Public Document Pack

Doncaster Council

Agenda

To all Members of the

HEALTH AND WELLBEING BOARD

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

Venue Room 007a and b - Civic Office, Waterdale, Doncaster, DN1 3BU

Date: Thursday, 15th March, 2018

Time: 9.30 am.

Item		Time/ Lead
1.	Welcome, introductions and apologies for absence	5 mins (Chair)
2.	Chair's Announcements.	5 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.)**	15mins (Chair)
5.	Declarations of Interest, if any.	1 min (Chair)

Jo Miller
Chief Executive

Issued on: Wednesday 7th March 2018

Governance Services Officer for this Meeting: Jonathan Goodrum
Tel. 01302 736709

Doncaster Metropolitan Borough Council
www.doncaster.gov.uk

6.	Minutes of the Meeting of the Health and Wellbeing Board held on 11th January 2018. *(Attached – pages 1 – 8)*		5 mins (Chair)
	Delivery of Health and Wellbeing Strategy		
7.	Tackling Health Inequalities in Doncaster - An Update on the Approach. *(Presentation/Paper attached - pages 9 – 38)*		15 mins (Susan Hampshaw/ Dr Victor Joseph/ Laurie Mott/ Dr Anna Ray)
8.	Health and Wellbeing Board Outcomes Framework 2018-2021 and Joint Strategic Needs Assessment Update. *(Paper attached – pages 39 – 50)*		15 mins (Allan Wiltshire/ Laurie Mott)
9.	Director of Public Health Annual Report 2017. *(Paper attached – pages 51 – 82)*		10 mins (Dr Rupert Suckling)
	Board Assurance		
10.	Health and Social Care Transformation/Better Care Fund (BCF) Update:		20 mins
	10 .1	Place Plan Update *(Verbal Update)*	(Anthony Fitzgerald)
	10 .2	BCF - Use of Earmarked Reserve *(Paper attached – pages 83 – 96)*	(Faye Tyas)
	10 .3	BCF Quarter 3 Update *(Paper attached – pages 97 – 110)*	(Dominic Armstrong)
11.	Doncaster Suicide Prevention Local Action Plan 2017-2020. *(Presentation/Paper attached – pages 111 – 134)*		10 mins (Helen Conroy/ Sarah Smith)
12.	Pharmaceutical Needs Assessment 2018-2021. *(Presentation/Paper attached – pages 135 – 192)*		10 mins (Nasar Ahmed)
13.	Doncaster's Affordable Warmth Strategy 2018-2021. *(Paper attached – pages 193 – 212)*		10 mins (Vanessa Powell-Hoyland)
	Developments and Risk Areas		
14.	Doncaster Approach to Customer Insight. *(Paper attached – pages 213 – 284)*		25 mins (David Ayre)
	Board Development		
15.	Report from Health and Wellbeing Board Steering Group and Forward Plan. *(Paper attached – pages 285 – 328)*		5 mins (Dr Rupert Suckling)

Date/time of next meeting: Thursday, 14 June 2018 9.30 am. in Room 007a and b - Civic Office, Waterdale, Doncaster, DN1 3BU

Members of the Health and Wellbeing Board

Chair – Councillor Rachael Blake – Portfolio Holder for Adult Social Care
Vice-Chair – Dr David Crichton, Chair of Doncaster Clinical Commissioning Group

Councillor Nigel Ball	Portfolio Holder for Public Health, Leisure and Culture
Councillor Nuala Fennelly	Portfolio Holder for Children, Young People and Schools
Councillor Cynthia Ransome	DMBC Conservative Group Representative
Dr. Rupert Suckling	Director of Public Health, Doncaster Council
Kathryn Singh	Chief Executive of Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
Steve Shore	Chair of Healthwatch Doncaster
Karen Curran	Head of Co-Commissioning NHS England (Yorkshire and Humber)
Richard Parker	Chief Executive of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Damien Allen	Interim Director of People, DMBC
Jackie Pederson	Chief Officer, Doncaster Clinical Commissioning Group
Commander Shaun Morley	South Yorkshire Police
Paul Tanney	Chief Executive, St. Leger Homes of Doncaster
Steve Helps	Head of Prevention and Protection, South Yorkshire Fire and Rescue
Paul Moffat	Chief Executive of Doncaster Children's Services Trust
Peter Dale	Director of Regeneration and Environment, Doncaster Council

This page is intentionally left blank

DONCASTER METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY, 11TH JANUARY, 2018

A MEETING of the HEALTH AND WELLBEING BOARD was held at ST. CATHERINE'S HOUSE, BALBY on THURSDAY, 11TH JANUARY, 2018, at 9.30 am.

PRESENT: Vice-Chair - Dr David Crichton, Chair of Doncaster Clinical Commissioning Group (DCCG), in the Chair.

Councillor Nigel Ball	Portfolio Holder for Public Health, Leisure & Culture
Councillor Nuala Fennelly	Portfolio Holder for Children, Young People & Schools
Dr Rupert Suckling	Director of Public Health, Doncaster Council
Joanne McDonough	Deputy Chief Operating Officer & Doncaster Care Group Director, RDaSH, substituting for Kathryn Singh
Karen Barnard	Director of People & Organisational Development, Doncaster & Bassetlaw Teaching Hospitals Foundation Trust, substituting for Richard Parker
Damian Allen	Director of People (DCS/DASS), Doncaster Council
Steve Shore	Chair of Healthwatch Doncaster
Paul Tanney	Chief Executive, St Leger Homes of Doncaster
Steve Helps	Head of Prevention & Protection, South Yorkshire Fire & Rescue
Peter Dale	Director of Regeneration & Environment, Doncaster Council
Paul Moffat	Chief Executive, Doncaster Children's Services Trust
Jackie Pederson	Chief Officer, DCCG

Also in attendance:

Allan Wiltshire, Head of Policy and Partnerships, Doncaster Council
Dr John Woodhouse, Independent Chair of Doncaster Safeguarding Adults Board
Angelique Choppin, Safeguarding Adults Board Manager
Dr Victor Joseph, Consultant in Public Health, Doncaster Council
Councillor Derek Smith (Observer)

35 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies were received from the Chair, Councillor Rachael Blake (Dr David Crichton in the Chair), Richard Parker (Karen Barnard deputised), Kathryn Singh (Joanne McDonough deputised), Councillor Cynthia Ransome and Karen Curran.

36 CHAIR'S ANNOUNCEMENTS

There were no announcements by the Chair.

37 PUBLIC QUESTIONS

In addressing the Board, Councillor Derek Smith referred to the question he had asked at the last meeting with regard to the number of District Nurses available to treat patients during the night in Doncaster and pointed out that he was still awaiting a

response. He added that he had heard that the number of District Nurses could be as low as 2 across the Borough.

In reply, Joanne McDonough began by stressing that the Community Nursing service was not an emergency service. With regard to response times for visiting patients, Joanne confirmed that the service was commissioned and resourced to respond within 2 hours for urgent referrals. She explained that daily reviews were undertaken to assess demand and ensure that the needs of patients were met. In terms of numbers of nurses available, she confirmed that for both the evening shift, which was from 7.30 p.m. to midnight, and the night-time shift, there were 3 registered nurses available, supported by 3 or 4 health care assistants, depending on demand. She explained that while there was an element of flexibility in terms of numbers of nurses and assistants available, it could be challenging at times in respect of providing end of life care and administering pain relief. All calls were triaged for urgency based on clinical need and all end of life patients were prioritised, especially in relation to pain relief. If the service was unable to respond more quickly than the 2 hours and patients were in pain, then discussions were held about changing the way that pain relief was administered, for example from injections as and when required to a steady administration via a controlled mechanism such as a syringe driver.

In reply to a further question from Councillor Smith, Joanne McDonough confirmed that she was of the opinion that there was a sufficient number of District Nurses available at night, but she stressed there was a need to ensure that the service could deal with peaks in respect of end of life patients, hence the need for daily reviews.

38 DECLARATIONS OF INTEREST, IF ANY

No declarations of interest were made.

39 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 2ND NOVEMBER 2017

RESOLVED that the minutes of the Health and Wellbeing Board held on 2nd November 2017 be approved as a correct record and signed by the Chair.

40 HEALTH AND WELLBEING BOARD OUTCOMES FRAMEWORK 2018-21

The Board considered a report which provided an update on the Outcomes Framework being developed for the Health and Wellbeing Board. It was noted that the Outcomes Framework, once agreed, would allow the Board to drive delivery and be sighted on the key outcomes and indicators identified as important for the Board.

In presenting the report, Allan Wiltshire explained that there were two assumptions that could be made in linking this Board's outcomes to other frameworks. Firstly, that the starting well age categorisation would be delivered by the Children and Young People's plan outcomes framework, to be monitored by the Children and Families Executive Board. Secondly, the Indicators that were currently in the Doncaster Growing Together outcomes framework would need to be monitored by the Health and Wellbeing Board.

Members noted that a set of statements had been devised for each section of the matrix to be clear about what the Board was trying to achieve in each matrix cell i.e.

what was important in the Prevention category and in the Ageing Well life course category. These statements described what each cell of the matrix meant to Doncaster residents as well as outcomes that would demonstrate success. Appendix A to the report listed these statements for the Board's endorsement. Appendix B to the report gave an example of how the reporting against key indicators against each cell of the matrix might look, as well as showing the range of indicators that would be used. It was noted that there would be a clear scheduling of reports back to this Board to aid monitoring of the outcomes throughout the year. The Board was being asked to endorse the framework proposals prior to receiving a more detailed report at its meeting in March.

In answer to a question, Allan Wiltshire explained the reason why there was no assessment against the benchmarks in relation to some of the indicators in the matrix, and pointed out that, over time, it was hoped that these gaps would be filled as more data was collected.

During subsequent discussion, Members made various observations/comments on the proposed Outcomes Framework, including the following:-

- It was felt that it would be useful if the matrix could also show details of trends upwards or downwards, perhaps by using arrows against each indicator;

- While it was acknowledged that there was a need for benchmarking, it was also vital that the *quality* of services provided for the people of Doncaster was considered at all times;

- With regard to the case for using local performance data as opposed to national data, it was acknowledged that the main benefit of using national benchmarks was that it allowed a more consistent approach in measuring against the performance indicators. It was noted that in instances where performance against a particular indicator looked awry, there would be the option of drilling down to more local data and compare this against the national picture;

- Arising from discussion on the need to make connections and ensure that the HWB made links to other outcomes frameworks, it was agreed to add to the Board's Forward Plan the following items for consideration at future meetings:

    - annual update from the Children and Families Executive Board on progress with the Children and Young People's Plan outcomes; and

    - information report on the performance measures being developed for the Doncaster Accountable Care Partnership.

It was then

RESOLVED:-

(1) To endorse the proposed Health and Wellbeing Board Outcomes Framework 2018-21 outlined in the paper;

(2) That the following items be added to the Board's Forward Plan for consideration at future meetings:-

- annual update from the Children and Families Executive Board on progress with the Children and Young People's Plan outcomes; and

- information report on the performance measures being developed for the Doncaster Accountable Care Partnership.

41 HOUSING AND HEALTH UPDATE

The Board received and noted a presentation by Paul Tanney on the links between health, housing and the Doncaster Growing Together (DGT) programme. The Board noted that a Housing (Homes for all) Programme Board had been established under the DGT theme of 'Doncaster Living'. Members were informed of the key projects and initiatives being pursued by the programme board under its 5 work streams, which comprised:

1. Housing Delivery
2. Care Leavers Accommodation
3. Older Peoples Housing
4. Homeless and Rough Sleeping
5. Accommodation for People with Learning and Physical Disabilities.

During subsequent discussion, the Board noted that, with regard to meeting Affordable Housing need, 1200 affordable houses per year had been provided in Doncaster over the last 2 years. This exceeded the target of 940 that had been set. Members also acknowledged that sometimes people with complex needs were in need of larger accommodation, such as when they needed to be supported by a live-in carer.

After the Board had discussed various issues in relation to housing, including the importance of designing homes for life, and the use of S106 monies for health and social care facilities, in addition to affordable housing, it was

RESOLVED to note the information provided.

42 DONCASTER SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2016/17

Dr John Woodhouse, Independent Chair of Doncaster Safeguarding Adults Board (DSAB), presented the Annual Report of the DSAB for 2016/17, detailing what the Safeguarding Adults Board had done during the year to achieve its main objectives and implement its strategic plan and what each constituent has done to implement the strategy. The Annual Report also set out the findings of any Safeguarding Adults Reviews and Lessons Learned Reviews completed during the year and the subsequent actions arising from the reviews.

In introducing the report, Dr Woodhouse outlined the current priorities and areas of development that the DSAB was focussing on, which included further work on enabling people to feel safe.

After some brief discussion, during which Members commended the DSAB on its production of a very accessible Annual Report, it was

RESOLVED to note the multi-agency activities undertaken during 2016-17 by the Doncaster Safeguarding Adults Board to safeguard adults at risk

and prevent abuse from occurring wherever possible, and also receive the multi-agency performance and training statistics for this period.

43 HEALTHY DONCASTER FRAMEWORK

Dr Rupert Suckling presented details of the Healthy Doncaster Framework 2017-18, which was a collaborative approach to addressing the complexity of the challenge that obesity brought to Doncaster. It was reported that the Framework would provide an annual assessment of work streams which supported the obesity/healthy weight agenda in line with the Board's revised outcomes framework.

Dr Suckling summarised the key work streams and initiatives identified under the themes of:-

- Delicious Doncaster;
- Get Doncaster Moving;
- Environment;
- Children & Young People and Families;
- Workplaces; and
- Weight Management Services.

The Board noted, in particular, that significant progress had been made under the theme of Get Doncaster Moving, in the area of Physical Activity, with the launch of a new Physical Activity and Sport Strategy and Doncaster's success in being selected by Sport England to take part in a pilot scheme aimed at making it easier for people to access sport and physical activity to help reduce levels of inactivity. This Scheme would enable the Borough to access £18 million of lottery funding.

After Dr Rupert Suckling had informed the Board that the national Workplace Charter run by Public Health England had been withdrawn at the end of last year, and that work was currently being undertaken to develop a South Yorkshire model and toolkit to take its place, it was

RESOLVED to endorse the Healthy Doncaster Framework and agree to receive reports as required.

44 SELF-MANAGEMENT PROGRAMME AND MAKING EVERY CONTACT COUNT TRAINING

The Board considered a report by Dr Victor Joseph which recommended some low-cost preventative initiatives aimed at helping to raise awareness of the benefits of healthy lifestyles and support people who wanted to make lifestyle changes.

It was reported that throughout the day people had countless opportunities to start healthy conversations with their colleagues, clients, patients or family members. A short 30 seconds to 2 minutes conversation when an opportunity arose could start someone's journey to a healthier life. Doncaster's Making Every Contact Count (MECC) programme would give frontline staff the confidence and knowledge to start conversations around healthy eating, smoking, physical activity and alcohol. The training programme would overcome some of the barriers to having healthy conversations such as lack of confidence, knowledge and skills. Essentially, by creating a workforce which was comfortable and confident in having healthy conversations, the aim was to reduce the burden on primary and secondary care

services and promote early help and prevention as well as self-management. The MECC training would not only raise awareness around risks associated with unhealthy behaviours but also promote local and national services that people could access in their communities. It was also proposed to establish a Self-Management Working Group for Doncaster, which would outline specific aims and priorities in response to the local needs and use limited funding for the self-care and prevention projects and initiatives.

After Dr Joseph had answered questions on the proposed training, and the Board had questioned the need to establish an additional new working group to lead on this piece of work, it was

RESOLVED:

(1) to endorse the face-to-face *Train the Trainer* programme for Making Every Contact Count in Doncaster across partner agencies; and

(2) that it be suggested that an existing forum should be identified to take the lead on driving this initiative forward, as an alternative to establishing a Self-Management Working Group, as proposed.

45 REPORT FROM HEALTH AND WELLBEING BOARD 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 particular, the report included updates for the Board on:

- Board Development (the Board considered a number of Board Development recommendations detailed in the report which had arisen from a recent Board Development day);
- Pharmaceutical Needs Assessment;
- Loneliness; and
- Forward Plan for the Board.

Members noted that copies of the minutes from the October and November 2017 meetings of the South Yorkshire & Bassetlaw Sustainability and Transformation Partnership Collaborative Partnership Board, which had been omitted from the report, were available at the meeting and would be circulated for information on the subsequent decision summary.

