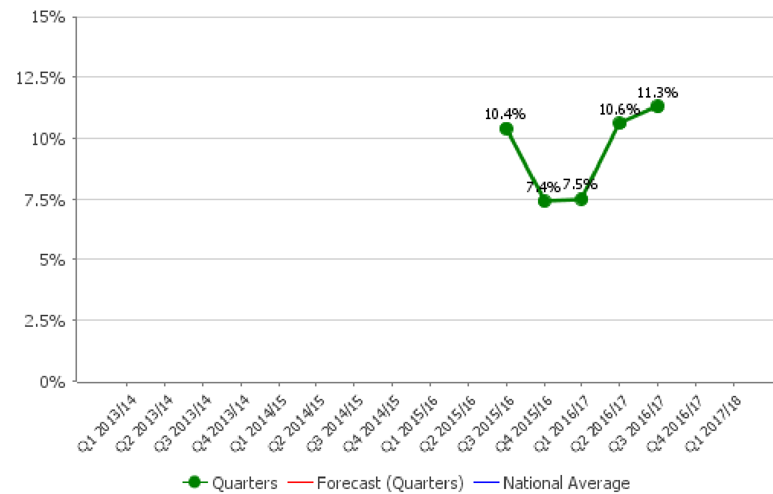
b) The proportion of clients in treatment who live with children



c) Number of People in Treatment (Opiate and Non Opiate)



d) Re-presentations to drug Treatment



<table>
<tr><td>STORY BEHIND THE BASELINE</td><td colspan="2">Indicator a: Performance remains good for the non-opiate group, but opiate users have not improved performance. Some of the reasons why this is, may be due to lack of recovery capital and complex needs of this client group such as aging opiate users who are somewhat ‘stuck’ in the treatment system. An action plan with number of opiate user discharges needed at a keyworker level has been developed and agreed with the provider. This indicator is linked to 2.5% of the annual contract value to be measured at 31st December 2016 (top quartile performance to be achieved)

Indicator b: It could be argued that a decrease in number of clients in treatment is preferable. However, due to the protective nature of treatment and support, an increase in number of clients in treatment is still a positive outcome for the families affected..

Measure c: Aiming to increase the proportion of non-opiate users into the treatment system relative to the number of opiate users over the 4 year period of the whole system contract. There is national evidence that numbers of younger (i.e. under 25 years) opiate users is falling, and new drug trends are emerging (New Psychoactive Substance, club drugs, Image and Performance Enhancing Drugs, Over The Counter medication). There is an ageing population of opiate users in the treatment system that have complex health needs that need to be met.

Measure d: Representations continue to perform better than target (14%). This means that for at least 6 months people are not coming back into treatment.</td></tr>
<tr><td rowspan="2">ACTION PLAN</td><td>What we will achieve in 2016-17</td><td>What we will do next period</td></tr>
<tr><td>1. Mobilisation of new whole system model delivered by Aspire from
2. A Hidden Harm Strategy is being developed for Doncaster jointly owned by key strategic partners, overseen by the H&WBB with an action plan due to be delivered in 2016/17.
3. Targeted awareness/prevention/education campaign is being devised across Doncaster
4. A new specialist needle/syringe exchange provision has opened across the Aspire service, including phased implementation at community hubs</td><td>1. Mobilisation of new whole system model delivered by Aspire from 1st April 2016. Monthly operational group meetings are taking place in order to monitor the developing service.

2. A Hidden Harm Strategy developed for Doncaster jointly owned by key strategic partners, agreed by the H&WBB with an action plan, is due to be amended to include domestic abuse factors.

3. A targeted IPED awareness/prevention/education campaign is being devised targeting gyms across Doncaster and training for gym owners and fitness professionals to be delivered in January 2017

4. A new specialist needle/syringe exchange provision has opened across the Aspire service, including phased implementation at community hubs</td></tr>
</table>

Doncaster Health and Wellbeing Board

Date: 16 March 2017

Subject: Black and Minority Ethnic Health Needs Assessment

Presented by: Susan Hampshaw, Public Health Principal

Purpose of bringing this report to the Board	
Decision	
Recommendation to Full Council	
Endorsement	✓
Information	✓

Implications		Applicable Yes/No
DHWB Strategy Areas of Focus	Substance Misuse (Drugs and Alcohol)	
	Mental Health	
	Dementia	
	Obesity	
	Children and Families	
Joint Strategic Needs Assessment		✓
Finance		
Legal		
Equalities		✓
Other Implications (please list)		

How will this contribute to improving health and wellbeing in Doncaster?
The HNA is part of an approach to improving inequalities in health outcomes in Doncaster and aims to highlight unequal outcomes (make the invisible visible) and develop actionable recommendations (see below).

Recommendations

The Board is asked to consider the following recommendations:

This BME HNA sits within work to reduce health inequality within Doncaster and aims to make health inequity related to ethnicity more visible and develop actionable recommendations. These actionable recommendations have been described throughout this report and are repeated below.

However, it is clear that to the implementation of these recommendations requires ownership, buy in, and on-going engagement and as a starting point these recommendations will be road-tested at a forthcoming Fairness and Inclusion event.

Recommendation 1 - assessing differences in access to and outcomes of health and social care services

Nationally, work is being undertaken to improve data monitoring on health inequalities which recognises the inter-sectionality and complexity of the issue and offers guidance on data collection beyond the legal requirements of the protected characteristics (NHS England, 2015). Locally, we know we have not yet been able to fully assess differences in access to and outcomes of health and social care services. This is a gap which we need to fill and this will form a work package for the Joint Strategic Needs Assessment (JSNA) which itself should not be considered to be a one off activity. Two key areas for the JSNA work package are outlined below:

- The work package should examine access to psychological therapies (Health and Social Care Information Centre, 2014) within Doncaster.

- Phase 1 of this HNA identified that some evidence that non-white groups in Doncaster continue to live in more overcrowded conditions. We did not specifically address this issue in the engagement phase of the needs assessment work and this is a gap, which we recognised during our stakeholder identification phase (described later). We recommend that this evidence be highlighted within current Health and Housing work and that Equality Impact Assessment is useful mechanism to facilitate this process (EEiC, 2016).

Recommendation 2 - accessing the evidence base

We have utilised an approach to evidence gathering that has taken advantage of networks, communities of practice and interest lists and the main steam media to scan for forthcoming and relevant research or publications. It is important to recognise that this evidence is not a systematic review and is instead a series of tailored forays into the literature. We have wherever possible utilised evidence that is in itself summary evidence of what is known rather than single studies. We recommend that this approach is systemised under the SPU work plan and acts as the means of horizon scanning for evidence to address inequalities for BME communities.

Recommendation 3 – developing the evidence base

During the course of the needs assessment process we have sought opportunities via networks to work for partners to develop the evidence base around what works to reduce inequity of outcomes. We have key opportunities to continue this work and these are outlined below:

- The team at Sheffield University has successfully applied to the Health Foundation to take part in the Evidence into Practice programme to develop 'online tools for GPs to help support new migrants in primary care. As a result of existing collaborations and relationships we are able to be part of this research project and can offer to work in partnership to co-develop these tools.

- Through the NIHR knowledge mobilisation fellow[1] we can have access to a case study on

[1] http://www.ethnicitycommissioning.group.shef.ac.uk/index.php/blog/

mobilising evidence on mental health and ethnicity which draw on the above sources (and others) and have an opportunity to learn from and apply this work in Doncaster and we recommend this course of action

In addition, the HWBB is sponsoring the Doncaster Research Festival in October 2017 and we recommend showcasing this work during the festival week.

Recommendation 4 - partnership working

Work by Nandi et al (2015) and NHS WRES work (NHS Equality and Diversity Council, 2016) examine the harmful impact of harassment and we recommend that that a representation from the Safer and Stronger Doncaster Partnership is sought for the HIWG. Work by the Gulliver (2016) highlights issues faced by BME communities in terms of housing and it is recommended that a representative from housing is sought for the HIWG.

Recommendation 5 - setting evidence based standards

Response to the local survey suggests that there is interest in understanding and addressing the areas of attention identified by the EEiC project. We recommend using these identified issues together with local analyse of the NHS organisation survey (NHS Equality and Diversity Council, 2016) and work with partners to develop an auditable local good practice statement.

Recommendation 6 – engagement approaches

Our earlier stakeholder analysis identified the importance of seeking the experience of people who were not necessarily part of established community groups. We were also keen to collect stories that might reveal issues with accessing services as this was theme identified in both the literature and earlier work to support the HWBB strategy refresh. The engagement approach has met these aims and produced evidence to inform the evidence safari. This means we have used a very focussed (data driven approach to engagement) and recognise that this means we have not engaged with the breadth of minority ethnic populations in Doncaster.

However, we are conscious that BME engagement within policy development needs to be strengthened and recommend work to develop evidence based approaches to engagement in a multi-ethnic population. The CoDE team used their analyses to support engagement and develop insight and we recommend that this data be used to form a specific piece of BME engagement work utilising existing forums and networks and that this should be part of the broader system engagement work.

Recommendation 7 – evidence safari actions

Several areas for action were identified and we recommend that these be tested via the Fairness Forum proposed event in April alongside recommendations 1-6.

Doncaster
Metropolitan Borough Council

Black and Minority Ethnic Health Needs Assessment

Report for the Doncaster Health and Wellbeing Board

March 2017

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Acknowledgements

This Black and Minority Ethnic (BME) Health Needs Assessment (HNA) has been carried out under the umbrella of Doncaster's Health and Wellbeing Board (HWB) and so we would like to acknowledge the support of partner organisations. The work has been supported by Lynne Carter who holds a National Institute for Health Research (NIHR) Knowledge Mobilisation Fellowship on mobilising evidence on ethnicity and health. Her insight, guidance and independent facilitation skills have been invaluable. We are pleased that our approach to the BME needs assessment will become a case study within her fellowship. We have also drawn on the NIHR's Evidence and Ethnicity in Commissioning (EEiC) work and have utilised their tools and guidance throughout

In terms of gathering demographic data we are indebted to DMBC's Strategy and Performance Unit (SPU), especially, Laurie Mott. The engagement work is reflective of partnership and we are grateful to colleagues in Public Health, in particular Caroline Temperton; at the CCG, especially Curtis Henry who supported access to primary care settings; within DMBC particularly, Wellbeing Officers, Customer Services and staff within SPU, especially Sheena Clark. We used Doncaster Healthwatch's Feedback Centre to gather experiences of health and social care services and we are grateful for the help, support, publicity and professionalism of the team there, especially Andrew Goodall and Akhlaq Hanif, and also to the many partners, and individuals who publicised this work. We are grateful to colleagues within the Doncaster Conversation Club and the Women's Centre Changing Lives project for supporting this BME HNA.

Finally, we would like to thank all participants and in particular speakers (Dr Victor Joseph, Lynne Carter, Radmila Fortune-West) at the *Evidence Safari* event for their time and enthusiasm.

Introduction

Background to the Health Needs Assessment (HNA)

The last specific BME health needs assessment in Doncaster was 2004. This was an extensive piece of work which focused on engagement with key groups representing BME populations to identify needs. Since then, the health needs of BME communities have been identified through Joint Strategic Needs Assessments (JSNA) and latterly have been included in individual organisational approaches to equalities and are recognised in organisational strategies including the Health and Wellbeing strategy. It is recognised that the make-up of BME communities in Doncaster are changing and the 2015 Director of Public Health (DPH) annual report identified inequity of health outcome between Doncaster communities and recommended we undertake a BME HNA. During 2016, we have revisited BME health needs across the borough and under the auspices of the HWB and have carried out a multi staged needs assessment, which culminated in an *evidence safari (see later)*. This report outlines the approach to assessing health needs and our findings. The recommendations are **visible** throughout the report and are repeated at the end of the document.

The BME HNA sits within work led by the Doncaster Public Health team to address health inequalities across the borough. By health inequality we mean 'systemic differences in the health of people occupying unequal positions in society'(Graham, 2009, p3. cited in Smith et al., 2016) This way of looking at inequality means that differences in health experience and outcomes are socially produced, avoidable, unfair and unjust (NHS England, 2015). In the UK, research around inequality has largely focused on social-economic determinants of health; however, there are other aspects of social position, such as ethnicity, that are important for health inequalities. Research focusing on other axes of inequality such as ethnicity acknowledges that outcomes in terms of inequality are more complex than a focus on a primary axes of socio-economic status (Hill, 2016). Of course individuals may experience a double or triple whammy in terms of health inequality because of their social status such as socio-economic, gender, ethnicity or sexuality (Graham, 2007 cited in Hill, 2016). This means that some people in our communities are living lives that are more short-lived, and more painful. Importantly, health inequality also represents lost opportunities for individuals, communities and economies.

Aims of the health needs assessment

Poor health outcomes in minority ethnic communities can, in large part, be explained by poorer economic status, but this is only part of the picture and this is why it is important for attention to focus on ethnicity (Allmark et al., 2010) . This BME HNA then aims to move our focus to ethnicity and health inequality.

One key idea underpinning Doncaster's work on health inequalities is that of *making the invisible visible.* By this we mean, recognising the important role of systematically identifying, examining and raising awareness of unequal health outcomes, in this case ethnicity, and using this *visibility* to ensure concerted attention on the issue.

The content of this BME HNA report takes us on this journey and should be viewed as a starting point for making the *invisible visible*; it aims to do this and make actionable recommendations that will both continue to make the invisible visible but also contribute to reducing inequalities.

Objectives

We used three intertwined phases and these are explained in more detail at the head of each section reporting the findings:

- To explore demographic data on Doncaster's BME population;
- To use this data analysis to support an overview of national evidence on BME health;
- To undertake focused engagement activities with local people (including individuals and groups) and organisations.

We also aimed to access and re-analyse previously collected data wherever possible. It is key to note that each stage is connected and aims to inform the next and focuses the needs assessment which we believe is a methodological strength.

Scope and limitations of the HNA

Traditionally, health needs assessments are a way of establishing the gap (if any) between the expressed needs of particular groups and both access to and outcomes from the current range of available services, public, private or voluntary. In addition through discussion with the communities themselves a range of possible options for improvements may be generated with implications for both commissioners and providers of services. We have used the phases outlined above to carry out the BME HNA and in particular have ensured that activities aimed to raise awareness and change the conversation i.e. to make the invisible visible and this work is a key strand within the emerging approach to Health Inequalities here in Doncaster.

We recognise that *making the invisible visible* is not a one off activity, nevertheless, this BME HNA report is good summary of activity since the DPH annual report's recommendation on the need to examine BME needs assessment (Doncaster Metropolitan Borough Council, 2015). The recommendations fall from these activities and we intend that the work forms a concerted effort to reduce inequity in health outcomes due to ethnicity. This needs assessment then should be viewed as a living document and progress on its recommendations will be updated via the DPH annual report.

There are inevitably limitations to both the report and the method and we identify these in the body of the text. We are aware that one major limitation is quality of data recording in terms of ethnicity; this is recognised issue and limits our ability to link local data to outcomes (Allmark et al., 2010). Nationally, work is being undertaken to improve data monitoring on health inequalities which recognises the complexity of the issue and offers guidance on data collection beyond the legal requirements of the protected characteristics

(NHS England, 2015). **Locally, we know we have not yet been able to fully assess differences in access to and outcomes of health and social care services. This is a gap which we need to fill and this will form a work package for the Joint Strategic Needs Assessment (JSNA) which itself should not be considered to be a one off activity.**

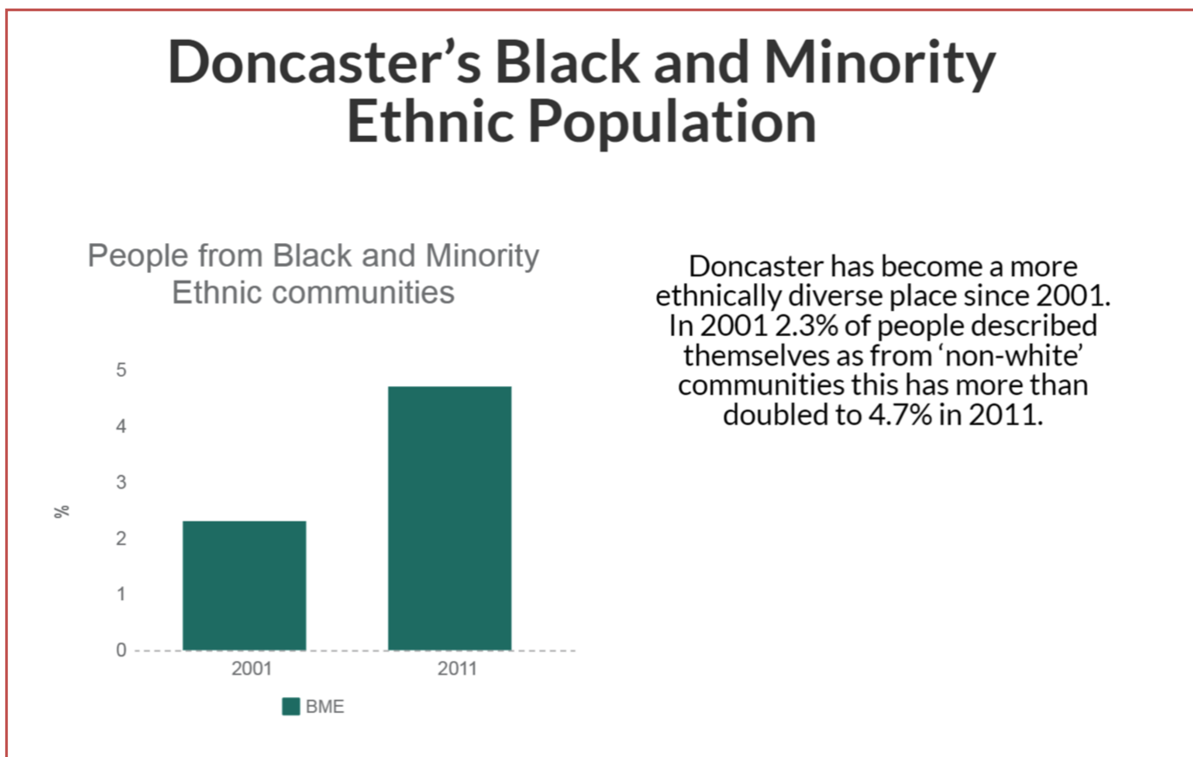
We have also undertaken a very focused (data driven approach to engagement) and recognise that this means we have not engaged with the breadth of minority ethnic populations in Doncaster. Work is being undertaken to develop a comprehensive engagement strategy and we make a recommendation around partnership work to ensure this includes an ethnicity perspective.

Definition of terms

It is important to recognise that ethnicity is a form of collective social identity that includes language, culture, shared histories and common ancestry (Karlsen and Nazroo, 2006 cited in Hill, 2016). We have found the following material produced by the Evidence in Ethnicity and Commissioning research project a valuable resource in terms of defining terms and have adopted it for our work (see Annexe 1).

Phase 1: Demographic information

Figure 1 Doncaster's BME population



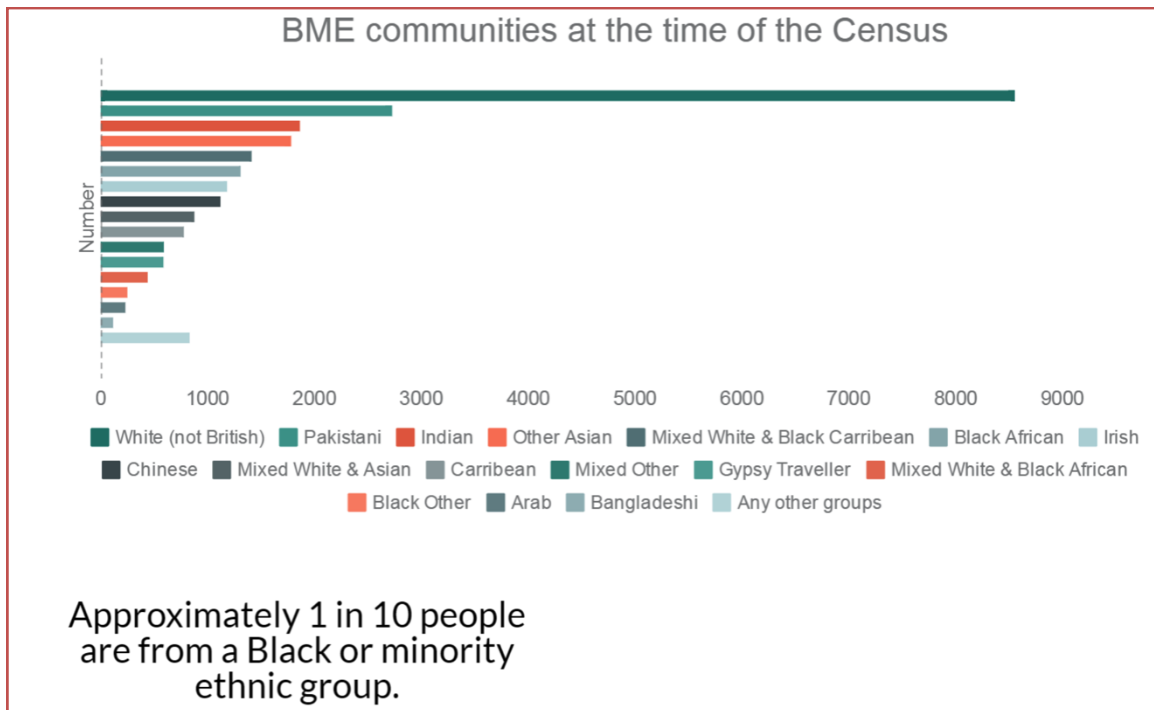
Phase 1 aimed to establish baseline demographic details using the most recent national census data, NHS data and other local census data e.g. school census data. The DPH annual report 2015 recognised that there were inequities in health outcomes for BME communities and used data from the 2011 census to provide an up-to-date picture of the

differences in health and the factors improving or damaging health (Doncaster Metropolitan Borough Council, 2015). Key issues identified from this analyses included:

- Overall Asian and Black groups had higher self reported health status (95.8% and 95.4%) than White British groups (91.3%), although both Asian and Black groups are less active than the general population.
- White British groups show twice the level of alcohol dependency than other groups, however both White and Black groups show the same level of drug dependence. The Asian group has the lowest levels of alcohol and drug dependency.
- National data shows that the Black population suffer from at least double the amount of Post Traumatic Stress Disorder than other populations and as much as 10 times the levels of severe mental illness (including psychosis).
- Other health conditions are more common in some ethnic groups, so heart disease is more common in the Asian population, stroke and hypertension more common in the Black population and both Asian and Black populations have high levels of infant mortality.
- The census also shows that the level of educational qualification varies across the ethnic groups with White Irish, Asian and Black groups having higher numbers of people with level 4 (degree level) qualifications than the general population. Asian and Black groups are also more likely to be students and as a result of being younger populations are more likely to be unemployed and less likely to be retired than the general population.

Based on Census 2011 data, the proportion of the total population in Doncaster classified as 'White British' equates to 91.8% (4.7% less than in 2001), and the national average is 80.45%. Those from BME backgrounds represent 8.2% of the total population. Young people from BME backgrounds represent 10.2% of the total 0-19 population. The working age population from a BME background represent 8.8%, and older people from BME backgrounds represent 2.9%. The proportion of BME population is not as large as the national average however key minority groups do exist in Doncaster. The ethnic group that is the second largest in Doncaster is 'white other' which includes 0.4% Irish, 0.2% Gypsy or Irish Traveller, and 2.8% White Other. Figure 2 below illustrates the BME communities at the time of the Census.

Figure 2: BME communities at the time of the Census



We recognise that, like many places, the make up of Doncaster has changed since the 2011 Census and so have used examined languages spoken and migration patterns to help us uncover evidence on newer populations.

Figure 3: Languages spoken in Doncaster

As can be seen from figure 3 above we have data which identifies languages spoken across Doncaster. Language spoken may be relevant in terms of an individual's ability to both access and navigate health and social care services as well as participate more broadly in

society and access resources within the Borough. The refresh of the HWB strategy identified gaps in services in relation to access to education and English courses. We have explored health and social care organisation responses to language in terms of availability within the provider survey undertaken in Phase 3.

Analysis undertaken by Migration Yorkshire (2016) on Doncaster migration patterns identifies reasons for migration and in particular around work and protection.

Table 1 Migration to Doncaster for work reasons during 2015

	Numbers of new migrant workers
EU accession countries	3070
Non-accession countries.	420

Data source: (Migration Yorkshire, 2016, p.2).

In terms of migration for work purposes the top countries of origin being Sudan and Spain. In terms of protection, according to Home Office figures at the start of April 2016, 269 people were being supported in Doncaster while awaiting a decision on their claim [known as Section 95 support]: 265 people were being accommodated, and there were four people receiving subsistence-only support i.e. no accommodation (Migration Yorkshire, 2016, p.3).

Migration Yorkshire analysis also identifies what it terms 'indicators of diversity'(2016) and these are listed below:

- Doncaster has 6% of the overall population in Yorkshire and Humber, but most counts of migration show it receives less than 6% of newcomers.
- In Doncaster, 8% of the community are non-British, a rise on the previous year, raising it above the Yorkshire and Humber regional average of 6%.
- 9% of the population were not born in the UK, an increase on the previous year, and now on par with the Yorkshire and Humber as a whole. They have settled particularly in Central, Wheatley and Town wards.
- Just over 3100 pupils at school in Doncaster have a first language that is not English. This is equivalent to 9% of primary pupils and 7% of secondary pupils; both figures are small increases on the previous year, but remain much lower than the Yorkshire and Humber averages of 17% and 13% respectively.
- 6 in every 1000 new GP registrations in Doncaster are made by people who previously lived abroad, compared with an average of 9 per 1000 across Yorkshire and Humber.

- The fertility rate in Doncaster has been in decline since 2009, and is now on par with the regional average. Births to mothers who were born outside the UK are lower than average but increasing over time; totaling 15% of all new births in 2014 compared to 20% across the Yorkshire and Humber.

Work undertaken to support the HWB strategy refresh identified gaps in services in relation to housing and homelessness for asylum seekers and refugees. Moreover, these analyses informed the next phases of the needs assessment and directed where we sought further evidence, for example, evidence around the health needs of migrants and engagement with services for refugees and migrants such as Health Access for Refuges Programme (HARP) and the Conversation Club.

In January of this year, the Manchester Centre on Dynamics and Ethnicity (CoDE) published local Ethnic Inequality Briefings [1] which were the culmination of work started in 2014 and funded by the Economic and Social Research Council (ESRC). We have taken aspects of this approach i.e. comparison of 2001 and 2011 data and applied it locally. It is important to note that it is more difficult to do these analyses in Doncaster because of our relatively small BME population (Gulliver, 2016). From a technical point of view this has meant that we have needed to collapse categories of ethnicity, and from an interpretation point of view it means that it is difficult to discern key messages from the data.

We have though in addition, to examining general health and disability looked at number of qualifications as an education indicator and have examined, overcrowding, and no central heating as an accommodation indicator. These analyses are presented below (figures 4 to 8). In terms of reading these figures, it is important to note that they compare the 2001 and 2011 census data. The important line to note is labelled zero, a bar to the right of this line indicates better positive health than the Doncaster average and to the left indicates worse than the Doncaster average.

In the accompanying commentary we have elected to highlight only where there seems to be area that may require attention. The CoDE team used their analyses to support engagement and develop insight and we recommend that this data is used to form a specific piece of BME engagement work utilising existing forums and networks.

[1] See http://www.ethnicity.ac.uk/research/outputs/briefings/inequality-briefings/

Figure 4: Ratio of people reporting poor general health

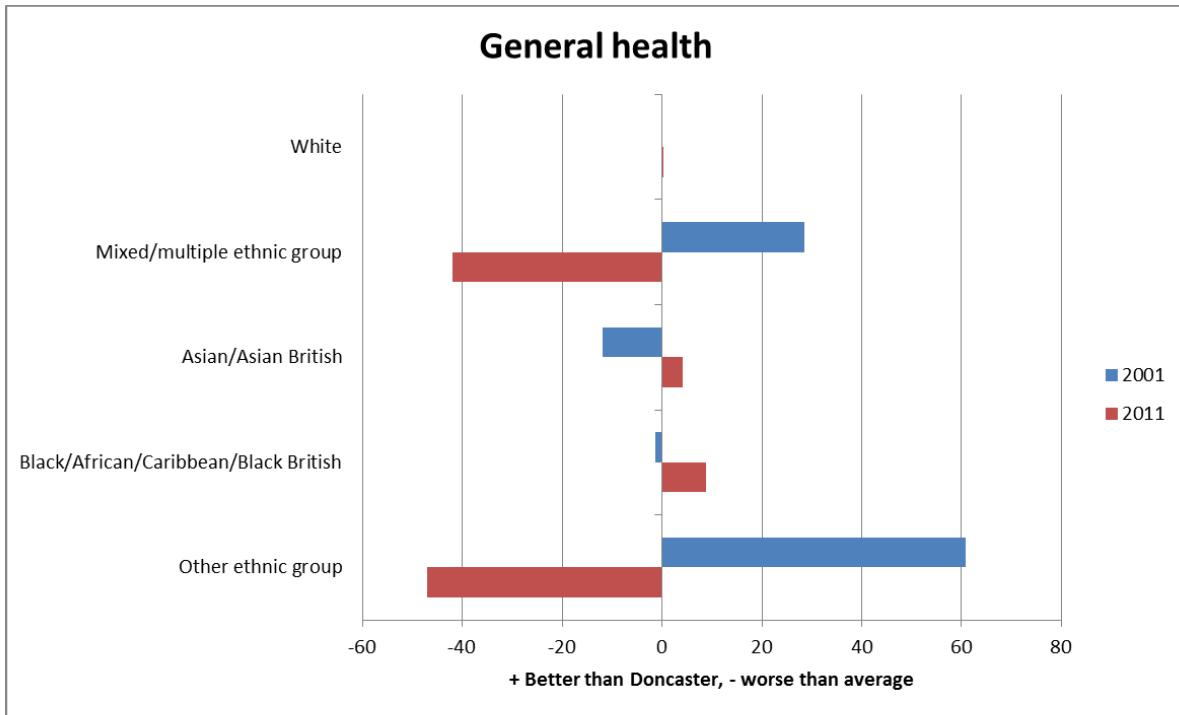


Figure 5: Ratio of people reporting a health problem or disability that is expected to last 12 months or more

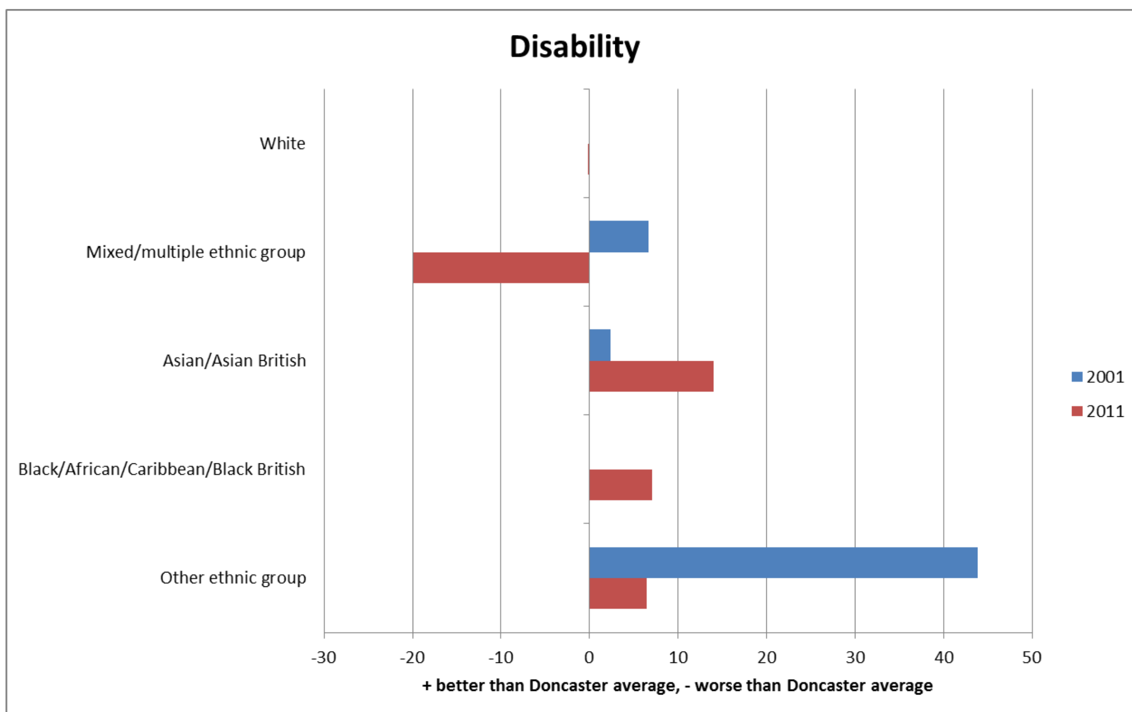
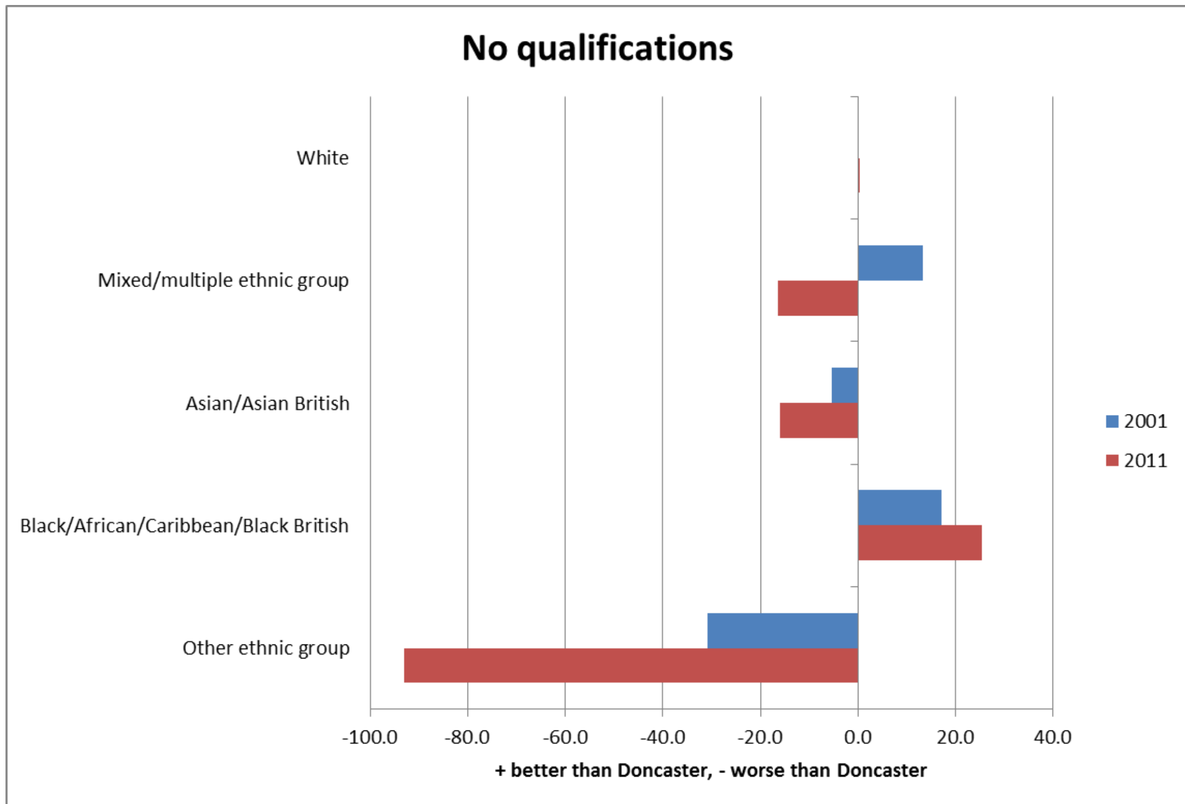


Figure 6: Ratio of people with no qualifications



In 2001, Black/African/Caribbean/Black British people were more likely to have a form of qualification than the Doncaster average and in 2011 this group was even more likely to have a qualification. The group most likely to not have a qualification was the 'other ethnic group.'