After the Board had discussed and supported the key recommendations that had arisen from the Board development day, and also discussed the problem of Loneliness and the role which Elected Members could play in proactively dealing with loneliness in their Wards, it was

RESOLVED that:

(1) the update from the HWB Steering Group be received and noted;

(2) the Board development recommendations listed on page 89 of the report be agreed; and

(3) the proposed Forward Plan, as detailed in Appendix A to the report, be agreed, subject to noting that the venue for the Board's workshop on 8 February will be The Point, South Parade, Doncaster.

CHAIR:_____ DATE:_____

This page is intentionally left blank

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 15/3/18

Subject: **Tackling Health Inequalities in Doncaster – an update on the approach**

Presented by: Susan Hampshaw, Dr Victor Joseph, Laurie Mott and Dr Anna Ray

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

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

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

1. In Doncaster, life expectancy for both men and women is lower than the England average. Evidence suggests that reducing health inequalities improves life expectancy and reduced disability for the population overall i.e. more equal societies are healthier societies.

Recommendations

THE BOARD IS ASKED TO:-

1. Note and endorse the proposed approach to tackling health inequality and agree to receive regular update on progress.

2. Note the approach to identifying, understanding and acting on unequal access and outcomes for BAME citizens in respect of mental health.

3. Note the on-going work to developing and agree recommendations arising out of the BAME focus group work (see appendix for report)

4. Agree to establish a BAME advisory group reporting to the Health Inequality Work Group.

Doncaster Council

Report

Agenda Item No. 7
Date: 15TH March 2018

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

TACKLING HEALTH INEQUALITIES IN DONCASTER – AN UPDATE ON THE APPROACH

EXECUTIVE SUMMARY

1. The Health and Social Care Act enshrined a duty to consider reducing inequalities in both access and outcome of healthcare (2012). Locally, the Health and Well Being Board (HWBB) leads work to describe, understand, and act to tackle unfairness and health inequalities and this work is supported by a Health Inequalities Working Group.
2. By inequality, we mean 'systematic difference in the health of people in the health of people occupying unequal positions in society' (Graham, 2009). This way of looking at inequality means that differences in health experiences and outcomes are socially produced, avoidable unfair and unjust.
3. In Doncaster, life expectancy for both men and women is lower than the England average.
4. It is increasingly recognised that local authorities can play a significant part in addressing and reducing health inequalities, although central government, and the rest of the public, voluntary and private sectors are also vital: a place-based approach is necessary (LGA, 2018). It is also recognised that there are no simple answers but there is useful guidance and frameworks to underpin this work. All guidance emphasises the centrality of involving and empowering local communities, and particularly disadvantaged groups in reducing health inequalities
5. The local public health team is central to this work but almost every local government function has an impact on health.
6. We have previously reported that the Health Inequalities Working Group was developing an action plan[1] and this paper (and the accompanying presentation) sets out the building blocks of the plan and also updates the board on one specific inequality project (i.e. further work on the BAME needs assessment incorporating collaborative work to identify and explain unequal access and outcome to mental health services and also work to further engage with local people to understand need (see appendix 1).
7. The Health Inequalities Action Plan (see appendix 2) sets out 3 main areas:

[1] Health and Well Being board workshop held in October 2016.

- Work to map, coordinate and report on health inequality work across the Borough
- Work to engage partners and citizens in the making the case for action on inequality starting with simplifying language and collectively owning the messages
- Undertake and support work for groups who may require a specific focus such as but not limited to the protected groups in inequality legislation.

8. The presentation on the BAME needs assessment inequality project will illustrate how the Health Inequalities Action Plan will operate.

EXEMPT REPORT

9. not exempt

RECOMMENDATIONS

10. That the HWBB note and endorse the proposed approach to tackling health inequality and agree to receive regular update on progress.

11. That the HWBB note the approach to identifying, understanding and acting on unequal access and outcomes for BAME citizens in respect of mental health.

12. That the HWBB note the on-going work to developing and agree recommendations arising out of the BAME focus group work (see appendix for report)

13. That the HWBB agree to establish a BAME advisory group reporting to the Health Inequality Work Group.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

14. Evidence suggests that reducing health inequalities improves life expectancy and reduced disability for the population overall i.e. more equal societies are healthier societies.

BACKGROUND

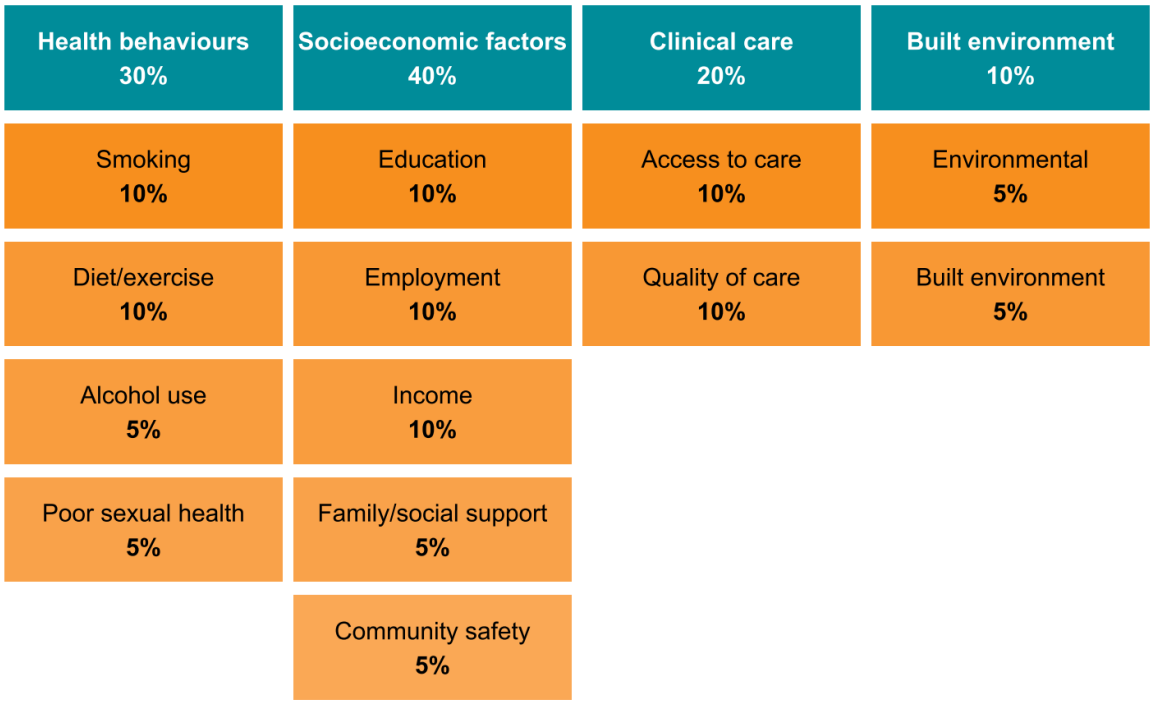
15. Health inequalities are differences in health outcomes between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.

16. The health of people in Doncaster is generally worse than the England average. Doncaster is one of the 20% most deprived district/unitary authorities in England and about 25% of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 10.8 years lower for men and 7.9 years lower for women in the most deprived areas of Doncaster than the least deprived areas of Doncaster (PHE, 2017)

17. Inequalities in the pattern of ill health are caused by different factors; Socio-economic factors e.g. the availability of work, education, income, housing and amenities; lifestyle and health-related behaviours e.g. smoking, diet and physical activity; healthcare factors e.g. access to services, understanding of the needs of the population, prevalence of disease and personal factors e.g.

age, gender, ethnicity, genetics. All of these factors contribute towards the likelihood an individual will develop ill health. One of the best ways of describing the relative contribution of these factors is the Robert Wood Johnson Foundation work which estimates the contribution of each factor. The figure below outlines these contributions (LGA, 2018).

Figure 1: Relative contributions of the determinants of health



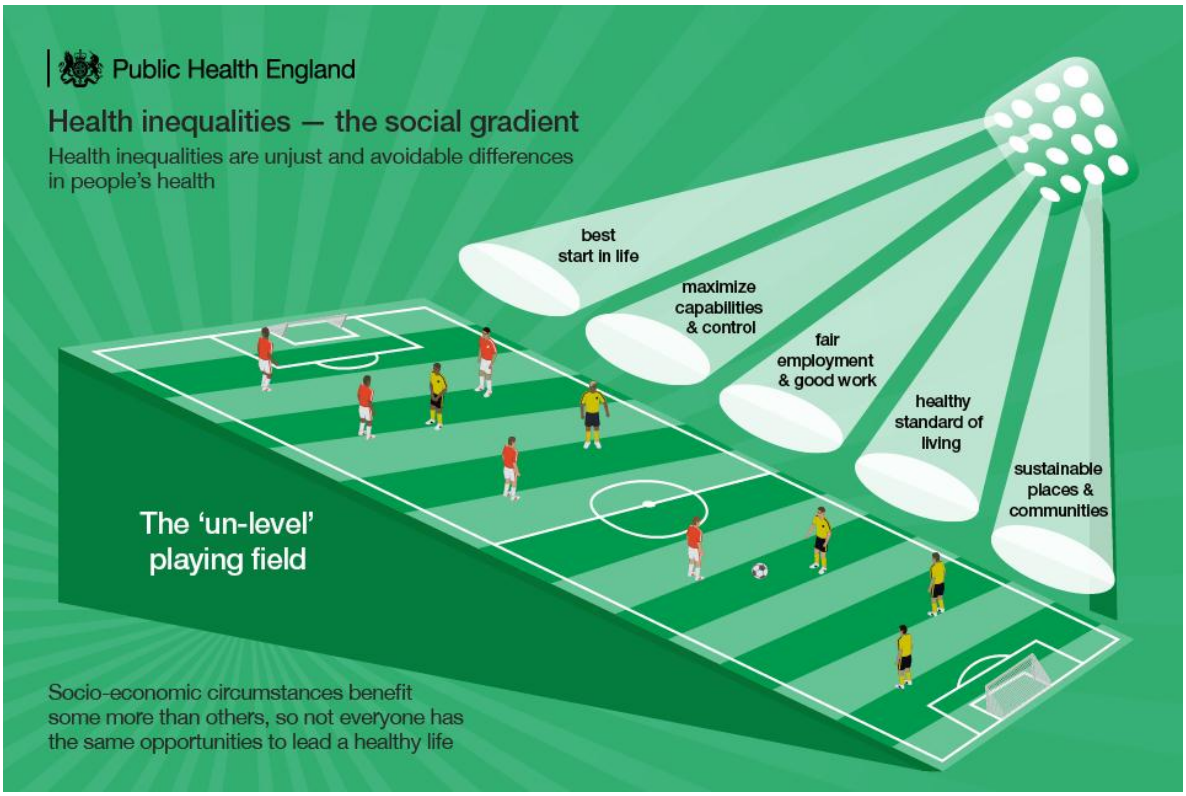
Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status

18. There are differences in the pattern of risk factors that cause disease across Doncaster and also with the number of people living with certain disease. For example people who live in more deprived areas of Doncaster are more likely to smoke and to have respiratory disease compared to people who live in less deprived areas. People in deprived areas are also more likely to report having a long term mental health problem than people living in less deprived areas. In terms of accessing health services people living in more deprived areas are more likely to have an emergency admission to hospital and less likely to attend a cancer screening appointment. Overall people living in deprived areas of Doncaster have a shorter life expectancy than people living in less deprived areas of the Borough.

19. In addition variation due to the geography of where people live health inequalities are also seen in relation to different protected characteristics may have. The Equality Act 2010 defines these characteristics as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation. There are also specific groups in the population who may experience inequality such as veterans, people who are homeless and sex workers.

20. The key and rather stark point here is that the length of time that people live and the number of years of ill health they experience is related to the extent of disadvantage and deprivation they experience. This is largely determined by circumstances outside an individual's control. Most inequalities are avoidable

because as a society, we can change the social and economic circumstances in which people live. A place-based approach is crucial to this change (LGA, 2018). Figure 2 outlines the social gradient that is in operation.



OPTIONS CONSIDERED

21. There are numerous activities across the Borough that contributes to tackling health inequalities and these have been examined to help develop the action plan.

22. In addition, there are multiple sources of guidance in this area and this has been used by the Health Inequalities Working to develop an action plan which aims to support work to tackle health inequalities.

23. Specific work has been undertaken on the BAME needs assessment and this approach has helped develop the overall health inequalities work plan.

REASONS FOR RECOMMENDED OPTION

24. Locally, we are recommending using an approach which builds on mobilising knowledge into action and which harnesses the knowledge of local people as well as people working in or designing services, policies or interventions. In addition, a key mechanism is the adoption of health implications in all policies approach.

25. Working together to identify, understand and act on unequal access or outcomes is seen as effective and ensures on-going and deliberate attention to the need address fairness and inequality. The two case studies within the accompanying presentation illustrate how this approach is working.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

	Outcomes	Implications
	Doncaster Working: Our vision is for more people to be able to pursue their ambitions through work that gives them and Doncaster a brighter and prosperous future; • Better access to good fulfilling work • Doncaster businesses are supported to flourish • Inward Investment	Given the part that the physical environment and socio-economic factors play in determining health it is crucial that health inequalities are considered in all work to develop this outcome.
	Doncaster Living: Our vision is for Doncaster's people to live in a borough that is vibrant and full of opportunity, where people enjoy spending time; • The town centres are the beating heart of Doncaster • More people can live in a good quality, affordable home • Healthy and Vibrant Communities through Physical Activity and Sport • Everyone takes responsibility for keeping Doncaster Clean • Building on our cultural, artistic and sporting heritage	Given the part that the physical environment and socio-economic factors play in determining health it is crucial that health inequalities are considered in all work to develop this outcome
	Doncaster Learning: Our vision is for learning that prepares all children, young people and adults for a life that is fulfilling; • Every child has life-changing learning experiences within and beyond school • Many more great teachers work in Doncaster Schools that are good or better • Learning in Doncaster prepares young people for the world of work	Given the part that the physical environment and socio-economic factors play in determining health it is crucial that health inequalities are considered in all work to develop this outcome

	Doncaster Caring: Our vision is for a borough that cares together for its most vulnerable residents; • Children have the best start in life • Vulnerable families and individuals have support from someone they trust • Older people can live well and independently in their own homes	It is recognised that specific focus on vulnerable people is required and this is included within the work plan.
	Connected Council: • A modern, efficient and flexible workforce • Modern, accessible customer interactions • Operating within our resources and delivering value for money • A co-ordinated, whole person, whole life focus on the needs and aspirations of residents • Building community resilience and self-reliance by connecting community assets and strengths • Working with our partners and residents to provide effective leadership and governance	The introduction of health implication in corporate reports supports the Connected Council agenda.

RISKS AND ASSUMPTIONS

26. Developing and delivering on Health Inequalities Action Plan support the duty to consider reducing inequality in access and outcome in health care. However, tackling inequalities is complex and requires ownership, collaboration and partnership area of work. The action plan represents deliberate attention on the issue and the requirement to update the board helps ensure on-going attention to the issue. In addition, adopting a knowledge mobilisation approach helps mitigate risks around delivery. A full risk assessment will be developed and attached to the plan.

LEGAL IMPLICATIONS [Officer Initials HMP Date 2/3/18]

27. Part 5, Chapter 2 of the Health and Social Care Act 2014 deals with the health scrutiny functions of local authorities and makes provision for the establishment of Health and Wellbeing Boards. It sets out their role in preparing the joint strategic needs assessment, the joint health and wellbeing strategy and in promoting integrated working between NHS public health and social care commissioners and introduces the first legal duties about health inequalities In addition under section 149 Equality Act 2010, the Public Sector Equality Duty (PSED). obliges public authorities, when exercising their functions, to have ‘due regard’ to the need to:

    a. Eliminate discrimination, harassment and victimization and other conduct which the Act prohibits;

b. Advance equality of opportunity; and
c. 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.

This report details its work concerning health inequalities, which assists in its compliance with the legal duties.

FINANCIAL IMPLICATIONS [HJW 05/03/2018]

28. There are no direct financial implications arising as a result of this report.

HUMAN RESOURCES IMPLICATIONS [Officer Initials BT **Date** 02/03/2018**]**

29. There are no obvious HR implications as far as this report is concerned as the theme leads within public health team establishment consulted and implemented last year co-ordinate all such aspects within '*health inequalities in doncaster'* on behalf of the authority. Any necessary changes to the structure will be dealt with in HR's regular liaison meetings with the Director Public Health and/or his 2 senior management.

TECHNOLOGY IMPLICATIONS [Officer Initials PW Date 5/03/18]

30. There are no direct technology implications at this stage. Where requirements for new, enhanced or replacement technology to support the delivery of the Health Inequalities Action Plan and/or the BAME Needs Assessment Inequality Project are identified, these would need to be considered by the ICT Governance Board (IGB).

HEALTH IMPLICATIONS [Officer Initials SH Date 1/3/18]

31. This work is focussed on identifying, understanding and acting on unequal outcomes of health care. There are no additional health implications.

EQUALITY IMPLICATIONS [Officer Initials SH Date 1/3/18]

32. The Inequalities action plan and BAME needs assessment work support equality, diversity and inclusion (EDI) work and the approach to identifying unequal access and outcomes is included in the EDI framework.

CONSULTATION

33. The action plan was developed by the Health Inequalities Working Group following workshops with the HWBB. In terms of the BAME needs assessment work; the consultation consisted of focus groups, workshops (in the case of the mental health work) and a consultation via social media on the proposed recommendations (see (https://www.facebook.com/Public-Health-Doncaster-1485296881729475/)

BACKGROUND PAPERS

34. Director of Public Health Annual Reports: https://issuu.com/doncastercouncil/docs/public_health_annual_report_web Public Health England: http://fingertips.phe.org.uk/profile/health-profiles and https://www.gov.uk/government/news/phe-resources-support-local-action-on-health-inequalities

Doncaster Health and Well Being Strategy http://www.doncaster.gov.uk/services/health-wellbeing/doncaster%E2%80%99s-health-and-wellbeing-board

BME HNA 2017 http://www.doncaster.gov.uk/services/health-wellbeing/doncaster%E2%80%99s-health-and-wellbeing-board

LGA, 2018 https://www.local.gov.uk/matter-justice-local-governments-role-tackling-health-inequalities

REPORT AUTHOR & CONTRIBUTORS

Susan Hampshaw, Public Health Principal (lead officer)
01302 734012 susan.hampshaaw@doncaster.gov.uk

Dr Victor Joseph, Public Health Consultant
Victor.joseph@doncaster.gov.uk

Laurie Mott, Senior Strategy and Performance Manager
Laurie.mott@doncaster.gov.uk

Doncaster Council

Report

Black and Minority Ethnic Health Needs Assessment; Community Engagement

February 2018

Contents

Introduction

Background to this Health Needs Assessment

During 2016 a multi-staged Health Needs Assessment for Black and minority Ethnic (BME) communities was commissioned by the Doncaster Health and Wellbeing board (HWB). This work was undertaken by the Doncaster Public Health team under the oversight of the Health Inequalities Working Group to address health inequalities across the Borough.

This HNA was presented to the HWB in March 2017. The HNA consisted of;

- **Phase 1:** An analysis of baseline demographic data on BME groups from previously collected data such as national census data.
- **Phase 2:** A review of evidence from published literature surrounding ethnicity and health. Evidence reviewed included that on access, mental health, housing and harassment.
- **Phase 3:** Stakeholder engagement. The approach consisted of feedback via Doncaster Healthwatch, re-analysis of previously collected focus group data and survey data from HWB member organisations.

The data driven approach of the March 2017 HNA meant engagement with BME populations across Doncaster was limited. This work builds on the initial HNA hoping to bring further detail and clarity to the findings.

Aims of Community Engagement

Underpinning the community engagement arm of this HNA are the overall aims set in commissioning the original HNA. In summary, this is to identify and examine any *invisible* factors that lead to health inequalities in ethnic minority groups in Doncaster. The purpose of this HNA is to make these *invisible* factors *visible* and make actionable recommendations that will address these causes of health inequalities.

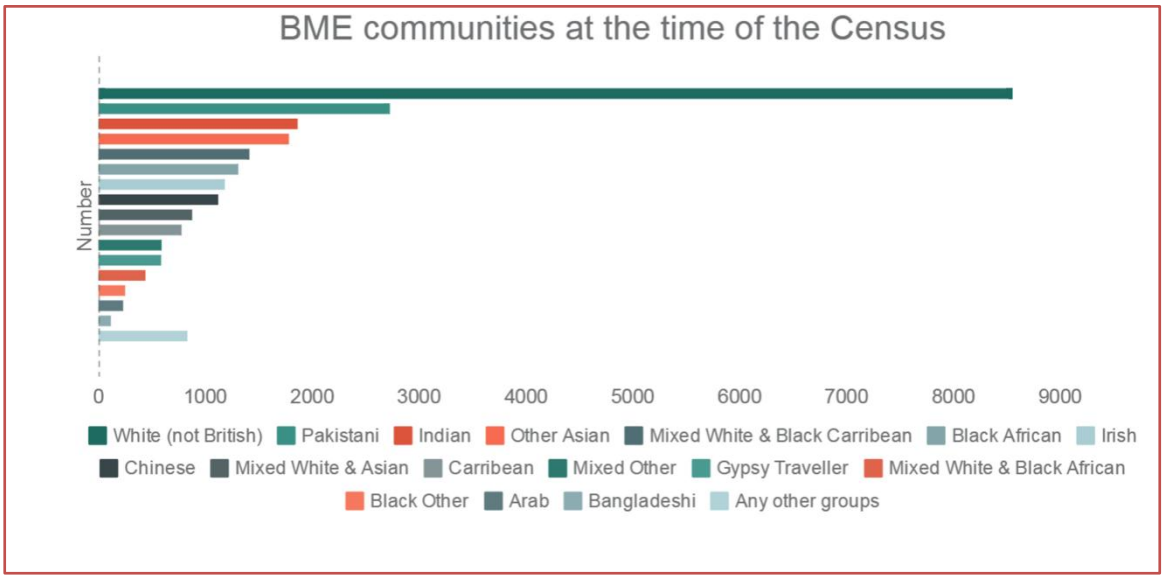
Objectives

- To explore the perceived health needs of key BME populations in Doncaster through direct community engagement
- To explore ideas of how these needs could be met or resolved
- Reconcile findings from this piece of work and the existing HNA to formulate actionable recommendations to address the identified health needs
- To establish a mechanism for engagement with BME groups in Doncaster on the health inequalities agenda

Methodology

Identification of key groups

The figure below was used in the original HNA report. It highlights the relative sizes of different BME community groups across Doncaster. A wide variety of ethnic groups are resident in Doncaster. To focus our time and resources effectively, we used this figure to identify and prioritise the largest ethnic groups to engage in discussions.



The March 2017 HNA identified that migrants and new arrivals were a key group for further attention. This priority reflects the migrant data collected subsequently to the 2011 National Census. For example, an analysis of spoken languages in Doncaster detailed in the March 2017 HNA report shows that Polish is the largest minority language spoken. This is likely to represent the large proportion of the 'White not-British' population documented in the above figure. Additionally it is documented in 'Migration Yorkshire 2016' that in 2015, for example, there were 3490 new migrant workers to Doncaster. This significant migrant working population are clearly important to engage, despite not perhaps being fully represented in the 2011 national census data.

Through the reasoning detailed above, we sought engagement with the following BME groups;

- Asian (including Pakistani, Indian and other Asian)
- Chinese

- Afro-Caribbean (including mixed white and black Caribbean and Caribbean)
- Polish
- ‘New Arrivals’ (focussing on asylum seekers and refugees, likely to represent a variety of Ethnic Origins including Black African and Middle Eastern groups)
- Gypsy Traveller

Recruitment

Opportunistic sampling was employed to gain access to ethnic minority communities through community gatekeepers. These gatekeepers were known community group leaders, religious group leaders, Healthwatch representatives and members of existing ethnic minorities working groups in the council. Gatekeepers then used their existing community networks to engage and recruit participants.

Methods of Engagement

Separate meetings were arranged for each key ethnic group and focus groups were undertaken. A brief presentation was given by Public health to each group providing background and the aims of the meeting. The focus groups were facilitated by Public Health Team members and two key questions were asked;

1) What issues are of main concern for your community?
2) What could be done to improve these issues in your community?

Groups were encouraged to think broadly about issues rather than constraining themselves to perceived health related topics only. Groups were then encouraged to prioritise the issues identified and focus their discussions more on their priority topics.

Data capture and analysis

During the focus groups, facilitators captured key topics that emerged through discussions. In addition, groups had post-it notes to document any key issues they felt they did not have the opportunity to discuss. These notes were then collated and analysed for key themes within the data and similarities in themes between groups.

Checking Recommendations

After completion of all the focus groups, participants and local partner organisations were invited to attend meetings where the report and recommendations were ‘sense checked’. The recommendations in this report are a reflection of these meetings.

Limitations

Due to the resource intensive nature of qualitative investigation and reasonable time constraints, only a small sample of each sub-population was engaged in focus group discussions (approx. 5-10 members of each community). However this did allow us to conduct focus groups with a broader range of sub-populations to ensure a voice is given to a wide variety of community groups. Furthermore this allows us to understand which issues are unique to particular minority groups or those that are associated more generally with being a member of a minority community. We considered saturation to be met once similar themes are re-occurring amongst sub-populations.

The ‘gatekeepers’ used to recruit focus group participants were mainly associated with an existing community group such as a church. It is likely therefore that those members of the public, who are disengaged from their broader community, may not have their views proportionately represented in our findings. However, the general tone of focus groups was that participants acted as ‘spokes people’ for health issues seen in their communities rather than personally experienced. As a result it is likely that the more vulnerable and excluded members of communities had their issues advocated for through the recruited participants.

Furthermore, a summary of the findings from each group was disseminated to the broader community through the focus group participants. This served to confirm the accuracy of points captured and ensure no key points were missed. This was performed in attempt to capture the voice of the broader community.

Results and Recommendations

When examining the themes emerging from the various focus group discussions, there were some topics that were important to all groups. These were themes around barriers to accessing health care, employment, mental health and social isolation. However there were some issues which were specific to one or two particular communities. In this results section, not every single issue that arose will be reported, but those that emerged as important or common.

Barriers in Accessing Health and Care Services

Part 1 of this HNA identified access the health care services in BME groups as a problem. It was recommended that more local insights were required for a fuller assessment of this issue in Doncaster.

All groups, except the Afro-Caribbean group, identified language as a barrier in health services. Participants accepted that interpreters reduced this barrier, but highlighted that there is a lack of interpreters from outside the patient's own communities. In turn this was felt to restrict a patients' ability to speak openly and with anonymity. The South Asian group particularly noted that anonymity was difficult within their community. It was noted by several groups that where telephone interpreters are used, communication is often difficult as there is no body language to aid understanding.

Recommendation 1: Where needed, review existing guidance on the use of interpreters in the public sector (for example health care). This guidance should state that;

a) A face-to-face interpretation is preferable to telephone interpretation services.
b) Patient preference should be sought on if an out-of-area interpreter is required. This aims to reduce the patient's perception of lack of anonymity within a consultation.
c) To reduce barriers in access to services organisations must ensure their front-line staff (i.e. receptionists) are fully aware of interpretation policies.
d) Organisations must undertake meaningful monitoring and evaluation of their interpretation services.

Recommendation aimed at: Doncaster interpretation and translation unit- Katy Scott, Primary Care, Doncaster Hospitals, Big Word Translation Services.

In some cases, it was not only language that impeded a health care consultation, but a lack of cultural understanding on behalf of the organisation or individual delivering

the health or social care. An example of this was discussed by the South Asian group that General Practitioners (GPs) may be misidentifying mental health problems as they commonly manifest as physical health problems. The Afro-Caribbean community felt that elderly members of their community experienced poorer quality social care due to a lack of knowledge in staff of their specific cultural needs. The Polish community felt that cultural barriers, and at times discrimination, meant GPs restricted their ability to access referrals to secondary care services.

In some communities specific cultural factors prevented engagement with services. These cultural issues included taboo and stigma surrounding alcohol use and the consequent denial of problem use, noted by both the Chinese and South Asian groups. For the new arrivals community, a basic lack of health knowledge surrounding mental health prevented people identifying and seeking help for these problems.

Recommendation 2: A commitment to training local GPs, hospital and social care staff on providing a culturally sensitive service to the BME community. Key issues this training should address are;

a) Reflection on staffs own beliefs, values and attitudes and how they impact on the clients they work with.
b) The different symptomology of some medical conditions in BME groups
c) Understanding religious connotations and cultural taboos relating to some conditions including alcoholism and mental health problems.
d) Providing practitioners with the skills and confidence to explore hidden issues of alcohol and substance misuse in the BME community.
e) Ensuring 'cultural needs' are asked about and addressed in care plans.

*Recommendation aimed at***:** Primary Care, Health and Social Care at DMBC, Doncaster Hospitals

The new arrivals community and the Polish community discussed practical issues hindering their access to health care. Both groups noted that communities had a lack of knowledge in navigating appropriate health services. New arrivals often may not know they need to register with a GP. The Polish group noted that securing a GP appointment was very challenging due to the lack of availability of appointments. On failing to secure a timely GP appointment participants said they would access Emergency Services instead. Furthermore, many new arrivals felt confused about the rules relating to financing healthcare and the fear of payments prevented or delayed their access.

Similarly the travelling community experienced difficulty registering with GP practices. Caravan sites are sometimes not viewed by practises as a "permanent address". It was reported that some patients have been removed from practice registers when surgeries realise that the patient is from the Traveller's community.

Furthermore dental registration among the Gypsy and Travellers community appeared to be a major gap, as one member acknowledged this “never happened”. The experience of “bad teeth” was acknowledged among the Gypsies and Travellers community.

Recommendation 3: Continue with the on-going work to increase access to primary care. Particularly to;

a) Increase timely access to GP appointments across all GP practises
b) To assist new arrivals navigate health care services
c) Improve access to registration with GP and dental practises for patients from the Gypsy and Travellers community
d) Monitor the impact that new ‘entitlement checks’ have on access to healthcare

*Recommendation aimed at***:** University of Sheffield Research Team on online tools for primary care, Health Access for Refugees Programme (HARP), Doncaster CCG, HealthWatch

The Gypsy and Traveller’s community group explained families like to stay together as family units in the community. They described that this is one of their core values. This principle extends to the care of the elderly. The community opts to look after their elderly people rather than let them be cared for in care homes. One of challenges associated with this is that the elderly among the community do not access services, unlike their counterparts in the wider community.

Recommendation 4:

a) To further explore of the needs of the Gypsy and Travellers community specifically relating to the needs of the elderly and the issue of domestic violence. Subsequently instigate culturally appropriate support services.
b) To gather information, build partnerships and facilitate engagement with this community, it is necessary to consider employing a link worker from within the community. Existing links with the community need to be made more widely known and a clear pathway of accessing these links needs to be established.

Recommendation aimed at: DMBC, Doncaster CCG

Mental Health and Social Isolation

The most discussed topic across all focus groups was Mental Health. Mental health problems were mainly discussed in the context of the perceived high rates of anxiety and depression in their communities. Multiple reasons were discussed for the high prevalence of mental health problems in the community. Despite its prevalence, it was also noted that often mental health issues were unrecognised by individuals and

were not discussed openly within community groups. Below is a list of reasons presented by each group detailing why they felt issues of anxiety and depression are so common;

- Chinese Group: Debt problems caused by gambling, lone living, high educational expectations, unemployment, carer stress
- South Asian Group: Changing familial expectations, loss of respect for the elder generation, social isolation, high levels of community judgement and disapproval, a tension between western and Islamic lived lives
- Afro-Caribbean Group: social isolation, lack of meeting places
- New Arrivals Group: separation from close family members, social isolation, high levels of poverty, immigration status, boredom, traumatic journeys to the UK, trauma from home country, food and housing insecurity
- Polish Group: Poor work life balance due to long working hours

Compared to all other groups mental health was most discussed by the new arrivals participants, and the severity of its impact appeared greatest within this group. One participant said “I struggle to learn new things”, where others said poor mental health resulted in panic attacks and thoughts about suicide. Almost all participants linked immigration status as a major stressor. Others assigned their anxiety to trauma saying,

> “The things I have seen…I have seen lots of death”.

The South Asian group and the new arrivals group noted that religious beliefs can complicate the issue of mental health. They described that often mental health can be interpreted as a religious problem such as spiritual possession or that the person has a “weak faith” (Link to Recommendation 2).