Figure 7: Ratio of people resident in overcrowded accommodation

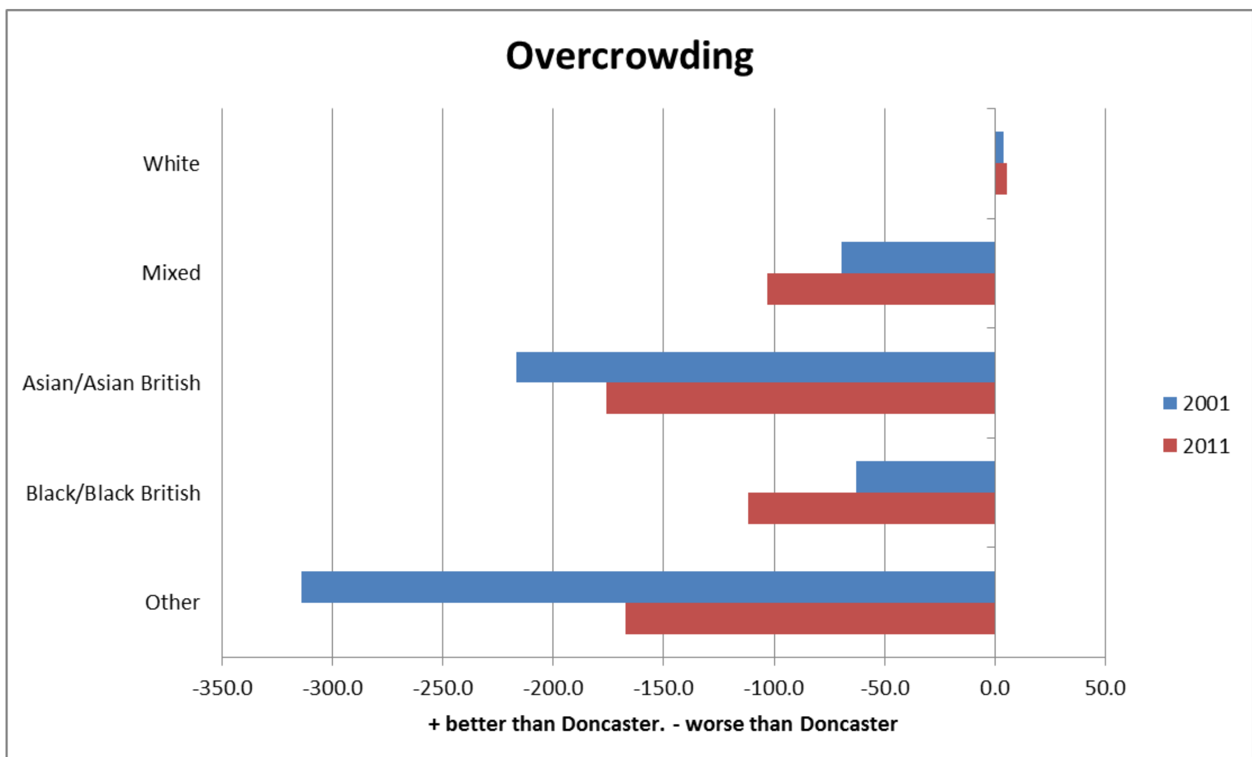
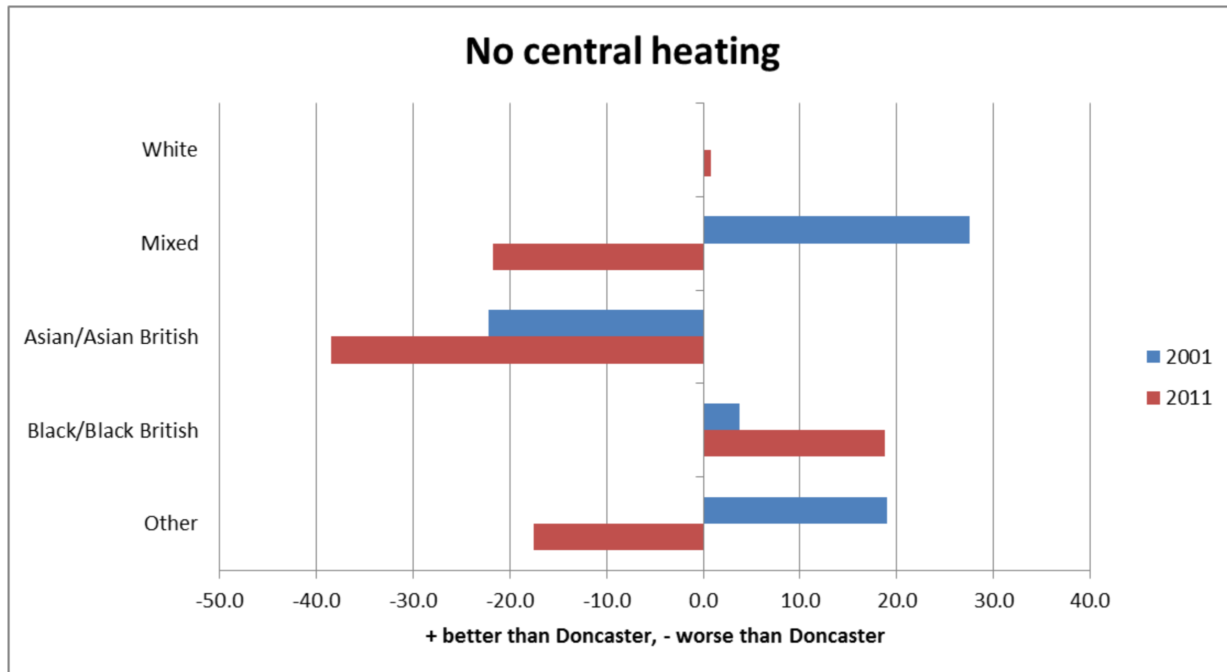


Figure 7 shows the ratio of people resident in overcrowded accommodation. This is defined as people resident in households with less than 1 room (excluding kitchen and bathroom) per person. This does seem to show people from non-white groups continue to live in more overcrowded accommodation.

Figure 8: Ratio of people resident on house with no central heating



Implications of phase 1

We have set out the data which explains the population make up of Doncaster in terms of BME communities. Doncaster has relatively small BME population but this analysis suggests that a key group for further attention is migrants and new arrivals. This also reflects evidence highlighted during the HWBB Strategy refresh work. We have used these insights to direct Phase 3 of the HNA.

These analyses also suggest areas for attention in terms of trawling the literature and highlight migrant health, metal health, and housing and our approach and findings form Phase 2 of the HNA. In addition, we were also conscious of the need to pay attention to how ethnicity can lead to 'differential exposure to health –related risk' and that can include harassment or discrimination. We included this in Phase 2 and 3 of the HNA.

It is also important to note that we further work is required to analyse health outcomes by ethnicity and this will form a work package in the Joint Strategic Needs Assessment.

Phase 2: Evidence from the literature

Approach to accessing the literature

Research on ethnicity and health is not located in one readily accessible place. Moreover, given the methodological complexity of evaluating outcomes of interventions designed to address health inequalities single studies can be misleading (Barr et al., 2016, p.260). Indeed, evidence based policy tends to advocate that it is best to use systematic reviews of high quality studies of evidence to guide policy and practice (Lavis et al., 2003). Ideally, then this section would comprise an overview of relevant (i.e. on issues such as mental health identified earlier) systematic reviews and guidance for practice. However, to date there are very few systematic reviews which address health inequalities (Bambra et al 2009, cited in Barr et al., 2016). There are also methodological challenges with using traditional systematic review approaches in the world of social policy intervention and more latterly synthesis which includes evidence from diverse sources has been advocated (Pawson, 2002).

We have not attempted to undertake such a review but have explored diverse sources to underpin the next section. In particular, we aimed to ensure that evidence on BME health needs sought from the literature and presented, was guided by issues identified during the HWBB refresh and as well as consideration of the issues arising from Phase 1 of this needs assessment specifically, migrant health, mental health, housing, and harassment.

Public Health England produce a guide on sources of evidence on ethnicity and inequality and this was our starting point (Public Health England, 2016a). Our approach to accessing the literature consisted of a number of strands of activity. Firstly, we revisited an NHS Evidence search undertaken by Knowledge and Library Services at Doncaster and Bassetlaw Teaching Hospitals (DBTH) in 2014. We then accessed centres of interest on health and ethnicity such as Sheffield University's Health Equity and Inclusion Unit (http://scharr.dept.shef.ac.uk/healthequity/) or Manchester's Centre on Dynamics and Ethnicity (http://www.ethnicity.ac.uk). Finally, we utilised an approach to evidence gathering that has taken advantage of networks, communities of practice and interest lists and the mainstream media (for example, recent reporting on breast cancer rates and Black women[2]) to scan for forthcoming and relevant research or publications.

It is important to recognise that this evidence is not a systematic review and is instead a series of tailored forays into the literature. We have wherever possible utilised evidence that is in itself summary evidence of what is known rather than single studies.

We recommend that this approach is systemised under DMBC's Strategy and Performance Unit (SPU) work plan and acts as the means of horizon scanning for evidence to address inequalities for BME communities.

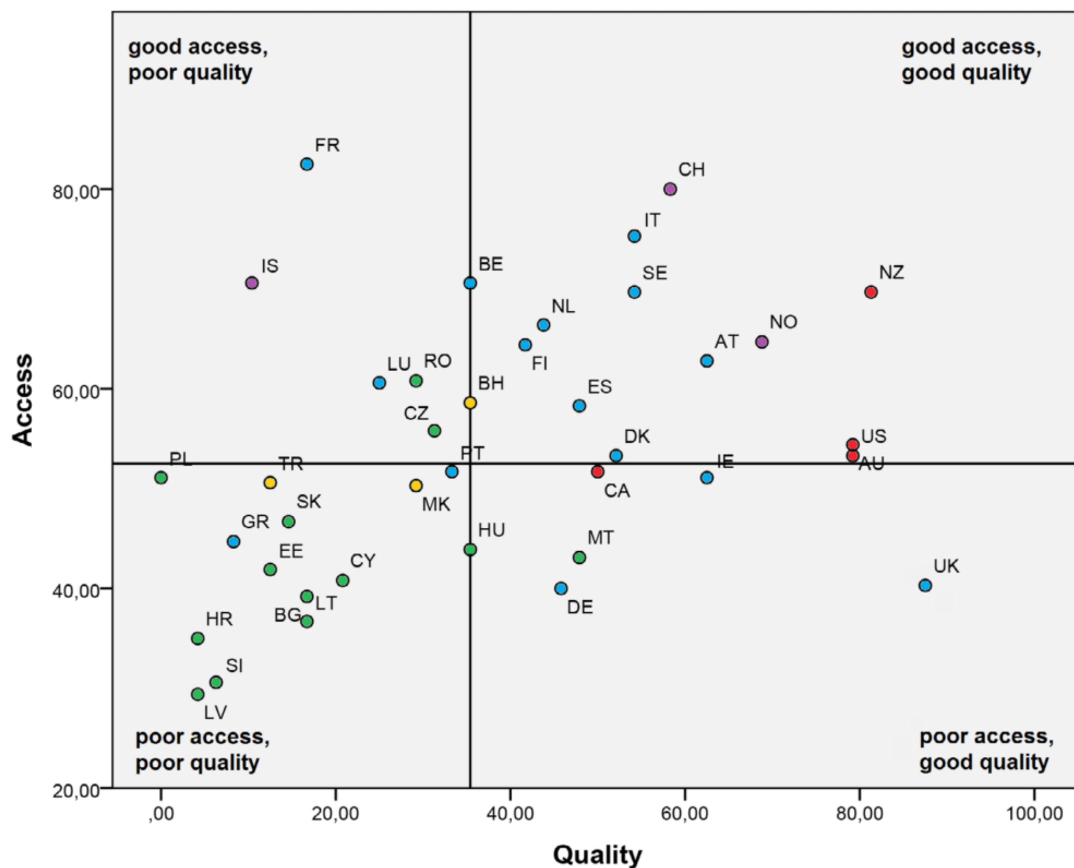
[2] http://www.bbc.co.uk/news/health-37991460

The forays into the literature enabled the development of evidence boards which were used in the *evidence safari* and this event was intended to provoke discussion and raise awareness. We have not reproduced these here but rather have set out key insights from the literature. At the end of the section we identify implications of this literature drawn from our analyses and from comments made at the evidence safari event.

Evidence from the literature on migrant health

We started with a recent international study on migrant health (IOM Migration Research Series, 2016). Figure 9 contains this international data which suggests that migrants coming to the UK receive high quality services but may have poorer experiences of access to services (IOM Migration Research Series, 2016).

Figure 9: Relation between access and quality



Key to colours:

Blue: EU15 countries
Green: Post-2000 accession countries
Purple: EFTA countries
Yellow: EU neighbour countries
Red: Non-European countries

Work within phase 3 (engagement and the evidence safari) has helped us understand how the local experience of these issues. One key issue within the literature is how primary care is able to adapt to new migrants. Staff at Sheffield University's Health Equity and Inclusion

group[3]) have been undertaking research in this area (Such et al., 2016). More information on the project can be found here https://newmigrantsinprimarycare.wordpress.com/

Key findings included:

- 84% of survey respondents reported migration had increased rapidly or steadily in their area in the past five years;
- One in five (21%) survey respondents did not identify any adaptations in service delivery for new migrant populations
- On average, respondents identified four barriers to adapting services for new migrants. The most frequently cited barriers were lack of funding (73%), lack of time (64%), insecurity of funding (47%), lack of staff (43%) and personal fatigue/'burn out' (34%);
- Adaptations were varied, including signposting patients to support agencies, coordinating primary care services with other agencies e.g. housing associations, providing cultural competency training for staff and providing 'one stop shop' clinics for new migrant patients. Case study organisations adapted their services in multiple ways.
- Drivers for adapting services included practitioner, organisational and wider contextual factors.
- Organisational and practitioner commitment to equity appeared to be critical.
- Adaptations aimed to enhance patient access, identify complex need, address the social determinants of health and improve patient-practitioner communication and trust

The team has successfully applied to the Health Foundation to take part in the Evidence into Practice programme to develop 'online tools for GPs to help support new migrants in primary care. As a result of existing collaborations and relationships we are able to be part of this research project and can offer to work in partnership to co-develop these tools.

[3] http://scharr.dept.shef.ac.uk/healthequity/

Evidence from the literature on mental health

Mental health was identified as a key issue from earlier work to refresh the HNA. Rees et al in their review of the prevalance of health disorders in adulty minority ethnic populations in England identified that there was limited information from appropriately desighed surveys (Rees et al., 2016) and make recommendations to improve this.

We set out below what they have been able to glean in the areas of suicidal thoughts and depression and anxiety.

Suicidal thoughts

The review of the prevalence of mental health disorders in adult minority ethnic populations found a relatively strong patterns for suicidal thoughts in both men and in adults although for different ethnic groups in each case (Rees et al., 2016). The picture was complex for both cases:

- A strong pattern was seen among analyses of the prevalence of suicidal thoughts in men and suggested that prevalence was relatively low for South Asian men and lower for South Asian men than it was for White men;
- A strong pattern was seen among analyses of the prevalence of suicidal thoughts for adults as a whole and suggested that prevalence was relatively low for Black adults, and lower for this group than it was for White adults;
- A pattern was seen among women in the prevalence of suicidal thoughts, with South Asian women having a relatively low prevalence when compared with women from one or more other ethnic groups (White women in particular);
- A pattern was seen among men in the prevalence of suicide attempts, with South Asian men having a relatively low prevalence when compared with men from one or more other ethnic groups (White men in particular).

Doncaster is developing a suicide prevention strategy which follows national guidance which identifies groups clearly at risk and is reflective of this evidence in terms of its focus. (Public Health England, 2016b).

Depression and anxiety

Rees et al identify the following patterns (2016):

- A pattern was found among adults in the prevalence of Any Common Mental Disorder, with adults from some South Asian ethnic groups (Pakistani in particular) possibly having a relatively high prevalence when compared with adults from one or more other ethnic groups (White adults in particular);
- A pattern was seen among women in the prevalence of Mixed Anxiety and Depressive Disorder, with South Asian women (Pakistani women in particular)

possibly having a relatively high prevalence when compared with women from one or more other ethnic groups;

- A pattern was seen among women in the prevalence of Any Depressive Episode, with South Asian women (Indian and Pakistani women in particular) possibly having a relatively high prevalence when compared with women from one or more other ethnic groups (White women in particular);

- A pattern was seen among adults in the prevalence of Any Depressive Episode, with adults from some South Asian ethnic groups (Indian and Pakistani) having a relatively high prevalence when compared with one or more other ethnic groups (White adults in particular);

These patterns suggest the need to examine access to psychological therapies (Health and Social Care Information Centre, 2014) within Doncaster and we recommend that is undertaken as part of the JSNA work package.

Finally, through the NIHR knowledge mobilisation fellow[4] we can have access to a case study on mobilising evidence on mental health and ethnicity which draw on the above sources (and others) and have an opportunity to learn from and apply this work in Doncaster and we recommend this course of action.

Evidence from the literature on housing

Nationally, Gulliver et al have undertaken a research project to examine progress over the last 40 years and conclude that progress has been made but that there is still much to be done. Specifically, Gulliver highlight that BME households are more likely to live in older, fuel poor and overcrowded housing and in flats, and terraced homes and be over concentrated in more deprived communities. Other findings included:

The level of housing deprivation is greater for the BME population. BME households account for more than 1 in 3 homeless acceptances by local authorities in England in contrast to their 1 in 7 presence in the general population.

Homelessness has grown proportionately more for BME groups over the last two decades from 17 to 37 per cent of the total. They are also more likely to be among the non-statutory and/or hidden homeless (2016).

Phase 1 of this HNA identified that some evidence that non-white groups in Doncaster continue to live in more overcrowded conditions. We did not specifically address this issue in the engagement phase of the needs assessment work and this is a gap, which we recognised during our stakeholder identification phase (described later). We recommend that this evidence be highlighted within current Health and Housing work and that Equality Impact Assessment is useful mechanism to facilitate this process (EEiC, 2016).

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[4] http://www.ethnicitycommissioning.group.shef.ac.uk/index.php/blog/

Evidence from then literature on harassment

We used an ESRC funded study which examines over time using a national survey the prevalence and persistence of ethic and racial harassment and its impact on health (Nandi et al., 2015). Key findings included:

- Ethnic minorities are most likely to experience ethnic and racial harassment and anticipate it in streets, shops and public transport;
- Chinese men and women, Pakistani men, Indian-Sikh men, Indian-Muslim men and Bangladeshi women are more likely to report such experiences than others – around 15%;
- For most ethnic groups, twice as many people anticipate or fear harassment than actually experience it, with the exception of black Caribbean and black African groups;
- Women are more likely than men to feel unsafe and avoid places, but men are more likely to report actually experiencing ethnic and racial harassment;
- These patterns persist after account for contextual factors that vary across ethnic groups;
- The likelihood of experiencing ethnic and racial harassment is lower for those living with a higher proportion of their own ethnic group members after taking into account area level deprivation.

The NHS Workforce Race Equality Scheme (WRES) work (NHS Equality and Diversity Council, 2016) also examine these issues. Nandi et al work is in an early phase and will go on to examine the impact of harassment, identify risk and protective factors (2015). We recommend that the Health Inequalities Working Group keep up to date with this work and that that a representation from the Safer and Stronger Doncaster Partnership is sought for the Health Inequalities Working Group.

Implications of Phase 2

Phase 2 provided insights that we wanted to test in our engagement phase specifically around experiences of new arrivals and refugees. A key issue throughout this literature is also access to services and phase 3 needed to consider how to access insights or local voice on accessing health and social care services.

This phase also has limitations in that our approach to needs assessment has involved outputs from one phase guiding the steps in the next phase (and this has largely being a chronological process. However, it does mean that the literature was focussed on specific issues rather than summarising evidence on, for example, poorer outcomes for cardio-vascular disease. This is obviously a gap but this can be addressed as part of the proposed JSNA work package around health outcomes and BME populations.

As a result of this phase we have also identified specific opportunities such as the chance to be part of work to develop online tools for GPs to support new migrants. We have also had the opportunity to take part in a regional practice sharing on meeting the physical activity needs of minority ethnic populations. Finally, we have the opportunity to work to mobilise knowledge on mental health and ethnicity using approaches developed during the NIHR Knowledge Mobilisation case study.

Phase 3: Engagement with local people and organisations

As stated earlier outputs from phases 1 and 2 informed our approach to engagement. In addition, in July 2016 we held an independently facilitated workshop and with a range of DMBC and NHS staff using the EEiC Stakeholder Identification and "In their shoes" tools.[5] These activities helped us identify a broad range of stakeholders and together with earlier phases resulted in the approach outlined in Table 2. We were also concerned to test innovative engagement approaches so that lessons learned might inform wider engagement approaches.

Table 2: overview of our approach to engagement with local people and organisations

Stakeholder group	Identified via:	Summary of engagement approach
New arrivals	Phases 1 and 2	Access organisations supporting these groups such as HARP, Doncaster Conversation Club and the Changing Lives Project Re-analyse of data collected as part of the HWBB refresh (4 focus groups – 2 BME from various background, 1 Polish participants, 1 gypsy and traveller community held at Changing Lives; 1 focus group Conversation club); documentary analysis
Settled communities	Stakeholder identification exercises	Collection of 'experience of using services' stories via the Doncaster Healthwatch Feedback Centre
HWB member organisations	Stakeholder identification exercises	Development and administration of survey instrument on 'common areas for attention'
Established groups	Stakeholder identification	We elected to focus on

[5] http://ethnicitycommissioning.group.shef.ac.uk/about.html

	exercises	groups supporting new migrants (see below)

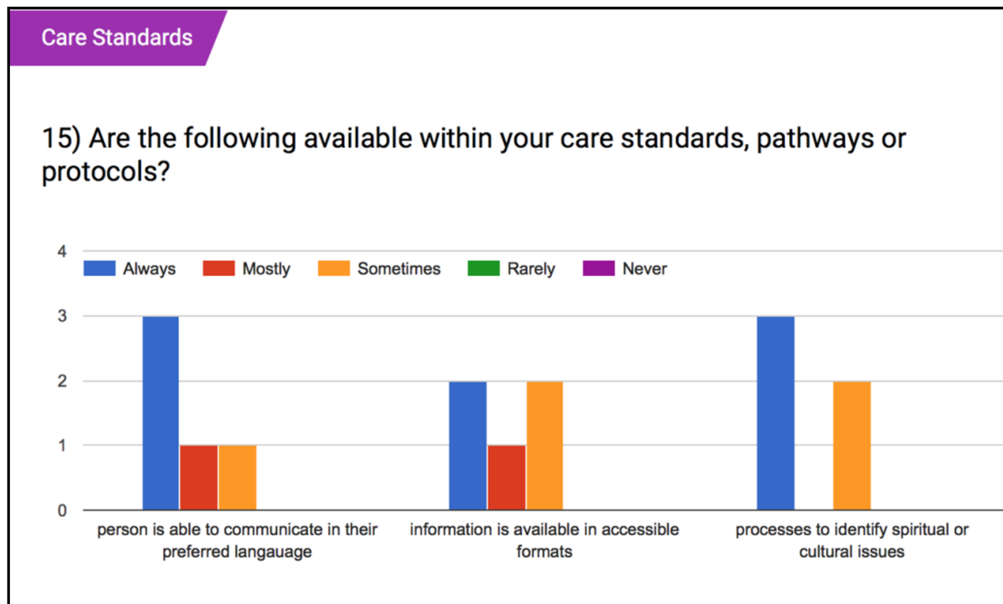
Partners

In terms of partners we designed and administered a survey on 'common issues' or areas for attention for improving services for multi-ethnic populations that had been identified by the EEiC project. This was administered to member organisations of the HWB (40% of which responded and key findings are outlined below.

- Respondents were asked whether they accessed national guidance or best practice on minority ethnic needs, over half stated that they did always or most of the time and produced list of sources they would consult.
- A third of respondents stated that they analysed complaints and compliments by ethnic group.
- Respondents were asked about activities to address minority ethnic needs such as outreach, awareness raising, monitoring referrals by ethnicity and monitoring DNA rates by ethnicity. The majority of respondents did not undertake this type of work.
- Half of all respondents stated that their organisation staff profile represented the ethnic profile of their local population. A third of respondents also said their staff undertook cultural competence training. In addition, we are aware that NHS partners have responded to other survey work on this issue. Indeed, the introduction of the Workforce Race Equality Standard (WRES), aims to prompt inquiry to better understand why it is that BME staff often receives much poorer treatment than White staff in the workplace and to facilitate the closing of those gaps (NHS Equality and Diversity Council, 2016).
- In terms of signage in relevant language few organisation always did this. However, local data suggests that we have relatively large percentage of residents who speak English at home (96%).
- None of the respondents stated that single sex accommodation; dietary and spiritual needs were rarely available.

Finally, organisations were asked about Care Standards and the figure 9 outlines responses.

Figure 9: responses to Care Standards question



This survey has produced some useful finding, although we recognise not all organisations were able to respond within the time frame**. Response to the local survey suggests that there is interest in understanding and addressing the areas of attention identified by the EEiC project. We recommend using these identified issues together with local analysis of the NHS organisation survey (NHS Equality and Diversity Council, 2016) and work with partners to develop an auditable local good practice statement.**

Engagement with local people

Previous direct engagement work had focussed on engaging with existing groups and so this time we aimed to engage with a wider population of people who perhaps did not attend groups. We were concerned to collect insight around the experience of new arrivals in Doncaster as well as insights from members of BME communities living in Doncaster to understand their experiences of accessing heath and social care services. Access to services was identified as key issue in the literature (Allmark et al., 2010; IOM Migration Research Series, 2016; Such et al., 2016) and as part of the HWBB strategy refresh

Data collected via the Healthwatch Feedback Centre

During November 2016, we encouraged local people from BME background to access the Doncaster Healthwatch Feedback Centre to tell us about their experiences of accessing health and social care services. Participants wanting to give feedback in languages over than English are able to do so via the Feedback Centre. The participant is also able to select from a variety of services and give outline their experience as well as score their experience. The specific questions are outlined in the figure 10 below.

In terms of encouraging participation we used 4 routes:

1. Promotion of the activity using a leaflet and landing page via networks and using, social media (details of the social media campaign can be found here https://storify.com/Hampshaw/hwbbvoices)

2. Staff from DMBC's Strategy and Performance Unit and Community team were given access to general practices located in areas with higher BME populations and supported local people to complete paper copies of the survey;

3. These staff also spent time in DMBC's One Stop Shop encouraging participation in the survey by people visiting this venue

4. Finally, volunteers from Doncaster Healthwatch visited the town centre to recruit participants to the survey.

Staff attended briefing sessions and received written guidance to support them in recruiting and we undertook an After Action Review[6], which will be used to develop any further engagement work.

[6] http://www.betterevaluation.org/en/evaluation-options/after_action_review

Figure 10 Healthwatch Feedback Centre

Leave feedback

How do you rate your overall experience of this service?*

Summary of your experience* **(max 45 characters)**

Give a brief description of your experience, or highlight a key observation

Tell us more about your experience*

Expand on your experience here. Why was your experience a good / bad one? List any reasons or specific detail that might help explain

Where do you live? **(town/city)**

Doncaster

Your ratings (select if applicable)

Staff Attitude

Waiting time

Treatment explanation

Quality of care

Appointments

Interpreting services

Admission

Discharge

Prescriptions

Reception

Findings

- During the data collection period (9th-18th November 2016) 153 feedback forms were received (either online or paper copies).

- All respondents were encouraged to define their ethnicity and religion. 38% of those who described their ethnic identity were from respondents with a BME background and these backgrounds were varied and reflective of BME people living in Doncaster.

- The largest groups of respondents defined themselves as Asian (34%) or Other white background (32%).

- The majority of comments (68%) were positive about the experience of using health care services in Doncaster and the following quotations are illustrative of this data:

'Not any long waiting times and the doctors are nice there' (Female, any other mixed, multiple ethnic background)

"All staff are excellent and I would not fault them" (Male, Chinese)

"Excellent doctors and communication here" (Male, any other Asian background)

"Appreciate the service' 'Frequently visit with mental health issues – very supportive" (female, Gypsy-Irish Traveller)

"Helpful and supportive"(Male, African)

- There were concerns about whether services were listening and the next quotations are illustrative of these concerns:

'"Very long waiting times, feels like nobody cares there"(Male, Any other Black / African / Caribbean background)

"Don't feel like they always listen to me properly. So don't feel like I should come unless I need to." (Female, White and Black Caribbean)

"Unable to get to the bottom of current health problems." (Male, Pakistani)

Insight from groups supporting new arrivals

We gathered information on experience of arriving in Doncaster via three key sources:

- Insight from Doncaster Conversation Club using focus group data from the HWBB refresh and a documentary analysis of the Club's newsletters[7].

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[7] http://www.doncasterccg.nhs.uk/2914/doncaster-conversation-club-newsletter/

- Insight from attendees at the Doncaster Women's Centre Changing Lives project using focus group data from the HWBB refresh and additional data requests facilitated by staff at the Women's Centre.
- During the evidence safari we worked with Doncaster's Health Access for Refugee Programme (HARP) and highlighted their work to support refugees to access health and social care services. We include two illustrative case studies below.

We have analysed this data to identify themes and these are outlined below together with illustrative quotations. We have also included poetry produced by members of the Conversation Club as these offer insight into arrival experiences and contribute to making the *invisible visible.*

In terms of evidence from the women we talked to we identified the following themes:

Knowledge about health issues and managing illness

- Generally, participants in all of the focus group were knowledgeable about key health messages. There was less certainty about how to navigate the health system, where to go to find out information and valued the Women's Centre for information. Translation was also an issue with some participants identifying that translator add a layer of interpretation or opinion to the issue being discussed rather than using the actual words used by the women.
- When asked about feeling ill and how to manage these the women talked about the importance of simple remedies such as paracetamol and sleep. Women would also seek help from a GP; the gypsy and traveller group participants talked about seeking advice about GP attendance from within their community.
- In terms of caring for children, the women expressed the importance of seeking acting quickly if a child was unwell and used the term "*children are emergencies;"* some of the women said they would call an ambulance if their child was not well.

Access to services

- All but one of the women in the mixed groups were registered with a GP and said it was an easy process. However, the Polish group were not registered as they return home for their treatment. The gypsy and traveller group reported issues of accessing a GP whilst travelling in the UK and that some of the older members of the community were reluctant to travel because of this issue. In terms of dentistry, many of the group were not registered unsure of the process or in the case of the Polish group travelled home for dental treatment
- During the needs assessment we also collected stories from the women about navigating the system and this quotation illustrate issues identified:

"I have problems with housing my landlord does no repairs my home very dangerous to our health. Been refused Asylum 2, it is so very hard. My home is horrible but can't

complain because they will say I am not grateful. I live in a shared house but people in there are not very nice. I stay in my room with my child or try to go out all the time which is hard as I have no money"

Preventative services

- Participants were asked about screening programmes and the majority had attended appointments for cervical smears and commented on the efficiency of the process. It was more difficult to discuss this issue with the gypsy and traveller group (see later).

- In terms of the child health programme, again the importance of protecting the young was a key theme and for most participants their children were up to date. The gypsy and traveller group participants expressed concerns about immunisation. There were also broader concerns about the HPV vaccine

Social isolation and loneliness

- The women talked about the value of socialisation, conversation and the information exchange role of the Women's Centre and this following quotations collected during the needs assessment illustrated this:

" I was very isolated with having limited English. I had no friends till I came to women centre and my husband is ok with it as there is no men" (A lady from Czech Republic)

"I feel very stressed I left my country not happy but I had to for danger not safe but now when I come to centre I feel less stressed with nice people around me and a good teacher that listens and helps me with my problems." (A lady from Algeria)

"I like centre because when I lost my husband I had no family in England, so I have new friends and can talk to someone as I was very lonely. So it makes me forget my pain". (A lady from Pakistan)

In terms of evidence from participants from the Conversation Club again the main theme was around accessing and navigating services to meet their perhaps complex needs:

- Participants explained that their issues are often complex and GPs and other services may not be able to respond. Adaption of primary care services to meet complex needs is an occurring theme (phase 2; Such et al., 2016).

- Participants also talked about knowing how to navigate the system and access services particularly for single people transitioning from M25 support and their own accommodation; concerns about homelessness (Gulliver, 2016). The issue of access to college courses including English was also raised.

- Participants also made suggestions to provide solutions to some of their concerns, for example the idea of a 'welcome to Doncaster' pack or 'some of kind of induction for new arrivals. ' This idea was also suggested by participants at the *evidence safari.*

Finally, we include a poem written by a Conversation Club member:

Litany by Denise – Issue 22
To live my life
I risk my life.
To live my life
I leave life.
To live my life
I leave my love.
I am person
Full of love.
I am here
My loves are there.
There is love.
I am lie down.
They lie me down
Like animal. Rape.
Cold like robot.
No love.
Men bring me
Beat me.
Hot water burn me.
Scars.
No love touch.
No eating
No drink
No bed
No human
No love.
I am here now.
Safe?
But they are there
Still. Still
Far away love.
Here I dream fear
Here I remember,
Mind shackled
Alone, different.
No one love
Here safe
But emptiness
But missing
But longing
For love

In terms of evidence from HARP, national evaluation of the programme identifies that asylum seekers that asylum seekers and refugees are prone to poorer states of health arising from situations in their respective countries of origin, the conditions they experience in their journeys to the UK and their lack of understanding of how to access health care services once they reach the UK. The evidence also shows that access is not just a demand-side issue. On the supply-side health practitioners have a responsibility to consider their own practices and how they enable or disable access by asylum seekers and refugees. HARP sets out to address these issues by training migrant volunteers to both support newly arrived people and train health service staff to understand specific needs of arrivals.

HARP have provided evidence to support this needs assessment:

- Since June 2016, over 30 volunteers in Doncaster have been trained to work directly with newly arrived asylum seekers and refugees supporting them to access local health services in an appropriate way. All volunteers are asylum seekers and refugees themselves and on average each volunteer stays over four months volunteering with the HARP. Most HARP clients have difficulties in language and they rely on our volunteers to support them with interpreting and advocating on their behalf.

- HARP runs advice and advocacy sessions. Since June 2016 volunteers have assisted 315 unique service users during the 25 separate sessions. Out of this 74 clients are female and 241 male from 30 different countries including the Albania, Afghanistan, Iraq, Iran, Ethiopia, Eritrea, Sudan Somalia and Syria.

- Since June 2016, 67 newly dispersed asylum seekers have attended the NHS Access course which is held and delivered by HARP volunteers at the Refugee Council Office on the Bennetthorpe Road, Doncaster.

The following two case studies illustrate the health access journeys:

The client was suffering from kidney failure and he was in pain for a period of three months. Due to language problem, he couldn't describe what he was suffering from and the interpreters were not able to give a full picture of his illness. Possibly due to different dialects.

He was referred to the HARP and was given one of the volunteers to mentor him and escort him to the hospital as his interpreter. It was at this time that the GP got a full picture and referred him to the hospital where he was diagnosed of an acute kidney failure. The doctors carried out an operation immediately because the left kidney was completely damaged.

(male, Eritrean Asylum Seeker)

The client received a penalty charge from the hospital due to an expired HC2* which was not renewed for over two months. The client got so confused that he did not eat for 2 days and did not know what the outcome would be. He said many thoughts surrounded his mind as he thought that they might arrest him because he didn't have the money being demanded and also thought that was going to affect his asylum case. He said, he cried and cried until *'a drop in day'.*

When he came to the drop he was in devastated state and never expected there was any solution. He was depressed and still sobbing. The NHS Prescription Exemption Checking (PEC) office was called and explained that he was an asylum seeker and his HC2 delayed, the fine was cancelled. Called the Support Team to follow up on the HC2 and was advised that it would be in within 5 days.

With these simple steps, [there was a visible] change in the client. He literally couldn't believe it and his countenance brightened up and he started chatting with other people. He enrolled to be one of the HARP volunteers and he is now one the most committed volunteer helping other asylum seekers to renew HC2 and cancelling PEC fines.

(Male, Sri-Lanka, Asylum Seeker) (* see http://www.nhsbsa.nhs.uk/HelpWithHealthCosts.aspx for further details on processes around

Implications of Phase 3

These comments captured via the Healthwatch feedback, Conversation Club and Changing Lives project offer some insight into the experience of BME communities accessing health and social care. Our earlier stakeholder analysis identified the importance of seeking the experience of people who were not necessarily part of established community groups. We were also keen to collect stories that might reveal issues with accessing services.

The engagement approach has met these aims and produced evidence to inform the evidence safari. However, we are conscious that BME engagement within policy development needs to be strengthened and recommend work to develop evidence based approaches to engagement in a multi-ethnic population. The CoDE team used their analyses to support engagement and develop insight and we recommend that this forms part of a specific piece of BME engagement work utilising existing forums and networks.

Bringing it all together: an evidence safari to make the invisible visible

What is an evidence safari?

The evidence identified above was used within a December HWB workshop. We used an evidence safari approach a technique promoted and advocated within the national Open Policy Toolkit. [8] This technique is particularly useful to explore need and therefore helpful in terms of examining BME health needs and supports our ambition of making the *invisible visible.*

The format [9] of the event consisted of an opening video from CODE[10] and an overview of the session. Participants worked in small groups and visited several evidence stations: an overview of the approach; who lives in Doncaster; local voices; what do we know about health needs & what works; migrant health (live workshop input from HARP project and Dr Victor Joseph.) At each station, participants were asked to read, discuss and write down their responses to the evidence. The whole group reconvened to identify gaps in the data or process, actions to support future stages and were able to prioritise the identified actions.

[8] https://www.gov.uk/guidance/open-policy-making-toolkit
[9] more detail can be found here https://storify.com/Hampshaw/hwbbsafari
[10]https://www.youtube.com/watch?v=eVklWWrmB1Y&index=4&list=PLu4jsRxIimNGgH7nTgKRgXuGnCb6a7zvF

Event summary and outcomes

44 people attended the event from a variety of organisations. Evaluation data is positive and included very helpful suggestions around the organisation of the evidence safari (in terms of the use of boards, number of stations, specific questions and widening attendance etc.) and these will be used to inform future work. Feedback also suggests that the use of an evidence safari is helpful in terms of our approach to tackling health inequalities as many participants felt the event had opened up their thinking and raised awareness. Overall, the event was well received. We have themed the actions below:

- Actions around building stronger engagement with BME communities and that this engagement needs to recognise the diversity within our BME population and that work should strengthen BME communities by seeking collaboration opportunities. Ideas for engagement included community development approaches; single gender groups; use of pharmacies
- Actions that ensure high quality and accessible interpretation and translation
- Actions to develop community understanding (seek opportunities to bring people together) challenge prejudice (from all sources offer training on cultural competence; unintended bias) and celebrate and value diversity
- Actions which focus on other determinants of health such as education (including education around navigating the system and induction for new arrivals and access to English courses)
- Actions which focus on more intelligence gathering from our BME populations
- Actions which focus on making sure the recommendations of the HNA are implemented (such as strong leadership, clear outcomes; reporting on protected characteristics)

This data together with all the evidence we have identified throughout this needs assessment report are to be tested via a Fairness and Inclusion Forum event at the end of April 2017.

Concluding remarks and recommendations

As stated earlier, this BME HNA sits within work to reduce health inequality within Doncaster and aimed make health inequity related to ethnicity more visible and develop actionable recommendations. These actionable recommendations have been described throughout this report and are repeated below.

However, it is clear that to implement these recommendations requires ownership, buy in, and on-going engagement and as a starting point these recommendations will be road-tested at a forthcoming Fairness and Inclusion event.

Recommendation 1 - assessing differences in access to and outcomes of health and social care services

Nationally, work is being undertaken to improve data monitoring on health inequalities which recognises the complexity of the issue and offers guidance on data collection beyond the legal requirements of the protected characteristics (NHS England, 2015). Locally, we know we have not yet been able to fully assess differences in access to and outcomes of health and social care services. This is a gap which we need to fill and this will form a work package for the Joint Strategic Needs Assessment (JSNA) which itself should not be considered to be a one off activity. Two key areas for the JSNA work package are outlined below:

- The work package should examine access to psychological therapies (Health and Social Care Information Centre, 2014) within Doncaster.

- Phase 1 of this HNA identified that some evidence that non-white groups in Doncaster continue to live in more overcrowded conditions. We did not specifically address this issue in the engagement phase of the needs assessment work and this is a gap, which we recognised during our stakeholder identification phase (described later). We recommend that this evidence be highlighted within current Health and Housing work and that Equality Impact Assessment is useful mechanism to facilitate this process (EEiC, 2016).

Recommendation 2 - accessing the evidence base

We have utilised an approach to evidence gathering that has taken advantage of networks, communities of practice and interest lists and the main steam media to scan for forthcoming and relevant research or publications. It is important to recognise that this evidence is not a systematic review and is instead a series of tailored forays into the literature. We have wherever possible utilised evidence that is in itself summary evidence of what is known rather than single studies. We recommend that this approach is systemised under the SPU work plan and acts as the means of horizon scanning for evidence to address inequalities for BME communities.

Recommendation 3 – developing the evidence base

During the course of the needs assessment process we have sought opportunities via networks to work for partners to develop the evidence base around what works to reduce inequity of outcomes. We have key opportunities to continue this work and these are outlined below:

- The team at Sheffield University has successfully applied to the Health Foundation to take part in the Evidence into Practice programme to develop 'online tools for GPs to help support new migrants in primary care. As a result of existing collaborations and relationships we are able to be part of this research project and can offer to work in partnership to co-develop these tools.

- Through the NIHR knowledge mobilisation fellow[11] we can have access to a case study on mobilising evidence on mental health and ethnicity which draw on the above sources (and others) and have an opportunity to learn from and apply this work in Doncaster and we recommend this course of action

In addition, the HWBB is sponsoring the Doncaster Research Festival in October 2017 and we recommend showcasing this work during the festival week.

Recommendation 4 - partnership working

Work by Nandi et al (2015) and NHS WRES work (NHS Equality and Diversity Council, 2016) examine the harmful impact of harassment and we recommend that that a representation from the Safer and Stronger Doncaster Partnership is sought for the HIWG. Work by the Gulliver (2016) highlights issues faced by BME communities in terms of housing and it is recommended that a representative from housing is sought for the HIWG.

Recommendation 5 - setting evidence based standards

Response to the local survey suggests that there is interest in understanding and addressing the areas of attention identified by the EEiC project. We recommend using these identified issues together with local analyse of the NHS organisation survey (NHS Equality and Diversity Council, 2016) and work with partners to develop an auditable local good practice statement.

Recommendation 6 – engagement approaches

Our earlier stakeholder analysis identified the importance of seeking the experience of people who were not necessarily part of established community groups. We were also keen to collect stories that might reveal issues with accessing services as this was theme identified in both the literature and earlier work to support the HWB strategy refresh. The engagement approach has met these aims and produced evidence to inform the evidence safari. This means we have used a very focussed (data driven approach to engagement) and recognise that this means we have not engaged with the breadth of minority ethnic populations in Doncaster.

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[11] http://www.ethnicitycommissioning.group.shef.ac.uk/index.php/blog/

However, we are conscious that BME engagement within policy development needs to be strengthened and recommend work to develop evidence based approaches to engagement in a multi-ethnic population. The CoDE team used their analyses to support engagement and develop insight and we recommend that this data be used to form a specific piece of BME engagement work utilising existing forums and networks and that this should be part of the broader system engagement work.

Recommendations 7 – evidence safari actions

Several areas for action were identified and we recommend that these be tested via the Fairness Forum proposed event in April along side recommendation 1-6.

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Annexe 1: EEiC definition of terms

EEiC
Thinking Clearly

What is ethnicity?

A complex term with many meanings

Though the terms 'ethnicity' and 'ethnic group' are used frequently in Britain today, their meaning is not always clear. Indeed, 'ethnicity' can be used to mean a range of different things, and is measured in a variety of ways, making it a confusing and contentious concept.

A form of 'bio-social' identity

Ethnic identity draws on a range of social and biological characteristics often linked to notions of ancestry, heritage, culture and appearance – 'where you come from', 'what you believe', 'what you do' and 'what you look like'.

Flexible not fixed

Ethnic identities are not natural or fixed. The meaning and importance of ethnicity varies across space and time.

A product of social relations

Ethnic identities are a product of the societies in which we live. In each social context particular bio-social characteristics become important markers of individual and group identity. Societal structures and ideologies reinforce feelings of 'belonging to' and 'difference from' particular groups or communities. Ethnic identities are hierarchical and shape access to resources within society. Minority ethnic identities are commonly constructed as inferior and minority ethnic people may face significant discrimination and exclusion.

A proxy for factors affecting health

Because ethnicity is operationalised in society along the lines of physical features, ancestry, religion and so on, ethnicity can often be a useful proxy for factors that affect health including: access to health-promoting resources; exposure to health risks; and health-seeking behaviours.

Ethnic groups and categories

There is a popular misconception that groups categorised using ethnicity are homogenous with innate genetic differences or distinct cultures. In fact, there is much heterogeneity within ethnic groups. Nevertheless, such categories are not meaningless and can be useful when they identify groups of people who are at risk of particular disadvantage. The categories used by government agencies – such as the Census 2011 categories – undergo extensive testing for acceptability and relevance, and are revised over time to reflect changes in this fluid concept. Nevertheless, these categories will not always be useful and meaningful.

An important measure of need and access

Because social relations influence the provision of healthcare, and because biological and social characteristics influence health need, we often find significant inequalities between ethnic groups in health outcomes and healthcare access and experience. Ethnicity is therefore an important variable to consider in planning health and social care services.

Now see Thinking Clearly! What are the links between ethnicity and health?

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Agenda Item 10

Doncaster Health and Wellbeing Board

Date: 16 March 2017

Subject: **Health and Social Care Transformation Update**

Presented by: **Patrick Birch**

Purpose of bringing this report to the Board	
Decision	None required
Recommendation to Full Council	Not applicable
Endorsement	Not applicable
Information	Yes

Implications		**Applicable Yes/No**
DHWB Strategy Areas of Focus	Substance Misuse (Drugs and Alcohol)	No
	Mental Health	Yes
	Dementia	Yes
	Obesity	No
	Children and Families	No
Joint Strategic Needs Assessment		No
Finance		No
Legal		No
Equalities		No
Other Implications (please list)		No

How will this contribute to improving health and wellbeing in Doncaster?
Doncaster Council's Adult's Health and Wellbeing Transformation Programme is a fundamental part of Doncaster's Place Plan.

Recommendations
The Board is asked to:- Note the progress made so far on health and social care transformation.

S:\Legal_Committees\Masters Forms\Toolkit Forms\Report Cover Sheet for Health and Wellbeing Board UPDATED Feb 2016

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Doncaster Health and Wellbeing Board – Adults Health and Wellbeing Transformation Programme Update

Transformation overview and background

On 22nd March and 29th November 2016, Doncaster Council's Cabinet considered and supported reports that set out the pressing need to transform Adults, Health and Wellbeing services in Doncaster due to the rising demand for, and pressure on, adult social care services in the UK, the need to offer better care to local people and major government cuts to Council funding.

The reports set out the plan for the future transformation of adults, health and wellbeing and the potential for a positive impact on local people. The new transformation programme emphasises the huge scale of change required and the significant and lasting effect it will have on the way the Council operates. The programme has at its heart a positive "asset based" approach to care, centred on what individuals are able to do and how they can be helped to live at home for longer. It is supported by a detailed and comprehensive business case and builds upon the work and achievements of the Council's current Immediate Business Improvement (IBI) programme.

Immediate Business Improvement Programme

The IBI projects have made good progress, including:

- On track to reduce long term residential care numbers from 1,506 to 1,404
- More robust commissioning and contracts
- Commissioned Care and Support at Home - better and more efficient care
- Redesigned Safeguarding Adults Personal Assets Team service
- Improved safeguarding arrangements
- Independence and better support for people with Learning Disabilities
- Improved information, advice and guidance
- Beginning of a shift in culture

The New Transformation Programme

The new programme will reinforce the developing culture of change, and boost the ambition of the Council and its partners to deliver transformation. The clear detailed and evidence based plan sets out a strategy for completely redesigned services that put people first. Better quality, person led services will be commissioned by integrated health and social care partners from a broader and more diverse range of professionals.

The components of the plan are set out in the following 7 portfolios of work:

1) **Community Led Support** - A new operating model built around community working – the proposed new operating model is built around localities, community led support and the evolution of a vibrant provider market. Staff at the front line and communities themselves are engaged in developing this model to support culture change and engagement. Doncaster people will have their strengths recognised rather than their weaknesses, which will shape the services they receive and enhance the capacity of local communities.

2) **Customer Journey** - to support the new ways of working, the end to end care management pathway for local people will be redesigned to reflect a new customer journey. This includes redesigning how we carry out critical activities such as reablement, respite and reviews, so that they build on people's strengths, and connect them with different ways of meeting need (including from community and voluntary groups).

3) **Transforming Commissioning** - redesigned commissioning (for all aspects of care) will be at the heart of the new blueprint. It is about working with local people to understand

local needs and outcomes, co designing and co delivering services that meet those needs whilst providing value for money. The local market will develop to include a wider range of providers. Personal budgets will stimulate the market and enable people to have more choice. Assistive technology will avoid premature admittance to residential care.

4) **Digital** - The Council has established a Digital Council programme which aims to deliver digital capabilities in order to improve services and to reduce costs. The digital portfolio of work builds on this programme by implementing improved case management and business support technology, and by making the right investments in analysis and predictive analytics to support early intervention

5) **Performance and Continuous improvement** - recognises the need to develop a much more structured approach to performance monitoring and management, which establishes stronger links between vision, outcomes and activity. Better performance management will also allow us to better predict and prevent demand and meet needs and outcomes more cost effectively

6) **Health and Social Care Integration** – Strategic partner EY have been appointed to help us shape and co-produce the place plan, aligning the cohorts and the transformation programme outcomes and working closely with Health and partners

7) **Alternative Service Delivery Models –** There are a number of potential projects within this portfolio of work which will focus very much on the best way to deliver a service, which may be directly through DMBC or through other models such as joint venture companies, trusts, staff mutual. Robust business cases will inform all decision making.

Local people are at the heart of this transformation and some of the anticipated outcomes are:

- More people (at least 60) with learning disabilities able to live independently, using and building their strengths and choosing their own care options;
- 200 more older people given the support they need to continue to live at home and link better with their communities;
- An improved range of options for people receiving care and support at home, so that they can choose the most effective way of meeting their needs, by exhausting natural support mechanisms first including from community groups, family and friends and private providers, with Council funded resources being a last resort not the first port of call;;
- Better use of assistive technology as a first consideration to form a fundamental part of packages of care, to promote independence and improve quality of life;
- Personalised budgets for all service users, including 150 more people receiving direct payments and a significant increase in personal budgets;
- Every month 600 more people will have meaningful conversations in their own communities about their strengths, care needs and options and communities providing their own solutions;
- At least 500 people receiving a better service, with social care needs being dealt with faster, more effectively and with more enabling outcomes;
- More efficient functions, resulting in a reduction in the number of staff required to provide and support services; and
- Building on these and other positive outcomes, the potential to deliver savings that will help to protect future services.

Recruitment

To be able to deliver transformation of this magnitude the right people with the right skills will be required. The council is currently taking steps to secure the additional workforce needed to deliver effective programme management and operational services. Recruitment will commence in April 2017 supported by an information and awareness campaign detailing, the ambition and innovation of Team Doncaster, the vision and values, and what an exciting time it is for the right people to get involved.

Communication and engagement

The campaign to communicate and promote the programme, now titled 'your life, your way', has commenced and is in the process of being rolled out across different channels. Items have appeared this month on regional news channels on both television and radio. The next phase of communication and engagement is planned to take place from June through to August.

Financial implications

The business case supporting the programme has identified potential net savings over the next 5 years of £14.6M, through changes to care provision, managing demand for services, increasing productivity and reducing inefficiency. This includes investments of £6.7M in areas such as supported living, direct payments and technology. These figures are entirely consistent with the council's Medium Term Financial Forecast and will make sure that resources can be focussed on those people who are most in need of support.

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Doncaster
Metropolitan Borough Council

Date: 16 March 2017

To the Chair and Members of the HEALTH & WELLBEING BOARD

BETTER CARE FUND UPDATE

EXECUTIVE SUMMARY

1. The purpose of this report is to provide members with an update on the BCF, Performance and future direction of travel.

EXEMPT REPORT

2. There is no exempt information contained within the report.

RECOMMENDATIONS

3. That the Health & Wellbeing board consider the information provided.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4. The Health & Wellbeing Board aims to improve health and wellbeing for the residents of Doncaster and reduce inequalities in health outcomes. This aim is shared by partners to the BCF and wider Place Plan.

BACKGROUND

5. Proposals around the Better Care Fund (BCF) were launched in December 2013 through a joint letter sent out from the Department of Health and Department for Communities and Local Government. Partners were required to formulate joint plans for better care, so that the pooled budgets worth £3.8m between health and social care announced in June 2013 could start from April 2015.

6. The BCF is the biggest ever financial incentive for the integration of health and social care. It has required Clinical Commissioning Groups and local authorities across the country to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation. In the first full year local areas contributed an additional £1.5 billion to the fund in addition to the £3.8 billion committed by the Government.

7. In year 2 of the fund – 2016-17, the mandated minimum deployed rose marginally to £3.9 billion with the flexibility to pool more if partners agreed. The emphasis of the fund is to support greater integration and this is seen as a potential way to use resources more efficiently, in particular by reducing avoidable hospital admissions and supporting early discharge. The BCF and other drivers of integrated care such as new care models are seen to pave the way for greater integration of health and social care services. There was also an emphasis on aligning the BCF plans to other programmes of work as set out

in the NHS Five Year Forward View and the delivery of 7 day services.

8. During 2016, work has accelerated around Place Plans and Sustainability, Transformation Plans (STP). In Doncaster a Place Plan has been developed and has already been shared with the H&WB, it features within the South Yorkshire and Bassetlaw STP. Work is currently in hand to develop the Place Plan as a delivery plan and partners from across Doncaster are working with a strategic partner to work this up and develop further the key elements outlined in the NHS Five Year Forward Plan.

9. The ambition remains to establish integrated health and social care across the country by 2020, this is set out in the spending review and will require everyone to have a plan for this in 2017. In Doncaster we consider the BCF to be both an important vehicle for integration but also a resource that will enable us to transform current services and delivery efficiencies to ensure that we can meet the increasing challenges of rising demand and an ageing population.

Performance in Q3

10. The BCF sets out a number of national conditions that must be met and subsequently delivered by each local plan. For 2016/17 those national conditions are:

1) Plans to be jointly agreed
2) Maintain provision of social care services (not spending)
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate
4) Better data sharing between health and social care, based on the NHS number
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

7) Agreement to invest in NHS commissioned out-of-hospital services
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan

11. Doncaster meets most of the national conditions for the BCF, however, work is still in progress in a few areas. For example although 7 day working is provided across many health and social care settings, work is being undertaken within intermediate care to better understand the benefits across the whole IC pathway.

12. With regards to the metrics linked to the £23,906,550 BCF spend in Doncaster, performance has been challenging. With regards to non-elective admissions the BCF plan, in line with national expectations, was to reduce the number of non-elective admissions in year. However, between April-December 2016 non-elective admissions increased around 0.7% (2.19% above the plan). This pattern is not unusual- during December 2015-December 2016 non-elective admissions via A&E increased by 3.6% nationally. Work to reduce non-elective admissions is currently focussed around intermediate care and the provision of a rapid response to urgent needs within the community, as detailed in the Doncaster Place Plan.

13. There were 5360 reported delayed days due to delayed transfer of care during April-December 2016 which is significantly above both the BCF target (35.2%) and the corresponding period in 2015 (28.3%). This is due to an improved understanding of national definitions and data capture locally, following the release of new national guidance. Further work is underway locally to drive this further forward to ensure that reporting is fully in line with national definitions. At this stage there is no concern that this represents a rise in actual delays, although this position is monitored weekly at the multi-agency operational group

14. Assistive technology installations per 100,000 population aged 65+ are on target during the year to December 2016, there were 942 installations which is 23.1% above BCF target.

15. Admissions to residential care per 100,000 population (65+) is on track for improved performance but not to meet the full target. There were 288 admissions in the period which is 28% lower than the corresponding period in 2015, but 38.1% above the BCF target of 209. A more robust multi-disciplinary residential admissions panel was introduced in November 2015 which has enabled more people to be cared for in the community rather than in residential homes. The proportion of people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services is on track for improved performance but not to meet the full target. The percentage of patients still at home was 78.9% which is lower than the BCF target of 83.6%.

16. The Doncaster Place Plan will establish a central assessment and navigation service which will coordinate reablement and rehabilitation plans in each of the 4 neighbourhoods in Doncaster.

17. In conclusion, although Doncaster is only ahead of trajectory in one of the metrics, good progress over last year is noted in two other areas. The planned transformation work together with the development of an integrated approach to the implementation of the Place Plan should see continued progress moving into 2017/18.

Governance and performance management moving forward

18. It is proposed that the current governance and performance management arrangements around the BCF are further strengthened during 2017. This will ensure that all projects funded through BCF are regularly reviewed so that remedial action can be taken early to ensure ineffective projects are decommissioned and others commissioned to support the delivery of key metrics. The revised proposals will be circulated to H&WB members for comment when they are completed, however, there will be no changes to the role of the H&WB as senior body within the sign off process.

Moving forward

19. Although we are yet to see the final arrangements for BCF for 2017-19, we have begun to plan for our submission for the period. Doncaster has a good track record for submitting high quality BCF plans, the 2017-19 submission will be strongly linked to the ambitions set out in the Doncaster Place Plan and proposals outlined in transformations across the system. This should enable us to accelerate our performance and deliver services that provide excellent outcomes for the citizens of Doncaster, H&WB will be updated regularly on progress.

OPTIONS CONSIDERED

20. There are no alternative options within this report. Any future proposal will receive an appropriate options appraisal.

REASONS FOR RECOMMENDED OPTION

21. N/A

IMPACT ON THE COUNCIL'S KEY OUTCOMES

22.

	Outcomes	**Implications**
	All people in Doncaster benefit from a thriving and resilient economy. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans*	The work of the health and wellbeing board has the potential to have an impact on all the Councils key objectives.

	• *Mayoral Priority: Protecting Doncaster's vital services*	
	People live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	
	People in Doncaster benefit from a high quality built and natural environment. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	
	All families thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	
	Council services are modern and value for money.	
	Working with our partners we will provide strong leadership and governance.	

LEGAL IMPLICATIONS

23. There are no specific legal implications arising from this report.

FINANCIAL IMPLICATIONS

24. The overall BCF fund is identified in Paragraph 11.There are no specific financial implications arising from the recommendations detailed in this report.

HUMAN RESOURCES IMPLICATIONS

25. There are no specific human resources implications.

TECHNOLOGY IMPLICATIONS

26. There are no specific technology implications.

EQUALITY IMPLICATIONS

27. There are no significant equality implications associated with this report.

CONSULTATION

28. Any specific issues arising from future de-commissioning/commissioning activity will be subject to appropriate communication.

BACKGROUND PAPERS

29. None

REPORT AUTHOR & CONTRIBUTORS

Jon Tomlinson, Assistant Director - Commissioning
Telephone: 01302 737519 Email: jon.tomlinson@doncaster.gov.uk

Kim Curry
Interim Director, Adults, Health & Wellbeing

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

11 November 2016, Birch/Elm Room, Oak House, Rotherham

Decision Summary

Reference	Item	Lead
1	**South Yorkshire and Bassetlaw Plan**	
05/16	(a) that the South Yorkshire and Bassetlaw Sustainability and Transformation Plan Collaborative Partnership Board (STP CPB) published the plan, supporting the principles, ambition, vision and priorities and to work with the STP partners, noting this would also be discussed by each organisation for a considered response.	**ALL**
2	**Communications approach and publishing the plan**	
06/16	(a) that The STP CPB approved the communications and engagement approach to publishing the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.	**ALL**
3	**Independent review of hospital services**	
07/16	(a) that Doncaster and Bassetlaw NHS Foundation Trust would share learning and information with WCG from work done to date on sustainability of services (b) GF agreed to lead on PH intelligence regarding the independent review of hospital services with support. Further detail to be discussed with WCG (c) that the Yorkshire Ambulance Service would be included within the terms of reference and further comments be received by the STP CPB by 25 November on the terms of reference (d) that the STP CPB supported the next steps, including the proposal for a summary scope to be developed to be used to invite proposals from external consultant. An update on progress to be delivered at the next meeting.	**DAWN JARVIS** **GREG FELL** **WILL CLEAY-GRAY, ALL** **ALL**
4	**Terms of reference**	
08/16	(a) that JS would provide comments on scope of the sustainability funding key responsibilities bullet point. (b) that the terms of reference be brought back to the next meeting as a holding position of governance and that these be kept live to be amended as required.	**JOHN SOMERS** **WILL CLEARY-GRAY**

5	**Summary Version of the STP**	
09/16	(a) that all comments on the summary STP document be received by 15th November to be published on that date to accompany the main plan.	**ALL**
6	**Strategic Commissioning Intentions**	
12/16	(a) that the STP CPB approved the STP Strategic Commissioning Intentions to the shared with the SYB System.	**RACHEL GILLOTT**
7	**Implementation plan and resourcing the approach proposals**	
13/16	(a) that the STP CPB noted the immediate resource requirements and capacity gaps and agreed the principle of a fair share approach across SYB providers, commissioners and local authorities to resourcing the STP. (b) that the STP CPB supported delegating the working up of proposals to the Finance Oversight Committee. (c) that the potential risk to delivery as a result of the resource gap was noted. (d) that a fair shares approach to resourcing be brought back to the next meeting	**ALL** **STP PMO** **ALL** **STP PMO**
8	**Governance review**	
14/16	(a) that the STP CPB noted the interim governance proposals and supported the approach to establish a Governance Review Group, Chaired by the STP Lead and supported by Jayne Brown, Chair of SHSC.	**ALL, STP PMO**

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

Minutes of the meeting of 11 November 2016, Birch/Elm Room, Oak House, Rotherham

Present:

Andrew Cash, South Yorkshire and Bassetlaw STP Lead/Chief Executive, Sheffield Teaching Hospital NHS Foundation Trust (CHAIR)
Louise Barnett, Chief Executive, The Rotherham NHS Foundation Trust
Adrian Berry, Medical Director, South West Yorkshire Partnership NHS Foundation Trust
Patrick Birch, Director of Improvement, Doncaster Council
Des Breen, Medical Director, Sheffield Teaching Hospital NHS Foundation Trust
Sandra Crawford, Associate Director of Transformation, Nottinghamshire Healthcare
Will Cleary-Gray, Director of Sustainability and Transformation, South Yorkshire and Bassetlaw STP
Chris Edwards, Accountable Officer, Rotherham Clinical Commissioning Group
Adrian England, Chair, Healthwatch Barnsley
Greg Fell, Director of Public Health, Sheffield City Council
Idris Griffiths, Interim Accountable Officer, Bassetlaw Clinical Commissioning Group
Steve Hackett, Director of Finance, Chesterfield Royal Hospital
Dawn Jarvis, Director of Strategy and Improvement, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Alison Knowles, Locality Director North of England, NHS England
Wendy Lowder, Acting Executive Director of Communities, Barnsley Council
Ainsley Macdonnell, Service Director – North Nottinghamshire & Direct Services, Adult Social Care, Health and Public Protection, Nottinghamshire County Council
John Mothersole, Chief Executive, Sheffield Council
Jackie Pederson, Accountable Officer, Doncaster Clinical Commissioning Group
Matthew Powls, Interim Director of Commissioning, Sheffield Clinical Commissioning Group
Mathew Sandord, Associate Director of Planning and Development, Yorkshire Ambulance Service
Kathryn Singh, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust
Steve Shore, Chair, Healthwatch Doncaster
John Somers, Chief Executive, Sheffield Children's Hospital NHS Foundation Trust
Helen Stevens, Associate Director of Communications and Engagment, Commissioners Working Together
Lesley Smith, Accountable Officer, Barnsley CCG
Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation Trust
Neil Taylor, Chief Executive, Bassetlaw Council
Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust
Janette Watkins, Programme Director, Provider Working Together Programme
Janet Wheatley, Chief Executive, Voluntary Action Rotherham
Kate Woods, Programme Office Manager, South Yorkshire and Bassetlaw STP

Apologies:
Julia Newton, Chief Finance Officer, Sheffield Clinical Commissioning Group
Jo Miller, Chief Executive, Doncaster Council
Diana Terris, Chief Executive, Barnsley Council
Simon Morritt, Chief Executive, Chesterfield Royal Hospital
Anthony May, Chief Executive, Nottinghamshire Council
Frances Cunning, Deputy Director of Health and Wellbeing, Public Health England
Mike Pinkerton, Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Ruth Hawkins, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust
Richard Stubbs, Acting Chief Executive, The Yorkshire and Humber Academic Health and Science Network
Maddy Ruff, Accountable Officer, Sheffield Clinical Commissioning Group

Tim Moorhead, Clinical Chair, Sheffield Clinical Commissioning Group
Mike Curtis, Chief Executive, Health Education England
Leaf Mobbs, Director of Planning and Development, Yorkshire Ambulance Service
Richard Henderson, Chief Executive, East Midlands Ambulance Service
Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust
Andy Hilton, GP, Sheffield Clinical Commissioning Group
Neil Priestley, Director of Finance, Sheffield Teaching Hospital NHS Foundation Trust

Minute reference	Item	ACTION
01/16	**Welcome and introductions** AC welcomed all to the inaugural meeting of the Sustainability and Transformation Plan Collaborative Partnership Board meeting (STP CPB)	
02/16	**Apologies for absence** Apologies were noted and recorded as above.	
03/16	**Reflections on past 9 months STP development** AC outlined the intentions of the first STP CPB; to support the vision, ambition and priorities of the SYB STP. It was advised that following the meeting, the SYB STP would be published in public. All interim governance arrangements would be discussed at the meeting. Reflections were noted by AC as follows: An SYB plan had been compiled in a very short space of time with clear ambition, vision and priories which was an achievement. The plan was high level and would be followed up with detailed work. Place plans, serving neighborhoods and keeping people close to home with care were fundamental to the SYB STP, connecting centres of health and social care, sectors of choice, opportunity, employment and education with a wider public sector reform programme. The high level ambitions developed to date would lead on to delivery. Some challenges were noted around moving from the current situation to realise the development of the strategic agenda. To achieve this, all leaders must hold their organisations to the plan to serve local neighbourhoods. Reflections were welcomed from the STP CPB. A comment was made around the political sensitives of the STP process to date, noting that all must be mindful of openness and transparency while engaging stakeholders as the STP developed. The publication of the STP should be viewed as a starting point for politicians. It was felt that it should also be emphasised that the detail of any changes that	

	followed the STP CPB meeting would go through all usual processes for engagement, service change and decision making. It was requested that local councils and politicians be given the time and space required to react to the document. A comment was made that the language being used to date had been helpful that the role of the leaders was clear in supporting the ambitions, visions and priorities of the STP. A comments was made that the STP being centered around place based design would be key moving forward. Chief executives would lead this through individual organisations. AC would also be meeting with key stakeholders after publication.	
04/16	**National update from the STP lead** The STP CPB noted that all 44 STPs were submitted on 21 October 2016. The SYB STP had been advised that work could commence. Nationally there were 4 cohorts that an STP could be placed within. The SYB STP was in cohort 1 alongside other well established collaborations such as Manchester. All STPs were now beginning to publish. AC reported on a meeting with the Arms Length Bodies (ALB), stating that work would take place with SYB STP on finances, the transformation themes relating to demand and flow, and the interface with social care. Discussions had also taken place nationally around reconfigurations and assistance would be given by the ALBs on this in due course if this was needed. Discussions had also taken place around capital and the need to be realistic on priorities. The STP would align with the contracting and planning round.	
05/16	**SYB Plan** The STP CPB received the plan that was submitted on 21 October 2016 noting that it had been well received. This would allow the SYB STP to have transparent conversations with wider stakeholders and the approach for this would be outlined further on the STP CPB agenda. The Board noted that initial testing of the plan had taken place with Health and Wellbeing Board Chairs and the feedback had been positive. Work would also take place with associate partnerships outside the SYB STP, noting that the vision, ambition and priorities linked well with other areas, especially supporting people to stay well within communities which was consistent in all the STPs. All noted the need to consider how to use the plan and subsequent supporting documentation around communications and engagement and incorporating existing collaborative work undertaken to date.	

Place feedback was requested from the group.

Barnsley

It was reported that the STP was built upon place based plans that had been developed with colleagues across the system and were in the process of being signed off. The principles of co design and coproduction would result in the right solutions for local people. The group was asked to consider the involvement of the police force in the STP particularly in relation to Mental Health.

Bassetlaw

The group noted that an accountable care partnership was in place and therefore place based plans fitted well with the STP. All local systems were sighted on the ambition and priories and supportive of it. Some local issues were noted around how to engage the public on this. A good correlation between the SYB STP and the Nottinghamshire STP was noted. IG would be presenting the place based plan to Nottinghamshire Health and Well Being Board in December. It was noted that meetings with the MPs would be a key component of the consultation process. Language being used in the STP was also important as part of the communication with the public.

Doncaster

Integrated commissioning with an accountable care partnership approach had been agreed in Doncaster. This had been codesigned across the system and had been a positive experience. Place plans had been discussed across the system, and the STP would be taken to Doncaster GB.

Rotherham

A joint plan, designed by the whole system was well established. A briefing session had taken place for councilors, MPs and stakeholders. Next steps would be to move to an accountable care system and work was taking place with Capsticks to design this.

Sheffield

A joint plan had been produced with a collaborative approach across the system. Two large stakeholder events had taken place in Sheffield. The local system was signed up to the plan. Governance arrangements were being worked through. Useful and robust sessions had taken place with scrutiny committee. Detailed work on clinical systems would be the next step.

LS highlighted to all that there may be some local interest in Barnsley when the STP was taken public with some potential opposition to the changes which would need careful management.

The SYB CPB agreed to publish the plan, supporting the principles, ambition, vision and priorities and to work with STP partners, noting this would also be discussed by each organisation for a considered response.

06/16	**Communications approach and publishing the plan** All noted that a supporting pack had been circulated for all to use locally, including a Board level paper to amend as required. This was to ensure a planned and consistent approach to publishing the SYB STP across the footprint. An email had been circulated to all MPs in SYB alerting them to the fact that the STP was being published. Joint OSC Chairs and local Healthwatch and Health and Wellbeing Board Chairs had also been contacted. The STP would be published on 11 November 2016 at 3pm. This would be placed on the website alongside videos from stakeholder events. Each organisation would be handling the management of the information on a local level. All communications leads from Local Authorities, Providers and Commissioners would input into the communication and engagment of the STP and all were asked to note a resource implication for individual organisations on this. Wider engagement with staff and public would take place December to March 2017. The dates for publication of other STPs was outlined to the group as well as the timeline for publication across the SYB STP. Any inaccuracies in the dates circulated should be highlighted to HS or KW. A reactive approach to handling the media until the plan had been discussed at boards would be adopted. A media protocol was in place and all enquiries should be directed to the STP PMO. A comment was raised around the decision to take a reactive approach to media enquiries, rather than proactive. It was highlighted that discussions should take place across all originations initially and then a proactive approach would take place with key partners. A query was raised around circulating the plan to regional unions and it was agreed that this would be a positive step, and the plan would be circulated when live with accompanying correspondance from AC. In response to a query around publication of place plans, it was noted that the STP been developed using local place plans and were therefore integrated. The communications and engagement around the STP would articulate this. The STP CPB approved the communications and engagement approach to publishing the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.	**ALL**
07/16	**Independent review of hospital services** The STP CPB noted the work to date, that trusts had collectively identified undertaking a review of hospital services to be able to plan and mitigate and identify sustainable models of provision, supported by commissioners. It was proposed that the SYB STP with wider partners	

	undertake a review of hospital services: - To define and agree a set of criteria for what constituted "sustainable hospital services" for each place and for SYB, ND and MY in the contract of the SYB STP - To identify any services that are unsustainable, short, medium and long-term including tertiary services - To put forward future services delivered within and beyond the STP - To consider the role of the District General Hospital in the context of the aspirations outlined in the SYB STP and emergent models of sustainable service provision. Draft terms of reference (ToR) were circulated to the STP CPB to enable providers to have a discussion around what a review might look like and to engage discussions around next steps. The ToR would remain draft until objectives had been developed. The timeframe identified for this work was ambitious, noted as December 2016 to September 2017, however this work would enable and develop a better understanding and new thinking about acute services for a number of key areas of the STP. The resource implications were highlighted as well as the benefits of this review in terms of developing an understanding and improving equity and access and quality for all. The STP CPB was invited to comment. AC highlighted that this had been discussed at a meeting of the CEOs and chairs of provider organisations and was supportive. A comment was made around the current drivers for providing hospital services. With a tier 1, 2, 3 service approach, the tiers would need to be agreed and to then agree how to deliver in a safe and sustainable way to a local population. This work would address the whole range of services. A comment was made that supporting services in the context of a wider plan will be beneficial. Services provided outside of hospitals must be considered as part of this work. It was suggested that calls for additional resources were not sustainable for CCGs and therefore must look ways of working together to support the STP in terms of resourcing.	
	It was noted that Doncaster and Bassetlaw Hospital NHS Foundation Trust had undertaken work around sustainability of services and findings of the work done to date would be shared with WCG. Some concerns were noted around the timescales for this work and that scrutiny must be involved.	**DAWN JARVIS**
	GF agreed to lead on PH intelligence regarding the independent review of hospital services with support. Further detail to be discussed with WCG	**GREG FELL**
	A request was made for YAS to be included within the ToR and this was agreed.	**WILL CLEARY-GRAY**

	All were asked to note that this was a large and important piece of work that would have implications on key work streams within the STP. The date of September 2017 would be important to shape commissioning for 17/18. It was requested that community services, currently outside of scope, be given careful consideration. These fed into place based discussions around developments of intermediate care and this should be cross referenced with this work. All further comments on the draft terms of reference were requested by 25 November to WCG. The STP CPB supported the next steps including the proposal for a summary scope to be developed to be used to invite proposals. An update on progress would be delivered at the next meeting.	**ALL TO NOTE**
08/16	**Terms of reference** The STP CPB received draft terms of reference noting the proposal that these would remain live. All were reminded that the partnership board had committed to looking at governance and that the current set up was interim. Governance would be reviewed around how to work collaboratively at a SYB level and the terms of reference should be viewed in this context. The following feedback was noted: - The scope of the sustainability funding under key responsibilities of the CPB was unclear. JS agreed to help redraft this bullet point. - That further consideration be given to inclusion of chairs for CCGs only under membership - That as the CPB was a collection of individuals on behalf of sovereign organisations, and would not be making decisions but to develop and recommend, a point on quoracy was not required for the ToR. - That comms briefings would need to clearly stipulate that the CPB was a guiding coalition and that responsibilities would remain within statutory organisations. - That Healthwatch be added to the membership list - That the STP finance lead be added to the membership list - CFO to be added to the list All further comments were welcomed to WCG. The ToR would be brought back to the next meeting as holding position of governance. The Terms of Reference would be kept live to be amended as required.	**JOHN SOMERS** **ALL**
09/16	**Summary Version of the STP** The STP summary plan was circulated. The document had been developed taking comments from all communications links across the footprint. It was anticipated that the summary version of STP would be used to support stakeholder discussions and would be placed on the website alongside the main version. LS highlighted some comments and agreed to pick up with HS outside	**LESLEY**

	the meeting. All were asked to comment on the document and this would be published Tuesday 15th November.	**SMITH** **ALL**
10/16	**NHS E arm's length bodies feedback on SYB plan** It was reported that each ALB in Yorkshire and the Humber had been asked to assess the plans independently and agree the assessment collectively. There had been consensus around how well the plan was presented with a clear level of ambition and clear strategic priorities. The overall rating was that the SYB STP was ready to progress. Medium confidence was noted in delivery of the plan. This was due to the work still to be undertaken to develop business cases and strategic priorities. The STP CPB noted the formal feedback from NHS England and the ALBS and the feedback on the plan which had been shared with the centre.	
11/16	**NHS planning round** An update was delivered on the operational planning round which would be the first step in moving from the plan to implementation. Key messages and must be dones were outlined to the group; milestones and metrics, finance including control totals, demand management, financial balance and other efficiencies including Right Care and carter, primary care with a GP Forward View emphasis, urgent and emergency care, referral to treatment times and elective care, cancer with a 62 day standard, mental health with a mental health forward view emphasis, people with learning disabilities and improving quality in organisations STPs would provide the basis for operational plans with a 2 year timeline for activity, workforce, finance and performance assumptions. The timetable had been brought forward so that all plans and contracts would be completed by 23 December 2016. The plans offered the opportunity for financial control totals for each STP. Local principles were being developed for how operational plans would be tested: - Each CCG and provider need to plan for level of growth articulated in the STPs - Operational plans must reflect milestones for the next two years - The figures from the STP must follow through into contracts Activity growth was outlined for the STP with big ambitions in terms of activity reductions. Local systems must work together to deliver. The timetable was outlined to all. The STP CPB noted the contents of the NHS England presentation.	