Recommendation 5: Commissioners and providers of mental health services should devise an action plan on how to tailor their services to also address the needs of the BME community. This will include ensuring;

a) Services are culturally sensitive
b) Language barriers are considered and addressed
c) Referral pathways are examined to enhance BME access to existing services
d) Consideration of BME needs in any future policies which are developed

Recommendation aimed at: RDASH, Doncaster CCG

Linked to mental health in all group dialogues was the issue of social isolation. This was noted to be a particular issue for the elderly and for women. Most groups identified language barriers as a cause, as well as the break down (or loss) of traditional family and community support structures. The barriers to leaving the

house identified included fear of harassment, and crime, bad weather and cultural expectations of women being carers for the home and family. For the new arrival community, social isolation resulted more from the lack of incentives to leave the home as they have no employment, very few friends and no money to pay for public transport or leisure activities. The Chinese group were concerned that social isolation means that many people are invisible to services and communities and that people may “fall through the gaps”.

Recommendation 6: Ensure that those working on the Loneliness and Social Isolation agenda across all directorates at DBMC are made aware of the burden of social isolation amongst the BME community in Doncaster. For those moving this agenda forward, to examine how the specific needs of the BME community can be addressed. This should include ensuring that existing services, such as local befriending schemes, are made culturally appropriate and accessible to the BME community.

Recommendation aimed at: Loneliness Lead within the Public Health Team (Louise Robson, Mental Health Steering Group (Emma Smith), Wellbeing Team (Lisa Swainston), DMBC

Social isolation was assigned to a lack of community meeting spaces in three groups. Community meeting spaces were viewed as positive places where people can meet to reduce isolation and improve community cohesion, as well as places to deliver programmes and educational messages. Lack of cohesion between ethnic groups was viewed as a particular issue by the Afro-Caribbean community. Participants noted there are often tensions between well-established settled communities, and communities of new immigrants.

Recommendation 7: Establish a working group to explore the community assets of buildings in Doncaster and how they could be used as community space. This group should focus on collaboration and partnership working. It should include members of the general public, including representation from a variety of BME communities. This group may consider examples of good practise from other regions. The group, led by a member of the council with expertise, would need to collectively determine;

a) The purpose for the community space (i.e. a multicultural space, a space for celebrations)
b) The location and building type (i.e. a location to maximise access from BME groups)
c) How the space could be managed (i.e. considering community ownership, volunteering)
d) How the space would be funded (i.e. crowd funding, sponsorship, social enterprise models)

e) Look for examples of best practise in other areas, and learn from previous endeavours locally.

Recommendation aimed at: Lead from DMBC Communities Team (Fay Wood-Community Led Support).

Substance Misuse

Alcoholism was seen as a very important issue by the Chinese community, especially amongst males. They assigned this problem to boredom and lack of awareness of safe drinking levels. They described it as a "hidden issue" where many men would not admit to their community or to services that they were problem drinkers. Similarly in the South Asian community they noted that drug and alcohol use were important but unrecognised and hidden issues. The cultural and religious taboos relating to alcohol force many to drink in secret, with this stigma preventing access to services.

Recommendations for substance misuse, namely alcoholism, link into those that address the causes such as unemployment and social isolation (recommendation 5, 6, 10). Furthermore they link in with recommendations on ensuring services are culturally appropriate (recommendation 2 & 4).

Recommendation 8: Highlight the hidden issue of alcoholism and substance misuse in some BME groups to the relevant teams tackling this issue within the council. Ensure that the local alcohol and drugs strategy is tailored to these communities finding innovative ways at engaging and addressing this problem.

Recommendation aimed at: DMBC Theme Lead on Vulnerable People (Helen Conroy and Andy Collins for Alcohol).

Gambling

A subject of great importance to the Chinese community was the issue of gambling. They were concerned that it was hidden, but very prevalent issue in their community which results in problematic debt and is a pathway into poverty. They described high stakes gambling of cars and businesses. They were also concerned that gambling companies often provide sponsorships of local Chinese community events.

Recommendation 9: Through the 'Gambling in Doncaster and Financial Inclusion' group, ensure that there is an action plan to address the issue of Gambling within the Chinese community. It is important that this specific issue of sponsorship of local Chinese community events by gambling companies is addressed.

Recommendation aimed at: Gambling in Doncaster and financial inclusion group – Caroline Temperton/Rupert Suckling

Nutrition

Nutrition was extensively discussed by the South Asian group, and only perhaps touched on by others. In younger people it was felt there was a large reliance on unhealthy take-away foods. Furthermore it was felt that traditional foods consumed at home were highly calorific and often used very few fresh fruits and vegetables in the cooking. They explained that there is a cultural expectation to cook these unhealthy foods when hosting. Interestingly the men in the community felt they had no control over improving what they ate at home as women had the responsibility for cooking, whereas the women felt disempowered by their families to cook healthy foods.

Recommendation 10: Establish a piece of work to explore ways in which BME communities (most notably the South Asian, African, Chinese, and Caribbean communities) can be supported to cook healthy foods and be encouraged in physical activity. This piece of work should be creative, empower and involve the communities they are targeted (such as micro-grants and resources for community groups to lead their own healthy cooking classes).

Recommendation aimed at: DMBC Public Health Team Physical Activity Lead (Claire Henry) and Obesity Lead (Louise Robson)

Education, Employment and Opportunities

Education, employment and opportunities was a strong theme present in all focus group discussions. Most groups noted unemployment as a concern. A common theme was discrimination causing inequalities in education and employment. This included being labelled as a 'problem' in education and being faced with the barrier of discrimination when applying for employment.

Recommendation 11:

a) Perceived discrimination when applying for jobs is problematic in the BME community. To address this, the equal opportunities requirements for Public Sector organisations should be extended to cover Private sector organisations and companies. Both public and private sectors organisations need to demonstrate due regard in relation to recruitment of BME groups.
b) Equal opportunities for BME groups in education, needs to be a goal. The findings of this HNA need to be considered by the education department in the council. A plan should be developed on how to decrease discrimination and enhance opportunities for BME children and young people in education.

Recommendation aimed at: Doncaster Growing Together

An emerging theme in several groups was the inequality in opportunities and its impact on the aspirations of young and working people. One group noted that young people were leaving Doncaster because of the limited opportunities available to them as a BME community member. One Afro-Caribbean participant summarised, “certain job roles just feel unachievable to a black person”. It was strongly noted on several occasions that there was a lack of political representation of the BME community, and more generally, a lack of role models in positions of power. It was said that this lack of representation damped people’s aspirations.

Recommendation 12: The creation of a BME advisory group to the council to increase BME political involvement and representation. This advisory group would meet quarterly. The group will provide a channel of accountability and feedback to the community on the progress of this HNA’s outcomes.

Terms of reference will be developed for this group using examples of good practise from elsewhere. A fair process of recruitment to this group will be developed by the strategy and performance unit.

Recommendation aimed at: Public Health Team, Health Inequalities Board

Again for the new arrivals community the barriers to employment discussed were somewhat different. It was highlighted by many participants that as an asylum seeker you have no right to work, but that poverty sometimes forced people into illegal employment, particularly if someone is a failed asylum seeker but is unable to return to their home country. Barriers to education in this group included lack of spaces on college courses to learn English and lack of childcare provisions in those who did have an opportunity to attend college. It was noted that childcare is a particularly difficult issue as many new arrivals have no social resources for informal childcare arrangements, and no financial resources to fund formal childcare.

Recommendation 13: Providers of ESOL courses should increase the number spaces available for new arrivals. Providers of these courses should consider how to improve access to these courses, especially for parents with problematic childcare responsibilities.

Recommendation aimed at: Local providers of ESOL (local colleges, charities), *Katie Scott- Refugee support in DMBC*

Crime

Crime was only discussed by the South Asian and new arrivals groups, however was an emphasised topic in both discussions. In the South Asian community there is growing concern regarding the incidence of Islamaphobic attacks, as well as robbery

and burglary and the impact on the frail, young and vulnerable. These issues feed into other themes, as it was discussed this backdrop of crime results in anxiety and social isolation.

Recommendation 14: For Team Doncaster to lead by example to demonstrate a zero tolerance policy to discrimination on the grounds of race. This zero tolerance policy is to be adopted by all members of the health and wellbeing board. The implementation of this policy should be reflected in the practise of each organisation such as providing robust reporting procedures for issues of discrimination.

Recommendation aimed at: Doncaster Growing Together, All partners of the health and wellbeing board.

The new arrivals group highlighted the important issue of exploitation. Stories were told of exploitation by drug dealers and gangsters as work is performed in exchange for housing in those that are desperate and destitute. Participants explained they are afraid of seeking police help for their issues of harassment, blackmail and threats, in case they get deported. Others were afraid of being implicated in criminal activities therefore felt trapped in a cycle of exploitation. Other members of this community said they felt unsafe because of the threat of terrorism in the UK. One participant noted,

"I feel like the war is following us… I fled from war and now the war has come here"

Recommendation 15: Raise awareness among all partnership organisations as to;

a) What the signs of modern slavery and exploitation are
b) What to do if anyone sees or suspects exploitation is taking place

Recommendation aimed at: Safer, Stronger Doncaster Partnership, Doncaster Growing Together, and South Yorkshire Police- Modern Slavery Team.

There was acknowledgement that domestic violence occurs amongst the Gypsy and Travellers community. However, it was explained that common practise is for the family to attempt to resolve the issue, rather than the police (Link to recommendation 4).

Housing

The new arrivals participants mentioned housing as an issue on multiple occasions. Participants said the housing they were provided with was often of very poor quality. Complaints included houses being very dirty, worn carpets, blocked sinks and toilets and excrement on the bathroom floor. Distress was caused by being expected to

share a bedroom with another unknown adult, often from a different country and background. It was described this caused tension in the different expectations around the home, for example, between those who drink alcohol and those that do not. Participants noted that often there was inadequate equipment in the home, for example a single shelf freezer between six residents, or no cooking equipment at all. People explained this meant they often couldn't buy, store and cook food so ate takeaway or instant foods.

Recommendation 16: The creation of minimum standards for housing in response to the poor housing conditions experienced by many asylum seekers and refugees. These standards will include items such as;

a) The provision of sufficient cooking and food storage appliances
b) Regulations against bedroom sharing for adults who are not members of the same family
c) A pathway for people gaining their refugee status to ensure that homelessness is avoided during the transition period

Recommendation aimed at: G4S, St Legers Homes, Complex lives

Accommodation was also an issue for the Gypsy and Travellers community. They noted that many object to Gypsies moving into their neighbourhood and, as a result, they faced racism. The fundamental desire of this community is to live together as a community. They explained they do not like being separated by being given individual family housing units that are scattered around Doncaster. Hence, they prefer traveller sites, not housing.

Recommendation17: Doncaster Council and St Leger Housing to work closely with the Gypsy and Traveller community in order to address their housing needs

Recommendation aimed at: St Legers Homes, DMBC

Consultation Process

Focus group participants attended meetings where the findings and recommendations of the report were discussed. The aim of these meetings was to ensure all key points from the focus groups had been captured accurately. Furthermore to check if participants felt the recommendations were a reasonable and proportionate response to the findings.

Each recommendation has been aimed at one or multiple health and wellbeing partners. Each partner was contacted and invited to attend a meeting to discuss the recommendations. Those unable to attend were given the opportunity to respond with written comments. This process included internal departments within DMBC. The aim of this consultation process was to ensure that recommendations were realistic and implementable. Changes to the recommendations were made according to the feedback received. This process has also fostered a sense of ownership of the relevant recommendations for partners and teams at DMBC.

The report was made available on the council website and social media pages for public consultation purposes. The public were asked to feedback their thoughts on the recommendations in the report. There were a small number of respondents. Generally there was a high level of agreement with the health issues highlighted within this report and the appropriateness of the recommendations. The public expressed concern that there needs to be careful monitoring of the implementation of recommendations to ensure change is seen.

Moving Forward

Action planning, implementation and monitoring are the next stages of this piece of work. The following stages of this are mapped out below;

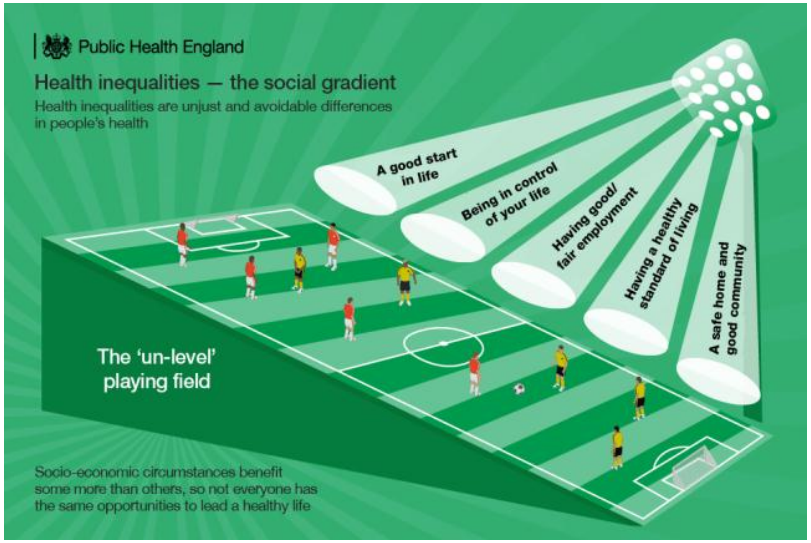
Action Required	By Whom	By When
Report on current work taken to the Health and wellbeing board for approval of recommendations	Dr Victor Joseph	15th March 2018
Partner organisations to own relevant recommendations	Key Partner Organisations	15th March 2018
Update the Action Plan of the Health Inequalities working group to reflect roles and responsibilities of this group. This includes an update of responsibilities regarding oversight of implementation of BME work	Health Inequalities Working Group	April 2018
In co-ordination with partners develop and agree upon a detailed action plan for this piece of work including; - Indicators to be monitored in implementation - Timeline for actions, outcomes and monitoring - Priority of actions	Health inequalities working group, key partner organisations identified in report,	September 2018
Establish terms of reference for BME advisory group, agree on a recruitment process and advertise for roles	Dr Victor Joseph, Strategy and performance Unit	June 2018

Health Inequalities Working Group: Action Plan

By inequality, we mean 'systematic difference in the health of people occupying unequal positions in society' (Graham, 2009). This way of looking at inequality means that differences in health experiences and outcomes are socially produced, avoidable unfair and unjust. In Doncaster, life expectancy for both men and women is lower than the England average.

Health Inequalities Working Group roles & responsibilities

- To advocate for action to reduce health inequalities
- To build a strong partnership (intelligent & purposeful)
- To ensure partners own actions related to addressing health inequalities
- To monitor progress on reducing health inequalities
- To engage the population on this agenda
- To mobilise knowledge of what works in practice and policy



Health behaviours 30%	Socioeconomic factors 40%	Clinical care 20%	Built environment 10%
Smoking 10%	Education 10%	Access to care 10%	Environmental 5%
Diet/exercise 10%	Employment 10%	Quality of care 10%	Built environment 5%
Alcohol use 5%	Income 10%		
Poor sexual health 5%	Family/social support 5%		
	Community safety 5%		

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status

1. The Health Inequalities Action Plan sets out 3 main areas:

- Work to map, coordinate and report on health inequality work across the Borough
- Work to engage partners and citizens in the making the case for action on inequality starting with simplifying language and collectively owning the messages
- Undertake and support work for groups who may require a specific focus such as but not limited to the protected groups in inequality legislation.

Action plan: key areas of work

Map, coordinate & report work across Doncaster

- Develop HI Dashboard
- Develop & share repository of HI work (start with what we know data) and what is happening e.g. street doctor, veterans, Burns practice, health ambassadors etc,
- Evaluate health in all policy work

Making the case: engagement & partnership

- Engage partners & local people
- Support the development of a Team Doncaster approach
- Develop a communication plan
- Celebrate and communicate success

Undertake & support key HI work

- Continue to develop and share BME needs assessment work
- Evaluate and utilise out methods for identifying unequal access and outcomes
- Inclusion health services
- Well Doncaster programme

Doncaster Council

Doncaster Health and Wellbeing Board

Date: 15.03.18

Subject: Health and Wellbeing Board Outcomes Framework 2018-21 and Joint Strategic Needs Assessment Update.

Presented by: Laurie Mott

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

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

How will this contribute to improving health and wellbeing in Doncaster?
The paper gives an update on the outcomes framework for the Health and Wellbeing Board which allows the board to drive delivery and be sighted on the key outcomes and indicators identified as important for the Board. It also provides a significant update on the Joint Strategic Needs Assessment which provides strategic insight and direction for the Board's activity over the next year.