12/16	**Strategic Commissioning Intentions** The purpose of the Commissioning Intentions was to provide a commissioning dimension of the STP ambition, to signal strategic intent to providers and stakeholders and to inform 17 – 19 contract discussions (in-year change). The CPB noted that there was a gap between scale of ambition and current business as usual, that this work was at a transitionary stage of planning timeline and was evolutionary and that change would be implemented within the contract period. Alignment of CCG operational plans to the STP and inclusions in contract agreements would be required. In response to a query, it was confirmed that with an SYB control total, each organisation would still retain its own control total. The CPB noted the recommendation of the Finance Oversight Committee in response to NHS England that flexibility on control totals would not be required at this point in time, however the SYB STP would wish to reserve the right to revisit this at a later date. The STP CPB approved the STP Strategic Commissioning Intentions to be shared with the SYB system.	
13/16	**Implementation plan and resourcing the approach proposals** A draft implementation plan had been circulated, addressing moving into implementation of the STP, highlighting that to date, work had been undertaking by the WTP teams as additional work and a robust mechanism to undertake the STP would be required. An immediate resource issue around senior finance capacity into the STP was noted and the roll forward of additional support to ensure the work continued to progress. A query was raised around involvement in the Finance Oversight Committee and it was noted that there was representation from each group at those meetings as per the terms of reference. The STP CPB noted the immediate resource requirements and capacity gaps and agreed the principle of a fair share approach across SYB providers, commissioners and local authorities to resourcing the STP. The STP CPB supported delegating the working up of proposals to the Finance Oversight Committee. The potential risk to delivery as a result of the resource gap was noted. The fair shares approach to resourcing would be brought back to the next meeting.	
14/16	**Governance review** The STP CPB noted a summary of the agreed interim governance for SYB STP, confirming the STP's commitment to undertake a review of governance between the point of reporting and the end of March 2017. It was noted that reshaped governance arrangements would run in parallel with partner's organisational statutory governance to help make decisions to deliver the STP ambitions at SYB level. LS advised that an aspect of the interim governance would be an	

	Oversight Group of members and chairs that would sit above the STP CPB and be in place by January 2017. The establishment of a governance review group would also take place, involving Jayne Brown, Chair of Sheffield Health and Social Care who had offered to assist with work around longer term governance. The STP CPB noted the interim governance proposals and supported the approach to establish a Governance Review Group, Chaired by the STP Lead and supported by Jayne Brown, Chair of SHSC.	
15/16	**STP work in progress** Item for noting	
16/16	**Unadopted minutes of the STP finance oversight committee meeting 31 October** Item for noting.	

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

16 December 2016, The Boardroom, 722 Prince of Wales Road

Decision Summary

Ref	Item	Lead
1	**Minutes of the previous meeting held 11 November 2016**	
19/16	(a) that we take a consistent approach of all partners taking Sustainability and Transformation Plan Collaborative Partnership Board (STP CPB) ratified minutes through their organisations Boards and Governing Bodies was agreed	**ALL**
	(b) that all would review the 11 November 2016 minutes and provide comments to WCG by 22 December with a view to ratifying at the 13 January 2017 STP CPB and publishing thereafter	**ALL**
	(c) that all future minutes would be routinely ratified at each meeting and published	**ALL**
2	**Summary update to the Collaborative Partnership Board**	
22/16	(a) that work stream leads and membership would be shared with the STP CPB	**STP PMO**
	(b) that the summary update was agreed and to be used to inform local discussions and form part of a consistent approach of partners taking through their organisations	**ALL**
3	**Terms of reference**	
23/16	(a) that amendments from the meeting be made to the Terms of Reference (TOR) and any further comments to be received from all by 24 December 2016	**WILL CLEARY-GRAY, ALL**
4	**Sustainable Hospital Services Review**	
24/16	(a) that the STP CPB approved the TOR and specification for the review, subject to amendments and discussion at the meeting	**JAMES SCOTT**
5	**SYB STP resources**	
26/16	(a) that all participating organisations were included in the resource plans	**JEREMY COOK**
	(b) that local authorities would take away and consider a proposal in due course which would be based on focusing support in each local place and therefore be removed from the SYB fair shares approach	**JEREMY COOK, LOCAL AUTHORITY LEADS**
	(c) that the STP CPB noted the fair shares approach and supported the proposal and the STP budget, subject to confirmation of actual	**ALL** **JERMEY COOK**

	costs and the reworking of the fair shares approach, following the decision above	
6	**Social Kinetic 3d Proposal for Leadership Analysis**	
29/16	(a) that the STP CPB would take the project forward in principle with a smaller leadership group to consider the detail. A meeting would be arranged for January 2016 for this	**STP PMO**
	(b) that Social Kinetic would discuss via WCG in further detail with a view to starting in February 2017	**SOCIAL KINETIC/WILL CLEARY-GRAY**

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

Minutes of the meeting of 16 December 2016, The Boardroom, 722 Prince of Wales Road, Sheffield

Present:

Andrew Cash, South Yorkshire and Bassetlaw STP Lead/Chief Executive, Sheffield Teaching Hospital NHS Foundation Trust (CHAIR)
Louise Barnett, Chief Executive, The Rotherham NHS Foundation Trust
Des Breen, Medical Director, Provider Working Together Programme
Catherine Burn, Director, Voluntary Action Barnsley
Julia Burrows, Director of Public Health, Barnsley Council
Tracey Clarke, Associate Director of Strategy and Commercial Development, Rotherham, Doncaster and South Humber NHS Foundation Trust
Will Cleary-Gray, Director of Sustainability and Transformation, South Yorkshire and Bassetlaw STP
Frances Cunning, Deputy Director of Health and Wellbeing, Public Health England
Jeremy Cook, Interim Director of Finance, South Yorkshire and Bassetlaw STP
Mike Curtis, Local Director, Health Education England
Chris Edwards, Accountable Officer, Rotherham Clinical Commissioning Group
Greg Fell, Director of Public Health, Sheffield City Council
Idris Griffiths, Interim Accountable Officer, Bassetlaw Clinical Commissioning Group
Sharon Kemp, Chief Executive, Rotherham Council
Alison Knowles, Locality Director North of England, NHS England
Ainsley Macdonnell, Service Director – North Nottinghamshire & Direct Services, Adult Social Care, Health and Public Protection, Nottinghamshire County Council
Simon Morritt, Chief Executive, Chesterfield Royal Hospital
John Mothersole, Chief Executive, Sheffield Council
Jackie Pederson, Accountable Officer, Doncaster Clinical Commissioning Group
Mike Pinkerton, Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Matthew Powls, Interim Director of Commissioning, Sheffield Clinical Commissioning Group
Sean Raynor, District Director, South West Yorkshire Partnership NHS Foundation Trust
Jade Rose, Head of Strategy, Barnsley Clinical Commissioning Group
Mathew Sandord, Associate Director of Planning and Development, Yorkshire Ambulance Service
Steve Shore, Chair, Healthwatch Doncaster
John Somers, Chief Executive, Sheffield Children's Hospital NHS Foundation Trust
Helen Stevens, Associate Director of Communications and Engagement, Commissioners Working Together
Richard Stubbs, Acting Chief Executive, The Yorkshire and Humber Academic Health and Science Network
Lesley Smith, Accountable Officer, Barnsley Clinical Commissioning Group
Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation Trust
Neil Taylor, Chief Executive, Bassetlaw Council
Jon Tomlinson, Assistant Director of Commissioning, Doncaster Council
Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust
Janette Watkins, Programme Director, Provider Working Together Programme
Kate Woods, Programme Office Manager, South Yorkshire and Bassetlaw STP

Apologies:
Adrian Berry, Medical Director, South West Yorkshire Partnership NHS Foundation Trust
Moira Dumma, Director of Commissioning Operations, NHS England
Adrian England, Chair, Healthwatch Barnsley
Matthew Groom, Assistant Director of Specialised Commissioning, NHS England Specalised Commissioning Services
Ruth Hawkins, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust

Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust
Jo Miller, Chief Executive, Doncaster Council
Tim Moorhead, Clinical Chair, Sheffield Clinical Commissioning Group
Leaf Mobbs, Director of Planning and Development, Yorkshire Ambulance Service
David Pearson, Corporate Director Adult Social Care, Health and Public Protection, Nottinghamshire County Council
Maddy Ruff, Accountable Officer, Sheffield Clinical Commissioning Group
Kathryn Singh, Chief Executive, Rotherham Doncaster and South Humber NHS Foundation Trust
Rob Webster, Chief Executive, South West Yorkshire Partnership NHS Foundation Trust

Minute reference	Item	ACTION
17/16	**Welcome and introductions** The Chair welcomed all members of the STP CPB. The aim of the session was noted; - to update all on the national position and place - to collectively debate resourcing for the STP - to welcome Social Kinetic 3de to receive information around the development of the STP - to receive information on core business.	
18/16	**Apologies for absence** Apologies were recorded as above.	
19/16	**Minutes of the meeting held 11 November 2016** The minutes of the meeting were accepted as a true and accurate record subject to the following: - Item 05/16 refers: South Yorkshire and Bassetlaw Plan, amend **supported** the plan to **published** the plan - Item 07/16 refers: Independent review of hospital services, amend to state that GF would lead on PH intelligence, with support, further detail to be discussed with WCG The STP CPB noted the intention to publish ratified minutes to be available to the public and all partners. A discussion took place around this. It was felt that that the minutes should be publically available. To enable all partners to have discussions with their organisations, the minutes would be published after the next STP CPB meeting on 13 January 2017. It was agreed that we take a consistent approach of all partners taking STP CPB minutes through their organisations Boards and Governing Bodies was agreed. In response to this a query was raised around briefings for boards and WCG confirmed that at the time of reporting, the STP was still being taken through key meetings. A further update and briefing would follow when this had been through all meetings across the patch. The STP CPB agreed to review the 11 November 2016 minutes and provide comments to WCG by 22 December. The November meeting minutes would be ratified at the 13th January 2017 STP CPB and	**ALL** **ALL**

	published thereafter. All future minutes would be routinely ratified at each meeting. It was confirmed that minutes only would be made public at this stage.	
20/16	**National STP Update** AJC delivered an update, noting that the South Yorkshire and Bassetlaw STP (SYB STP) had been well received nationally. There would be no further progression on STPs nationally until the new year. It was noted that discussions had taken place with the national team around funding for the plan and capital. This was being favorably received and feedback would be given in due course. Contracts and delivery were being confirmed locally by 23 December 2016. Some issues were reported around operational delivery plans at place level not matching the STP. These were being worked through. The STP would assist in doing things differently and moving all into different ways of working and would be a health and care plan for all. A discussion followed around some concerns that had been raised; these were around governance, local decision making and local accountability. It was noted that the governance of the STP was a key area to develop and would be considered carefully. A crucial piece of work would be on communications and engagement and how messages were put across must be considered by all. Due process must be in place to engage and a scrutiny process was required. All leaders were asked to support the process around how place plans connected to the STP and facilitate local conversations. The importance of the STP collaboration for system resilience and sustainability of services was noted by all.	
21/16	**Update from local place plans** The STP CPB were updated on local place plans, noting visions and principles of system collaboration, priority work areas, engagement, and next steps across the footprint. The presentations would be shared with all.	
22/16	**Update from the Collaborative** **Commissioners Working Together** The STP CPB were briefed on commissioning collaborative working, noting the key business of the Joint Committee of CCGs (JCCC) around the Hyper Acute Stroke Unit and Children's Surgery and Anaethesia consultation and the Acutely Ill Child case for change. This group was evolving and anticipated that this would become the forum for collective commissioning decisions with delegated authority around STP transformation.	

	Providers Working Together The STP CPB were updated on progress of the three hub model – with further work being undertaken around localised theatre procedures. Radiology workforce challenges were being focused on, developing education and recruitment programmes. Engagement across the trusts was taking place. Responses to the consultation to ensure this fitted together with children's provision were being compiled. Work was taking place around a pilot across Rotherham and Sheffield regarding integration of the community through to relationship with children's. This was being undertaken, interfacing with other elements of the AIC work as well as elective work. Work to drive out further savings regarding procurement was taking place. Some savings had been made to date. Cancer pathway reviews were taking place. Links were being made with the STP digital work stream to ensure road map activity came together. Work was also taking place around corporate services the principles of working together, noting some difficulties around the practicalities of implementation. A governance proposal around estates would be brought to the next meeting. **Combined Authorities** The STP CPB noted that the Combined Authority was focusing on the economy. CE would be a member of this Board bringing together all partners system wide from January 2017. **Mental Health Alliance** The mental health work stream would be up implemented from January 2017, supporting vulnerable services and addressing workforce issues and back office opportunities. The alliance would develop from this. An initial meeting between the two executive teams of Sheffield Health and Social Care and Rotherham, Doncaster and South Humber Foundation Trusts would take place in January 2017.	
22/16	**Summary Update to the Collaborative Board** A summary document had been compiled by work stream leads. The STP CPB agreed that the format was useful and be adopted for updates to individual organisations. It was anticipated that programme leads would produce these updates for timely sign off by SROs. The STP CPB noted an offer from the Leadership Academy regarding funding for leadership development. The STP had been asked to outline the proposals to utilise this funding and this was being developed by WCG and LB. The STP CPB were asked to join this small working group if of interest. It was reported that funding had been made available from NHS England to support the primary care work stream to work with local place on primary care to support the implementation of the GP Five Year Forward View (GPFV) and a recruitment process was completed on this. It was agreed that work stream leads and membership would be shared with the STP CPB. A workshop was planned for January to review working together, with a piece of work taking place to look at how the collaboratives were working. All areas of commonality would be addressed as part of this.	 **STP PMO**

	The intention was for private boards to use these as part of communications out to organisations. It was noted that a session around governance to include the Local Authority Chief Executives would be useful and would be considered. The STP CPB noted the summary update and agreed this would be used to inform local discussions and form part of a consistent approach of partners taking through their organisations.	**ALL**
23/16	**Terms of reference** The STP CPB noted the revisions to the interim ToR since the previous meeting. WCG highlighted discussions that had taken placed around primary care representation at the meetings and this may impact on governance and the ToR when resolved. The ToR would be brought back to the next meeting as final. Further comments were received by the STP CPB as follows: - that Doncaster Children's Trust be added to the TOR. - that the key responsibly of the STP CPB was to engage with patients and the public in the work of the STP and this be added. - that engaging trade unions be considered further - that "consider" replace "adopt" under paragraph 2. Any further comments were requested by 24 December 2016.	**ALL**
24/16	**Independent review of hospital services** A summary of the comments received since the 11 November STP CPB was delivered and the group was invited to comment further. It was requested that resilience be added to theme and scope as many rotas, currently sustainable, were close to being unsustainable and this needed addressing. It was noted that themes should focus on outcomes as well as effectiveness. It was requested that governance links be made across with this work and membership across the groups (this work, the JCCC, the STP CPB) should be consistent. It was noted that a clinical chair on the steering group was positive however this should also have a commissioning officer as support and a link through to the commissioning review. A comment was made that the review should be cognisant of other reviews taking place across the region and the knock-on impact across trusts and factor in impact of other reconfigurations. A discussion took place around research as a key driver within the sustainable hospital review terms of reference and how this might unduly impact on the scope of the review. A comment was made that research	

	helped to attract and maintain workforce and therefore whilst research was not the main criterion for assessing sustainability it was non the less an important criterion to consider. The STP CPB approved the TOR and specification, subject to amendments and discussion at the meeting.	
25/16	**Communications and engagement approach to public consultation** This item would be deferred until the next meeting.	
26/16	**SYB STP resources** The STP CPB noted the action from the previous meeting for the STP Finance Oversight Committee (FOC) to consider a fair shares proposal and provide clarity around the impact of this. A possible additional funding requested from NHS E/I was noted that could reduce the contribution requirements from partners. An indicative budget for 17/18 was put forward noting final budgets to be brought back to the STP CPB in March around 17/18. This paper had been shared widely with finance colleagues. The STP CPB noted principles and activity taking place that may impact on 17/18: - National transformation funding - Review of how work together - Review of NHS E around resource, ALB support the STPs - Review of commissioning The STP CPB were invited to comment. It was noted that Nottinghamshire County Council be added into the proposals. A query was also raised around some omitted providers, to be addressed. The proposal was made to the group that local authorities would take away and consider a proposal in due course which would be based on focusing support in each local place and therefore be removed from the SYB fair shares approach. This was agreed. In response to a query raised, it was confirmed that money for 16/17 would come out of cost pressures immediately and further work was required for future years. The timeline for further development of the 17/18 indicative plan would be brought back to March 2017 board. The STP CPB were asked to note that system commissioning must be regarded as core business moving forward and to consider existing resources differently. In response to a query it was confirmed that the repurposing of some existing resource was taking place to support communal aims of the STP. The STP CPB noted the fair shares approach and supported the proposal and the STP budget, subject to confirmation of actual costs and	**JEREMY COOK, LA CEOS**

	the reworking of the fair shares approach, following the decision above.	
27/16	**Healthy Lives** This item would be deferred until the next meeting.	
28/16	**Health disability and employment** This item would be deferred until the next meeting.	
29/16	**Social Kinetic 3De proposal for leadership analysis** A presentation was delivered to the STP CPB, noting that a change readiness tool was being developed with NHS E and had been piloted successfully. The Social Kinetic were looking to test this pilot in its second phase with the SYB STP. The background to the 3d framework and tool was outlined to the STP CPB, including opportunities for the SYB STP. As part of this work, a facilitated workshop would take place to map the ecosystem, the data would be analysed and a further workshop to dissect the data would follow. The action plan was collaboratively created. Post event support was also given. The SYB STP leadership team would work together on the vision for the ecosystem blueprint for change to develop a blue print of the ecosystem and how it fitted together. The STP CPB were invited to comment. It was noted that this was an effective organisational development tool and applying to a whole ecosystem would be interesting. Some concerns were noted around the commitment of senior leader's time. It was confirmed that the Y&H Academic Health and Science Network were paying for the academic evaluation by York Health Economic Consortium that will support the activity. In response to a query, it was confirmed that the programme had been designed around working within the NHS and the workshops were interactive to enable a clear and collaborative understanding of the issues. Extra time was also built into the schedule to refine and work with all to ensure the best possible outputs, outcomes and return of investment. A discussion took place around the future potential of rolling this out to the wider workforce however this would have to be a separate activity. The STP CPB discussed the possibility of creating an OD work stream and this linked to early discussions around leadership development that were taking place. The STP CPB would take this forward in principle with a smaller leadership group to consider the detail. A meeting would be arranged for January 2016 for this. Social Kinetic would discuss via WCG in further detail with a view to starting in February 2017.	**STP PMO**

30/16	**Review of Commissioning** This paper was formally noted by the STP CPB.	
31/16	**Specialised Commissioning Transformation Programmes in Yorkshire and the Humber** This paper was formally noted by the STP CPB.	
32/16	**Next steps on STPs and the 17-19 planning round** This paper was formally noted by the STP CPB.	
33/16	**Unadopted minutes of the STP Finance Oversight Committee meeting on 13 December 2016** This paper was formally noted by the STP CPB.	

Doncaster
Metropolitan Borough Council

Date:

To the Health & Wellbeing Board

Children and Young People's Plan 2017-20

EXECUTIVE SUMMARY

1. The interim Children and Young People's (CYP) Plan will expire at the end of 2016-17. The Children and Families Partnership Board established an Interim Executive Group in the summer of 2016 to deliver the JSNA, the updated CYP Plan, and an outcomes framework. An updated CYP Plan is attached in Appendix 1.

2. This plan sets out how the overall ambition for children and young people translates into action and how we can assess the impact we are having. It sets out who is doing what and the priorities for the next 3 years and acts as the overarching document that directs strategic commissioning across the partnership.

3. The Plan sets out 12 priorities for improving the lives of children and young people in the borough. The priorities are set out under four key themes: safety, health, achievement and equality. These are drawn from the intelligence gathered from the JSNA, and using insight from the direct participation of children and young people.

4. Specific to the Health and Wellbeing Board, there are a number of issues that were raised both from JSNA evidence and from engagement with children and young people. In terms of evidence led priorities, there is a need to reduce levels of childhood obesity, implement the LTP, and work to ensure alignment early help cohort of the Place Plan. In terms of Voice driven priorities, the most prominent issue was access to emotional wellbeing and mental health support. This was consistently raised by children and young people.

EXEMPT REPORT

5. This report is not exempt.

RECOMMENDATIONS

6. It is recommended that HWBB consider and endorse the Children and Young People's Plan and the overarching ambition therein.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

7. The Children and Young People's Plan is established to ensure that those institutions with a responsibility for children work and plan together, agree

on a collective set of priorities and take collective responsibility for improving children's outcomes.

BACKGROUND

8. The Council and its partners will be clearly seeking to deliver on our ambition to become the most child friendly borough in the country. Central to this is a fundamental shift in our approach – moving from simply trying to respond to national directives to seeking to shape the narrative and become an example of best practice. In a time of constrained finances, this is absolutely essential, and is a clear indication of determination to see the children and young people of Doncaster consistently achieve their full potential.

9. Collectively, the partnership in Doncaster spent £364m on children and young people in 2015/16. There are approximately 65,000 children and young people under the age of 18 in Doncaster. This amounts to an average of £5,600 spent per child. Out of this money children are schooled, kept healthy, supported in their early years, kept safe and secure and the most vulnerable children and young people properly cared for.

10. The Council and its partners have identified four priority themes to frame the collective effort to improve the lives of children and young people:

THEMES	KEY PRIORITIES		
Safe	Children have access to the right services at the **earliest opportunity**	Domestic abuse practice is **transformed** across Doncaster	No child suffers significant harm resulting from **neglect**
Healthy	Children and young people are healthy and have a **sense of wellbeing**	Children have the best **start in life**	Children and young people's **development** is underpinned through a healthy lifestyle
Achievement	Ensure all children are **school ready**	All children **attend** a **good or better** setting and **aspirations** are raised to ensure they reach their **full potential**	Young people are equipped to access **education, employment or training**
Equality	Diminish the difference between **disadvantaged** and **non-disadvantaged** children and young people		Fewer children live in **poverty**

11. The crucial element for the Health & Well-being board to consider is the

healthy theme. This is not to say that there are not strong links with other areas of work that need to be closely coordinated; rather, that from a governance perspective this is the area with the most direct links. The proposals for the revised governance structure for the updated Plan would see the creation of 3 key groups to drive action and hold partners to account: the Starting Well strategy group (currently under the HWBB structure), a Children and Young People mental health & well-being strategy group (currently under the HWBB structure), and the establishment of a new Healthy Choices group which would have a specific focus on 5-19 year olds.

12. The Plan sets out a three key actions to deliver improved outcomes across each of these priority areas. Full details of these actions, which member of the partnership is responsible for delivering them, and the governance group that will hold the partnership to account, can be found on page 12 of the CYP Plan.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

13. There is strong correlation between the four identified priority areas of the CYP Plan, and the council's key outcomes. The implications for these are set out below:

	Outcomes	**Implications**
	All people in Doncaster benefit from a thriving and resilient economy. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	Young people are equipped to access education, employment or training
	People live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	Ensure no child suffers significant harm resulting from neglect Domestic abuse practice is transformed

	People in Doncaster benefit from a high quality built and natural environment. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	
	All families thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	Fewer children live in poverty Diminish the difference between disadvantaged and non-disadvantaged children and young people
	Council services are modern and value for money.	
	Working with our partners we will provide strong leadership and governance.	

RISKS AND ASSUMPTIONS

14. The refreshed CYP Plan mitigates the risk of not having a commissionable plan in place to improve outcomes for children and young people. The performance against the agreed outcomes will be regularly reported on and monitored through a revised governance structure, details of which can be found in Appendix 5 of the Plan.

15. The CYP Plan will be supplemented by 4 area plans that will set out in greater detail the actions that will take place at a local level. These will be delivered by the end of summer 2017. These will ensure that there is specific action to tackle specific issues based on local needs.

LEGAL IMPLICATIONS

16. A Local Authority has a number of specific statutory duties to children and young people. Two general duties are within the Children Act and Education Act. S17 of the Children Act 1989 provides that it shall be the general duty of every local authority to safeguard and promote the welfare of children within their area who are in need; and so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs. S436A of the Education Act 1996 gives Local Authority's a duty to make arrangements to establish the identities of children in their area who are not registered pupils at a school and are not receiving suitable education otherwise. The programs of activity which will deliver the Plan will require specific and detailed legal advice as they develop further.

17. The decision maker must be aware of their obligations under the public sector equality duty (PSED) in s149 of the Equality Act 2010. It requires public authorities when exercising their functions to have due regard to the need to: eliminate discrimination, harassment and victimization; advance equality of opportunity; and foster good relations between people who share relevant protected characteristics and those who do not. The relevant protected characteristics under the Equality Act are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The duty also covers marriage and civil partnerships, but only in respect of eliminating unlawful discrimination.

FINANCIAL IMPLICATIONS

18. There are no specific financial implications arising from this report. The financial implications of the Children and Young People's Plan will be set out in subsequent service plans and revised commissioning arrangements.

HUMAN RESOURCES IMPLICATIONS

19. There are no specific HR implications arising from this report.

TECHNOLOGY IMPLICATIONS

20. There are no specific technology implications arising from this report.

EQUALITY IMPLICATIONS

21. An Equality Impact Statement has been produced and is attached. Extensive efforts have been made to ensure that a broad cross-section of children and young people, alongside the partners that work in Doncaster, have been consulted and their feedback incorporated. Additionally, activity is planned to further strengthen this aspect of the Plan through an updated Participation and Engagement Strategy which is due for publication in summer 2017.

CONSULTATION

22. The CYP Plan has been consulted on extensively with partners across Doncaster during its production. The full list of partners that have engaged with the Plan can be found in Appendix 2 of the Plan.

BACKGROUND PAPERS

23. Children and Young People's Plan 2017-20
24. Interim Children and Young People's Plan 2015-17
25. Joint Strategic Needs Assessment 2017-20

REPORT AUTHOR & CONTRIBUTORS

David Ayre, Head of Service, Strategy & Performance Unit
01302 735412 david.ayre@doncaster.gov.uk

Damian Allen,
Director of Learning, Opportunity and Skills

Doncaster Children and Young People's Plan 2017-20

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II. List of partners consulted with for production of the Plan
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1. Introduction: A Commissionable Children and Young People's Plan

Responsibility for the lives and well-being of children across Doncaster largely rests primarily with their families and carers who are supported by Doncaster Council, Doncaster Schools, Doncaster Children's Trust, St Leger Homes, South Yorkshire Police & the NHS. The efforts of these institutions, together with families and carers, are critical to children staying safe, being healthy and achieving.

Collectively, these institutions spent £364m on children and young people in 2015/16. There are approximately 65,000 children and young people under the age of 18 in Doncaster. This amounts to an average of £5,600 spent per child. Out of this money children are schooled, kept healthy, supported in their early years, kept safe and secure and the most vulnerable children and young people properly cared for.

The Children and Young People's Plan is established to ensure that those institutions with a responsibility for children work and plan together, agree on a collective set of priorities and take collective responsibility for improving children's outcomes. These outcomes are measured and grouped as follows

- Staying Safe
- Being Healthy
- Achieving
- Equality

While measuring children's outcomes in these areas will tell us a lot about children's progress and well-being there has to be a balance with how children and young people experience life and what is important to them, the challenges to families in raising children and how they feel services should work for them.

Also, austerity has seen significant cuts in the money going to public services so there is a need to work differently and achieve better with less.

So, the Children and Young People's Partnership, having reflected on recent progress wants to focus on some key themes to better build the notion of a child friendly Borough. These are:-

- Listen to what children and young people have told us is important to them and improve outcomes in these areas.
- Adopt new ways of working that builds resilience in young people, their families and their communities.
- Place a renewed focus on social mobility and how services enable young people to achieve and 'get on'

This plan sets out how the overall ambition for children and young people translates into action and how we can assess the impact we are having. It sets out who is doing what and the priorities for the next 3 years and acts as the overarching document that directs strategic commissioning across the partnership.

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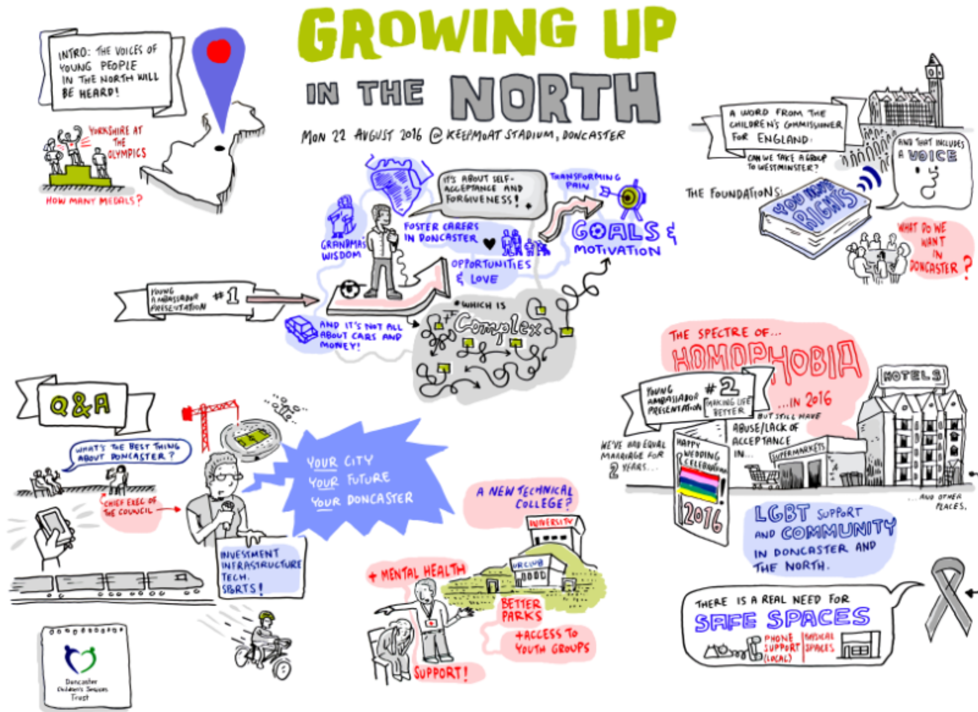
2. What's the story in Doncaster?

Consistent with the partnership's pledge put the voice of children and young people at the centre, we set out here a summary of what they have had to say and their priorities.

Schools and services for children maintain a day to day conversation with children and young people who are eager to both have their voice heard and also to take decisions. The illustration below is typical and sets out the complex relationship between their lives, families, schools and some services and what would improve their lives.



Here we see the words Children and Young People use most often. In coming years the partnership will work with young to find ways to measure how issues such as communication, trust , empathy , equality and respect have improved. This will be at the heart of efforts to make Doncaster a more Child friendly place.

4

Children and Young People's Priorities

Engagement with young people across the partnership has resulted in them identifying the following priorities. These are grouped against the 4 themes.

THEMES	CHILDREN & YOUNG PEOPLE'S PRIORITIES			
Safe	Feel safe - knowing that they can safely live and thrive in the borough	Supported by someone they trust	Equipped to handle bullying – more resilient and better able to handle difficult situations	
Healthy	Better knowledge of services – what is available to them in their area	Reduced stigma around mental health – timely support and access to services	School Nurses to be available more around school and offer increased access	
Achievement	Life skills – making sure that they are well prepared for adulthood	Pathways to employment – ensuring that they are moving towards good quality, sustainable work	A broad and balanced curriculum equipping them with the life skills they need to be independent and successful as an adult	
Equality	Treated respectfully – seen as valuable members of society with something unique to bring to discussion	Listened to – make them feel that their opinion is valued. This should happen in a supportive, nurturing capacity or an informative capacity to enable them to explore a variety of career paths	Better incentives – encouraging positive choices and patterns of behaviour	More positive stories – moving from a negative perception of young people to one which focusses on their strengths and achievements

When testing these priorities back with children and young people, they were particularly keen to stress issues around 'mental health support', 'being listened to', 'being supported to stop bullying' and 'having someone to talk to'. In the surveys these were the most important issues for young people in the series of important issues.

In Section 6 we set out how the partnership intends to respond to these priorities.

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3. Progress against the 2014/16 Plan

What has been achieved under the recent plan informs the priorities of this plan, the main outcomes of which are set out below:

Key Performance Areas

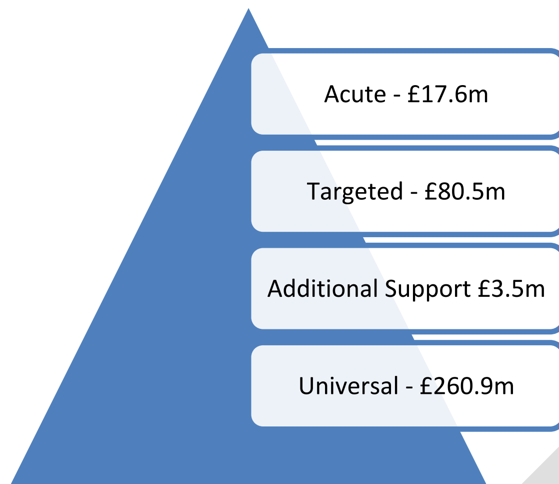
- Improved performance means that levels of school readiness and NEET (not in education, employment or training) young people are comparable with the national average and lower than our regional and statistical neighbours.
- Attainment in Doncaster is improving and the rate of improvement is showing healthy signs. However educational outcomes at both KS2 and KS4 remain below the national average. The number of schools rated 'Good or Better' is still significantly lower than the national average, and in Key Stage 1 and 2, fewer Doncaster pupils achieved the expected standard in reading writing and maths than nationally
- Doncaster has the second highest Children in Care numbers among the statistical neighbours, and the rate of children subject to a Child Protection Plan is higher than statistical neighbours, regional and national averages.
- Particular health concerns are obesity levels in Yr 6 children, hospital admissions among adolescents due to substance misuse and the numbers holding level 2 qualifications by the age of 19. In each of these areas, performance has worsened.
- The Troubled Families Programme appears to be having an impact on young people's school attendance but more broadly persistent school absences at primary school have not improved and sit well above national averages

Actions

- Since October 2014, Doncaster has operated with a Children's Services Trust, and the local authority and other partners have forged a successful working relationship with this new provider, driving an improvement in outcomes for some of the most vulnerable children
- In 2015 Team Doncaster established an independent Commission on Education and Skills. Its 2016 report included a series of recommendations, which highlighted the "existing and developing networks of individuals across the public, private, voluntary and charitable sectors, committed to working together to improve Doncaster's education and skills system."