Recommendations
The Board is asked to:- a) Note and comment on the information contained within the JSNA and the proposed method of receiving future reports on the Health and Wellbeing Board Outcomes Framework.

Doncaster Council

Agenda Item No: 8
Date: 15.03.18

To the Chair and Members of the Health and Wellbeing Board

HEALTH AND WELLBEING BOARD OUTCOMES FRAMEWORK 2018-21 AND JOINT STRATEGIC NEEDS ASSESSMENT UPDATE.

EXECUTIVE SUMMARY

1. The paper gives an update on the outcomes framework for the Health and Wellbeing board which allows the board to drive delivery and be sighted on the key outcomes and indicators identified as important for the Board and links into the outcomes identified as part of the plan for the Borough – Doncaster Growing Together (DGT). It also provides an update on the Joint Strategic Needs Assessment 2017/18 which provides strategic insight and direction for the Board's activity over the next year.
2. The JSNA for 2017-18 is combing a series of products to give a richer picture of Health and well-being across the borough. A full list of products is described in paragraph 9 but include an assessment on the newly agreed outcomes framework for the Board. A presentation of the key findings will be given at this agenda item.
3. The Outcomes framework has been refined and included for the Boards consideration along with an example of how a performance report may look in future reporting periods.

RECOMMENDATIONS

4. The Health and Wellbeing Board is asked to:-

    a) Note and comment on the information contained within the JSNA and the proposed method of receiving future reports on the Health and Wellbeing Board Outcomes Framework.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

5. Good strategic intelligence and performance management arrangements will ensure the board can target improvements to services and peoples experience of the local health, care and wellbeing system is positive.

BACKGROUND

6. The Health and Well-being board has a statutory duty to prepare an assessment of need within the local area, a **Joint Strategic Needs Assessment (JSNA)**. This assessment id prepared each year and can focus on different aspects of need to fit with the priorities of the Health and Well Being Board, in 2016/17 this was focused around Children and young people which would support the development of the Children and Young People's

plan. In 2017/18 the JSNA will be composed of a number of assessments made across the Health and Well-Being system.

7. After consultation and workshops the **outcomes framework** for the Health and Well Being board was agreed at the board meeting in January 2018. Although there is a need to acknowledge a need to be flexible to meet the future needs of the health and care system and board priorities the main strategic frame to monitor progress is in place.

Joint Strategic Needs Assessment (JSNA) Update

8. The JSNA in 2017/18 consists of a number of pieces of analysis reflecting the increasingly dynamic nature of health and wellbeing analytics, but also how the JSNA relates to the State of the Borough and Doncaster Growing Together. Products include

    - Health and Wellbeing Board outcomes framework assessment
    - BME Health Needs Assessment Mental Health analysis
    - Data to support health and care integration including complex lives and Doncaster Talks
    - Baseline data to inform the physical activity and sport strategy
    - Updated community profiles
    - Updated pharmaceutical needs assessment

9. There has been an assessment on each cell of the outcomes framework (see fig 1). It includes an assessment on primary indicators, those which have been identified within the framework, to understand how they perform nationally but also to ascertain if disaggregated data shows the extent of inequalities that exist within the borough. The assessment has gone further and analysed and secondary indicators that may impact upon each cell of the framework and in combination with the data described above, understand which of the cells in the framework need more of the board's attention over the next 12 months and directly impact on how the board may wish to focus on performance monitoring on a planned basis.

Health and Wellbeing Board Outcomes Framework 2018-21 Update

10. The framework is based upon two criteria so a matrix can be formed, firstly against a life course categorisation (All Age, Starting Well, Living Well and Ageing Well) and secondly against a segmentation of care (Wellbeing, Prevention, Care and Support). This is consistent with the current Doncaster Health and Wellbeing Strategy.

	All ages	**Starting well (ages 0-17),**	**Living well (ages 18-64),**	**Ageing well (ages 65+),**
Wellbeing				
Prevention				
Care				
Support				

Figure 1: HWB Outcomes Framework Matrix

11. At the Board meeting in January there was agreement of the framework and feedback on enhancements that would improve the existing arrangements;

- The summary benchmarking page for the outcomes framework would benefit from having a sense of direction as well as benchmarking information
- There should be clear links between the framework and delivery of the place plan / Accountable Care Partnership (ACP)
- Where possible we should assess all indicators against a benchmark (reduce the number of grey dots)
- Use the JSNA and other strategic insights to direct the focus of performance reporting to specific parts of the outcomes framework.

12. We have taken the feedback and enhanced the framework over the past month to improve, specifically;

- We have added in directional arrows on the Outcome Framework Summary Page to a give sense of journey and progress. There is at the moment no sophistication of practice with a simple getting better / higher and getting worse / lower against the previous period.
- Work is now underway to map the areas of opportunity in the place plan to this outcomes framework with the idea that service level measures will emerge across the framework which will allow a clear alignment from our strategic priorities to our operational work.
- The JSNA element to this paper has already begun to assess the cells within the framework to assess the areas that need more attention from the Board.

13. **Appendix A** provides an updated summary outcome framework page and a proposed example report on one of the cells; Well Being: Ageing Well. The proposed report layout allows the board to understand in more detail what is happening in that cell which will include the performance data but may also include other supplementary information to enhance the boards understanding of that 'Cell'. It should also include where appropriate any service performance measures from the opportunity areas.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

14.

	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 JSNA and HWB Outcomes Framework will demonstrate the contribution the board is making to the key strategic priorities to the Borough.
	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.	

RISKS AND ASSUMPTIONS

15. N/A

LEGAL IMPLICATIONS

16. No Legal Implications have been sought for this update paper.

FINANCIAL IMPLICATIONS

17. No Financial Implications have been sought for this update paper.

HUMAN RESOURCES IMPLICATIONS

18. No HR Implications have been sought for this update paper.

TECHNOLOGY IMPLICATIONS

19. No Technological Implications have been sought for this update paper.

EQUALITY IMPLICATIONS

20. The theme of health inequalities has been identified as a key theme in the development of an outcomes framework for the board and the work of the JSNA. Understanding inequalities in health and care outcomes and how we can describe and analyse them is a vital part of our success. It is included specifically as part for the JSNA analysis in 2018.

CONSULTATION

21. NA

BACKGROUND PAPERS

22. NA

REPORT AUTHOR & CONTRIBUTORS

Laurie Mott
Senior Manager, Strategy & Performance Unit
01302 737652
Laurie.mott@doncaster.gov.uk

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

Dr Rupert Suckling
Director of Public Health

This page is intentionally left blank

	All ages	Starting Well (Delivered by Children and Families Executive board)	Living Well	Ageing Well
Well-being	T1:Healthy Life Expectancy at birth (years) Male	T2:Percentage (%) of children scoring themselves medium or high on the composite resilience score (Pupil Lifestyle Survey Q84/85)	T2:% point gap in the employment rate between those with a learning disability and the overall employment rate	T1:% of adult social care users who have as much social contact as they would like
	T1:Healthy Life Expectancy at birth (years) Female		T2:% point gap in the employment rate between those accessing mental health services and the overall employment rate	
	T1:Life Satisfaction Survey (ONS Well Being)			
Prevention	T1:% of population that achieve 150 mins Physical activity per week	T2:Percentage (%) of children born with a low birth weight	T2:Smoking Prevalence in Adults	T2:Emergency hospital admissions for injuries due to falls in persons aged 65+
	T1:% of people using outdoor space for exercise/health reasons	T2:Excess weight in childhood at 5 Years	T2:Hospital admissions for alcohol-related conditions	T2:% of eligible adults aged 65+ who have received the flu vaccine
	T1: Preventable deaths in local population (Mortality Rate per 100,000)	T2:Excess weight in childhood at 11 Years	T2:% of Adults Overweight or Obese	
Care (Delivered by ACP)	T1:Delayed Transfers of Care from Hospital (all) per 100,000 population per day	T2:Hospital Admissions for Self-harm (aged 10 - 24 rate per 100,000)	T2: Cancer mortality rate(<75)	T1:Emergency Hospital Admissions (65+) to Hospital
	T1: satisfaction with experience of care and support services.	T2:Inpatient Admissions rate: mental health disorders for 10-17 year olds (per 100,000)	T2: Cardiovascular disease Mortality Rate (<75)	T1:Rate of permanent admissions to Residential Care per 100,000 (65+)
	T1: The proportion of people still at home 91 days following a period of reablement		T2:Complications associated with diabetes	T1: Requests for Support for Adult Social Care (65+) per 100,000 population
Support (Delivered by ACP)	T2: Proportion of people who use services and carers who find it easy to find information about services	T3:Percentage (%) of children in care with an up to date health assessment	T2:Adults in contact with Mental health services who are living in stable and appropriate acoomodation	T2: % of people who have a terminal diagnosis have an End of Life plan
		T1:Proportion of Children in Need per 10,000 population		T2: Dementia diagnosis rate
		T1:Proportion of Children in Care per 10,000 population	T2:Adults with a learning disability who are living in appropriate accommodation	

Key (national benchmark used)

●	No assessment against benchmarks
◆	Worse than national benchmarks
▲	Similar to national benchmarks
●	better than national benchmarks

T1	Tier 1 Population indicator contained within the DGT Outcomes
T2	Tier 2 Population Level Indicator
T3	Tier 3 Service Level performance measure

↑	Better / Higher than Previous Period
↓	Worse / Lower than previous Period
–	No Previous Data or no change

Health and Well Being Board Performance Report (March 18)

Focus of Report: Wellbeing – Ageing Well (CELL)

What this will mean Doncaster Residents

Support healthy aging across Doncaster, recognising that preventative approaches that reduce loneliness and social isolation or promote self-care and independence are important at every life stage

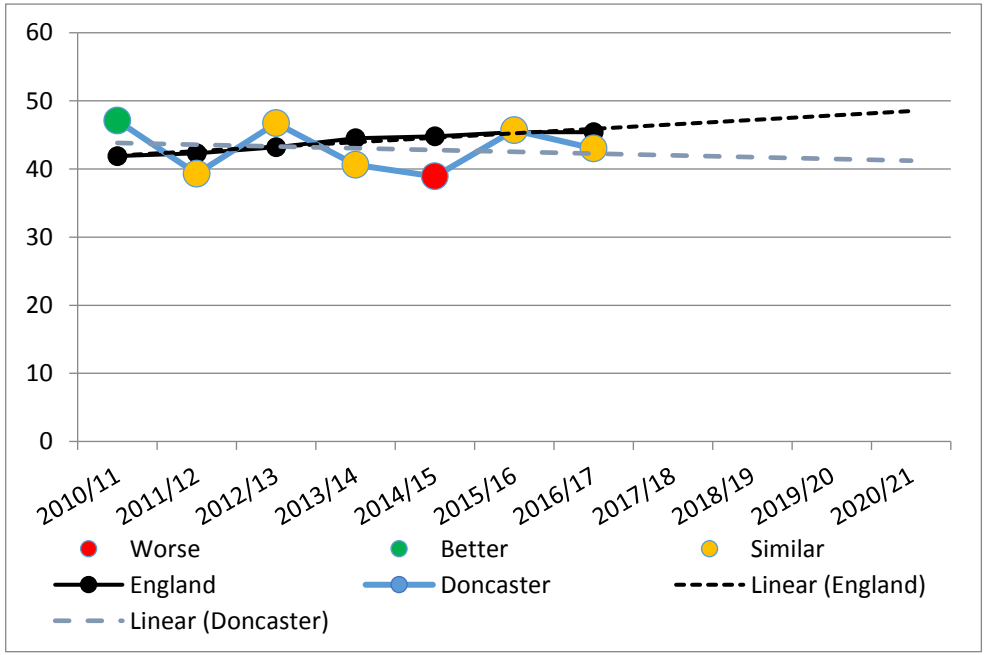
How we will know we have succeeded (the outcomes we want to deliver)

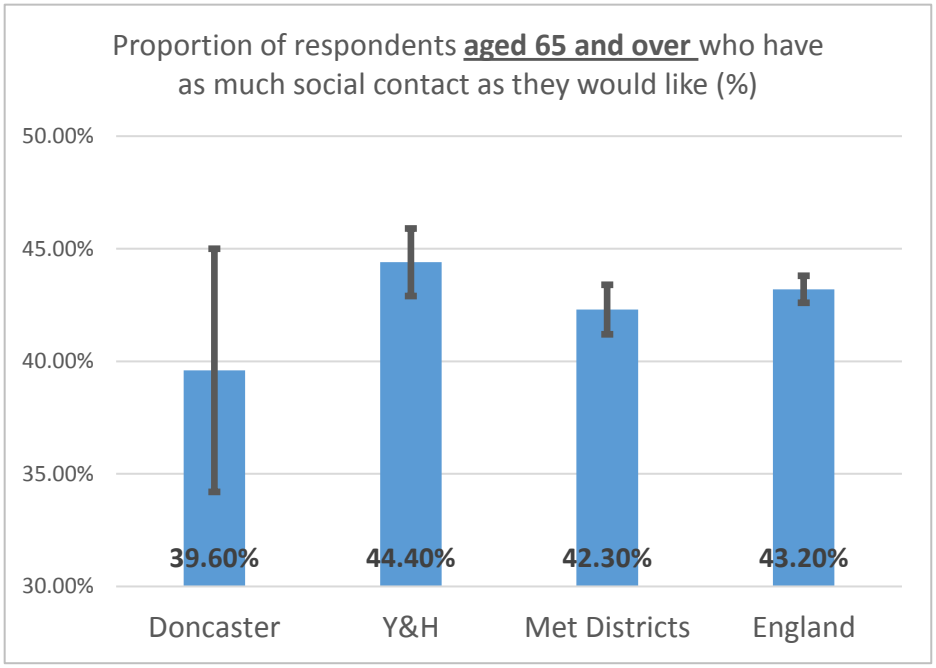
More people remain healthy and independent for longer with fewer people socially isolated

Tier 1 & 2 (Population Indicators - Doncaster Growing Together Framework)

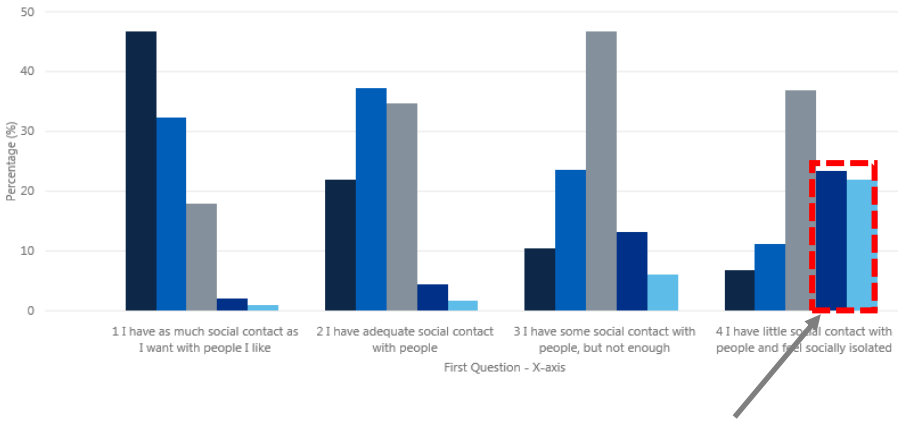
% of Social Care Users who have as much social care contact as they would like

DOT Benchmark





Perceptions: Social Isolation vs Quality of Life



The chart above demonstrate Doncaster respondents to the Adult user survey who have little social contact have much poorer perceptions of their quality of life.

What is the story

Key factors that are driving these population measures performance

Social isolation can result because of a variety of factors but common factors include bereavement, loss of mobility, poor living conditons and caring responbilities. With an ageing demographic and people living longer a number of these factors may impact on more people and for longer periods.

Over the next 3 years we predict that there will be an extra 1100 people in Doncaster aged 65+ living alone.

What is going well...

What is not going well....

Tier 3 (Service Performance Measures)

Performance Measure	Actual	Target	Status	DOT
% of Intermediate care that is not bed based	X	Y	R/A/G	
Impact of Intermediate Care on Quality of Life	X	Y	R/A/G	
TBC	X	Y	R/A/G	

What are we doing about this

Are service we provide performing well? If not why and what is planned?...

This page is intentionally left blank

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 15 March 2018

Subject: Director of Public Health Annual Report 2017

Presented by: Dr Rupert Suckling

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

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

How will this contribute to improving health and wellbeing in Doncaster?
The Director of Public Health annual report for 2017 was approved for publication by Doncaster Council at its January 2018 meeting. All the recommendations impact on health and wellbeing and the Board is asked to take action to address those recommendations within its control and work with other boards where the Health and Wellbeing Board's role is of a more supportive nature.

Recommendations
The Board is asked to:- NOTE the report, and AGREE the relevant actions to deliver against the recommendations.

This page is intentionally left blank

Doncaster Council

Agenda Item No. 9
Date: 15 March 2018

To the Chair and Members of the Health and Wellbeing Board

Director of Public Health Annual Report 2017

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Cllr Nigel Ball	All	No

EXECUTIVE SUMMARY

1. The 2017 Doncaster Director of Public Health Annual Report is the third authored by Dr Rupert Suckling and is the fifth since the transfer of the specialist public health function form the NHS to the council in April 2013.

   Whereas the 2015 report identified four challenges and then four building blocks for health and wellbeing locally, and the 2016 report demonstrated the impact of the council's public health team this report specifically focuses on the impact the wider council is having on public health.

   This report provides updates on progress against the four building blocks for good health and wellbeing as well as sharing a number of real life stories. This report advocates continued focus on the four building blocks but also proposes further work on a fifth building block. These are:

   - Give every child the best start in life
   - Make good growth our watchword for economic development
   - Improve healthy life expectancy through preventing disability
   - Tackle unfairness and health inequalities
   - Build a Sustainable and Resilient Borough

   This report was approved to be published by Doncaster Council on 25th January 2018.

EXEMPT REPORT

2. No

RECOMMENDATIONS

3. The Health and Wellbeing Board is asked to take ACTION on the relevant recommendations.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4. The publication of this report demonstrates the council's commitment to its leadership duties with regard to health improvement, health protection and health and social care quality.

BACKGROUND

5. The Director of Public Health (DPH) has a statutory duty to write a report on the health of the local population and the authority has a duty to publish it (section 73B (5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act). The content and structure of the report is something to be decided locally.

OPTIONS CONSIDERED

6. No other options considered.

REASONS FOR RECOMMENDED OPTION

7. The recommendation fulfils the Health and Wellbeing Board's duty to act on the published Director of Public Health annual report.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

8.

	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 health and wellbeing of the residents is central to developing a thriving and resilient economy. Adopting the principle of 'good growth' and the recommendations in the report will support this outcome. Addressing the building block of a sustainable and resilient borough could also add to this outcome.

	People live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	The health improvement and health protection duties of the council contribute directly to this outcome. Addressing the building block on preventing disability will support this outcome.
	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 improvement and health protection duties of the council contribute directly to this outcome. Adopting the building block of a sustainable and resilient borough could also add to this outcome.
	All families thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	The health improvement and health protection duties of the council contribute directly to this outcome. Addressing the building block on giving children the best start in life will support this outcome.
	Council services are modern and value for money.	Integrated evidence based partnership work to deliver the 5 building blocks will contribute to this outcome. This will be supported by taking into account the social value act
	Working with our partners we will provide strong leadership and governance.	Making progress on the challenges and then the recommendations highlighted in this report will require partnership working initially through the Children, Young People and Families Board, the Working element of Doncaster Growing Together and the Health and Wellbeing Board.

RISKS AND ASSUMPTIONS

9. There are no specific risks associated with this report.

LEGAL IMPLICATIONS

10. The Director of Public Health (DPH) has a statutory duty to write a report on the health of the local population and the authority has a duty to publish it (section 73B (5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act). The content and structure of the report is something to be decided locally.

FINANCIAL IMPLICATIONS

11. There are no specific financial implications with this report.

HUMAN RESOURCES IMPLICATIONS

12. There are no specific human resource implications with this report.

TECHNOLOGY IMPLICATIONS

13. There are no specific technology implications with this report.

EQUALITY IMPLICATIONS

14. This report continues to identify reducing health inequalities and addressing fairness as one of five building blocks for health and wellbeing. Health varies across the Borough and is associated with deprivation, with those living in the most affluent parts of the Borough perceiving, experiencing and having better health than those living in the less affluent parts of the Borough.

    Last year's report highlighted the importance of identifying issues and solutions to the health perceived and experienced by Black and Minority Ethnic (BME) populations. This report extends the approach further to identify and address differences in health, both perceived and experienced between men and women, with a focus on women's health.
    Any policy or strategy developed as a response to this report will require the local public bodies to demonstrate 'due regard' under section 149 of the Equality Act 2010: the Public Sector Equality Duty (PSED).

CONSULTATION

15. No formal consultation has taken place to contribute to this report.

BACKGROUND PAPERS

16. Director of Public Health Annual Report 2017.

REPORT AUTHOR & CONTRIBUTORS

Dr Rupert Suckling, Director of Public Health
01302 734010 rupert.suckling@doncaster.gov.uk

Dr Rupert Suckling
Director of Public Health

Health and Wellbeing: A Strength For Life

Director of Public Health annual report for Doncaster 2017

Doncaster Council

Contents

FOREWORD and Introduction

Welcome to my third Annual Report as Director of Public Health for Doncaster Council.

Winston Churchill famously said "Healthy citizens are the greatest asset any country can have" and that sentiment applies just as much to Doncaster as to any country. Whereas illness and ill-health can be seen as a cost to local people, a demand on local services and a burden on tax-payers, good health and wellbeing should be seen as a strength for life, a resource for living and something that's worth investing in. Throughout 2017 there has been steady progress against the four challenges I outlined last year:

- 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

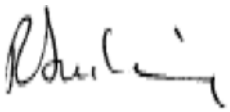
This report shows some of that progress and through real life stories gives a flavour of the sort of approaches that are working based on improved working relationships between individuals, families and communities, along with statutory services. However, the impact of these initiatives needs to be more systematically captured to ensure that we are making enough progress to impact health outcomes, which can take years to change.

It is still the case that the best predictor of good health is having a good job, or if your parents have/had a good job. So, as our main goal we need to make sure our watchword for economic development is 'good growth' that everyone can benefit from. The downside of 'bad growth' is that individuals and families can enter a downward spiral and make short-term decisions that exacerbate the situation they find themselves in. Increasingly we can view poor diet, lack of exercise, smoking and excessive alcohol use as a response to the situation people find themselves in and not merely a lifestyle choice.

The focus on children's health and wellbeing, particularly the first 1001 days of a child's life should allow impact to be measured quickly. There is still more to do to tackle unfairness and health inequalities. The work on Black and Minority Ethnic (BME) health is identifying barriers to accessing health service for new arrivals to Doncaster as well as looking at any difference in access to or outcomes from mental health treatment. However, this is only a small part of the picture, gender based health inequalities should be reviewed. Finally despite the progress made some of the gains appear fragile and I would suggest a fifth building block for health and wellbeing be added and that Doncaster should become a sustainable and resilient borough.

In compiling this report I am grateful for the help of a number of colleagues. In particular I would like to thank Claire Hewitt, Dr Nick Leigh-Hunt, Steve Betts, Steph Cunningham, Dr Victor Joseph, Susan Hampshaw and Dan Debenham for designing and contributing to the overall report. I would also like to thank those that supplied updates including Allan Wiltshire, Jon Gleek, Riana Nelson, Carrie Wardle, Lee Golze, Leanne Hornsby, Clare Henry, Shaun Ferron, Jonny Bucknall, Louise Robson, Kirsty Thorley, Richard Smith, Matt Cridge, Nick Germain, Andy Maddox, Jenny Holmes, Tracey Harwood, Steve Helps, Paul Tanney and Cllr Charlie Hogarth.

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 Council

THE HEALTH of Doncaster people

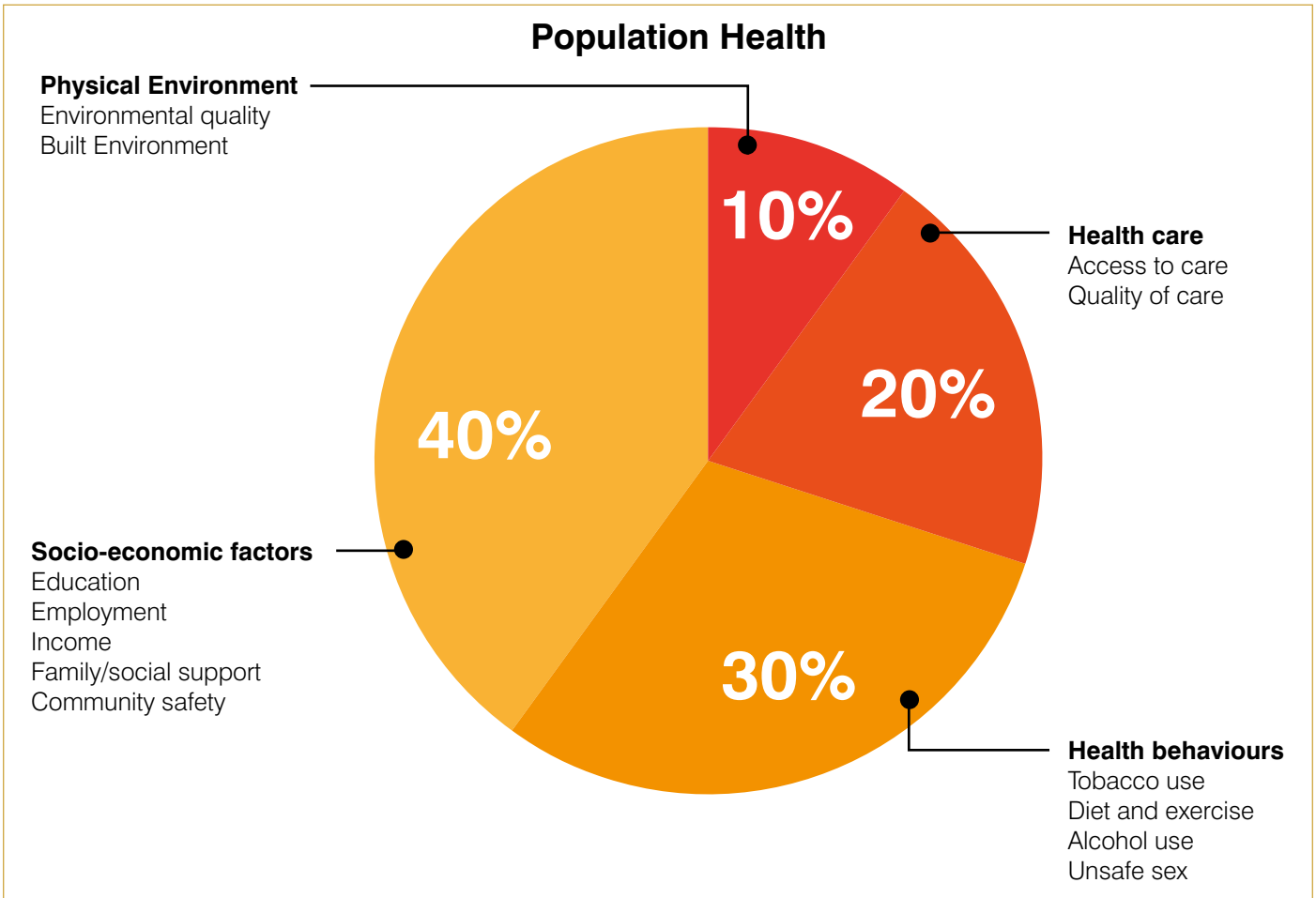
How healthy are we?

Health can be a difficult word to define. As individuals we can all describe times when we feel healthy, and equally, can all describe times when we feel unhealthy. When we try and describe the heath of the whole of Doncaster we often use length of life (life expectancy) or the number of deaths (mortality). Obviously both these measures are related. We also try and capture the quality of life of the population and use healthy life expectancy (years lived in good health) as a measure of this.

There is mixed news about how Doncaster is doing on both measures of health (length of life and the number of deaths). Although life expectancy is unchanged at 77.6 years for men and 81.6 years for women. It is good that Doncaster has not seen the fall in life expectancy that other parts of the UK have seen, however this average life expectancy measure may mask different impacts in different groups of the population. The number of deaths in people under the age of 75 is falling as mortality from heart disease and cancer continue to decrease. However, there is still more that could be done. Although falling, the deaths from heart disease and cancer are still higher than regional and national averages. The gap in life expectancy between the most affluent and the least affluent parts of Doncaster remain stubborn and persistent (8.9 year difference for men and 7.2 years for women). The length of time people can expect to live in good health in Doncaster is below national averages at 59.7 years for men and 61.0 years for women.

What makes us healthy?

There are a lot of factors that contribute to health and many of these factors accumulate over the course of our lives. Recent research has shown that many of these factors impact us through stress and the body's natural response to continuous stress. One of the best ways to describe the relative contribution of these factors to health is the Robert Wood Johnson Foundation work, estimating 20% of what makes us healthy is from medical services, 30% from behavioural factors (e.g. smoking), 40% from socio-economic factors (e.g. education) and 10% from the quality of our built environment including housing.



Source: Authors analysis and adaptation from the University of Wisconsin. Population Health Institute's County Health Rankings model (2010)

How is Doncaster doing on these causes?

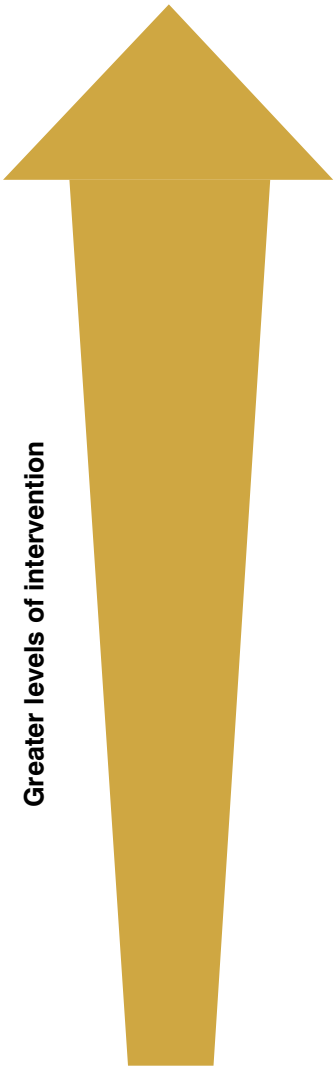
It is good news that Doncaster's economy is growing. However, the next challenge is to develop higher skilled, and therefore, higher paid jobs. In that way the benefits of economic growth will go to local people. Educational attainment is important too and the numbers of children ready for school at five-years-old has increased to 69%. Together, with the reduction in mothers smoking at the time of delivery to 12.9%, it is a step in the right direction to help every child to have the best start in life.

People could take more control of their own health and be supported more to do this. Almost a third of the population is inactive and only 50% of people are eating healthily. Smoking, although falling, is still a major risk factor and new risks including air pollution are being recognised and addressed.

Approaches to improving health

The council and its partners take two broad approaches to improving health. The first approach is to work with those people at highest risk of ill-health and the second is to support the whole population. In both cases a range of approaches from monitoring the situation, through to encouraging behaviour change (nudge) and finally considering legislation can be used. The choice of approach depends on local need, evidence of effective interventions, availability of resources, public perception and political priority.

The Nuffield Ladder



Eliminate Choice: regulate to eliminate

Restrict Choice: regulate to restrict the options available

Guide Choice through disincentives: use financial or other disincentives to influence people to not pursue certain activities

Guide Choice through incentives: use financial or other disincentives to guide people to pursue certain activities

Guide Choice through changing the default: make healthier choices the default option for people

Enable Choice: enable people to change their behaviours

Provide information: inform and educate people

Do nothing or simply monitor the current situation

BUILDING blocks for health

If we want a healthier, more prosperous Doncaster, we should continue to focus on four building blocks for health.

1. Give every child the best start in life
2. Make 'good growth' our watchword for economic development
3. Improve healthy life expectancy through preventing disability
4. Tackle unfairness and health inequalities

This section provides an update on progress over the last year against these recommendations.