Our investment in children and young people

The amount of public sector funding that is spent on children and young people in the borough has been subject to consistent pressure since 2010. The four year Spending Review, running from 2011/12, has seen around a quarter of budgets removed from local government, with similar cutbacks in Health, Police, Fire and Rescue and other areas of public spending. Collectively, £364m was spent on children and young people in 2015/16. This represents spending from the local authority, children's trust, health, police and housing. The money can be seen to have been spent across the following four tiers:



Conclusions

While there have been some notable improvements in some areas, the following conclusions can be drawn

- Improvement in children's outcomes across the partnership is inconsistent. Many areas show marginal significant improvement and others demonstrate little real change
- In establishing the Doncaster Children's Trust and the Doncaster Commission on Education and Skills, the partnership is demonstrating it is responding to these challenges
- The scale of reduced resource implies that performance has in some ways been affected so the process of prioritisation is more important than ever
- The approach to strategic commissioning should be reviewed and strengthened

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4. The Evidence Base

To complement the voice of children and young people, the partnership collates a wealth of socio economic data to illustrate key local challenges. Key findings are set out here. A more comprehensive analysis can be found in the Joint Strategic Needs Assessment.

Joint Strategic Needs Assessment

A key supporting source of information for understanding the lives of children and young people in the borough is the Joint Strategic Needs Assessment. This allows us to establish trends in data across a wide range of variables and discern where more effort is needed, or a new approach, along with understanding what is already working well.

Theme	*Key Areas of Concern*
Safe	• Increasing referrals to Early Help • Referrals for Statutory Intervention • Children in Need with neglect numbers • Children in Care numbers • Incidents of Domestic Abuse • Children going missing from home • Children at risk of CSE • Youth Justice system entrants
Healthy	• Infant mortality rates • Breastfeeding prevalence • Babies living in smoking households • Emergency Admissions to hospital • A&E Attendance by 0-4yr children • Childhood Obesity in reception and Yr 6 • Teenage Pregnancy • STIs in young people • Substance Abuse
Achievement	• EYFS good level of development • Increasing eligibility for 2yr old funding • KS1-4 attainment • Looked After Children's outcomes • NEET
Equality	• Gap in KS1-4 performance between pupils receiving FSM and those children living in low income/workless households • Children living in income deprived households in 10% most deprived areas • The number of children in poverty continues to increase (currently 30% after housing costs) - the 4th highest rate regionally, behind only Bradford, Hull and North East Lincolnshire • The recent Social Mobility Commission report also highlighted that Doncaster is in the bottom 10% of areas nationally for social mobility. • The national Households Below Average Income statistics also demonstrate that the number of

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	children in poverty that live in families with at least one person in work now stands at 66%. This clearly shows that while families are moving into work, they aren't moving out of poverty

Emerging priorities from the JSNA

The analysis of our performance and progress to date, alongside the emerging trends identified in the JSNA, has led us to identify a number of priorities for action over the course of this Plan.

THEMES	KEY PRIORITIES		
Safe	Children have access to the right services at the **earliest opportunity**	Domestic abuse practice is **transformed** across Doncaster	No child suffers significant harm resulting from **neglect**
Healthy	Children and young people are healthy, have a **sense of wellbeing and are resilient**	Children have the best **start in life**	Children and young people's **development** is underpinned through a healthy lifestyle
Achievement	Ensure all children are **school ready**	All children **attend** a **good or better** setting and **aspirations** are raised to ensure they reach their **full potential**	Young people are equipped to access **education, employment or training in a way that supports future social mobility**
Equality	Diminish the difference between **disadvantaged** and **non-disadvantaged** children and young people		Fewer children live in **poverty**

We are also aware of initial and anecdotal evidence that young people's housing needs is an issue – it is our intention to do further analysis of this to better understand the problems facing young people as they move into independent living arrangements, and therefore develop plans accordingly.

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5. Priorities Action Plans

Evidence Driven

Priorities	3 Key Actions	Governance & accountability
Children have access to the right services at the earliest opportunity	• Develop a comprehensive and robust local offer is to support families • Promote the use of the team around the child approach at a universal and single agency level to prevent the escalation of need • Ensure that early help and prevention services are available for children of all ages through the provision of age appropriate strategies	Early Help Strategy Group
Ensure no child suffers significant harm resulting from neglect	• Develop new practice model for intensive work with families experiencing long term neglect; • Ensure consistent use of the DSCB neglect toolkit across all levels of need and by all professionals across the partnership. • Ensure that there is a clear pathway across the partnership for addressing neglect and support all partners in identifying early signs of neglect in their core roles. • Provide in school resources and learning around domestic abuse (age appropriate) so children know how to recognise the signs and know how to get help	Tackling Neglect Strategy group
Domestic abuse practice is transformed	• Raise awareness, visibility and identification of domestic abuse issues through programmes of engagement and support to children, young people and families • Influence and support the development of policies and procedures in all workplaces to support organisations to act responsibly for the wellbeing of their employees through programmes of direct support • Improve the quality and use of data, research and local intelligence across the partnership to inform commissioning and target resources more effectively and efficiently to address levels of need and risk	Safer Stronger Partnership
Children and young people are healthy and have a sense of wellbeing	• Develop targeted programme for obesity prevention for primary schools • Develop and implement DCSB suicide prevention strategy and revise the	Emotional health and wellbeing strategy group Healthy Choices Group

	arrangements for children in care to have timely health and wellbeing assessments and effective and timely plans to meet identified needs. • Implement the Local Health Transformation Plan.	
Children have the best start in life	• Ensure a coordinated offer focusing from conception through to the first 1001 days, with clearly defined pathways through services based on a family's continuum of need • Intervene at the earliest opportunity with identified families, to ensure they are prepared for parenthood and able to parent effectively ensuring the optimal health and development of their child • Partners work to a common purpose to target vulnerable families and work in a coordinated way to support the whole family, aligning with the early help cohort of the Place Plan.	Starting Well group
Children and young people's development is underpinned through a healthy lifestyle	• Undertake a systematic review of the delivery and provision of physical activity and sport. • Develop a playing pitch strategy is currently being commissioned with financial and technical support from Sport England • Extend NCS programme reach including free access for all children in care and the 'This Girl Can' sports engagement programme for girls and young women who are in care or care leavers. • The early years and dental workforce have access to evidence based oral health training. • A campaign to promote free emergency hormonal contraception through Pharmacies	Healthy Choices group
Ensure all children are school ready	• To provide accessible, flexible and high quality effective early learning and childcare for all children • To narrow the attainment gap especially for children in the most deprived areas • To support early year's organisations and child-minders across the sector to work together to ensure the early year's workforce has the knowledge, skills and support that will enable children to reach their full potential.	Starting Well Group
All children attend a good or better	• Ensure Children in Care and Care leavers are supported in the school	Corporate Parenting board / Virtual School

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setting and aspirations are raised to ensure they reach their full potential	system through better advice and guidance, better tracking , improved advocacy programmes and workforce development	governing body Education and Skills Board
Young people are equipped to access education, employment or training	• The roll out of the Education and Skills Commission • The number of care leavers accessing further education, including degree level qualifications increases to be in line with the young people who have not been Looked After (currently 31% as of August 2016) • Create opportunity for young people at all ability levels to access community interest or social enterprise models, which are sustainable and provide a pathway to success	Education and Skills Board
Diminish the difference between disadvantaged and non-disadvantaged children and young people	• Schools have robust strategies to ensure effective use of pupil premium spend • Ensure data analysis underpins a system wide approach to improving outcomes for all children including the most vulnerable. • Work with strategic partners to ensure that StEP visits scrutinise the use of resources to improve outcomes for disadvantaged pupils.	Education and Skills Board Anti-poverty strategy group
Fewer children live in poverty	• Through the Troubled Families programme and Early Help, support parents with a history of worklessness and disadvantage to be economically viable; • Roll out of the Education and Skills Commission • Support the provision of sufficient high quality, affordable and accessible childcare to enable parents to attend work or training.	Anti-poverty strategy group Education and Skills Board Starting Well group
Keeping teenagers and young people safe	• Develop inquisitive approaches to mapping complex safeguarding issues between CSE, Organised Crime, FGM, trafficking, forced marriage and Domestic violence • Develop locality profiles to understand what the current risks to teenagers and young people are in terms of location, activity and people and ensure that teenagers/young people know about healthy relationships and issues relating to consent • Ensure that diversionary activities are targeted where they are needed and	Tackling Neglect Group Local Safeguarding Children's Board Healthy Choices group SSDP

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	safe spaces in the town centre and localities for teenagers and young people	
Young Carers	• Assess the needs of the adult or child who needs care and support and then see what remaining needs for support a young carer in the family has. • Trigger either an assessment or the offer of an assessment to the person needing care using a whole family approach • As appropriate offer targeted and time limited support or sign post to universally delivered specific YCs services	Early Help strategy group (Actions will be delivered through existing young carers arrangements undertaken by DCST)

Children and Young People's Voice Driven

Priority	Key Actions	Lead
Feel safe - knowing that they can safely live and thrive in the borough	• Children and families receive timely interventions that meet their needs as they arise. • The support families receive helps to reduce concerns escalating.	DCST, DSCB
Supported by someone they trust	• Children are supported by professionals who listen to them and take action to meet their needs and tackle concerns they raise. • Develop a participation strategy which provides all children with the opportunities to engage in the development of services	DCST
Equipped to handle bullying – more resilient and better able to handle difficult situations	• Mental Toughness Project	DMBC
Better knowledge of services – what is available to them in their area.	• Better Transport Project	Youth Parliament
Reduced stigma around mental health – timely support and access to services	• Young People's Better Mental Health Plan • Mental Toughness Project	Youth Parliament DMBC
Life skills – making sure that they are well prepared for adulthood	• Education and Skills Commission • Engagement with Education and Skills Commission Project	Team Doncaster Youth Parliament
Pathways to employment – ensuring that they are moving towards good quality,	• Education and Skills Commission • Engagement with Education and Skills Commission Project • Living Wage Project	Team Doncaster Youth Parliament

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sustainable work		Youth Parliament
A broad and balanced curriculum equipping them with the life skills they need to be independent and successful as an adult	• Education and Skills Commission implementation • Engagement with Education and Skills Commission Project • Curriculum for Life Project	Team Doncaster Youth Parliament Youth Parliament
Treated respectfully – seen as valuable members of society with something unique to bring to discussion	• Youth Council • Families moving on together	DMBC DMBC
Better incentives – encouraging positive choices and patterns of behaviour	• Healthy learning, healthy lives • Respect Yourself	DMBC DMBC
Listened to – make them feel that their opinion is valued. This should happen in a supportive, nurturing capacity or an informative capacity to enable them to explore a variety of different career paths	• Education and Skills Commission implementation • Good Childhood Index	Team Doncaster The Children's Society
More positive stories – moving from a negative perception of young people to one which focusses on their strengths and achievements	• Education and Skills Commission implementation	Team Doncaster

6. The partnership operating environment & national policy context

Accountability and changing roles

Doncaster is largely unique in that all of its secondary schools are Academies or part of Multi Academy trusts. This shift in the locus of control for education has perhaps best been characterised by the introduction of a regional schools commissioner.

Also in 2014 Doncaster established a Children's Services Trust to manage the children's social care system. This is a fairly fundamental shift in a relatively short period of time and changes significantly the role of the local authority.

The Wood Review[1] in May 2016 set out recommendations for making local safeguarding children boards (LSCBs) more effective. This included reducing the

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf

number of agencies who had to be a part of the board to just the local authority, the police and health.

Changes to LSCBs are incorporated into the Children and Social Work Bill. It is expected that LSCBs will retain current functions until the end of March 2018. Constructive local challenge against a clearly agreed and owned joint endeavour is the means of binding partners together and holding each other to account. In Doncaster, we are already trialling a local 'Performance Accountability Board' which is independently chaired. (The agreed change propositions can be found in Annex 4).

The combination of all these factors means that partnership and collaboration is of the utmost importance in Doncaster and that the Children and Families Partnership Board has a truly vital role in enabling collaboration.

Legislation

At the time of writing 2 key areas of legislation are going through Parliament.

- The Children and Social Work Bill introduces a number of new requirements for local authorities and providers. This legislation sits alongside the new strategy called Keep on Caring[2]. The strategy sets out how the Government will use the Children's Social Care Innovation Programme to rethink transitions to adulthood for young people in the children's social care system.
- The 'Schools that work for everyone' Green paper that proposes the expansion of selective schools

The Partnership will be required to revisit the implications of this legislation on its plans once assent is in place and the Government sets out its plans for implementation.

Social Mobility Opportunity Area

At the time of writing Doncaster had been nominated to receive a share of a DFE announced £72m fund to promote social mobility. Doncaster is one of 12 so called 'opportunity areas' - areas which are ranked as 'cold spots' in the government's social mobility index. As details of this emerge the partnership will need to revise its plans appropriately. The objectives of the social mobility funding closely reflect the ambitions set out in the Doncaster Education and Skills Commission

Sheffield City Region

The Sheffield City Region has been pursuing an ambitious devolution deal to secure a Mayor for the combined authority. This would see the region look to deliver an integrated skills and training system across the local area, 'driven by the needs of the economy and led by the private sector, giving local businesses the skilled labour they need to grow'[3]. Crucially, there are plans for the SCR to play a central role in enabling businesses, especially SMEs, to take up and invest in apprenticeships. This

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[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535899/Care-Leaver-Strategy.pdf

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403161/FINAL_Sheffield_City_Region_Devolution_Deal.pdf

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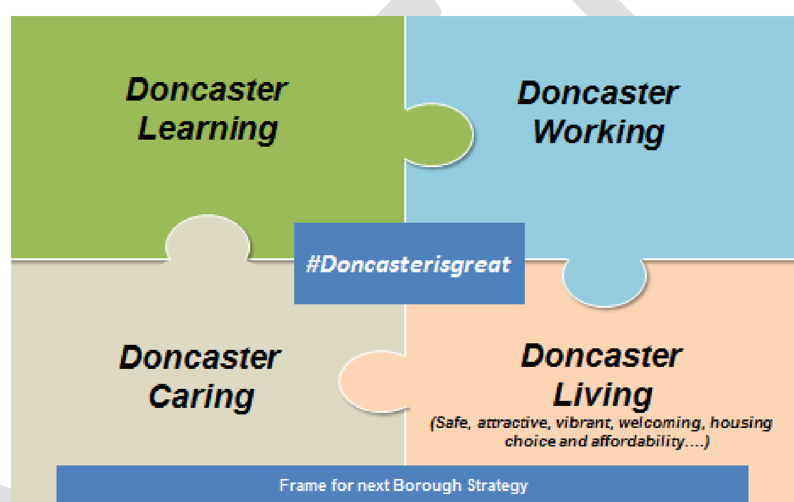
is a crucial development in terms of the long term employment prospects in the borough.

Doncaster strategies

DN21 – borough strategy

The DN21 (borough strategy) programme sets out the long terms partnership vision for Doncaster. It is based on the knowledge that the next four years represents a series of challenges and opportunities for the business, citizens and local agencies in the borough. The work will focus on four policy priority areas: learning, living, caring and working. There are key links to children and young people in the borough through these areas; for instance, children in care and young carers, two groups of young people identified as priorities in Doncaster, will see their work co-ordinated across Doncaster under the 'Caring' priority area.



Doncaster CCG Transformation Plan

The CCG has developed a Local Transformation Plan[4], which is Team Doncaster's five year vision to transform the emotional wellbeing and mental health system, in response to the Future in Mind[5] document. The key focus is on early intervention and prevention and strengthening Children, Young People and their families involvement in all decisions. The key deliverables are:

- Support Universal Services
- Development of Intensive Home Treatment Provision
- Caring for the Most Vulnerable
- Implement the Crisis Care Concordat
- Eating Disorders
- Children, Young People and Families have a Voice

Health and Well-being strategy 2016-21

The Doncaster Health and Wellbeing Strategy has three key aims:

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[4] http://www.doncasterccg.nhs.uk/wp-content/uploads/2016/11/Doncaster-LTP-2016-20-Finalised-.pdf)

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

1. This Strategy presents a high level vision for health and wellbeing in Doncaster and describes the locally adopted model for health and wellbeing
2. The Strategy outlines the roles and ways of working for key partners to play in ensuring the effective delivery and implementation of the Health and Social Care Transformation Fund which will focus on developing early interventions and lower level wellbeing support in communities
3. The Strategy has identified 4 key themes for development to improve health and wellbeing outcomes in Doncaster:
    - Wellbeing
    - Health and Social Care Transformation
    - Five Areas of Focus
    - Reducing Health Inequalities

Taken together these three aims form the work plan of the Health and Wellbeing Board, which will continue to be the key partnership for health and wellbeing in Doncaster and is part of the wider Team Doncaster Strategic Partnership. This is also supplemented by the production of the Director of Public Health's Annual report, which demonstrates the state of health within communities.

Doncaster NHS Place Plan

The Place Plan articulates a shared vision across health and social care in Doncaster. There are four key outputs that are associated with this Plan, which connect to the Children and Young People's Plan:

- Facilitation of the development of integrated commissioning and provision.
- Work with system leaders
- Development and delivery of training
- Engagement and communication plan

It is expected that this joint vision will help to drive new ways of working, based on a model that looks to deliver early help and more community based solutions that keep people well rather than treating them only when they become ill. This will see the partnership working in co-terminus localities and taking a neighbourhood and integrated approach across health and social care system. The key deliverables are:

- A multi-disciplinary approach that brings a range of professional skills and expertise to bear through a 'Team Around the Child, Young Person/Family'
- A relationship with a trusted lead professional who can engage with the child / young person and their family, and coordinate the support needed from other agencies.
- Practice that empowers families and helps them to develop the capacity to resolve their own problems.
- A holistic approach that addresses a child / young person's needs in a wider context
- Simple, streamlined enquiry and assessment process

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Doncaster safeguarding children's board (DSCB)

The DSCB has a clear set of agreed priorities and an action plan that seeks to achieve them. This helps to ensure that there are effective arrangements in place to respond to key safeguarding risks, stay aware of emerging issues which have implications across the partnership, and have a clear understanding of the effectiveness of the safeguarding system in Doncaster and can evidence how this is used to influence the Boards priorities.

Doncaster Education & Skills Commission

The Independent Commission on Education and Skills in Doncaster in their *'One Doncaster'* report identified the need for the education and skills system in the borough to thrive. The Local Authority will work with strategic partners, school leaders and governors, national agencies and other partners and stakeholders to ensure that the system delivers what is expected and required.

There are four key tenets of the reform programme that will tie in to the Children and Young People's Plan:

From plans to action: Shared leadership of reform that delivers for Doncaster's citizens and its economy

The key deliverables are:

- Developing a 'whole person whole life' focus
- Create a local all age Careers and Employment guidance system
- Provide outstanding teacher development opportunities

Doncaster Raising Aspiration and Achievement Strategy

To deliver the improvements that Doncaster needs the local authority will work with strategic partners to ensure that school and college leadership at all levels is of the highest quality and that leaders in turn improve the quality of provision their schools and colleges offer. Children and young people and their families will also receive the additional support they need, both in and out of a school or college setting, to ensure that the young person has every chance to take advantage of the better opportunities they are given.

The Council has clear ambition for the schools and colleges in Doncaster and the children and young people who attend them. It is committed to achieving excellence in education and believes that all children and young people are entitled to be educated in successful local schools. The key deliverables include:

- To reduce by half the number of schools that are categorised as Schools Causing Concern and to improve the LA Ofsted schools' profile
- To improve the behaviour continuum for vulnerable students in Doncaster
- To improve safeguarding in schools so that it is judged as effective

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Area Working

During 2017 the Children and Young People's partnership will agree 4 area based implementation plans which will enable it to better shape delivery and respond to need. This will build localised data and insight to enable the partnership to better assess impact.

Doncaster Confident Families Programme

Doncaster Stronger Families programme is central to all Early Help and family support work across the wide range of partners in Doncaster. It focus on families with children that face challenges around crime and anti-social behaviour, school attendance , children who need help , at risk of worklessness and a range of health problems. A whole family assessment and action plan must take into account all issues (both child and adult) and have in place interventions to tackle these.

7. Delivering on our ambition in 2017-20 - How we intend to work together to achieve this

We will be clearly seeking to deliver on our ambition to become the most child friendly borough in the country. Central to this is a fundamental shift in our approach – moving from simply trying to respond to national directives to seeking to shape the narrative and become an example of best practice. In a time of constrained finances, this is absolutely essential, and is a clear indication of determination to see the children and young people of Doncaster consistently achieve their full potential.

Partnership Principles

- Be child focussed – children and young people are our primary concern
- Use evidence-based approaches to ensure effective interventions
- Use relationship-based interventions to maximise families' trust and confidence in our services
- Use resources wisely
- Use an integrated 'right first time' approach to ensure best use of resources
- Deploy high quality performance management and quality assurance arrangements to ensure that we are self-aware and able to react quickly to changing needs.
- Agree strengths informed approaches to ensure maximum engagement and strengthening of families
- Be curious about what we don't yet know – and determined to find out
- Be champions for children and young people in every aspect of our work
- Recognise and act upon our responsibilities as corporate parents for children in care and care leavers
- Be respectful of difference and celebrate diversity
- Respect customers, stakeholders and colleagues, treating them with courtesy, dignity and consideration
- Do what we say we are going to do
- Bring innovation and creativity into our planning and delivery of services
- Work ethically and safely at all times; be fair, honest and transparent
- Deal with information about other people with sensitivity, care and consideration
- Take time to listen: it's a two-way conversation
- Make sure we say sorry when things go wrong
- Respect and encourage the hopes and dreams of the children and young people we work with
- Seek always to raise aspirations for CYP, families and communities
- Be ambassadors for Doncaster
- Challenge poor practice and accept challenge constructively
- Be change agents in people's lives and empower families through our work

Participation, voice and influence – "No decision about me without me"

- Recognise that children, young people, parents and carers are experts by experience
- Making sure that involvement is seen as a continuous process of dialogue-building and not just a series of one-off exercises.
- Children and young people are treated with respect and honesty and their contribution is acknowledged as important.
- Investing resources in developing people with the skills and knowledge to build trusted and imaginative ways of involving children and young people.

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- Avoiding duplication across the partnership and therefore avoiding unnecessary cost and 'consultation fatigue'.
- Working with children and young people to understand "what works for them" in terms of involvement.
- Making sure that involving children and young people in the democratic decision-making process is seen as a valuable end in itself and an important part of our work.
- Accepting that children and young people are not always going to tell us what we want to hear - in the way that we want to hear it.
- Providing a range of opportunities for involvement to meet the needs and preferences of our diverse community.
- Making sure that when we ask children and young people what they think about issues and services that we are committed to respond.
- Using the Youth Parliament, Children in Care Council, Care Leavers' Council and social media to make sure that children, young people and their advocates can see what has changed as a result of their involvement.

Common Outcomes Framework

The Children and Young People's Plan follows on from the ambition of partners and their own individual priorities, focusing the borough on the outcomes that really matter for children and young people, and connecting children and young people to the growing number of opportunities that we are seeking to provide over the next few years.

It means that whilst our individual roles and services may deliver on particular issues, overall our models of support for children will add up to a something greater than the sum of our parts. It also means that we will place critical importance on understanding what matters to children and young people, updating our plans and service specifications accordingly – through regular listening and engagement with practitioners, families, and children and young people, supported by rigorous analysis of statistical data, such as the Joint Strategic Needs Assessment, and research.

Working in partnership

Achieving our vision will only be possible through working with partners across organisational and service boundaries. Doncaster has an ever improving platform to work from in this regard, both in terms of new, improved governance arrangements, and integrated strategies to work from. The partnership is collectively working towards four policy priority areas for its work over the next four years: living, caring, working, and learning, and this Plan is cognisant of this, seeking to integrate crucial outcomes specific to children and young people into the broader borough-level ambition.

Work is on-going through the Children and Families Partnership Board to drive improvement in outcomes for children and young people. The Board acts as the overall steering and coordination body, working with partners across Doncaster to focus effort around the priorities and outcomes. It also provides high level oversight of the work of the partners, working to deliver coherency in plans and that actions can contribute effectively to the key outcomes for the borough.

We have also established an interim executive group (IEG) that has taken forward 4 key strategic tasks in the borough: the JSNA, the CYP Plan, the production of an

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updated outcomes framework, and a governance review to better align to our new priorities to established, accountable groups. This will help to ensure that all partner organisations are action focussed and deliver against agreed actions seeking to improve the health, wellbeing and attainment of children and young people across the borough. (The proposed new structure is included in Annex 1).

Joint Strategic Commissioning

Joint Commissioning is currently carried out through an Executive Group that includes partners from the local authority, Children's Trust and Health partners. This group will revisit its commissioning priorities as a consequence of this plan and deliver joint commissioning strategies by June 2017

The review will entail:

- Baseline current commissioned activities by all agencies for children aged -25 covering costs
- Analyse the impact of existing activities against JSNA priorities for relevance
- Analyse performance framework against the new outcomes framework
- Identify decommissioning and re-commissioning against existing procurements and contracts
- Establish revised commissioning strategies

Local Office of the Children's Commissioner

The local authority is committed to a new role of the Local Office of The Children's Commissioner. This strategic role will help to drive forward our new approach to engagement, and ensure greater co-ordination of action and intent across Team Doncaster. There are three key principles which will drive the way that we take our work forward over the next four years:

- Be child and young person centred
- Listen to and respond to children and young people
- Focus on strengths and building resilience

By committing to this approach, we are confident that we will deliver on our ambition to make Doncaster the most child friendly borough in the country.

Policy Implementation Gateways

Of central importance to this is the development of an approach based on policy 'gateways'. This rigorous analytical toolkit ensures a consistency in the approach to developing policy and strategy in the long term, and will mean that there is less duplication of effort alongside a clear rationale for implementation of interventions at a practice level. It will also allow for a more robust process of evaluation of the effectiveness of our strategies, allowing us to change course if something is not delivering the outcomes that we want to see. Incorporating best practice tools and techniques, such as horizon scanning, examples of new evidence based practice, and looking for examples of innovation, this will complement the and underpin the work on our DN21 (borough strategy) programmes of work.

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New approaches to assessing impact

The combination of better data and better insight is changing policy around children and young people. As such we propose a rejuvenated approach to assessing rounded impact based on the following areas. These approaches are being adopted precisely because they are able to inform our partnership better in respect of our local challenges.

Life Course Thinking

Increasingly, evidence on child and early adolescent development has resulted in a shift towards life course assessment. This in turn challenges Children and Young People's partnerships to think more expansively around the development of children and young people and, while organisations within our partnership will be largely responsible for specific areas of delivery, as a partnership we will shift to a 0-25 life course measure of collective success. This is reflected in our outcomes framework in appendix 5 that brings together responses to particular areas of need and the wider life course approach.

Children & Young People Typologies

The current Schools Green paper centres on the notion of social mobility. It especially focuses on the fortunes of those families 'just managing'. This has emerged on the back of a progressive shift to the use of typologies. In Doncaster we are interested in the development of a method by which we can develop a deeper understanding of the characteristics and motivations of different social groups, develop more tailored interventions and assess how a range of services can act as an escalator to support social mobility. .

Social Mobility

The notion of typologies and social mobility go hand in hand. The latest report of the Social Mobility Commission identifies major challenges for Doncaster. Facing up to these challenges has to begin with children and young people and interventions have to respond to this challenge. Consequently this plan will routinely assess shifts in social mobility using the data recommended by the Social Mobility Commission.

Well-being, Happiness and Resilience

Children and Young People's voice is central to this plan and we will supplement this with assessment of their happiness and well-being. The most respected vehicle for this is The Children's Society's 'Good Childhood' Index**.** This includes a five-item measure of life satisfaction, a single-item measure of happiness with life as a whole, and a series of questions about well-being in 10 key areas of children's lives - family, friends, health, appearance, time use, the future, home, money and possessions, school and amount of choice. Analysis of the 2008 survey yielded the discovery that these ten areas explained over half of the variation in overall well-being.

Mental Toughness

Mental Toughness is a concept most commonly associated with elite sporting performance, but one that has gained traction in education over the past 10 years. It is based on the premise of more resilient young people performing better academically, and has been trialled in locations across the country. Based on the concept of 4 C's – control, commitment, confidence and challenge – a series of

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interventions take place over a defined period of time that seek to improve these aspects of personal resilience, with a view to it leading to a more rounded and 'mentally tough' young person. There has been a great deal of research and evaluation of this approach, as evidenced by the publications[6] where the correlation between increased mental toughness and increased academic performance is assessed. The partnership intends to explore the prospect to using the MTQ48 methodology of testing mental toughness with the support of participating schools.

Social Value and Costs Benefit

The partnership is interested in pursuing further the notion of social value and social impact brought about through the positive actions of children and young people. While the notion of social value has been more recently aligned to public procurement, we feel there is a strong case for expanding its notion across key areas of public service delivery, and are exploring taking this forward through revised procurement arrangement.

The recent report of the Doncaster Independent Commission for Education and Skills proposes a series of radical notions around the wider accreditation of the talents of children and young people and a guaranteed set of experiences before the ages of 11 and 16. We would wish to explore the impact of these on the children and young people themselves, their families and communities in the context of the social value they create. We would align to this harder cost benefit of cost benefit using the model developed by New Economy of Manchester in partnership with HM Treasury.

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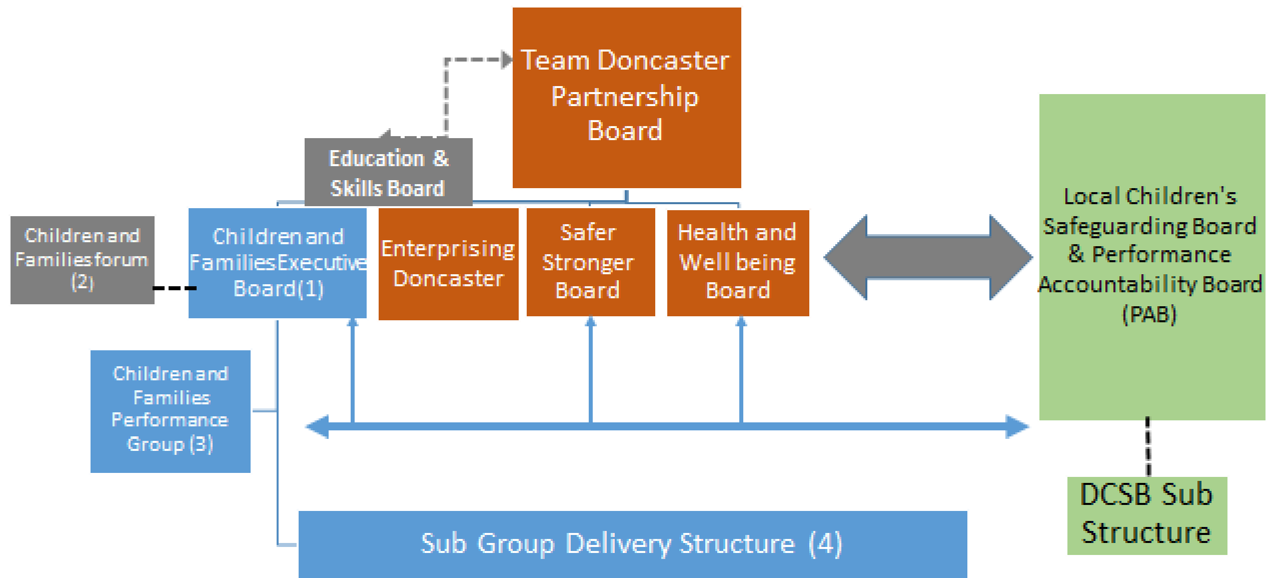
[6] https://kar.presswarehouse.com/books/BookDetail.aspx?productID=383786

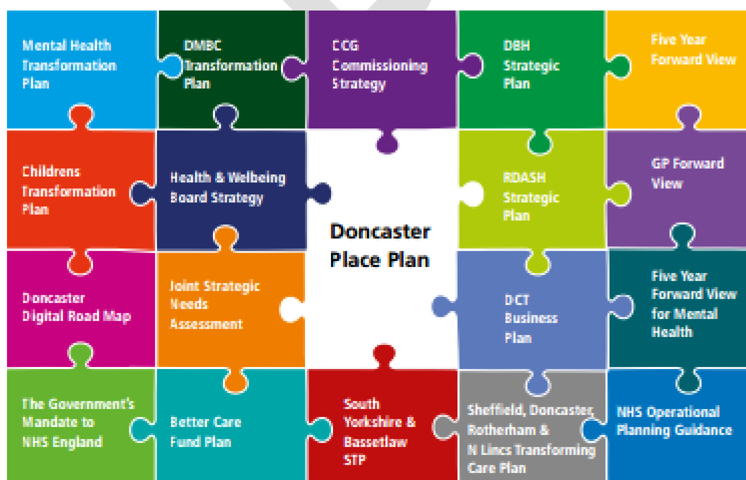
Appendix 1 – proposed new governance structure



Appendix 2 – list of partners engaged

Doncaster Council
Doncaster Children's Services Trust
Doncaster Clinical Commissioning Group
Partners in Learning
South Yorkshire Police
St Leger Homes
Public Health
Doncaster Chamber
Doncaster Wildlife Park
Robin Hood Airport
Don Valley
Rdash
Doncaster CVS
South Yorkshire Fire & Rescue
Strategic Youth Alliance

Appendix 3 – integrated planning



Appendix 4 – key change proposition of wood review

RESPONDING TO WOOD REVIEW: KEY CHANGE PROPOSITIONS

- Retain DSCB as a basis for developing modified multi-agency safeguarding arrangements that represent 'best fit' for key partners
- Retain Independent Chair role, with remit to work with key partners to initiate and lead streamlining of multi-agency safeguarding arrangements (in effect, taking forward propositions in Wood Review within a retained DSCB framework to promote continuity and reduce risk).
- Use opportunity of Team Doncaster's governance review to rationalise 'partnership clutter' as part of new arrangements for promotion and coordination of safeguarding
- Strengthen focus of DSCB on local assurance, scrutiny and challenge and using partnership business support more effectively
- Identify opportunities for multi-agency safeguarding functions to be carried out on a joint, sub-regional or regional basis where this would promote greater consistency and efficiency
- Encourage a regional or sub-regional approach to issues such as FGM, Modern Slavery and Prevent.
- Ensure regional dissemination of shared learning from local learning enquiries

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Appendix 5

Principles Applied

Outcomes framework should be based on sample of “pulse” measures that will measure impact of activity

The basis of the Framework is the JSNA priority framework against which all measures can be mapped

Indicator owners are identified in order to provide the insight and detail that sits beneath the measure.

The Outcomes Framework will map and link to existing strategies and plans, where the further detail and granularity will lie.