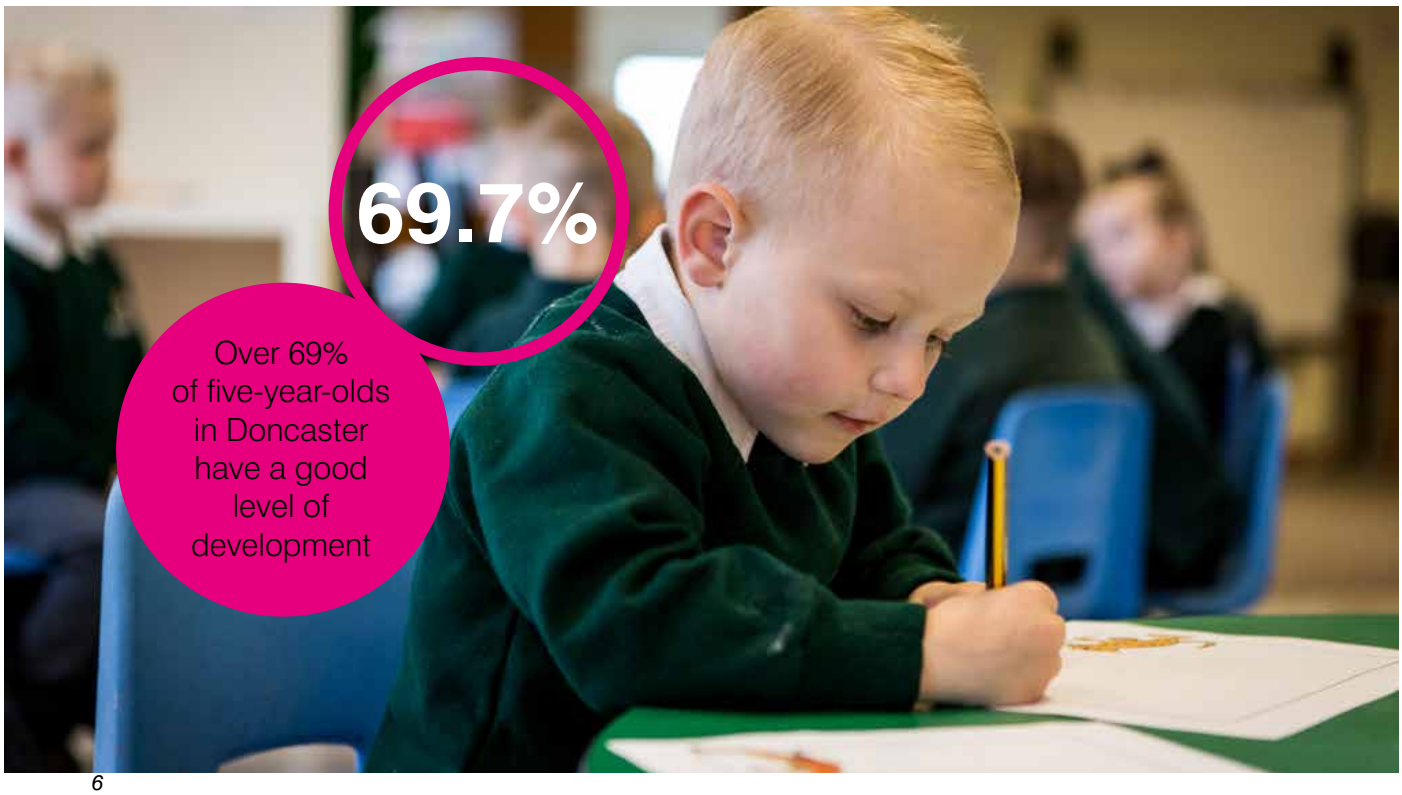
Give every child the best start in life

Last year five recommendations were made to give every child the best start in life and progress against those is reported below.

Continue to monitor the effectiveness of the Early Help Strategy

The Early Help Strategy has been updated. It now reflects a clear definition of early help and includes an understanding of our areas of strength with our areas for improvement. The strategy sets out the principles and approach for early help which is informing our conversations and commissioning intentions with partners (e.g. adoption of principles and working practice in the Starting Well Strategy, Raising Aspirations and Achievement). The early help approach has been embedded and as a result we know that:

- Contacts into the Referral and Response service that require an early help response is steadily decreasing
- 75% of all enquiries (6,628 of 8,835) into the early help hub are for children living in the 30% most deprived areas of Doncaster and 55% of enquiries are for children under 9-years-old
- Early help episodes have increased by 24% and average 442 per month
- There continues to be an increase in the number of open early help cases from 1100 in Q1 16/17 to 2052 in Q1 17/18, representing a 87% increase
- Data suggests that once children have been identified as having multiple or complex needs these are being assessed earlier, resulting in children and young people being supported with a trusted person as their lead practitioner
- There is evidence that the quality of assessments has also improved and audits show that 68% are judged as good or better
- Over 74% of cases closed by the Early Help Team Around the Child (TAC) have been sustained within universal services following closure



Focus on vulnerable mothers from pregnancy until the child is 2 ½ years old (the first 1001 days)

In April 2017, the Health Visiting Service launched an enhanced element to their service offer. The aim of this service element is to intervene at the earliest opportunity with vulnerable families, to offer an enhanced service that ensures that those families are prepared for parenthood and are able to parent effectively, ensuring the optimal health and development of their child.

The recently approved Doncaster Starting Well strategy sets out a partnership vision to develop a Doncaster-wide Starting Well (0-5) offer. It highlights the collective ambition to achieve better outcomes and develop a shared ambition for integrated leadership, commissioning and delivery. A key priority of the strategy is to drive a focus on the first 1001 days of a child's life.

Partners in Doncaster are exploring the potential to develop an 'accountable care system', focused on collaboration as opposed to competition. The first 1001 days has been chosen as an 'area of opportunity' in the first phase implementation of the Doncaster Place Plan.

Build on the national Future in Mind developments to address bullying and improve the mental health of school children

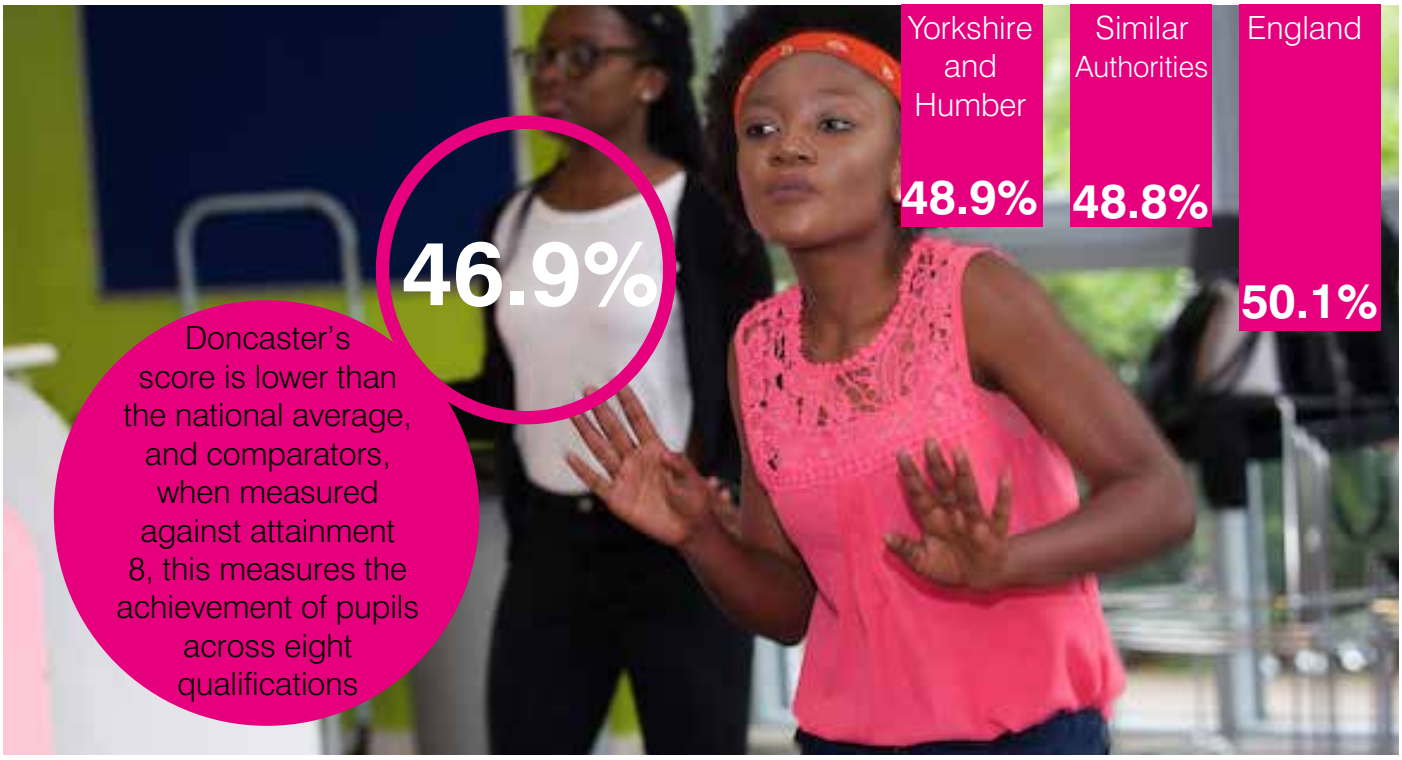
The Local Transformation Plan is the agreed approach to addressing these issues and an updated report was published in November 2017.

The new community eating disorder service continues to evolve and grow. There have been strong links built between 20 academies, colleges and Child and Adolescent Mental Health Services (CAMHS) to promote a more joined up way of working with great effect and there has been the development of a new schools, academies and colleges mental health competency framework, which is being piloted in 2017/18. Working with Young Minds, we now have 15 mental health participation champions who will be at the heart of shaping how we do things in the future.

Support schools to develop a Curriculum for Life

The Education and Skills programme recognises the importance of a broad and balanced curriculum that not only provides a rich educational experience for children and young people, but also seeks to build their levels of social and cultural capital, so that they can learn and increase their aspiration in a range of settings and contexts. The development of a project called '100 things to do before you're 11' which introduces a mutually agreed, guaranteed set of experiences for all children under the age of 11 in the borough, has helped bring this to life.

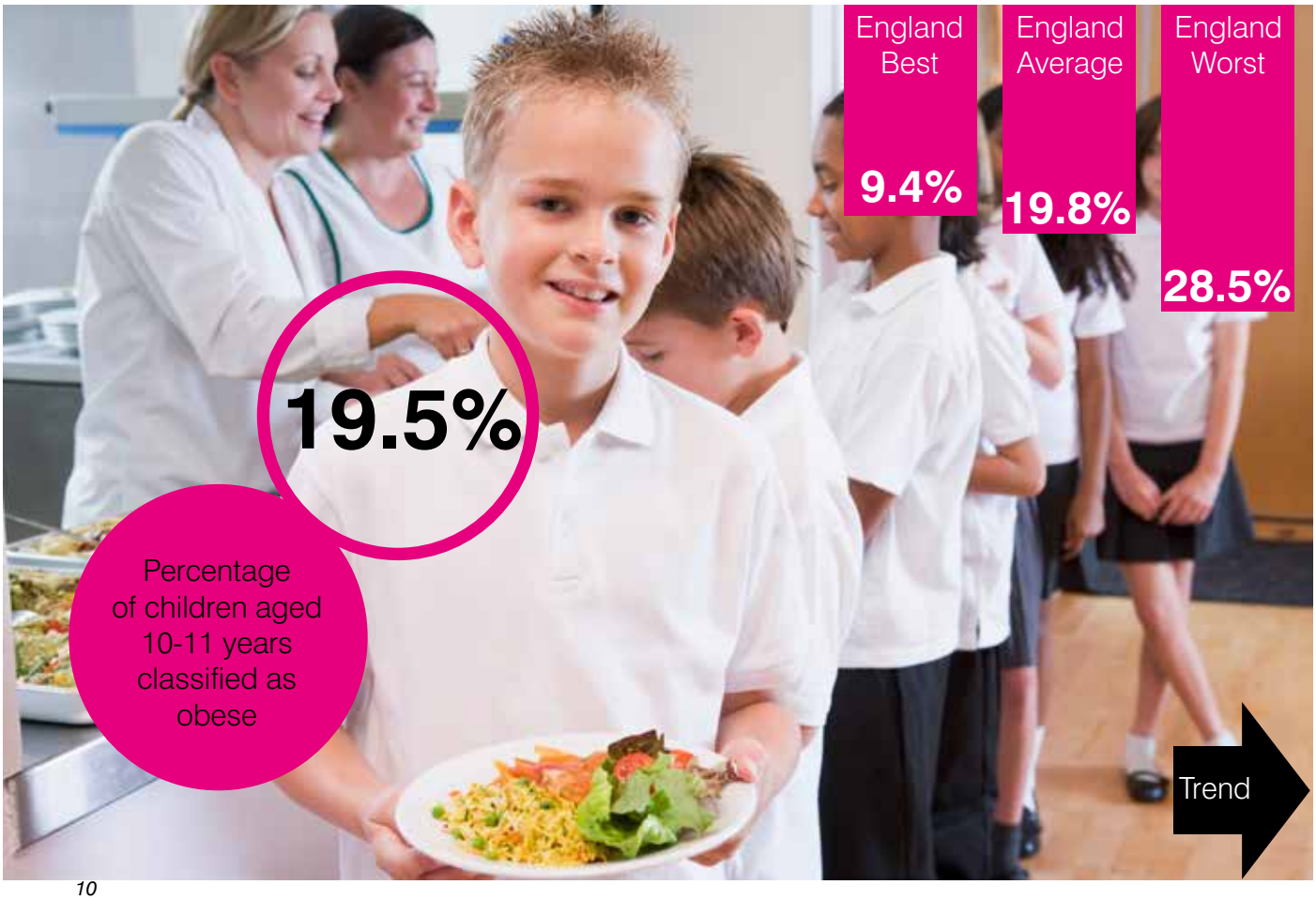
The expansion of the Doncaster Skills Academy over the next two years will ensure that young people in Doncaster meaningfully engage with employers and develop the skills necessary to meet their employment goals. Both of these strands are vital to the success of the Social Mobility Opportunity Area, which aims to improve social mobility for Doncaster children and young people by closing the gap in attainment between disadvantaged and non-disadvantaged children at primary school; improving the performance of the borough's secondary schools, helping Doncaster's young people to find the right academic and vocational routes to the careers they aspire to; and taking active steps to help the most vulnerable, to access opportunities that will support them in and out of education.



Support schools to increase physical activity in the curriculum

The Daily Mile programme could lead to an additional 20 minutes of physical activity in every Doncaster school each day, contributing to improved learning, behaviour and health. It is being promoted to all schools with the offer of support if required to help with implementation.

Monitoring is taking place to measure uptake and materials have been produced. Healthy Learning, Healthy Lives (HLHL) is the Doncaster health and wellbeing award scheme designed for schools, colleges and early years providers. Launched in January 2018, it provides free support and guidance to education settings, including a comprehensive website and an accreditation scheme that recognises work to increase and support health in education settings.



REAL life stories

St Leger Homes improving children's health and wellbeing

St Leger Homes rehouse approximately 1500 households each year into council homes which are affordable, have security of tenure and benefit from an effective management, repairs and maintenance service.

In addition to ensuring that homes are safe and warm, St Leger also contributes to the health and wellbeing of their residents and provides a range of budgeting advice and signposting to support agencies if required. The team has also developed pathways to address cases where complex needs have been identified which impact on a child's wellbeing including the Housing Assessment Panel, Vulnerable Person's panel and day to day collaborative working.

Recently, St Leger rehoused an applicant who was living in a one-bedroom flat. His nine-month-old child had been removed from his former partner's care and had been placed in a temporary foster placement. Working with the applicant and Doncaster Children's Services Trust (DCST), St Leger awarded social and welfare priority and rehoused the tenant into a house near to his family for support. This minimised the amount of time that his child was in care.
St Leger has also rehoused a number of other children where there has been intervention from DCST and have either prevented or reduced the length of time they have been in the care system.

Providing play areas to improve children's health and wellbeing

Doncaster Council Street Scene and Highways operations have supported improving children's health and wellbeing by providing fixed play area and sports facilities on parks and open spaces across Doncaster. The parks and open spaces are maintained to a high standard and a green flag award has recently been achieved as a result of the increased community involvement and work to improve the local environment. Free junior football facilities are also provided, these are popular and the sites are well used.