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STAY SAFE

Children have access to the right services at the earliest opportunity

Measure	Source	Frequency	x-ref to other plans	Baseline	Position	Target
Rate of Children receiving a multi-agency Early Help Intervention	DCST	Quarterly	TBC	TBC	TBC	TBC
Time taken from an early help enquiry to a family receiving an early help intervention	DCST	Quarterly	TBC	TBC	TBC	TBC
Rate of Children in Need	DCST	Quarterly	TBC	TBC	TBC	TBC
Rate of Children in Care	DCST	Quarterly	TBC	TBC	TBC	TBC
%Re-Referrals for statutory social care services	DCST	Quarterly	TBC	TBC	TBC	TBC
%Re-referrals for Early Help Services	DMBC	Quarterly	TBC	TBC	TBC	TBC
%of Social Care referrals previously receiving an Early Help service (EHA)	DCST	Quarterly	TBC	TBC	TBC	TBC
Number of families worked with through the Stronger Families programme	DMBC	Quarterly	TBC	TBC	TBC	TBC
Children fatally or seriously injured through Road Traffic Accidents	SYSRP	Annual	TBC	TBC	TBC	TBC
Admissions to A&E for unintended injuries	CCG	Quarterly	TBC	TBC	TBC	TBC
Pupil Lifestyle Survey: Do children feel safe going out in the day?	DMBC	Bi-Annual	TBC	TBC	TBC	TBC
Domestic abuse practice is transformed across Doncaster						
% of Statutory Assessments completed where Domestic Abuse is identified as a factor	DCST	Quarterly	TBC	TBC	TBC	TBC
% of re-referrals to social care where DANs have been involved	DCST	Quarterly	TBC	TBC	TBC	TBC
Rate of Children in Need where Domestic Abuse was a factor	DCST	Quarterly	TBC	TBC	TBC	TBC
Rate of Children in Care where Domestic Abuse was a factor	DCST	Quarterly	TBC	TBC	TBC	TBC
Pupil Lifestyle Survey: Experience of violence in the home (Q36b)	DMBC	Bi-Annual	TBC	TBC	TBC	TBC
Ensure no child suffers from neglect						
% of referrals where Neglect identified as a factor	DCST	Quarterly	TBC	TBC	TBC	TBC
% of Statutory Assessments completed where Neglect is identified as a factor	DCST	Quarterly	TBC	TBC	TBC	TBC
% of Early Help Cases open with Neglect as a presenting factor	DCST	Quarterly	TBC	TBC	TBC	TBC

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Rate of Children in Need where Neglect was a factor	DCST	Quarterly	TBC	TBC	TBC	TBC
Rate of Children in Care where Neglect was a factor	DCST	Quarterly	TBC	TBC	TBC	TBC

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BE HEALTHY

Children and young people are healthy and have a sense of wellbeing

Measure	Source	Frequency	x-ref to other plans	Baseline	Position	Target
Number of young people admitted to an acute mental health bed (tier 4)	CCG/RDaSH	Quarterly	TBC	TBC	TBC	TBC
Hospital Admissions for Self Harm	DCCG	Quarterly	TBC	TBC	TBC	TBC
Referrals into specialist CAMHs	RDaSH	Quarterly	TBC	TBC	TBC	TBC
%Children in care with up to date health assessment, dental check and immunisations	DCST	Quarterly	TBC	TBC	TBC	TBC
Pupil Lifestyle Survey: %Children scoring themselves high on the composite Resilience Score (Q84/85)	PH	Bi-Annual	TBC	TBC	TBC	TBC
Children have the best start in life						
%of children born with a low birth weight	CHIMAT	Annual	TBC	TBC	TBC	TBC
Breast Feeding prevalence at 6-8 weeks post delivery	CHIMAT	Annual	TBC	TBC	TBC	TBC
%Children with “Healthy Weight” at 5 years	NCMP	Annual	TBC	TBC	TBC	TBC
Hospital admissions for Dental Caries for under 5 year olds	CHIMAT	Annual	TBC	TBC	TBC	TBC
<18 Conception Rates	CHIMAT	Annual	TBC	TBC	TBC	TBC
%Children with “Healthy Weight” at 11 years	NCMP	Annual	TBC	TBC	TBC	TBC
Children and young people’s development is underpinned through a healthy lifestyle						
Pupil Lifestyle Survey: Have you been drunk in the last 7 days? (Q53)	DMBC	Bi-Annual	TBC	TBC	TBC	TBC
Pupil Lifestyle Survey: CYP reporting that they smoke regularly (Q59)	DMBC	Bi-Annual	TBC	TBC	TBC	TBC
Pupil Lifestyle Survey: %CYP reporting that they have taken drugs during the last month	DMBC	Bi-Annual	TBC	TBC	TBC	TBC
First Time Entrants to Drug and Alcohol Treatment Services	CCG	Quarterly	TBC	TBC	TBC	TBC

ACHIEVE

Ensure all children are ready for school

Measure	Source	Frequency	x-ref to other plans	Baseline	Position	Target
% of children taking up 2,3 and 4 year old early years entitlement	DMBC	Termly	TBC	TBC	TBC	TBC
% of children achieving a good level of development by the age of 5 (EYFS)	DMBC	Annual	TBC	TBC	TBC	TBC
Achievement gap between lowest achieving 20% of children in EYFS with their peers	DMBC	Annual	TBC	TBC	TBC	TBC
All children attend a good or better setting and aspirations are raised to ensure that they reach their full potential						
% of EY settings rated as good or better	DMBC	Quarterly	TBC	TBC	TBC	TBC
% of children attending a school graded as Good or Outstanding	DMBC	Termly	TBC	TBC	TBC	TBC
Rate of fixed term exclusions	DMBC	Termly	TBC	TBC	TBC	TBC
Rate of permanent exclusions	DMBC	Termly	TBC	TBC	TBC	TBC
Primary school persistent absence rate	DMBC	Termly	TBC	TBC	TBC	TBC
Secondary school persistent absence rate	DMBC	Termly	TBC	TBC	TBC	TBC
%children achieving expected standard in RWM at KS2	DMBC	Annual	TBC	TBC	TBC	TBC
%children achieving at a higher standard in RWM at KS2	DMBC	Annual	TBC	3% (2016)	TBC	TBC
Attainment 8 score at KS4	DMBC	Annual	TBC	TBC	TBC	TBC
Progress 8 score at KS4	DMBC	Annual	TBC	TBC	TBC	TBC
Young people are equipped to access education, employment and training						
%pupils achieving a grade 5 or better in English and Maths at KS4	DMBC	Annual	TBC	TBC	TBC	TBC
%pupils who stayed in education or went into employment after Y11	DMBC	Annual	TBC	TBC	TBC	TBC
%young people aged 16-18 in EET	DMBC	Quarterly	TBC	TBC	TBC	TBC
Achievement of a Level 2 qualification by the age of 19	DMBC	Annual	TBC	TBC	TBC	TBC
Achievement of a Level 3 qualification by the age of 19	DMBC	Annual	TBC	TBC	TBC	TBC
First Time Entrant rate to the Youth Justice System	YJB	Quarterly	TBC	TBC	TBC	TBC

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ECONOMIC WELLBEING

Diminish the difference between disadvantaged and non-disadvantaged children and young people

Measure	Source	Frequency	x-ref to other plans	Baseline	Position	Target
%Children in care attainment 8 score at KS4	DMBC	Annual	TBC	TBC	TBC	TBC
Progress 8 measure for Children in Care	DMBC	Annual	TBC	TBC	TBC	TBC
% Children in care achieving grade 5 or better in English and Maths at KS4	DMBC	Annual	TBC	TBC	TBC	TBC
%children in care achieving expected standard in RWM at KS2	DMBC	Annual	TBC	TBC	TBC	TBC
%Care Leavers in Employment, Education or Training (EET)	DCST	Quarterly	TBC	TBC	TBC	TBC
%Care Leavers in Suitable Accommodation	DCST	Quarterly	TBC	TBC	TBC	TBC
Achievement gap between disadvantaged pupils and their peers at KS2	DMBC	Annual	TBC	TBC	TBC	TBC
Achievement gap between disadvantaged pupils and their peers at KS4	DMBC	Annual	TBC	TBC	TBC	TBC
Achievement gap between pupils receiving SEND support and their peers at KS2	DMBC	Annual	TBC	TBC	TBC	TBC
Achievement gap between pupils receiving SEND support and their peers at KS4	DMBC	Annual	TBC	TBC	TBC	TBC
Achievement of a level 3 qualification by the age of 19 for disadvantaged pupils	DFE	Annual	TBC	TBC	TBC	TBC
Fewer children living in poverty						
Children living in workless households	CHIMAT	Annual	TBC	TBC	TBC	TBC
Proportion of children eligible for Free School Meals	DMBC	Termly	TBC	TBC	TBC	TBC
Number of JSA claimants aged 18 to 21	NOMIS	Quarterly	TBC	TBC	TBC	TBC
Intelligence Gaps: indicators that require further development during the life of the Plan						
Availability of Apprenticeships within Doncaster, by level and sector						
Apprenticeship enrolment and success for young people						
Skills gaps for employers in the area						
Children from income deprived backgrounds entering Higher Education						

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Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Date: 16 March 2017

Subject: Director of Public Health Annual Report 2016

Presented by: Dr R Suckling

Purpose of bringing this report to the Board	
Decision	X
Recommendation to Full Council	
Endorsement	X
Information	

Implications		**Applicable Yes/No**
DHWB Strategy Areas of Focus	Substance Misuse (Drugs and Alcohol)	Yes
	Mental Health	Yes
	Dementia	Yes
	Obesity	Yes
	Children and Families	Yes
Joint Strategic Needs Assessment		Yes
Finance		No
Legal		No
Equalities		Yes
Other Implications (please list)		No

How will this contribute to improving health and wellbeing in Doncaster?
The Director of Public Health Annual Report is an independent report on the health of Doncaster. Doncaster Council has agreed to its publication and the recommendations impact directly on the health of Doncaster people. The implementation of all the 2016 recommendations will be monitored by the Office of the Director of Public Health and an exception report will be provided to the Board.

Recommendations
The Board is asked to:- REVIEW the progress made against the 2015 recommendations NOTE the 2016 recommendations AGREE three or four high impact areas for the Board to focus on in 2017. Potential high impact areas include: ‘Delicious Doncaster’ approach to food and nutrition ‘Get Doncaster Moving’ campaign to increase physical activity Work with communities and community organisations to build connected, resilient and supportive communities, developing the learning from Stronger Families, Well North and social movements. Adopt work as a health outcome, supporting people back into work and helping people with health issues in employment stay in work

Director of Public Health Annual Report 2016

Doncaster Metropolitan Borough Council

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Foreword

Welcome to my second Annual Report as Director of Public Health for Doncaster Metropolitan Borough Council.

In 2015, I identified four challenges that needed to be addressed to sustain the progress that had been made in improving health and wellbeing locally. The challenges were

- Improving children's health and wellbeing
- Making the link between education, work and health
- Increasing healthy life expectancy and reducing preventable health conditions
- Reducing inequalities in health between and within Doncaster communities

On the basis of these challenges I made a number of recommendations and progress is captured in section 1, but I have yet to see major impacts or changes in health outcomes.

This report then describes the health of Doncaster people using the Public Health England 2016 health profile, and I have made comparisons to the 2015 and 2011 profiles which are included as appendices to this report. I have then represented the work of the Robert Wood Johnson Foundation and the University of Wisconsin to illustrate the factors that contribute to good health, but also reminded readers that the factors that contribute to health accumulate over time and I introduce the concept of the life course. Sections 3, 4 and 5 describe the way in which the council's public health team is working with partners to adopt a life course approach and section 6 describes emerging approaches to social and environmental factors. Section 7 provides an update on health protection and health care public health. Sections 8 and 9 describe the emerging local approach to addressing health inequalities and how this has been translated into the Well Doncaster approach starting in Denaby.

Finally, I have only made one new recommendation this year as although there is action against all of last year's recommendations none of them can be considered complete.

The one new recommendation is for Team Doncaster to consider a 'Delicious Doncaster' approach to food and nutrition to run alongside the 'Get Doncaster Moving' approach for physical activity. A 'Delicious Doncaster' approach could reconnect people to the land and growing, supporting both economic development and gardening together with improving health and wellbeing. The approach could support schools, communities and urban farms as well as celebrating Doncaster's rich food heritage.

I have also decided to use videos based on info-graphics to share the content of this report. I hope you enjoy watching the videos.

In compiling this report I am grateful for the help of a number of colleagues. In particular I would like to thank Claire Hewitt, Carrie Wardle, Louise Robson, Helen Conroy, Clare Henry, Nick Germain, Dr Victor Joseph, Susan Hampshaw and Dan Debenham.

If you have any questions or comments about any aspect of the report please send them to me at PublicHealthEnquiries@doncaster.gov.uk

Dr Rupert Suckling
@rupertsuckling

Director of Public Health

Doncaster Metropolitan Borough Council

Section 1: Progress on Recommendations from the 2015 Annual Report

In 2015 I identified four challenges that Team Doncaster would need to address to maintain progress on improving health and reducing health inequalities. The challenges were:

- Improving children's health and wellbeing
- Making the link between education, work and health
- Increasing healthy life expectancy and reducing preventable health conditions
- Reducing inequalities in health between and within Doncaster communities

In order to help Team Doncaster, I made a series of recommendations addressing overarching themes, children, young people and families, employment and health and the prevention of disability. I have asked the relevant leads for an update on progress and this is attached below recommendation by recommendation.

Overarching Recommendations

- Adopt a 'Health in All Policies' approach
- Make a strategic shift to prevention
- Empower people and communities to take control of their own health and if services are required involve people in co-designing the services
- Improve data capture, sharing and reporting so that services can become more seamless and based on insight to address inequalities in access and outcomes
- Carry out a local Health Needs Assessment for Black and Minority Ethnic (BME) Groups
- Move beyond integration to population health systems and budgets

Adopt a 'Health in All Policies' approach	The Doncaster Local Plan will be the new planning strategy for the borough. It is the comprehensive statement of the borough's most important planning policies and will set out detailed development management policies to guide new development in the borough. Within the new Local Plan we have developed a Health and Wellbeing policy to ensure that future developments consider the impacts upon health and wellbeing.
Make a strategic shift to prevention	The Doncaster Place Plan and the South Yorkshire and Bassetlaw Sustainability and Transformation plan both highlight the need for a strategic shift to prevention. More work is needed to clarify the

	content of and funding for this work stream.
Empower people and communities to take control of their own health and if services are required involve people in co-designing the services	Community Led Support models are being rolled out across Doncaster. Well North approach embedded in 'Well Denaby'. A booklet that aims to empower patients with chronic chest diseases to manage their conditions has been refreshed. The same approach will be developed for patients with other long term conditions.
Improve data capture, sharing and reporting so that services can become more seamless and based on insight to address inequalities in access and outcomes	The Business Intelligence Board has been established to develop analytic tools to improve insight into the experiences of Doncaster people. The board are concentrating on improving geographical analysis and the use of maps as a tool to improve insight into people's health and wellbeing experience. The board will also be seeking to develop a range of analytic tools to enable officers, elected members and the public describe the challenges the borough faces.
Carry out a local Health Needs Assessment for Black and Minority Ethnic (BME) Groups	During 2016, we have revisited the BME health needs across the borough and under the auspices of the Health and Well Being Board (HWBB) we have carried out a multi staged needs assessment which culminated in a HWBB evidence safari (see https://www.gov.uk/guidance/open-policy-making-toolkit/understanding-policy-problems-and-user-needs for more information on evidence safari). We looked at information about BME communities in Doncaster. We also looked at what published research said about what might work in addressing inequalities for BME communities and people. We spent time talking to people by collecting their experiences of using health and social care services across Doncaster using Doncaster Healthwatch's Feedback Centre as well as within GP practices, the council's One Stop Shop, the Women's Centre and Doncaster Conversation Club. The final report is due in January 2017.
Move beyond integration to population health systems and budgets	The Doncaster Place Plan describes the first steps to address this. It describes a shared vision, the integration of planning (commissioning) and more seamless service provision. Consultation with the public and staff is planned for early 2017.

Recommendations for Children, Young People and Families

- Implement and evaluate the Early Help strategy
- Focus on vulnerable mothers from pregnancy until the child is 2 ½ (the first 1000 days)
- Build on the national Future in Mind developments to address bullying and improve the mental health of school aged children
- Support schools to develop a Curriculum for Life
- Support schools to increase physical activity in the curriculum

Implement and evaluate the Early Help strategy	A successful multi-agency Early Help Improvement Task Group (EHITG) was established in January 2016 to drive the implementation of the Early Help strategy including: • The appointment of eight Early Help coordinators to support multi-agency colleagues to implement the Early Help strategy and navigate the Early Help processes / understand the early help model in localities. • The roll out of an updated 'practitioner friendly' Early Help handbook and the training of staff and volunteers from a wide range of agencies to undertake the role of lead practitioner and use the Early Help module. Early indicators of success: By August 2016, the Department of Education's improvement partners reported: 'Good progress has been made since the first review in May 2016. In terms of Ofsted judgements, early help services are now firmly in the 'requires improvement' category with a trajectory moving steadily towards good.' Children requiring early help are being identified at an earlier age. Over half of all enquires to the Early Help Hub are now for children aged under nine years old. The engagement of health partners increased significantly, with over 400 GP practice based staff undertaking early help training. Likewise, schools made 1,312 enquiries of the early help hub between November 2015 and November 2016. As of October 2016 48% of open early help cases had been de-escalated and only 10% of cases had escalated to social care intervention. The proportion of children achieving a good level of development at the end of the Early Years Foundation Stage was the highest ever seen in the Summer of 2016, and just above national levels (this is a key success measure of the Early Help strategy).

Focus on vulnerable mothers from pregnancy until the child is 2 ½ years old (the first 1001 days)	DMBC and Doncaster Clinical Commissioning Group (CCG) are working together to form a joint 'Starting Well offer' that will see a coordinated approach to delivering services for pregnant women and families with a focus from conception to the second year of life (first 1001 days). The emphasis will be on prevention and early intervention with vulnerable women and families being offered targeted support before issues arise or worsen.
Build on the national *Future in Mind* developments to address bullying and improve the mental health of school aged children	The Local Transformation Plan refresh has been completed and NHS England is fully confident in progress to date. The new elements of the service are being implemented and metrics put in place to measure mental health.
Support schools to develop a Curriculum for Life	Doncaster Education Commission reported in October 2016. Further work on implementation to be agreed by Team Doncaster.
Support schools to increase physical activity in the curriculum	We have developed a Healthy Schools approach to encourage schools to provide a healthy setting for pupils. This includes best practice standards for physical activity, physical education and sport.

Recommendations for Employment and Health

- Use the Social Value Act to maximise equitable employment opportunities when commissioning
- Recommission the 'work programme' as part of the Sheffield City Region deal to help those furthest from the labour market find work
- Work to keep those with health issues in employment longer, improving health literacy and self management
- Continue to help residents keep their homes warm through collective switching schemes, improving energy efficiency of properties and ensure access to welfare advice
- Use community assets to join up health, social care, education, skills and employment around the family building on the Stronger Families and Well North approaches

Use the Social Value Act to maximise equitable employment opportunities when commissioning	One of the council's key performance indicators is the number of contracts which contain social value principles. The target for 16/17 is 72%. Indications are that we will meet this target by the end of the financial year. We have also developed and published on our intranet pages social value guidance for staff i.e. to promote inclusion of social value into our contracts and tender specifications.

Recommission the 'work programme' as part of the Sheffield City Region deal to help those furthest from the labour market find work	Commissioning of the 'Work and Health Programme' the successor to the Work Programme, is being led by Sheffield City Region (SCR) who, through devolution, have a co-commissioning and co-design role. This means future delivery is shaped together with SCR colleagues. Doncaster is represented on the working group that is supporting the co-design work. The new 'Programme' is expected to go live in Autumn 2017 but will be vastly reduced in terms of financial value when compared to the current Work Programme.
Work to keep those with health issues in employment longer, improving health literacy and self management	The Sheffield City Region (SCR) is currently developing a health led employment pilot, working with the Government's Work and Health Unit which will include a focus on those who are in work but at risk of becoming unemployed through ill health. The project will go live in summer 2017 and the public health team at Doncaster have been central to its development and implementation to date. To encourage self-management, the following have been completed: - Updated Doncaster Chronic Obstructive Pulmonary disease (COPD) Booklet - Development and roll out of Making Every Contact Count e-Learning module
Continue to help residents keep their homes warm through collective switching schemes, improving energy efficiency of properties and ensure access to welfare advice	Over 6,700 people have registered for Doncaster collective switching schemes. 24% of those have switched saving on average £250 each. The Energy Action for Health Scheme carried out 64 home advice visits for the period 1st April 2016 to 6th December 2016. Hot Spots Referrals have referred 21 people to Department of Work and Pensions (DWP) for benefit entitlement checks. 'Boilers on Prescription' have assisted 12 households so far for the 2016/17 period. We have 2 more currently being processed. The total spend to date is £35,035.26. Neighbourhood Energy Officers visit 20 homes per week and have now visited around 4000 homes to offer energy saving advice and support residents. Department of Energy and Climate Change Central Heating Fund. To date we have received 161 applications for this central heating scheme to replace expensive and install mains gas central heating into homes. We intend to complete our target of 172 properties by February 2017. The budget for this scheme is £ 675,000. St Leger Homes Doncaster (SLHD) Solar PV Scheme. In 2015/16 684 properties received solar panels estimating £175 savings. SLHD External Wall Insulation. In 2015/16 1144 properties received this measure, saving £300 on heating bills and in 2016/17 512 properties received this measure. Winter Warmth - 2016/17. 12 Road shows are planned to be delivered between Oct 2016 - Feb 2017 to areas identified by public health as

	being most likely to be at risk of fuel poverty and with highest excess winter death rates. To date we have reached almost 100 residents offering advice and support in respect of keeping warm and well. Winter warmth packs have been distributed to the most vulnerable with the help of Well Being Officers/Stronger Communities Officers / Energy Team.
Use community assets to join up health, social care, education, skills and employment around the family building on the Stronger Families and Well North approaches	Well North has been operating in Denaby Main since August 2015. The programme has worked with community groups and statutory partners to engage with local people, with residents helping deliver the changes they want to see (creating a community library, a network of peer support, an allotment growing project, increased access to social prescribing, widened access to volunteer and work experience opportunities). A range of community-led events have celebrated arts, culture and heritage within the community. The project is working with local people, social enterprises and the Chamber of Commerce to create an enterprising culture in Denaby Main, with support from a micro-grant scheme. Building Better Opportunities, a programme with South Yorkshire Housing Association (SYHA), will co-locate from Denaby Children Centre and offer intensive support to people with complex barriers to work.

Recommendations to Prevent Disability

- Include preventative approaches in all patient pathways and clinical services
- Launch 'Get Doncaster Moving' campaign to increase physical activity
- Continue to reduce the negative impact of takeaways and fast food on health and air pollution by considering health impacts in spatial planning decisions
- Develop local approaches with South Yorkshire Fire and Rescue to promote fire safety and address falls including enhanced home safety checks

Include preventative approaches in all patient pathways and clinical services	The Doncaster Place Plan 2016-2021 has been produced and it has identified prevention and early help as a key approach. The Plan includes a Primary Care Strategic Model that aims to embed self-management as part of the keeping well pillar. An incentive scheme (CQUIN) for secondary care contract will come into force in 2017/18 and 2018/19 that will require patients admitted to hospital to be screened for smoking status, given brief advice, offered stop smoking medication and referred to specialist advisors. Similarly, the scheme will include alcohol screening, brief advice and referral.
Launch 'Get Doncaster	The use of #getdoncastermoving was launched this year in

Moving' campaign to increase physical activity	conjunction with a stakeholder event on a whole systems review of physical activity and sport. This has included themed social media campaigns linking physical activity to air quality, active travel, green spaces, Quick Response (QR) code trails and even the Guinness World Record! Since June 2016 we have tweeted a 107 times had 53,730 impressions and 1276 engagements.
Continue to reduce the negative impact of takeaways and fast food on health and air pollution by considering health in spatial planning approaches	A Health Impact Assessment approach has been developed as part of the Health and Wellbeing policy for the new Local Plan. An evidence review of fast food takeaways has been completed and comments have been submitted on planning applications for fast food establishments.
Develop local approaches with South Yorkshire Fire and Rescue to promote fire safety and address falls including enhanced home safety checks	Extended home safety checks, known as 'Safe and Well' checks have been rolled out from September 2016. These checks are addressing crime prevention, falls and health promotion in addition to fire safety. The checks link into the local falls pathway and services. The evaluation of this approach is due in spring 2017.

Section 2: The Health of Doncaster People 2016

The Public Health England health profile for 2016 categorises health need in a number of ways. My assessment for Doncaster of the most recent release of data is the following:

Our Communities

- 23.5% of children live in low income families and this is increasing
- According to national data educational performance is not shifting, but local data from this year's GCSEs is encouraging and should be reflected in next year's national data
- Reports of violent crime are increasing but this may be related to changes in the way crime statistics are recorded. The numbers are not back to 2011 levels though.
- Long term unemployment is down
- Homelessness has not really changed, but the current measure of homelessness does not reflect the number of people living in temporary accommodation

Children's and young people's health

- 20.5% of mothers smoke during pregnancy and at delivery, but this number is reducing
- Rates of teenage pregnancy have fallen by almost a half over the last 5 years
- 63.2% of mothers start breastfeeding, but this number continues to fall
- 20% of children in year 6 are obese and although too high is not increasing

Adults' health and lifestyle

- Smoking prevalence has fallen from 26.3% of adults in 2011 to 19.6% in 2016
- Only 52.6% of adults take enough physical activity to help them keep healthy
- 74.8% of adults are overweight or obese, one of the highest in England

Disease and poor health

- Hospital stays for self harm fell in 2016 compared to 2015 but this is still higher than in 2011
- Hospital stays for alcohol related harm are falling
- 7.7% of adults have diabetes and this is increasing
- The rates of hip fractures in people aged over 65 is reducing but is still higher than in 2011

Life expectancy and causes of death

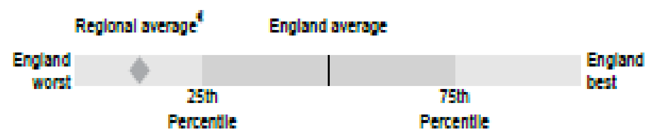
- Life Expectancy is flat, 77.5 years for men, 81.6 years for women
- Infant mortality is falling
- Suicide mortality is increasing
- Under 75 mortality from cardiovascular disease and cancer is falling but not as fast as regional and national levels

Doncaster Health Profile 2016

Health summary for Doncaster

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain	Indicator	Period	Local No total count	Local value	Eng value	Eng worst	Eng best
Our communities	1 Deprivation score (IMD 2015) #	2015	n/a	29.1	21.8	42.0	5.0
	2 Children in low income families (under 16s)	2013	13,345	23.5	18.6	34.4	5.9
	3 Statutory homelessness†	2014/15	40	0.3	0.9	7.5	0.1
	4 GCSEs achieved†	2014/15	1,640	50.0	57.3	41.5	76.4
	5 Violent crime (violence offences)	2014/15	4,450	14.7	13.5	31.7	3.4
	6 Long term unemployment	2015	1,507	7.9	4.6	15.7	0.5
Children's and young people's health	7 Smoking status at time of delivery	2014/15	691	20.5	11.4	27.2	2.1
	8 Breastfeeding initiation	2014/15	2,253	63.2	74.3	47.2	92.9
	9 Obese children (Year 6)	2014/15	608	20.0	19.1	27.8	9.2
	10 Alcohol-specific hospital stays (under 18)	2012/13 - 14/15	71	36.4	36.6	104.4	10.2
	11 Under 18 conceptions	2014	186	34.6	22.8	43.0	5.2
Adults' health and life style	12 Smoking prevalence in adults†	2015	n/a	19.6	16.9	32.3	7.5
	13 Percentage of physically active adults	2015	n/a	52.6	57.0	44.8	69.8
	14 Excess weight in adults	2012 - 14	n/a	74.8	64.6	74.8	46.0
Disease and poor health	15 Cancer diagnosed at early stage #	2014	x[1]	x[1]	50.7	36.3	67.2
	16 Hospital stays for self-harm	2014/15	582	192.8	191.4	629.9	58.9
	17 Hospital stays for alcohol-related harm	2014/15	2,116	714	641	1223	374
	18 Recorded diabetes	2014/15	19,342	7.7	6.4	9.2	3.3
	19 Incidence of TB	2012 - 14	70	7.7	13.5	100.0	0.0
	20 New sexually transmitted infections (STI)	2015	1,432	736	815	3263	191
	21 Hip fractures in people aged 65 and over	2014/15	360	640	571	745	361
Life expectancy and causes of death	22 Life expectancy at birth (Male)	2012 - 14	n/a	77.5	79.5	74.7	83.3
	23 Life expectancy at birth (Female)	2012 - 14	n/a	81.6	83.2	79.8	86.7
	24 Infant mortality†	2012 - 14	52	4.7	4.0	7.2	0.6
	25 Killed and seriously injured on roads	2012 - 14	343	37.7	39.3	119.4	9.9
	26 Suicide rate†	2012 - 14	83	10.3	10.0		
	27 Deaths from drug misuse #	2012 - 14	60	6.8	3.4		
	28 Smoking related deaths	2012 - 14	1,874	371.1	274.8	458.1	152.9
	29 Under 75 mortality rate: cardiovascular	2012 - 14	691	89.4	75.7	135.0	39.3
	30 Under 75 mortality rate: cancer	2012 - 14	1,376	177.3	141.5	195.6	102.9
	31 Excess winter deaths	Aug 2011 - Jul 2014	549	19.4	15.6	31.0	2.3

13

Indicator notes

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 12 Current smokers, Annual Population Survey (APS) 13 % adults achieving at least 150 mins physical activity per week 14 % adults classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population 21 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged <1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10+) 27 Directly age standardised rate per 100,000 population 28 Directly age standardised rate per 100,000 population aged 35 and over 29 Directly age standardised rate per 100,000 population aged under 75 30 Directly age standardised rate per 100,000 population aged under 75 31 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
# New indicator for Health Profiles 2016. x[1] Value not published for data quality reasons

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

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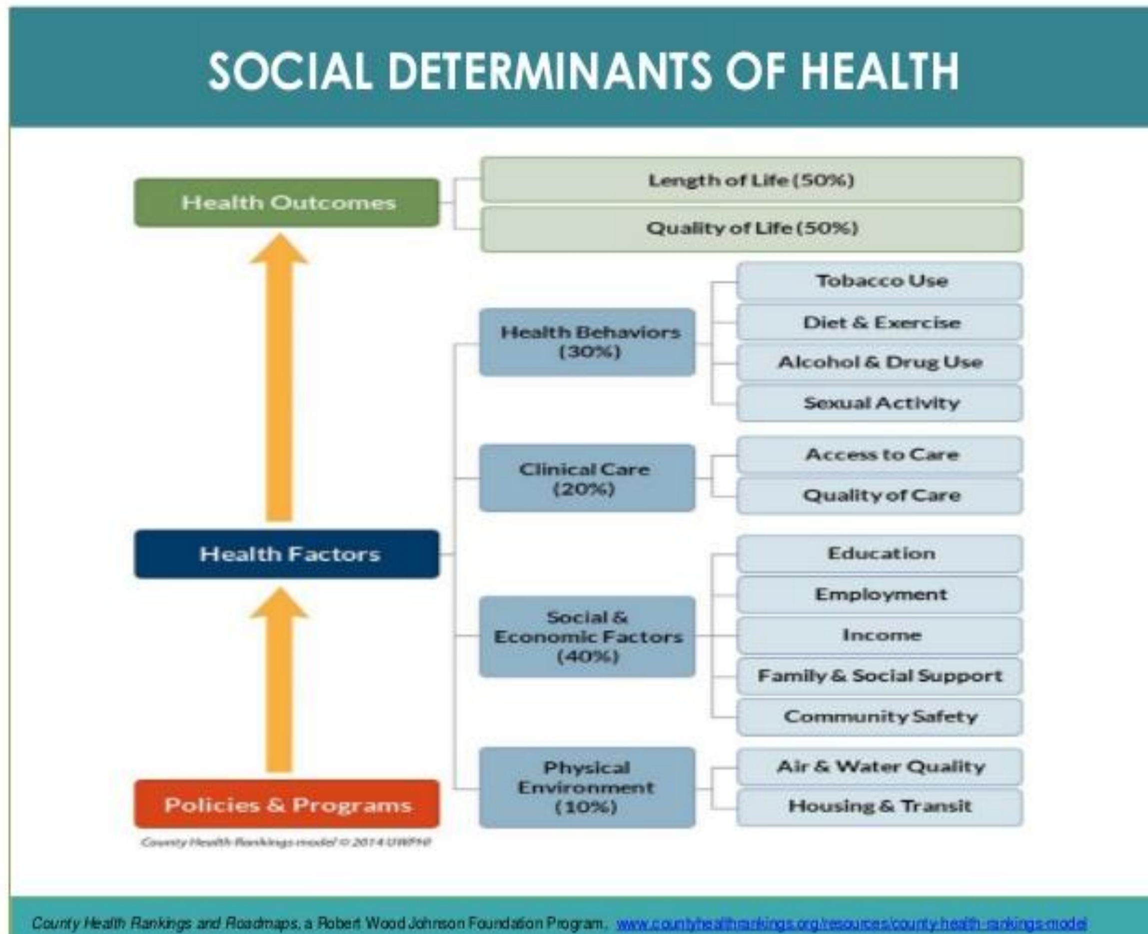
What makes us healthy?

As I outlined in my report last year there are a number of factors that can contribute to our health. The Robert Wood Johnson Foundation and the University of Wisconsin have estimated the contribution of the most important factors to our health. They include clinical care, which is about 20%, whilst social and economic factors contribute 40%, supported by health behaviours 30% and physical and environmental factors 10%.



The factors that contribute to health also accumulate over time and demonstrate that we all have crucial periods in our lives where our health can be particularly influenced. This approach is known as the life course approach and examples of crucial periods of time include the first 1001 days of a child's life, going to nursery/school for the first time, leaving school, getting married or retiring.

Section 3: Children, Young People and Families

What we're trying to achieve and why?

1. Every child has the best start in life

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development - physical, mental and emotional – are set in place during pregnancy and in early childhood. During pregnancy and in the first 2 years, neural pathways in the baby's brain are being laid down for life with 80% of a baby's brain development taking place during this time. What happens during these early years has lifelong effects on many aspects of health and wellbeing, educational achievement and economic status.

The Healthy Child Programme is a prevention and early intervention public health programme that lies at the heart of universal services for all children, young people and families. It aims to inform and support families, promote child development, and improve child health outcomes. The early year's element of the programme is primarily delivered by Health Visitors who have specialist training in promoting the health and wellbeing of children, young people and families.

The public health team and partners are running a variety of programmes and initiatives to not only empower and inform families but also to help establish positive relationships and connections. These include the distribution of free vitamins during pregnancy, information on how to stay healthy during pregnancy, UNICEF Baby Friendly initiative, healthy eating and oral health promotion initiatives.

Case Study: First Friends

First Friends is a community based, health led group which provides support, advice and information to new parents in the first (birth to moving around the floor) post natal period with a view to supporting positive attachment, recognition of early cues, encouragement of early interactions, identification of low mood and reduction of post natal depression through development of parental confidence.

Postnatal depression affects 10–15% of parents and can lead to cognitive and emotional impacts on the infant alongside health deficits for the mother (Patton et al 2015). Evidence shows that peer support and advice is an effective mechanism for building resilience and effective coping mechanisms in parents.

All lead health practitioners for First Friends are trained in the Brazleton Newborn Behavioural Assessment which is used in groups to encourage parental awareness of early developmental stages, responsiveness to cues and supports the building of a positive, reciprocal relationship. Containment provided in a regular setting allows parents to access reassurance, knowledge and increases parental confidence.

2. Children receive good information about how to keep themselves healthy and the environments they grow up in support and promote their health

A solid start ensures the foundations for a long, productive, and healthy life. As a child reaches school age, these foundations must be built upon and maintained to ensure they flourish, stay safe and achieve as they grow up. We know that a child's health is inextricably linked to their ability to do well at school and in turn increase their potential to be a productive member of society. As well as educating children and young people to make healthy choices and maintain their own health, the environments they grow up in must be conducive to promoting and supporting their health and wellbeing.

School nurses primarily deliver the Healthy Child Programme for school aged children. They are integral in supporting the school community to achieve and maintain good health through delivery of the programme. In addition, the public health team work with a number of partners working with children and young people to ensure services act as good health role models and that the environments children and young people grow up in promote and support healthy behaviours. Some of the projects currently underway include: Healthy Schools accreditation, Food and Drink guidelines for settings, and supervised tooth brushing sessions.

Case study: Supervised brushing pilot

Six private nurseries in the areas with the poorest dental health for 5 year olds across Doncaster have been taking part in a supervised tooth brushing pilot. The settings taking part were not only provided with staff training around how to carry out supervised tooth brushing and key oral health and nutrition messages but all the resources they needed to carry out supervised tooth brushing on a daily basis with their 2-5 year olds. Overall feedback was positive from parents, children and staff. Nearly all staff involved felt the children enjoyed the tooth brushing, 80% of parents said it was easier or sometimes easier to brush their child's teeth since being involved in the pilot and children enjoyed brushing their teeth with their friends and finding the toothbrushes on the racks.

> "Children whose parents say they have trouble brushing their teeth at home have actively taken part in nursery" (staff)
>
> "It's made her more aware of brushing her teeth, she reminds me now!" (parent)

3. Vulnerable families and children are identified early and supported appropriately

A small group of more vulnerable children and young people can often suffer much worse outcomes. This can be for a number of reasons associated with the effects of deprivation, poor attachment, parental substance misuse or mental ill health and being in the 'looked after system' to name a few.

The establishment of the Early Help Hub in Doncaster has introduced a new way of working with families to prevent need arising by intervening early to tackle emerging problems. It challenges partners to sharpen their focus on early help, coordinate services better for families and ensures that the right level of service is provided at the right time to the right families. Services delivering the Healthy Child Programme are tailored to meet the needs of families and children who are identified as having additional needs by using a tiered approach to service delivery. Children and families will receive additional support where it is identified and can be escalated up or down depending on their needs.

Evidence about brain development highlights an important challenge for children and young people who, particularly during puberty, face the beginning of a rapid and dramatic re-organisation of the brain. These changes in social functioning coincide with a time when peer interaction is increasing and reliance on parents and family is decreasing. The combination of these changes can lead to greater risk-taking behaviours resulting in poorer health outcomes for these individuals. Risk taking or exploratory behaviours include the use of drugs and alcohol, unsafe sex and smoking. It is recognised that these types of behaviours are often linked and must be addressed together. Project 3 is an integrated health and wellbeing commissioned service for young people aged 18 years and under that addresses the inter-related nature of exploratory behaviours. The service offers advice information, help, support and intervention around: sexual health; stop smoking; drugs, alcohol, legal highs; young people affected by somebody else's drug or alcohol use.

4. Everyone achieves good sexual health

Good sexual health is important because it is an issue that can affect peoples' mental health, their physical well-being, and their relationships with others. The public health team are striving to achieve good sexual health for all, through the promotion of safer sexual behaviour and the provision of high quality sexual health services.

Effective Relationships and Sex Education (RSE) that is taught from a young age using a whole school approach, in collaboration with families, can prevent teenage pregnancies and equip young people with the knowledge to protect themselves against sexually transmitted infections including chlamydia and HIV. Young people who have honest and comprehensive RSE have sex later than their peers and are more likely to use contraception when they do start having sex. The team works with School Nurses, Big Talk Education, Doncaster Pride, primary, secondary and post-16 settings to try and improve the quality and consistency of RSE across the borough. In addition, Doncaster has just launched the Respect Yourself Doncaster website to break down the barriers to accessing sexual services and provide young people with a safe place to access honest and comprehensive information about relationships, bodies, and sex.

Provision of good quality, effective contraception methods is essential to prevent unwanted pregnancy and protect from sexually transmitted infections. Increasing access to contraception, including Long Acting Reversible Contraception (LARC), in young-person-friendly sexual health services (Project 3) and non-sexual health services (School Nursing, GP, community pharmacy) has been shown to be effective in reducing the number of teenage pregnancies.

Case study: Respect Yourself
The dual platform relationships and sex education website 'Respect Yourself Doncaster', aimed at young people age 13+, was launched in Sexual Health Week (12th-19th September 2016) to engage with young people around issues of relationships and sex and to increase access to sexual health services. Evidence shows that young people who receive honest and comprehensive information about relationships and sex generally have sex later than their peers and are more likely to use contraception when they do have sex. As well as providing a platform for delivering positive messages about healthy relationships and safer sexual behaviour, the resource also contains a behaviour change tool that is shown to overcome barriers to accessing sexual health services. The website is a partnership approach between DMBC, Warwickshire County Council, Diva Creative, University of Coventry, and Going Off the Rails. In the first four weeks there were over 4,000 hits to the website. Work continues to maintain this momentum and our next steps are to meet with PSHE leads in secondary schools to get the resource into their lessons. The website is available at www.respectyourself.info/doncaster

Who are we working with?

Prevention and early intervention is at the heart of the work the public health team and our partners carry out for children, young people and families. A universal offer from both the health visiting and the school nursing services ensures *all* families receive advice and information to ensure the best outcomes for their children. The universal offer also ensures families with vulnerabilities or in 'at-risk' groups can be identified early and given specialist intervention.

Poor health disproportionately affects certain groups of children and young people and the team aims to support and protect the groups that have the worst health outcomes by ensuring that programmes are targeted appropriately and services are able to respond to the needs of children and families with emerging and/or on-going additional needs.

Key partners include Rotherham, Doncaster and South Humber NHS Foundation Trust (Health Visiting, Project 3, Childhood Sexual Exploitation (CSE) team and School Nursing): Doncaster and Bassetlaw Hospitals NHS Foundation Trust (Midwifery and Trihealth); Children's Centres (DMBC); Early Years settings; Doncaster Clinical Commissioning Group (CCG); Education (DMBC); Leger Therapy Services; British Pregnancy Advisory Service; Local Medical Committee and GPs; Local Pharmaceutical Committee and community pharmacists; Doncaster Children's Services Trust; NHS England; Public Health England PHE; University of Coventry; University of Sheffield; Primary & Secondary schools; post-16 education and training providers; Doncaster Pride; Big Talk Education; Going Off the Rails; Diva Creative; Changing Lives; HIV Well-Being team; SY Police; Doncaster Rape and Sexual Abuse Counselling Service (DRASACS)

How will we know if we're successful?

The Public Health Outcome Framework (PHOF) identifies the following outcomes as being indicative of the success of service provision across services for children, young people and families:

- Infant mortality
- Measles, mumps and rubella (MMR) vaccination for one dose (at 2 years)
- Diphtheria, tetanus, whooping cough (pertussis), polio and Hib disease (Haemophilus influenzae type b) vaccination (at 2 years)
- Children achieving a good level of development at the end of reception
- Low birth weight of 'full term' babies
- Obese children (4-5 years)
- Smoking status at time of delivery
- Breastfeeding initiation
- Breastfeeding prevalence at 6-8 weeks after birth

- A&E attendances (0-4 years)
- Hospital admissions caused by injuries in children (0-14 years)
- Chlamydia detection rate greater than 2,300 per 100,000 15-24 year old population
- Reduce the under 18 conception rate
- HIV late diagnosis rate less than 25% of all newly diagnosed adults

These indicators are useful on an overall population level and are indicative of how the overall 'system' is working. Public Health Outcomes Framework indicators should be monitored as high-level strategic informers. However, the time lag between data being collected and published and frequency of the published data can also be unhelpful in terms of establishing short term/real time impact for children and families. The nature of them being 'Doncaster wide' can also be unhelpful in looking to establish local need and priorities. A joint framework of outcomes measures should be established to measure programme impact based on existing tools in use (e.g. Ages and Stages Questionnaire (ASQ); Early Years Foundation Stages (EYFS); Outcomes star; Whooley/GAD-2).

Section 4: Working Age, Healthy Lives

The Working Age, Healthy Lives team aims to support Doncaster residents to have the best quality of life possible and to add years to life and reduce the health inequalities which are still prevalent across our communities. It also aims to reduce loneliness and social isolation through targeted approaches with our key partners and to ensure that local residents have the information they need to make informed choices and improve their life expectancy. The Health and Wellbeing Board in its 2016-21 strategy outlined a vision for the Borough which is:

"A strong local economy; progressive, healthy, safe and vibrant communities; all residents will be able to achieve their full potential in employment, education, care and life chances; all residents to be proud of Doncaster"

The Doncaster Health and Wellbeing Board identified 4 key themes: Health Inequalities, Wellbeing, Health and Social Care Transformation; 5 areas of focus: substance misuse (drugs and alcohol), obesity, families, mental health and dementia. The Working Age, Healthy lives team will aim to support all of these areas and in particular will focus on obesity, families, health inequalities, self-management, work place health and general wellbeing .

To achieve this, the team needs to promote a supportive environment which enhances wellbeing where prevention is the key. In order to do this the public health team needs all the partners on Board as prevention is everyone's business. The **NHS Health Checks** service and awareness campaigns provide information and advice at an early stage to provide the best chance for a good quality of life and prevent the onset of more serious long term conditions .The **workplace health programme** enables local employers to provide a supportive and health promoting environment for their workforce and to improve staff health and wellbeing and their wider families. The **Making Every Contact Counts (MECC)** principle will be rolled out across all key partners to ensure that every opportunity is made to raise awareness and to provide up to date information around key health issues. The **Healthy Doncaster Alliance** will provide a vehicle to understand and address our healthy weight issues in Doncaster and to provide a whole system approach to cultural change. For the ageing population we will continue to support the Dementia friendly communities programme and strive towards a **healthy ageing** town in Doncaster and to provide support around managing long term conditions, falls and wider health and social care issues. Through the South Yorkshire Fire and Rescue Service Safe and Well checks programme partners will be supported to deliver appropriate health messages and reach the most vulnerable people in our communities.

To measure success local data will be used to measure the baseline and collate evidence around the interventions and measure impact over a longer period. Good news stories and case stories will be collected which will promote positive news and demonstrate health improvement.

NHS Health Checks

One of the key areas for prevention is detecting disease at an early stage when treatment is often more effective. One of the ways this is done for cardiovascular disease is through NHS Health Checks. The NHS Health Check service is designed to identify cardiovascular disease at an early stage in people aged 40 – 75 years. In 2015/16 nearly 7000 checks were completed in Doncaster and almost a third of the people checked were found to be at a high risk of having heart or other circulatory problems in the next 10 years. The majority of checks are completed in GP practices but one in five checks takes place in another community setting to try and give people the best opportunity of accessing the service. People who have had a health check say that they found out important things about their health in particular their blood cholesterol levels and their blood pressure and they have said that this has encouraged them to take control of their health and make lifestyle changes such as eating more healthily and exercising.

Early Diagnosis

This aims to increase the awareness of the early signs and symptoms of cancer and other long term health conditions and to demonstrate how lifestyle choices can affect a cancer diagnosis along with other long term conditions. Doncaster has a higher incidence of some cancers compared with the national average and other Local Authorities. The work with diverse communities, workplace settings, schools and Learning Disability Teams to encourage a change in behaviour in choosing a healthier lifestyle with a view to reducing long term illness and increasing survivorship will continue. The team will also work with the key partners to promote self-management and to increase awareness of the key signs and symptoms through a Making Every Contact Count approach (where every clinical contact is a an opportunity to improve health) and a prevention package which supports national and local communication and social media campaigns.

Work Place Health

Research shows that fair employment is not only good for our individual health and wellbeing but it also has economic benefits for our local economy. It is recognised that the workplace holds a captive audience in which we are able to promote public health messages not only to the staff but also through their social connections between their families, friends and local communities.

Doncaster's Workplace Wellbeing Programme aims to work with local businesses to support them to be a healthy employer and educate them of the benefits of workplace health.

The team is accredited to deliver Public Health England's Workplace Wellbeing Charter which is a national award demonstrating an organisations commitment to supporting their workforce.

The accreditation process contains a set of core standards, which includes leadership, absence management and mental health which businesses are able to benchmark themselves against.

The programme also provides free training, workshops and direct access to a range of services that employees can access to promote wellbeing, encourage behaviour change and promote self-management.

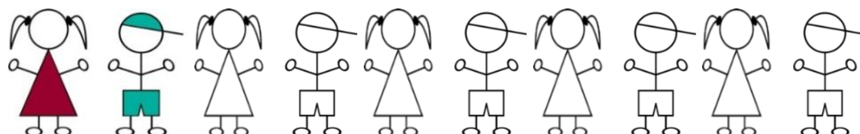
The workplace wellbeing offer suits both private and public sector organisations and can be tailored to suit small businesses.

The team worked closely with Doncaster Chamber of Commerce, Business Doncaster and the local business economy to launch the programme in 2016. Initial progress has included a first business event attended by 70 local business managers, awarding 2 local businesses workplace wellbeing accreditation, supporting 8 businesses to work through the self-assessment process, trained 35 Health Champions and coordinated several training workshops up-skilling managers around workplace issues such as disability in the workplace, reasonable adjustments, substance misuse and mental health.

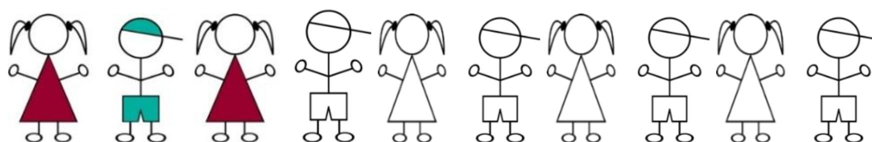
Obesity

Tackling obesity remains a priority for Doncaster Health and Wellbeing Board. Obesity can reduce life expectancy by up to 9 years and accounts for 9000 premature deaths per year; it also contributes to about 10% of all cancer deaths amongst non-smokers.[1] Obesity is a major public health problem due to its association with serious chronic diseases such as type 2 diabetes, hypertension and raised cholesterol.[2] In Doncaster:

More than 2 out of 10 children aged 4-5 are overweight or obese (22.2%)



More than 3 out of 10 children aged 10-11 are overweight or obese (34%)



More than 7 out of 10 adults are overweight or obese (74.8%)

The public health team commissions the pre-surgery adults weight management service to support people to lose weight and take greater control of their health. The formation of the Healthy Doncaster Alliance encourages a whole system approach involving both internal and external partners to tackle obesity. The Alliance has identified the following areas of focus to overcome obesity and help people and families make better and informed choices about their health and lifestyle:

- Physical Activity
- Food
- Environment and Planning

[1] Department of Health (2011). Healthy lives, healthy people: a call to action on obesity in England. London: Department of Health

[2] Niblett, P (2016). Statistics on obesity, physical activity and diet. Health and Social Care Information Centre (HSCIC) http://digital.nhs.uk/catalogue/PUB20562/obes-phys-acti-diet-eng-2016-rep.pdf Last accessed on 17.08.2016

- Weight Management

Healthy Ageing

People in the UK are living longer than ever before. If the right support, advice and information is not available, poor health can restrict older people's ability to continue living life to the full. It is important that opportunities for good health are optimised so that older people are able to live as independently as possible within their community and enjoy a high quality of life. Encouraging older people to make informed choices about a healthy lifestyle can make a big difference.

South Yorkshire Fire and Rescue have teamed up with Doncaster Council, Doncaster Clinical Commissioning Group and South Yorkshire Police to deliver healthy ageing advice alongside falls and crime prevention to people over the age of 65 as part of the Safe and Well programme. The 'Living Well for Longer; A Guide to a Healthier Later Life' resource developed by public health provides members of the public with information on how to live healthily, happily and independently for longer and where to get help and support.

Dementia is not a natural part of the ageing process however the likelihood of developing dementia does rise with age and is a common concern for many people as they grow older. There are 850,000 people living with dementia in the UK today. It is estimated that just over 3,500 people are currently living with dementia in Doncaster with almost 2,700 on GP dementia registers.

The Getting There: Doncaster Dementia Strategy 2015-17 produced by the Doncaster Dementia Strategic Partnership (DDSP) sets out the future vision for Doncaster and outlines five areas of improvement in dementia care; pre diagnosis information and support, assessment and treatment, peri and post diagnostic care and support, care homes and end of life. The public health team is working alongside a number of partners to support the pre-diagnosis information and support strand of the strategy, to raise awareness of the condition and enable people to access the right advice and information and ensure they receive the support they require.

Doncaster is working towards becoming dementia friendly with 16,114 Dementia Friends across the borough. Our 142 Dementia Friend's Champions have delivered a total of 1000 information sessions throughout Doncaster, helping to increase peoples understanding of dementia and change perceptions of the condition. 85 members have now signed up to Doncaster Dementia Action Alliance to support the delivery of the dementia friendly community work plan. Through the commissioning of DARTS' interactive performance, *Unlocking Dementia*, and organised campaigns such as Dementia Awareness Week we continue to raise awareness of the condition.

With prevention as an area of focus, a resource was developed highlighting important lifestyle factors which may contribute to the development of dementia including, eating well, maintaining a healthy weight, managing cholesterol and blood pressure, limiting alcohol intake, stopping smoking and keeping physically, mentally and socially active and the steps people can take to reduce the risk or delay the onset of dementia.

Case Studies

George is 55 years old and has recently had an NHS Health Check in his workplace which identified he might be at risk of heart disease. The check found that George is overweight, has high blood pressure and high cholesterol.

Georges' workplace has recently been accredited with the Workplace Wellbeing Charter. His employers have transformed the staff canteen so that it is now much healthier. A lot of work has been done to reduce the salt and fat content of the dishes he usually eats there and he has also joined the lunchtime walking group that he saw advertised in the staff newsletter. He also has access to a local wellbeing service in his community which is helping him keep his health on track including advice on how to manage his weight, reduce his stress levels etc.

Sue is 76 and lives alone. Her children have recently noticed that Sue is becoming quite forgetful. After agreeing to a visit to see her GP, Sue's memory showed that she had been diagnosed with Alzheimer's. Sue and family were referred to the Admiral Service for further support.

Sue became withdrawn after her diagnosis worrying this would mean she would no longer be able to live in her house.

One of the Admiral Nurses met with Sue and her daughter and offered some much needed emotional support along with the information they required to help Sue live independently at home for as long as possible.

Details of the Memory Café and the Singing for the Brain that is based in Sue's local community Centre were passed onto her. After feeling apprehensive at the first thought of going along, Sue has discovered her love for singing and met a lot of new friends which she meets each week for a coffee and catch up.

Section 5: Vulnerable People and Improving Lives

This public health work theme aims to address many unjust health differences (known as health inequalities) between people, which arise due to complex socio-economic factors.

The portfolio covers substance misuse, smoking/tobacco control, public mental health and suicide prevention, domestic violence, physical disabilities and learning disabilities.

The public health team is responsible for directly commissioning some of these treatment and care services and for co-ordinating approaches to prevention and promoting health and well- being. The approach recognises that all individuals are unique and that often people's needs are multiple and complex.

Substance misuse

The Doncaster public health team commissions an adult substance misuse service incorporating a whole system integrated drug and alcohol treatment and recovery ethos. The service meets the constantly changing needs of the population of Doncaster whilst ensuring we have an upstream approach to prevention and awareness raising.

The team aims to ensure the commissioned treatment services are run in a person centred and recovery focused environment. This includes ensuring services that address all aspects of an adult's life, including substance misuse, housing, work, education, training, healthcare, offending, spirituality, family life, relationships, community participation and support networks.

These services are delivered from 'recovery hubs' in Thorne, Bentley and Mexborough with Doncaster town centre maintaining a single point of access function.

Smoking cessation and tobacco control

The public health team commissions specialist and GP services to help people to quit smoking. The team leads, supports and participates in the local Tobacco Alliance, a partnership approach, which aims to achieve smoke free environments and tackle illicit/counterfeit tobacco.

Public mental health & suicide prevention

The public health team works towards improving the health of the population through preventing disease, prolonging life and promoting health. This includes targeting the determinants of health and well- being rather than the illness itself. Good mental health provides the bedrock for good physical health and for a range of other important life skills, capacities and capabilities.

Suicide prevention has been identified as a priority for Doncaster. A multi-agency strategic suicide prevention group has been established to lead on the prevention agenda.

Domestic Violence

The public health team supports the delivery of victim and perpetrator services, and participates in a co-ordinated response to domestic abuse in conjunction with other partners. Families have a wide range of needs and may be experiencing a number of issues which contribute to or initiate domestic abuse. The response therefore needs to be tailored to the needs of individual families and may involve a range of professionals from both statutory and voluntary organisations working together.

Learning Disability and Physical Disability

The approach to disability recognises that disability is viewed as something which is imposed on people, by a society which creates barriers to equality. The team works with service users and professional groups to improve access to services and change attitudes that regard disabled people as inferior, helpless, weak or vulnerable. This includes work to address the environmental, institutional and attitudinal barriers.

What are we trying to achieve?

To prevent ill health across the whole population, and in targeted groups, and reduce premature mortality

To reduce health inequalities between individuals and communities

To improve access to, and experience of services for service users

Who are we working with?

The team works with all statutory and voluntary organisations and service user organisation to address current and potential public health harms. These harms could include the whole of the adult population of Doncaster who are, or may be, affected directly or indirectly by substance misuse, domestic violence, physical disabilities, learning disabilities, mental health or smoking

How will we know if we are successful?

Through a regular process of needs assessment the team monitors change in patterns of smoking substance misuse, mental health, physical and learning disabilities, and domestic violence in local communities.

Success would mean reducing prevalence of substance misuse, smoking and domestic violence, and improved health and social outcomes for people with illness, disability or impairment.

Case Study Andrea Days (names have been changed for the protection of client's identity)

I first met Jane over two years ago, she had moved area's to try and make a new start after being well known as the local drug dealer, she had her windows put through by locals and had a terrible reputation for dealing a bad batch of drugs. Her decision to move was to change her life for good. She came into service and completed a detox which was her first stepping stone; she had been drug free for about 3 month's at the time when she requested support from the "Moving on" project, she was a little withdrawn at our first meeting but as time went on her confidence improved massively.

I had some promotional leaflets to hand out in the area that Jane lived in so as a way to get to know her better and to also give her a feeling that she was helping me I asked her to show me all the local health centres, Sure Starts, Doctors, Libraries etc. and together we gave out our marketing material then afterwards we had a chat about what she wanted to do, she expressed an interest in support work, she thought that the work the "Moving on" team do is amazing and would love to start some form of training to better her chances for the future of support working. I had a chat with her about a Counselling course that I was involved in, I explained that it was a course that involves learning the skills of listening and relationship building in a practical way. It seeks to enable students to become more empathic to the needs of other people by developing increased self-awareness. She could then consider level two if she thought the first course was beneficial, she thought this sounded great and was just what she wanted.

Jane embraced the course although at times she admitted she struggled with her own issues from time to time throughout the course, the fact that this course is designed to reflect upon students own issues as well as others does on occasion brings out students emotions and potentially can cause a certain amount of upset. As the course progressed so did Jane, her confidence grew and upon completion of the course she was eager to continue to 'up skill' her training, she continued her training by enrolling on the level two counselling course which encouraged her to then train and become a learning mentor, once qualified in this field she began volunteering as a support worker for learners of my Job club/ IT course, my learners and I benefited from Jane's help, this gave me more time to give one to one support knowing that other learners got help at the same time.

After about 9 months of volunteering Jane asked if I would help her fill in an application form for a job as support worker in her own village and could she give my details as a reference, I was more than happy to do this.

Within a fortnight I received an application for a reference followed shortly after by a phone, thanking me for the reference.

Jane rang me to let me know she had been offered the position on a permanent basis and was over joyed

I regularly contact her to see how she is doing, she is still enjoying the job she said "thank you for all you support, I couldn't have done this without you, this is my dream job"

What fantastic progress Jane has made throughout her journey with the help and support of the Moving on team.

Section 6: Wider Determinants of Health

In 1865 Doncaster appointed its first medical officer for health for the Borough following promptings from the Board of Poor Law Guardians. At the time his main priorities were focused on combatting the spread of diseases such as cholera whilst recognising that things such as improved housing and sanitation were crucial in reducing disease thus improving the health of the population.

Today however, there is a different story. Many of the public health challenges faced in Doncaster in the 21st century continue to be influenced by where people live, learn, work and play. These wider factors are interconnected with other factors, described as 'the causes of the causes' and can be outside of our control: such as gender or genetic make-up or are factors that can be improved upon with support from organisations such as the Government, Local Authorities and the NHS. These factors concern the environment, the economy, society and health as a whole (see diagram).[3]

Socio-economic Status: The link between socioeconomic status and an individual's health is a clear one – lower social position and associated socio-economic deprivation results in poor health.

Education: The availability of high quality education is key in enabling our residents to maximise opportunities. Educational attainment can determine future employment and income as well as lowering the risk of alcohol and drug misuse and teenage pregnancy.

Physical Environment: Environmental themes can play a significant role in affecting our quality of life and health. Those living in areas with safe water supplies, clean air, a healthy working environment and comfortable housing are more likely to be in good health than those lacking such conditions.

[3] Barton, H. and Grant, M. (2006) A health map for the local human habitat. The Journal for the Royal Society for the Promotion of Health, 126 (6). pp. 252-253

Social Environment: Having support from family, friends and the local community is important for preventing isolation and loneliness, contributing to good mental wellbeing and therefore improving overall health.

Wider Determinants Team

The wider determinants team aims to ensure that the health impacts of these determinants are explicitly considered when making decisions and therefore work with a range of partners and organisations to help make Doncaster a place where healthy choices are an easy choice. Three examples of the areas that we have addressed in 2015/16 include spatial planning, physical activity and fuel poverty. Since 2015/16 the team has :

- Embedded health into the planning process for Doncaster
- Began a 'Whole Systems Review' for physical activity & sport including interviewing 20 strategic leaders and having 50 attendees at our stakeholder event.
- Established Doncaster Active Travel Alliance to increase cycling and walking
- Led interventions on 'Keeping People Warm in Winter' including delivering 'spotting the signs of living in cold houses and homes' winter warmth training to 88 frontline staff and volunteers, supporting hospital discharge with telecare, winter warmth packs and ambient temperature monitors, over 263 home visits and distributing over 700 winter warmth resources including blankets, socks and hats.
- Produced a Hot Food Outlet Policy as part of an approach to address the access to healthier food.
- Continued to commission a service that provides health promotion advice and guidance for Black and Minority Ethnic (BME) women in Doncaster as well as the opportunity to access ESOL training and qualifications. During 2015/16 Changing Lives engaged with 529 BME women from over 40 different ethnicities. 21 women successfully completed an ESOL qualification, four community champions were developed and 10 moved on into Education, Training or Employment and 29 health related sessions were delivered.
- Supported the Council's response and preparedness to emergencies and incidents ensuring that the public health elements of plans are up to date including the development of two new multi-agency outbreak and mass treatment plans.
- Launched the newly designed Move More Doncaster physical activity service for residents aged over 50 years.
- Installed the Discover Lakeside QR code trail.

Spatial Planning

How we plan and design our towns and villages can help to address some of the modern day challenges. The way roads and paths are laid out can make it easier for people to walk or cycle. Green spaces can be designed into developments so that people can access and utilise them safely, high streets and shopping areas can be planned to make sure they include a variety of shops and services and workplaces can include facilities such as secure cycle parking and changing rooms to encourage people to travel more actively.

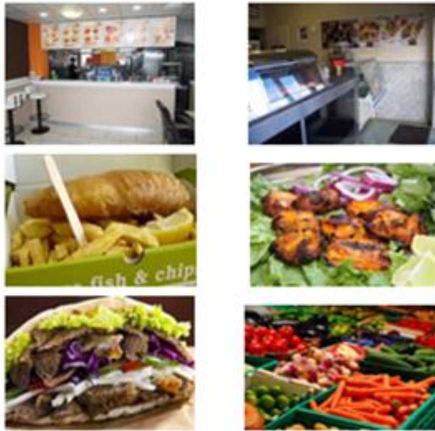
What have we done so far?

In 2016 public health staff started working closely with planning and development colleagues. Together steps are being taken to ensure that as Doncaster develops and grows the environment, where people live and work is shaped to support healthier lifestyles and provides opportunities to make healthy behaviour part of everyday life. This year has focussed on building strong foundations. So far the team has:

- Developed a health chapter for inclusion in the Doncaster Local Plan and provided public health input into policies as they are being refreshed. This is an important step forward as without having the right plans and policies in place the planning team and Planning Committee are unable to challenge applications or to impose conditions. An example of this is the inclusion of a Hot Food Takeaway policy which aims to reduce access to secondary school children at lunchtimes and also give some control to the number of takeaways in any given area.

Hot food takeaways.

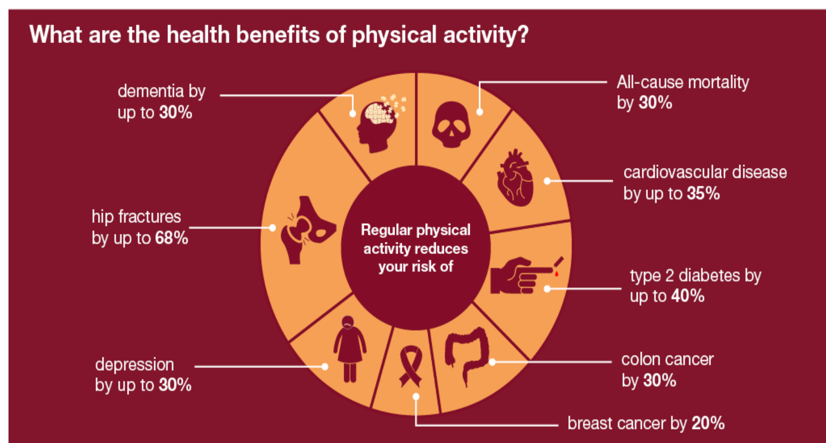
An evidence base review for Doncaster



•	Delivered information sessions to planning colleagues and Planning Committee members reaffirming the links between public health and planning. The sessions look at all the different influences on health, such as those mentioned in the introduction, and why it is important to improve the health and well-being of Doncaster residents.

•	Facilitated Health Impact Assessment (HIA) training to staff in public health and planning. HIAs are a way to highlight where a development impacts positively and negatively on a person’s health. For instance, a positive impact might be the creation of better quality housing or jobs but a negative impact might be the noise and dust that is created during the construction period. Because the process opens up an opportunity for dialogue between the developers and the community, people are able to share their viewpoint and look for acceptable solutions.

Physical Activity - #Get Doncaster Moving



There is vast substantial evidence on what the health benefits are to being physically active. However in Doncaster just over half of adults in Doncaster (52.6%) meet the Chief Medical Officer's guideline of 150 minutes of physical activity per week, and one third of adults in Doncaster (29.6%) fail to achieve even 30 minutes of physical activity over the course of a week, which makes them 'physically inactive'. This equates to 70,000 of our residents who are physically inactive (Active People Survey, 2015).

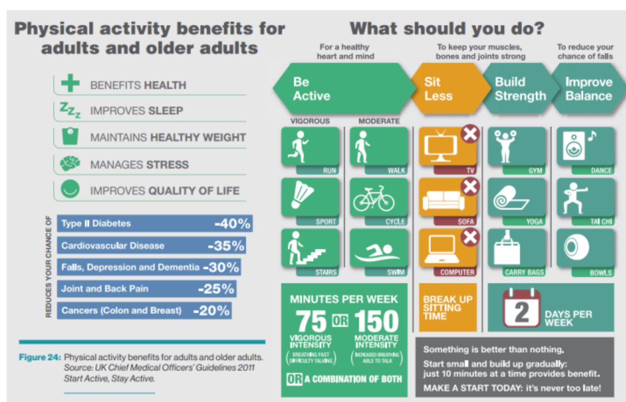


Figure 24: Physical activity benefits for adults and older adults. Source: UK Chief Medical Officers' Guidelines 2011 Start Active, Stay Active.

Rapid changes to our social and work environments encourage sedentary behaviour, and for many, reduce opportunities to build activity into our daily routines. More than 40% of women and 35% of men now spend more than six hours a day sitting or being desk-bound. We know that this harms the health of even those who exercise on a regular basis. At the same time, rates of walking are falling and almost two-thirds of all journeys are made by car.

In Doncaster, the burden of inactivity can be estimated at 24,000 additional GP visits by inactive residents and an estimated cost of £5million in direct health costs (Sport England 2009/10).

Changing social trends are also affecting how our children play at school and in their spare time. The Doncaster Children and Young People Survey 2015 identified that only 8% of primary school pupils and 8% of secondary school pupils actually met government guidelines (60 minutes every day) of physical activity for children.

Case Study: Discover Lakeside

The public health and regeneration and environment teams worked with partners to identify methods of encouraging the use of the green space at Lakeside. Design-method mentorship has been provided by the User-centred Healthcare Design team at Sheffield Hallam University to work with various partners within Doncaster to look at solutions that were innovative and pragmatic.

This collaborative and unique way of working was identified in the Local Government Association (LGA) peer based challenge review of the Public Health & the Health and Wellbeing Board in local authorities and was presented at the national Public Health England conference and as part of a design for health symposium at the Royal College Nursing research conference.

The ideas from the work with Sheffield Hallam University were to deliver a series of trails around Lakeside using mobile device QR codes and embedded posts encouraging visitors to exercise, learn, relax and enjoy the space. Residents with a smartphone like an iPhone, Android or Blackberry could scan the QR codes on the posts around Lakeside to upload free data such as heritage information and facts on the surrounding natural environment.

In July 2016 we launched the 'Discover Lakeside' project. This saw 15 QR codes introduced to Doncaster's Lakeside providing options of trails for the public to enjoy as they walk around the lake. Flat and accessible, Doncaster's Lakeside is a prime location for physical activity. In the first 9 weeks that the project was live, QR codes were scanned a total of 353 times and there were 81 downloads of resources from our main webpage. Work is on-going to bring new trails to the project to appeal to a wider audience. www.doncaster.gov.uk/discoverlakeside

Affordable Warmth- Keeping warm and well during the winter months

During the winter months cold weather has a direct effect on the incidence of heart attack, stroke, respiratory disease, flu, falls and injuries and hypothermia. The lack of "Affordable Warmth" is known as "Fuel Poverty". A household is in fuel poverty if they cannot keep warm and healthy in their own home at a price they can afford. Fuel poverty has been identified as a key priority for Doncaster, one which partners can have a significant impact on by working more effectively together i.e. reducing the number of our vulnerable residents whose lives are negatively impacted by fuel poverty. Statistics suggest that there are an estimated 14, 835 households in fuel poverty in Doncaster.

In 2015-16 the public health team worked in partnership with the public and voluntary sector, to provide additional support for residents during the winter months, helping to reduce levels of illness and deaths attributable to the cold weather. Through a variety of interventions the winter warmth program has benefited the most vulnerable residents living in cold homes, including children, the elderly and those with long-term health conditions.

Targeted activity to improve energy efficiency and affordable warmth amongst vulnerable groups including: delivering a health promotion campaign around how to keep warm and well during the winter; delivering training sessions to frontline staff on how to spot the signs of living in a cold, damp home; promoting "The Big Power Switch" joining local residents together to increase their buying power and negotiate a better deal on their energy.

In the cold winter period of 2015-16, 32 residents at risk of ill health received free boiler and heating repairs, with some receiving replacement heating systems where repairs were not possible. Increasing their health and wellbeing significantly and saving an energy cost on average of £731.22 per household over the winter period.

Case Study

One local resident in Mexborough, aged 58 had major health conditions and was recovering from a brain haemorrhage in Oct 2015, had no central heating, just 3 room heaters which did not keep the whole house warm enough. He was unable to fund the cost of central heating, especially since hew only received sick pay and his wife had given up her job up to be his carer.

This couple received a Worcester Greenstar combination boiler, 6 radiators with thermostatic radiator valves

"The new system is brilliant and such a good idea". It is so easy to use and lovely to wake up in the morning to a warm home". "We never knew how much having central heating would mean to us and we can't imagine not having it now"

The key areas of work for 2016/17 are:

- Drive a systematic approach to embedding physical activity and sport strategically to help partner organisations address their key priorities.
- To continue to promote the benefits of physical activity and develop good quality opportunities for residents to lead active lives with 250 people aged over 50yrs accessing our Move More Doncaster service.
- Utilise Health Impact Assessments to ensure that health and wellbeing is considered in future planning applications in Doncaster.
- Include public health participation in pre- application discussions. One way to influence developments is to work with developers at the pre-application stage.
- Contribute to the neighbourhood planning process by providing information to support the process, encouraging residents to think about some of the health challenges for the area and how locally well thought out planning and design can contribute to improving the environment for them.
- To design and deliver a Healthy Homes/Healthy people programme for Doncaster.
- Support the Sheffield City Region work and health programme to design a system that supports those residents that are furthest from the job market.

Section 7: Health Protection and Health Care Public Health

This section reports on activities in Doncaster related to health protection and health care public health (using public health skills to supporting effective commissioning of quality health service by NHS commissioners).

What are we trying to achieve?

The goal of public health is to help the people of Doncaster to live longer, healthier and enjoy full quality of life. We are also trying to reduce the variation in health outcomes experienced by our communities in Doncaster, as well as narrow the gap between Doncaster and England.

Health Protection

Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impacts from environmental hazards such as chemicals and radiation. The scope of health protection is wide and ranges from infection prevention and control to vaccination and screening programmes.

Under the Health and Social Care Act 2012, the Director of Public Health (DPH) has the duty to protect the health of the population and to provide leadership on health protection within the local authority. Locally this is discharged through a local health protection committee and by ensuring that there are multi-agency agreements in place for responding to health protection challenges.

The following are some of the key activities related to health protection in Doncaster:

- Doncaster Health Protection Assurance Group (HPAG) was established in 2013. It meets quarterly to provide assurance on the delivery of a range of health protection functions. In 2016 the HPAG incorporated the functions District Infection Prevention and Control Committee, which was previously chaired by Doncaster Clinical Commissioning Group (CCG).
- A multi-disciplinary and multi-agency tuberculosis (TB) steering group is in place that reports to the HPAG to provide assurance of effective delivery of TB services in order to control TB in Doncaster. The TB steering group also meets quarterly.
- The public health team in the Council has commissioned a community infection prevention and control service and this is provided by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH). The service aims to prevent and control community infections e.g. Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile.

Healthcare Public Health

The public health team in the local authority is also expected to provide specialist public health advice to Doncaster CCG (the local NHS Commissioner) in order to ensure that effective, safe and high quality healthcare is commissioned and delivered for the people of Doncaster. Locally, the public health advice is underpinned by a memorandum of understanding (MOU) between local authority public health in Doncaster Council and Doncaster CCG. Over the past year, some of the major pieces of work undertaken together with Doncaster CCG with input from public health included the following:

- Intermediate care review (needs assessment)
- Out-of-hour GP service (now co-located with A&E at Doncaster Royal Infirmary)
- Sustainability and Transformation plan (STP): part of Five Year Forward View challenge of transforming the NHS in the next five years ending 2020/21.
- Doncaster Place Plan 2016-2021: The plan embraces prevention and early help as part of delivery of health and social care services in Doncaster. The plan also includes intermediate health and social care.
- A joint health inequality action plan between Doncaster Council and Doncaster CCG.

Why this is important?

There are at least three reasons why health protection and healthcare public health are important. These include:

The legal basis: This is outlined in the Health and Social Care Act 2012. The Act enshrined the duty of the council and Director of Public Health in protecting the health of the local population and providing specialist public health advice to the NHS.

Population health outcome case: The fact that health outcomes in Doncaster are generally worse than the national average but also show variation across Doncaster should be a call for action. Specific methodologies including health equity audits can be used to ensure resources are targeted at the areas of greatest need.

Local versus global health dimension: Doncaster Sheffield Airport is opening travel routes across the globe and this brings both economic benefits but also increases the risk of importing infectious diseases. Health protection policies and procedures need to be up to date to minimise this risk.

Who are we working with?

The task of protecting and improving the health of the people of Doncaster rests with every one of us, as individuals, community groups, charities, businesses, government organisations, etc. For health protection, the public health team in the local authority works closely with colleagues from across the council such as environmental health. The team also works with local partner agencies, including Public Health England, NHS England, Doncaster CCG, Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT), RDaSH, and local general practices. There are good networks with the neighbouring public health teams in South Yorkshire and across Yorkshire and the Humber.

In relation to healthcare public health, the team works closely with Doncaster CCG and a range of providers in shaping effectiveness of local health and social care services in Doncaster.

How will we know if we are successful?

A range of health indicators exists as part of Public Health Outcome Framework (PHOF) that details progress made over time for each local authority area. The relevant indicators are those related to health protection, and healthcare and premature mortality (i.e. deaths in people aged under 75 years old). These indicators are updated and/or supplemented by other reports such as those on immunisation and screening, infectious diseases reports, and notifications reports. Details of these reports and indicators are available separately. The Health and Adult Social Care Overview and Scrutiny panel reviews health protection on an annual basis.

Section 8: Health Inequalities in Doncaster: using evidence to make the invisible visible.

The public health team at Doncaster Council is at the centre of local work to understand and address health inequalities. By health inequality we mean 'systemic differences in the health of people occupying unequal positions in society' (Graham, 2009, p.3 cited in Smith et al, 2016).[4] This way of looking at inequality means that differences in health experience and outcomes are socially produced, avoidable, unfair and unjust. There is also a social gradient in health outcomes put simply 'health gets worse at every step down the social level' (Wilkinson and Pickett, 2009).[5] From research we know that health inequalities impact on everyone and that it is in all our interests to address these issues. We also know that some people face a double or triple whammy in terms of health inequality because of some characteristic such as gender, disability or ethnicity. As a result, some people in our communities are living lives that are more short-lived, more miserable and more painful because of these structural embedded health inequalities. Importantly, health inequality also represents lost opportunities for individuals, communities and economies.

This may seem a gloomy and intractable problem but in the UK we lead the world in our approach to tackling health inequality (Smith el al 2016). In Doncaster, we believe that the key to unlocking the lost potential can be summed up in three phases:

1) It is essential **to describe** inequalities found locally so that we raise awareness and **change the conversation** so that people, policy makers and practitioners recognise that poor outcomes are not predicated on individual behaviour but are products of systemic inequalities.
2) Secondly, we need **to explain** these inequalities and this again helps change the conversation and helps support a case for change.
3) Thirdly, we need **to collectively prescribe** a course for action.

One of the ways we are putting these ideas into practice is by undertaking specific pieces of work all designed to help us describe and understand health inequalities.[6] To guide the work we are undertaking to tackle inequalities in Doncaster we have established a Health Inequalities Group

[4] Smith K.E, Hill S and Bambra, C. (2016) Health Inequalities: critical perspectives Oxford University Press
[5] Wilkinson K and Pickett S (2009) The Spirit Level. Why More Equal Societies Almost Always Do Better Penguin Books
[6] Cooke, J, Langley , J, Wolstenholme, D and Hampshaw, S (2016). 'Seeing' the Difference: The Importance of Visibility and Action as a Mark of 'Authenticity' in Co-production. International Journal of Health Policy Management, 5. (In Press) (available from http://shura.shu.ac.uk/13810/1/'Seeing%20the%20Difference'%20-%20visibility%20in%20co-production.pdf accessed November 2016)

which reports to the Health and Well Being Board. We are ambitious in our aims to change the story of Inequalities across Doncaster and to work with local partners and people to make this happen.

Case Study: Networking and Researching

One thing that can help us both describe and explain is knowledge bringing together what we know and extending this knowledge by carrying out investigations or studies. Doncaster council are members of the CLAHRC YH (see http://clahrc-yh.nihr.ac.uk/) a partnership between the NHS, universities and local government intended to support both knowledge production and sharing. The essence of this work is that areas to be investigated are identified and agreed by both those that will use the knowledge and those who help create it. This is known as co-production and the idea is that knowledge produced by this process is more likely to get into practice and policy. Members of the public health team are working on these ideas (see Cooke et al, 2016)

In terms of describing and explaining inequalities this means that research about inequalities that takes into account the views about what is important and how the world works from the point of view of policy makers and citizens is likely to be better more useful and actionable research. The public health in Doncaster are part of the public health and Inequalities Theme within the CLAHRC and also part of the Local Authority Research & Knowledge (LARK) network contributing to both suggesting areas of work and undertaking research relevant to understanding health inequalities. In addition, we are also active in a number of research networks such as the Yorkshire and Humber offender health and evidence and ethnicity communities of practice.

One recent example is our work on fuel poverty and families. See http://bmjopen.bmj.com/content/6/1/e009636.full for more information.

Case study: The BME Health Needs Assessment (HNA)

The 2015 DPH Annual Report identified inequity of health outcome between Doncaster communities and recommended we undertake a BME HNA. During 2016, we have revisited BME health needs across the borough and under the auspices of the Health and Wellbeing Board (HWB) we have carried out a multi staged needs assessment which culminated in a HWBB evidence safari (see https://www.gov.uk/guidance/open-policy-making-toolkit/understanding-policy-problems-and-user-needs for more information on evidence safari). See #HWBBevidencesafari storify for details of the event itself.

We have looked at information about BME communities in Doncaster. We also looked at what published research said about what might work in addressing inequalities for BME communities and people. We spent time talking to people by collecting their experiences of using health and social care services across Doncaster using Doncaster Healthwatch's Feedback Centre as well as within a GP practice, the council's One Stop Shop, the Women's Centre and Doncaster Conversation Club.

At the evidence safari we identified a number of actions. We would like to run the evidence safari as series of community events to test and improve the actions that have been identified so far.

The final report will be available in January 2017.

Section 9: Well Doncaster

"Well North is creating a movement to unleash healthy communities across the North of England. Starting in nine places, we are inspiring change by backing real people and local ideas"

Lord Andrew Mawson, Executive Chairman

Introduction

Well North is a collaboration between local areas, Public Health England and The University of Manchester. Doncaster is currently one of nine Pathfinders alongside Sefton, Oldham, Halton, Skelmersdale, Bradford, Newcastle, Cumbria and Sheffield.

Everyone wants a comfortable home, a good job and a healthy life to enjoy with family and friends. But life isn't always equal or fair and people who get a raw deal often lose health, happiness and hope. But people and places can change for the better and local people are the solution.

Creating better health and wellbeing is about being part of a vibrant and connected community and living in a pleasant environment, as well as whether we smoke, exercise or eat healthily. Health means tackling debt, a lack of jobs, missed education opportunities, poor housing and loneliness.

Well North follows an asset-based approach to develop communities along these lines, building on the positives in life that create wellbeing and protect health. Denaby Main, in the West of Doncaster, is the initial area of focus.

The Principles of Well Doncaster

The Well North Pathfinders follow a set of guiding principles to;

- Ensure services focus on purpose over process and managing value over cost
- Make the invisible visible by making sure people are known to the services they need.
- Promote relentless kindness to build self-esteem and positive behaviours
- Empower people to own their health and wellbeing, de-medicalising problems and de-professionalising solutions and ensuring issues are solved not managed
- Improve the integration and sequence of support to tackle the root cause of poor health
- Improve the health and wellbeing of everyone

- Back real people's dreams and ideas
- Work alongside people and trusting them to shape their own futures
- Bring energy and creativity to kick start change
- Tap into existing assets, resources, talents and skills
- Build new connections and relationships
- Work with social entrepreneurs and businesses to create new enterprises and jobs
- Spark community-centred investment and regeneration
- Work with communities to shape more effective health, care and welfare services
- Create a culture which, wherever possible, says 'yes' rather than 'no'
- Use language which is positive, concise and cuts the jargon
- Boost confidence through creative and inspiring activities involving everyone
- Create culture change, enterprise and inspiration that lasts long after we've gone
- Establish robust evaluation to test the potential to grow and replicate the approach

Our Objectives and Outcomes

The objectives of Well Doncaster are to;

- Address inequalities, improving the health of the poorest, fastest
- Increase resilience at individual, household and community levels
- Reduce worklessness, a cause and consequence of poor health
- Evaluate, replicate and scale-up Well North in other suitable areas

By sticking to the principles and by focusing on the determinants of health and wellbeing, Well Doncaster can impact on the complex outcomes relevant to many people and services;

- Reducing demand on unplanned healthcare (reducing the number of A&E attendances and emergency admissions)
- Reduced demand on social care (reducing the number of long term residential placements and increasing the number of people with direct payments)
- Reducing the number of people receiving out of work benefits (reducing the number of people claiming JSA, ESA and IB).

The story so far

Well North is developing a way of working that can be repeated across Doncaster, the other Pathfinders and the North of England.

The project is focused rather than working across the whole Borough, so the first step found a fair way to decide where to start. The Doncaster Data Observatory devised a ***Hotspot Analysis*** between April and August 2015, combining health and socio-economic data at a small scale to suggest possible areas. By looking at crime, out of work benefits and unplanned healthcare, the Well Doncaster Steering Group chose Denaby Main.

Having chosen Denaby Main, the next step began a conversation with the community and engaged local residents and staff. The Four D model of ***Appreciative Inquiry*** (AI) was used to understand positives in the area or identify things that could improve Denaby in the future;

- Discovery; gaining a positive insight, highlighting strengths and successes
- Dream; builds on the Discover stage to imagine 'what might be'
- Design; narrows the Dream stage to describe 'what should be'
- Deliver; sets out specific action plans to turn design into reality

Since August 2015, community explorers have had over 400 conversations with local people - on the streets, on door steps, at the market and at community events. These conversations defined the plans for 'Phase 1' between September 2015 and May 2016. These included opening a community library, creating a network of peer support, brokering volunteer and work experience opportunities, accessing employment support, addressing housing issues, making environmental improvements, maximising social prescribing and fostering events to reduce social isolation.

A review of Well North introduced a ***Two-day Workshop*** for each Pathfinder area; an opportunity for local people and advisors from the wider programme to come together and raise the vision and ambition. The Doncaster workshop took place in May 2016 and built on the work to date. The workshop involved local residents, a Ward Councillor and key people from St Leger Homes, NHS Doncaster CCG, DMBC Learning & Opportunities, DMBC Communities and DMBC Public Health, as well as advisors from the Bromley-by-Bow Health Partnership, the University of Manchester, Public Health England and the Marmot Review Team.

Where are we now?

The Phase 2 plans have been drawn up by the people who live and work in Denaby. These have been grouped into seven themes;

Theme	Detail
The Crags	The Crags is a limestone outcrop and countryside space that connects Denaby Main and Conisbrough. The vision is to work with partners to make the area cleaner and safe so that more local people and visitors use the area for recreation, relaxation and physical activity.
Denabloom	Compared to many urban areas, Denaby Main has lots of green space and trees. The vision is to maximise these areas and make sure they are well maintained, alongside wider work such as improvements to the precinct on Grays Court and a growing project using the allotment space.
Denergy	It is important to have fun and celebrate success, a calendar will set out celebratory events which are spaced throughout the year. Both small and large events will showcase the Denaby spirit and make links between community groups, faith groups, schools and businesses. External funding will be sought for a community-wider arts project.
Denaby assets	Lots of things are already happening in Denaby Main and these resources will operate as an active network. Community groups will operate together in a nurturing environment with more mentoring and less duplication, meaning local people can access a wider range of opportunities.
Denaby dosh	Denaby will create an enterprising culture that supports people to pursue their passions and ideas; peer to peer support, positive role models, links with schools and a hub for young enterprise that support young people to

	start their own business.
Community leadership	Creating the conditions where local people step forward as leaders; understanding how to develop, support and back local people to do more.
Individual support	People are identified at an early stage of difficulty or ill-health and connected to the services they need, including support for self-management and links to wider services such as Social Prescribing, DMBC Wellbeing, NHS Health Checks, South Yorkshire Fire and Rescue (SYFR) Safe & Well Checks and developments through Community Led Support,

Who are we working with?

Over the last year Well Doncaster has worked with a huge range of groups and organisations across the third sector, with social enterprises, statutory partners and increasingly with local businesses.

Community, voluntary sector and social enterprise partners; Craganour TARA, Doncaster West Development Trust, Conisbrough Forward, Edlington Community Organisation, Aspiring 2, Reread, Refurnish, Doncaster CVS, All Saints Church, St Albans Church, Citizens Advice, People Focused Group, Flower Park Care Home, Darling Buds of Denaby.

Statutory partners; St Leger Homes, Church View Surgery, Denaby Children Centre, Tom Hill Youth Centre, RDaSH Adult Mental Health Services, NHS Doncaster CCG, Stronger Families, Street Scene, South Yorkshire Housing Association, Ward Members, Schools and Colleges, Doncaster Chamber of Commerce, Doncaster & Bassetlaw Hospitals, DMBC Skills & Enterprise, and Healthwatch,

Wider programme partners; Bromley-by-Bow, Public Health England, The Marmot Review Team, The University of Manchester, Pathfinder Areas

How will we know if Well Doncaster is successful?

Evaluation is critical to Well Doncaster, to judge if the work is effective and to decide whether the approach can be applied successfully in other areas. The project is using Outcome Based Accountability to track progress and maintain a focus on the things that matter, and Realist evaluation to get a true understanding what is driving the changes that we see.

- Outcome Based Accountability provides a template to help plan and focus on outcomes. The approach is based on working backwards from the ends we want to achieve – the conditions of well-being we are trying to impact – and then taking a step by step approach to understanding how we want those conditions to look and feel different; how to measure if that is happening and why; who needs to be involved in making the changes and what practical steps are going to be taken to actually achieve that change. This is often called ‘turning the curve’.

- But people may not act in a predicable way and communities can be very complex. A Realist evaluation recognises this and begins to account for wider influences. It is not enough to simply ask 'does it work?' but rather 'what works, for whom, in what respects, to what extent, in what contexts and how?' This means developing a theory about how something works and then testing it through interviews, observations and other data. In Well Doncaster we have used Realism to evaluate an early initiative (the Bumping Space) and this learning will then be used to apply Realism to other parts of the project.

Section 10: Conclusions and Recommendations 2016

The four challenges identified in 2015 remain and they are still

- Improving children's health and wellbeing
- Making the link between education, work and health
- Increasing healthy life expectancy and reducing preventable health conditions
- Reducing inequalities in health between and within Doncaster communities

The data in the 2016 Public Health England health profile supports these challenges. However, across all four challenges there have been areas of success and areas where more needs to be done.

In our communities, long term unemployment is down but the percentage of children living in low income families is increasing and is now 23.5%, the indicators show violent crime is increasing and homelessness and educational attainment are static, but the indictors themselves aren't sophisticated enough to pick up real changes e.g. people living in temporary accommodation.

For our children and young people smoking by mothers during pregnancy through to the time of delivery has fallen to 20.5%, but still too high, leading to reduced infant mortality. Breastfeeding rates continue to fall, childhood obesity is static but teenage pregnancy has fallen by almost half in the last 5 years.

For adults smoking prevalence has fallen by 1% a year since 2011, but overweight and obesity and lack of physical activity will be offsetting the health improvement from not smoking. This is reflected by increasing numbers of people with diabetes and a slower fall in cardiovascular disease mortality than seen regionally or nationally and increased suicide mortality which disproportionately impacts young people. Overall this results in no change in life expectancy. It is not all about mortality though. Falls and hip fractures are still too high, there are increased hospital stays for self harm but alcohol related admissions are falling.

The changes in the data also demonstrate the predictable health and wellbeing impacts of a recession, austerity and reduced public spending. Despite local economic growth in Doncaster we need to ensure that this is good growth that everyone can benefit from and that in-work poverty is addressed.

I have only made one new recommendations this year as although there is action against all of last year's recommendations none of them can be considered complete.

The one new recommendation is for Team Doncaster to consider a 'Delicious Doncaster' approach to food and nutrition to run alongside the 'Get Doncaster Moving' approach for physical activity.

Overarching Recommendations

- Continue to adopt a 'Health in All Policies' approach
- Make a strategic shift to prevention through the Doncaster Place Plan
- Empower people and communities to take control of their own health and if services are required involve people in co-designing the services
- Improve data capture, sharing and reporting so that services can become more seamless and based on insight to address inequalities in access and outcomes
- Report back on the local Health Needs Assessment for Black and Minority Ethnic (BME) Groups
- Continue to move beyond integration to population health systems and budgets

Recommendations for Children, Young People and Families

- Continue to monitor the effectiveness of the Early Help strategy
- Focus on vulnerable mothers from pregnancy until the child is 2 ½ (the first 1000 days)
- Build on the national Future in Mind developments to address bullying and improve the mental health of school aged children
- Support schools to develop a Curriculum for Life
- Support schools to increase physical activity

Recommendations for Employment and Health

- Use the Social Value Act to maximise equitable employment opportunities when commissioning to secure social, environmental as well as economic benefits
- Recommission the 'work programme' as part of the Sheffield City Region deal to help those furthest from the labour market find work and deliver the Work and Health Unit trial
- Work to keep those with health issues in employment longer, improving health literacy and self management
- Continue to help residents keep their homes warm through collective switching schemes, improving energy efficiency of properties and ensure access to welfare advice
- Use community assets to join up health, social care, education, skills and employment around the family. Extend both the Stronger Families and Well North approaches to other groups and geographical areas in the Borough

Recommendations to Prevent Disability

- Include preventative approaches in all patient pathways and clinical services
- Focus on 'Get Doncaster Moving' campaign to increase physical activity
- Develop a 'Delicious Doncaster' approach to food and nutrition
- Continue to reduce the negative impact of takeaways and fast food on health and air pollution by considering health in spatial planning and licensing approaches
- Evaluate local approaches with South Yorkshire Fire and Rescue to promote fire safety and address falls including enhanced home safety checks

Appendix 1. Doncaster Health Profile 2011

Health summary for Doncaster

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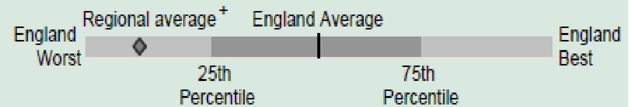
The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	107658	37.3	19.9	89.2		0.0
	2 Proportion of children in poverty	14825	22.7	20.9	57.0		5.7
	3 Statutory homelessness	77	0.63	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1843	51.4	55.3	38.0		78.6
	5 Violent crime	4918	17.0	15.8	35.9		4.6
	6 Long term unemployment	2073	11.2	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy			14.0	31.4		4.5
	8 Breast feeding initiation	2398	68.1	73.6	39.9		95.2
	9 Physically active children	23080	57.1	55.1	26.7		80.3
	10 Obese children (Year 6)	629	20.0	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	1.2	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	338	60.3	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	26.3	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	28.9	23.6	39.4		11.5
	15 Healthy eating adults	n/a	21.4	28.7	19.3		47.8
	16 Physically active adults	n/a	13.2	11.5	5.8		19.5
	17 Obese adults	n/a	29.0	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	36	12.2	13.1	27.2		3.1
	19 Hospital stays for self-harm	342	124.5	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	6833	1948	1743	3114		849
	21 Drug misuse	3079	16.3	9.4	23.8		1.8
	22 People diagnosed with diabetes	15745	6.46	5.40	7.87		3.28
	23 New cases of tuberculosis	13	5	15	120		0
	24 Hip fracture in 65s and over	317	465.2	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	215	23.3	18.1	32.1		5.4
	26 Life expectancy - male	n/a	76.4	78.3	73.7		84.4
	27 Life expectancy - female	n/a	81.2	82.3	79.1		89.0
	28 Infant deaths	21	5.48	4.71	10.63		0.68
	29 Smoking related deaths	611	273.9	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	268	79.5	70.5	122.1		37.9
	31 Early deaths: cancer	412	123.9	112.1	159.1		76.1
	32 Road injuries and deaths	146	50.4	48.1	155.2		13.7

Indicator Notes

1 % of people in this area living in 20% most deprived areas in England 2007 2 % children in families receiving means-tested benefits & low income 2008 3 Crude rate per 1,000 households 2009/10 4 % at Key Stage 4 2009/10 5 Recorded violence against the person crimes crude rate per 1,000 population 2009/10 6 Crude rate per 1,000 population aged16-64, 2010 7 % of mothers smoking in pregnancy where status is known 2009/10 8 % of mothers initiating breastfeeding where status is known 2009/10 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2009/10 10 % of school children in Year 6, 2009/10 11 Weighted mean number of decayed, missing or filled teeth in 12-year-olds, 2008/09 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2007-2009 (provisional) 13 % adults aged 18+, 2009/10 14 % aged 16+ in the resident population, 2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 16 % aged 16+ 2009/10 17 % adults, modelled estimate using Health Survey for England 2006-2008 (revised) 18 Directly age standardised rate per 100,000 population under 75, 2005-2007 19 Directly age and sex standardised rate per 100,000 population 2009/10 20 Directly age and sex standardised rate per 100,000 population, 2009/10 21 Estimated problem drug users using crack and/or opiates aged 15-64 per 1,000 resident population, 2008/09 22 % of people on GP registers with a recorded diagnosis of diabetes 2009/10 23 Crude rate per 100,000 population 2007-2009 24 Directly age and sex standardised rate for emergency admission 65+, 2009/10 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.06-31.07.09 26 At birth, 2007-2009 27 At birth, 2007-2009 28 Rate per 1,000 live births 2007-2009 29 Per 100,000 population aged 35 +, directly age standardised rate 2007-2009 30 Directly age standardised rate per 100,000 population under 75, 2007-2009 31 Directly age standardised rate per 100,000 population under 75, 2007-2009 32 Rate per 100,000 population 2007-2009

For links to health intelligence support in your area see www.healthprofiles.info More indicator information is available online in The Indicator Guide.

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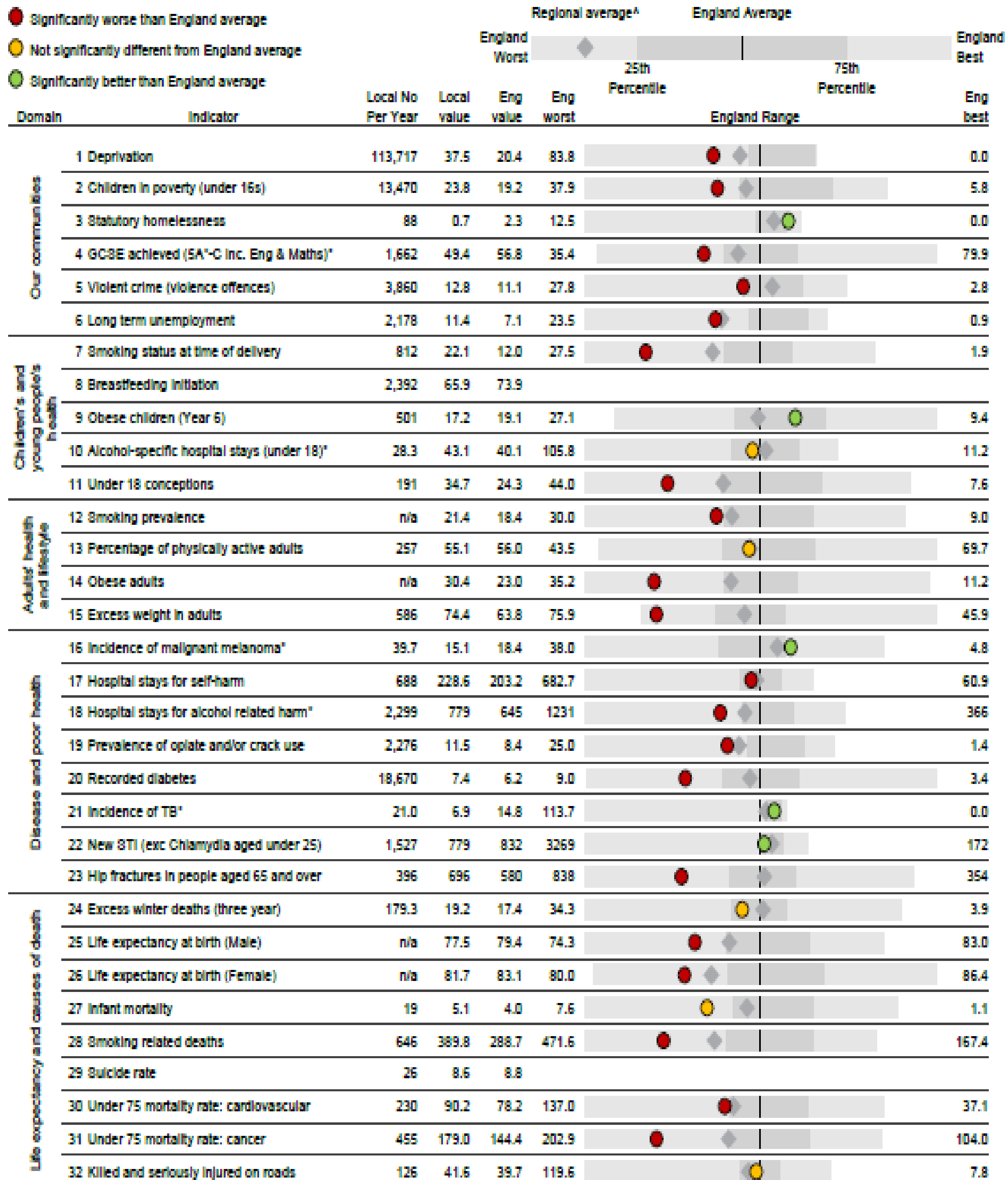
Appendix 2. Doncaster Health Profile 2015



Health Summary for Doncaster

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

Domain	Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1 Deprivation	113,717	37.5	20.4	83.8	0.0
	2 Children in poverty (under 16s)	13,470	23.8	19.2	37.9	5.8
	3 Statutory homelessness	88	0.7	2.3	12.5	0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)*	1,662	49.4	56.8	35.4	79.9
	5 Violent crime (violence offences)	3,860	12.8	11.1	27.8	2.8
	6 Long term unemployment	2,178	11.4	7.1	23.5	0.9
Children's and young people's health	7 Smoking status at time of delivery	812	22.1	12.0	27.5	1.9
	8 Breastfeeding initiation	2,392	65.9	73.9		
	9 Obese children (Year 6)	501	17.2	19.1	27.1	9.4
	10 Alcohol-specific hospital stays (under 18)*	28.3	43.1	40.1	105.8	11.2
	11 Under 18 conceptions	191	34.7	24.3	44.0	7.6
Adults' health and lifestyle	12 Smoking prevalence	n/a	21.4	18.4	30.0	9.0
	13 Percentage of physically active adults	257	55.1	56.0	43.5	69.7
	14 Obese adults	n/a	30.4	23.0	35.2	11.2
	15 Excess weight in adults	586	74.4	63.8	75.9	45.9
Disease and poor health	16 Incidence of malignant melanoma*	39.7	15.1	18.4	38.0	4.8
	17 Hospital stays for self-harm	688	228.6	203.2	682.7	60.9
	18 Hospital stays for alcohol related harm*	2,299	779	645	1231	366
	19 Prevalence of opiate and/or crack use	2,276	11.5	8.4	25.0	1.4
	20 Recorded diabetes	18,670	7.4	6.2	9.0	3.4
	21 Incidence of TB*	21.0	6.9	14.8	113.7	0.0
	22 New STI (exc Chlamydia aged under 25)	1,527	779	832	3269	172
	23 Hip fractures in people aged 65 and over	396	696	580	838	354
Life expectancy and causes of death	24 Excess winter deaths (three year)	179.3	19.2	17.4	34.3	3.9
	25 Life expectancy at birth (Male)	n/a	77.5	79.4	74.3	83.0
	26 Life expectancy at birth (Female)	n/a	81.7	83.1	80.0	86.4
	27 Infant mortality	19	5.1	4.0	7.6	1.1
	28 Smoking related deaths	646	389.8	288.7	471.6	167.4
	29 Suicide rate	26	8.6	8.8		
	30 Under 75 mortality rate: cardiovascular	230	90.2	78.2	137.0	37.1
	31 Under 75 mortality rate: cancer	455	179.0	144.4	202.9	104.0
	32 Killed and seriously injured on roads	126	41.6	39.7	119.6	7.8

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13, aged 65+ 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

* - Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

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Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No.
Date:

Subject: Report of the Steering Group and Forward plan

Presented by: Dr R Suckling

Purpose of bringing this report to the Board	
Decision	X
Recommendation to Full Council	
Endorsement	
Information	X

Implications		Applicable Yes/No
DHWB Strategy Areas of Focus	Substance Misuse (Drugs and Alcohol)	Yes
	Mental Health	Yes
	Dementia	Yes
	Obesity	Yes
	Children and Families	Yes
Joint Strategic Needs Assessment		Yes
Finance		No
Legal		Yes
Equalities		Yes
Other Implications (please list)		No

How will this contribute to improving health and wellbeing in Doncaster?
This report provides an update on the 2017 Joint Strategic Needs Assessment (JSNA) , health-led Work and Health Unit trial, Doncaster festival of research, Doncaster CCG primary care committee, Pharmaceutical Needs Assessment (PNA) and governance.

Recommendations
The Board is asked to:- NOTE the report, AGREE the proposal for the 2017 JSNA, NOMINATE a replacement for the Primary Care Committee if necessary, AGREE the approach to the PNA and DISCUSS and AGREE the forward plan.

Doncaster
Metropolitan Borough Council

Agenda Item No. 13

To the Chair and Members of the
HEALTH AND WELLBEING BOARD

REPORT FROM THE HEALTH AND WELLBEING BOARD STEERING GROUP AND FORWARD PLAN

EXECUTIVE SUMMARY

1. The purpose of this report is to provide an update to the members of the Health and Wellbeing Board on the work of the Steering Group to deliver the Board's work programme and also provides a draft forward plan for future Board meetings.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

2. The work programme of the Health and Wellbeing Board has a significant impact on the health and wellbeing of the Doncaster population through the Joint Health and Wellbeing Strategy, the Joint Strategic Needs Assessment, system management and any decisions that are made as a result of Board meetings.

EXEMPT REPORT

3. N/A

RECOMMENDATIONS

4. That the Board RECEIVES the update from the Steering Group, and CONSIDERS and AGREES the proposed forward plan at **Appendix A**.

PROGRESS

5. At the first full Board meeting on 6th June 2013, Board members agreed that there would be a Health and Wellbeing Officer group to provide regular support and a limited support infrastructure to the Board. In March 2016 this support was changed to a steering group.

The Steering group has had one meeting since the last Board in January 2017 and can report the following:

- **Joint Strategic Needs Assessment (JSNA) 2017**

The Health and Wellbeing Board needs to commission the 2017 JSNA. It is recommended that the 2017 JSNA is co-ordinated by the HWB steering group and consists of three broad areas of work.

1. A stocktake of the health of Doncaster people and communities using the 3 national outcome frameworks i.e. NHS outcome framework, Adult Social Care outcome framework and the Public Health outcome framework.

2. A number of discreet work packages addressing key questions or hypotheses, including:.

- What is driving low healthy life expectancy and what might we do about it?
- What is happening with life expectancy in Doncaster and what might we do to improve it?
- What is the role of Adverse Childhood experiences on healthy life expectancy and life expectancy and how might these be prevented and ameliorated?
- Why is childhood poverty increasing, what should our response be?

3. Develop an open data repository as a mechanism to share health and wellbeing data and analyses for Doncaster with partners and the public.

- **Health-led Work and Health Unit trial**

The approval of the health led trial with the Work and Health Unit is still awaited. Locally work has continued to propose Individual Placement Support should be tested alongside social prescribing, Improving Access to Psychological therapies (IAPT) services and musculoskeletal services.

- **Doncaster Festival of Research 2017**

The Health and Wellbeing Board is supporting a Doncaster research festival week commencing 16th October 2017. The format is in development but will include events across Doncaster and across all sectors. Board members are asked to note this and nominate a key contact to develop this further.

- **Doncaster CCG Primary Care Committee**

The HWB has a seat on the CCG's primary care committee. The current representative Dr Suckling is unable to fulfil this role and the Board is asked to consider nominating a different representative.

- **Pharmaceutical Needs Assessment**

One of the statutory duties of the Health and Wellbeing Board is to produce a PNA. Under the current regulations the PNA will need to be updated by 1st April 2018. It is proposed that a South Yorkshire approach is taken wherever possible to produce the next PNA.

- **Governance**

The Health and Wellbeing Board steering group is reviewing the governance of the various boards and groups that report to it and to the HWB. A further report will be brought in June.

- **<u>Forward Plan for the Board.</u>**

This is attached at **Appendix A**.

6. **IMPACT ON THE COUNCIL'S KEY OUTCOMES**

	Outcome	Implications
	All people in Doncaster benefit from a thriving and resilient economy. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	The dimensions of Wellbeing in the Strategy should support this priority.
	People live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	The Health and Wellbeing Board will contribute to this priority
	People in Doncaster benefit from a high quality built and natural environment. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	The Health and Wellbeing Board will contribute to this priority
	All families thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	The Health and Wellbeing Board will contribute to this priority
	Council services are modern and value for money.	The Health and Wellbeing Board will contribute to this priority
	Working with our partners we will provide strong leadership and governance.	The Health and Wellbeing Board will contribute to this priority

RISKS AND ASSUMPTIONS

7. None.

LEGAL IMPLICATIONS

8. None.

FINANCIAL IMPLICATIONS

9. None

EQUALITY IMPLICATIONS

10. The work plan of the Health and Wellbeing Board needs to demonstrate due regard to all individuals and groups in Doncaster through its work plan, the Joint Health and Wellbeing Strategy and Areas of focus as well as the Joint Strategic Needs Assessment. The steering group will ensure that all equality issues are considered as part of the work plan and will support the Area of Focus Leads to fulfil these objectives.

CONSULTATION

11. None

REPORT AUTHOR & CONTRIBUTORS

Dr Rupert Suckling, Director, Public Health
01302 734010 rupert.suckling@doncaster.gov.uk

Louise Robson, Public Health Theme Lead, Public Health
01302 734015 louise.robson@doncaster.gov.uk

Dr Rupert Suckling
Director Public Health

APPENDIX A

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2017

<table>
<tr><th rowspan="2">Date</th><th colspan="2">Board Core Business</th><th rowspan="2">Partner Organisation and Partnership Issues</th><th rowspan="2">HWBB Steering Group Work plan</th></tr>
<tr><th>Meeting/Workshop</th><th>Venue</th></tr>
<tr><td>6th April 2017
*Please note that this workshop is now cancelled</td><td>Workshop cancelled</td><td>Cancelled</td><td rowspan="2">• Plans and reports from
  ○ CCG
  ○ NHSE
  ○ DMBC
  ○ Health watch
  ○ RDaSH
  ○ DBH
• Safeguarding reports
• Better Care Fund
• DPH annual report
• Role in partnership stocktake
• Wider stakeholder engagement and event
• Relationship with Team Doncaster and other Theme Boards
• Relationship with other key local partnerships
• Health Improvement Framework
• Health Protection Assurance Framework
• Wellbeing and Recovery strategy
• Adults and Social care Prevention Strategy
• Housing
• Environment
• Regeneration</td><td rowspan="2">• Areas of focus – schedule of reports and workshop plans
• Integration of health and social care (BCF)) workshop plan
• Other subgroups – schedule of reports
• Communications strategy
• Liaison with key local partnerships
• Liaison with other Health and Wellbeing Boards (regional officers group)
• Learning from Knowledge Hub</td></tr>
<tr><td>8th June 2017</td><td>Board Agenda
• Q4 Performance Report
• Health and social Care Transformation update
• Town centre planning update
• Health watch update
• Housing and Health update
• HWBB Steering group update</td><td>Civic office 007a and 007b</td></tr>
</table>

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2017

6th July 2017	**Workshop** • TBC			
7th September 2017	• Board Agenda TBC	Civic office 007a and 007b		

***Supported Living and Wellbeing workshop/Fuel Poverty workshop** to be rescheduled in 2017

2017 Health and Wellbeing Board meetings

8 June 2017 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

7 September 2017 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

2 November 2017 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

Health and Wellbeing Workshop Dates – Topics to be confirmed (Mary Woollett centre 9am-1pm)

6th April 9 – 1pm **cancelled**

6th July 9 – 1pm

5th October 9 – 1pm

7th December 9 – 1pm