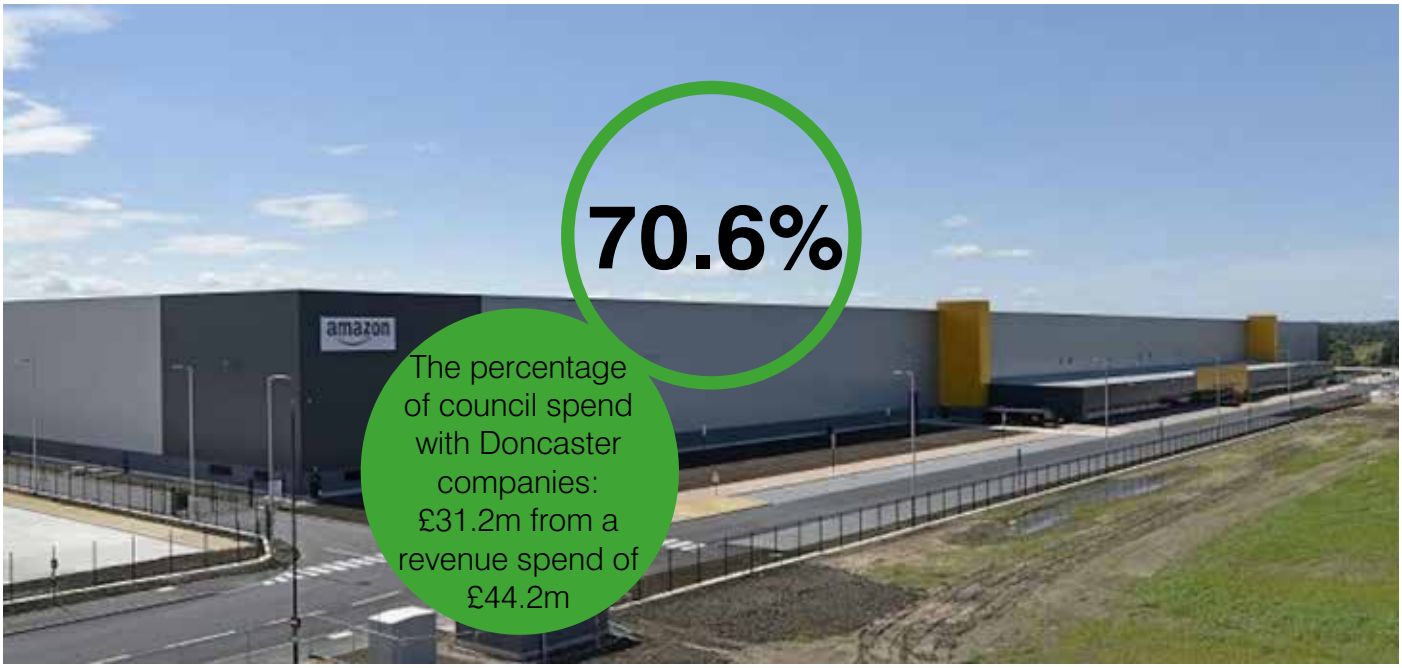
One particular example is the Sandall Park inclusive swing project. In 2017 Street Scene and the communities' team worked with the Friends of Sandall Park group to secure external funding for the installation of a Disability Discrimination Act (DDA) compliant access friendly swing for all children to enjoy.

Make ‘good growth’ our watchword for economic development

Last year five recommendations were made to make the link between health and work stronger and ensure that economic growth benefits everyone and progress against those is reported below.

Use the Social Value Act to maximise equitable employment opportunities when commissioning

The council has started work on the development of a Social Value strategy and revised procurement guidance which will be linked to the ‘Doncaster Growing Together’ strategy. The aim of the strategy and guidance will be to ensure a consistent approach to the delivery of social value and initiate discussion amongst commissioners as to how social value can be delivered across the council’s key policy areas.



Recommission the ‘work programme’ as part of the Sheffield City Region to help those furthest from the labour market find work and delivery of the Work and Health Unit trial

Led by the Sheffield City Region Executive, the Work and Health Programme is in the final stages of commissioning.

The tender scoring process was finalised and contracts were due to go live in autumn 2017. However, the funding for this programme from central government to the Sheffield City Region has been paused.

The Work and Health Unit trial is progressing well. South Yorkshire Housing Association has been awarded the contract to test the effectiveness of Individual Placement Support (IPS) to support people with less severe mental health problems and those with musculoskeletal problems into work. This new service will begin in early 2018.

Work to keep those with health issues in employment longer, improving health literacy and self management

The Workplace Wellbeing Programme continued to support local businesses to gain accreditation against the national Workplace Wellbeing Charter until it was withdrawn in late 2017. A new charter is being developed in partnership with other South Yorkshire local authorities to maintain momentum. In October the annual workplace health conference was held to support European Health and Safety Week.

The conference focussed on the ageing workforce with keynote speakers delivering presentations on topical issues such as musculoskeletal problems, carers and physical wellbeing.
A self-management programme proposal and mapping process is underway and is being shared with key partners. A number of options are currently being explored and recommendations on the way forward are being considered, as part of the Doncaster Place Plan.

Continue to help residents keep their homes warm by improving the energy efficiency of properties, ensuring access to welfare advice and helping residents find a cheaper energy tariff via Great North Energy

Great North Energy launched on 7 November 2017. In addition the council continues to work with the National Energy Action (NEA) to address fuel poverty through the 'Warm Homes' fund and with Doncaster Clinical Commissioning Group to fund 'Boilers on Prescription' through the Better Care Fund.

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

Loneliness and social isolation can be addressed through increasing the number of and strength of social networks. This can start in childhood, and can be sustained and built on in later life. The new Starting Well Service has begun operating with a focus on the first 1001 days and Children's Centres have been transformed into Family Hubs in line with the All Party Parliamentary Group report from late 2016. Stronger Families principles and practices are being transferred to the Complex Lives programme to support adults with multiple issues. Well Doncaster continues to join up community groups and organisations, local schools, the Family Hubs, primary care, social care and employment programmes. Aspects of the work have been extended to include Conisbrough, while maintaining a focus on Denaby Main.
A workshop in October 2017 helped develop plans for sustainable and inclusive growth in line with Doncaster Growing Together, drawing together Doncaster Council, Well North advisors and community organisations from Denaby, Edlington, Bentley and Stainforth.

Community organisations continue to be the basis for health and wellbeing in Doncaster communities. There has been an increase in both formal and informal activity to reduce the impact of loneliness locally involving established 'health' groups (e.g. MIND, the Alzheimer's Society, People Focussed Group and Age UK), established local organisations (including the Development Trusts, Parish Councils) or relative newcomers (e.g. Community Circles, b:Friend and Home Instead Senior Care). This is an increasingly complex area where more could be done to ensure local community organisations thrive and link with statutory sector approaches including social prescribing and Your Life Doncaster. New networks of organisations such as Expect Youth for children and young people could be adopted for adults.

REAL life stories

The World of Work academy programme

The World of Work (WOW) academy programme run by St Leger Homes offers a range of work related opportunities to tenants and their families. This includes training contracts such as work experience and a two-week work ready course in conjunction with Doncaster College.

Mark Redgrift is now a World of Work Handyman. He initially contacted WOW through his estate officer and requested more information. The WOW co-ordinator arranged to meet with Mark to discuss his barriers to employment, what his expectations were and what sort of employment he was seeking.

After discussing the possible options available to him, Mark completed a two-week customer service course with Doncaster College where he gained a full level 2 qualification in customer services and subsequently applied for the St Leger Homes temporary handy person vacancy that allows a candidate to earn while they learn. Mark hadn't experienced this type of work before and was excited to learn a new skill. He was also looking forward to the extra training he would receive such as IOSH working safely, manual handling and gaining his Construction Skills Certification Scheme card.

Mark said: "The scheme run by St Leger Homes gives me a lot of pride, especially when you finish a job and realise someone is going to move into that house and make it a home.

"You know that you are doing something positive. World of Work has helped open up my finances and we've been able to live properly as a family."

Manna counselling at Bentley Library

Manna counselling in Bentley Library offers clients a non-clinical, anonymous and accessible safe place to come to alongside other local services that serve the community. Bringing services together means easier access for clients and less travelling, which can sometimes be difficult when suffering from physical and mental illness. Supported by the Manna counsellor and local volunteers, a cancer support group meets at the library every Thursday mornings. The group is designed to bring people together to share their experiences, support one another and help combat loneliness and isolation.

As a result of the group, some people have found supporting others increases their self-confidence and self-esteem. Others find it helpful and easier to talk to the support group rather than with family or close friends as they don't feel the need to hide their feelings or emotions that they perceive may distress those close to them.

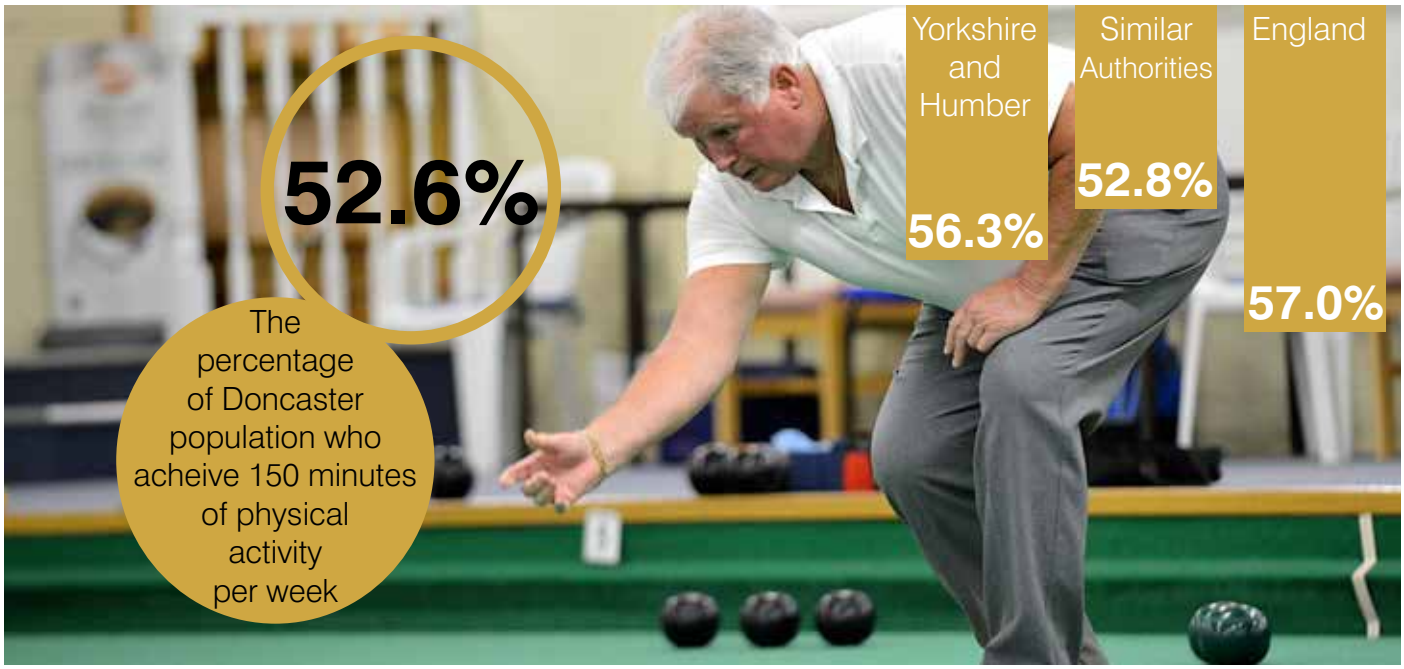
The library also supports the mental health and social isolation needs of the wider community by providing a place to meet others and volunteering opportunities, enabling individuals to gain skills in getting back to work, which in turn provide purpose in life and improve self-esteem and a positive outlook. All of these positive outcomes link together and provide the people of Bentley with a place to provide a great many of the services to meet their needs by a committed and integrated team.

Include preventative approaches in all patient pathways and clinical services

The Doncaster (health and care) Place Plan recognises the importance of prevention. In the six areas of opportunity identified for greater collaborative working (complex lives, intermediate care, starting well, vulnerable adolescents, unplanned and emergency care and dermatology) prevention will be explicitly addressed. This should focus on the behavioural risk factors that determine health and includes smoking, diet, physical activity and alcohol, through both universal approaches such as Making Every Contact Count and more targeted approaches like the National Diabetes Prevention Programme. Locally, the council is working with partners, the Local Government Association and the Design Council to revamp the approach to self-management.

Focus on the Get Doncaster Moving campaign to increase physical activity

Get Doncaster Moving is one of the transformational programmes of Doncaster Growing Together. The 10 year strategy will be launched in 2018 with the vision of 'healthy and vibrant communities through physical activity and sport'. It includes a focus on supporting the most inactive in Doncaster to get active using a number of approaches including cycling, walking, sport, dance and green spaces. Get Doncaster Moving will enable these improvements to be delivered more quickly and this will be further supported by the successful Sport England Local Delivery Pilot.



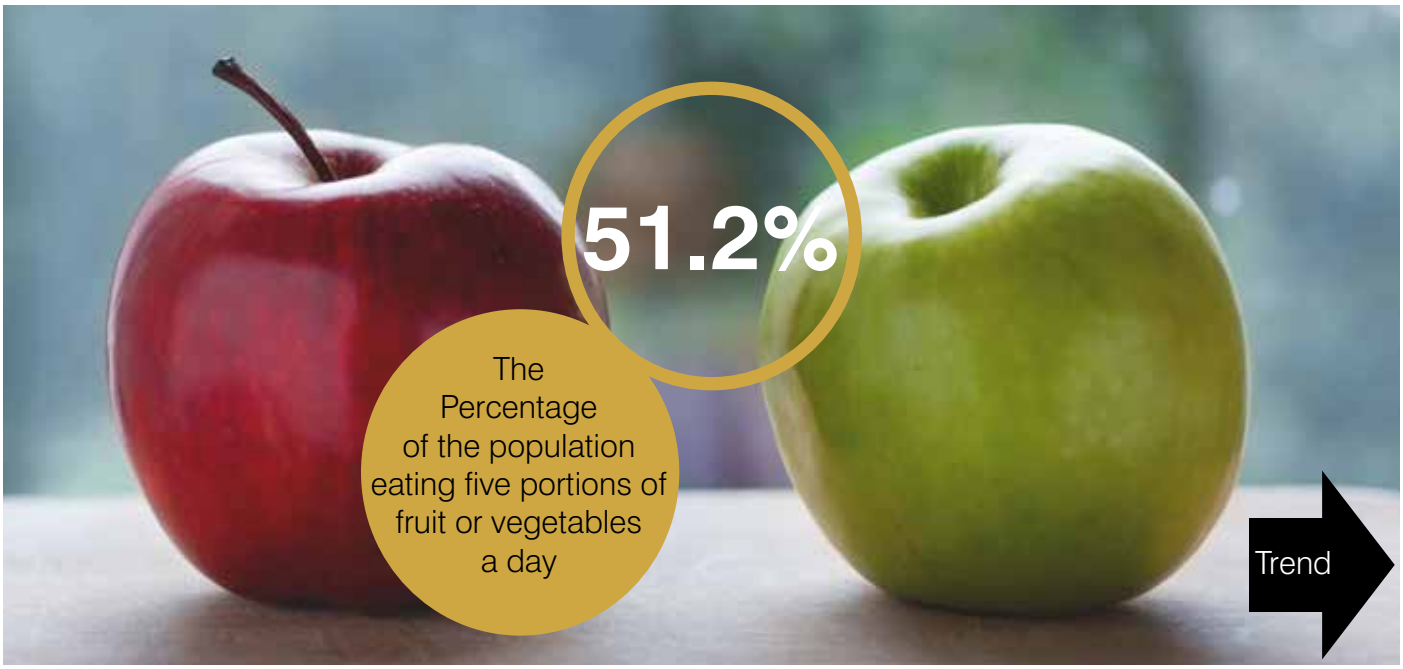
Include preventative approaches in all patient pathways and clinical services

A 'Food Hack' event held in June 2017 brought together a wide network of participants from Doncaster's food system and began the process of establishing a partnership of people interested in Doncaster's food future. Following this an external food partnership has been established which includes a range of members from the council, Health Watch Doncaster, Flourish Enterprises, and other charity/community organisations. This partnership will work on a range of initiatives around an action plan, including four key points on promoting physical and mental health. This partnership has recently been awarded 'Sustainable Food City' status.

A new council food strategy will include a focus on reducing diet-related ill health, and promote workplace wellbeing. The strategy will include existing documents such as those in public health and environmental health, but will also cover the wider approach to food in the borough and will look at five key points:

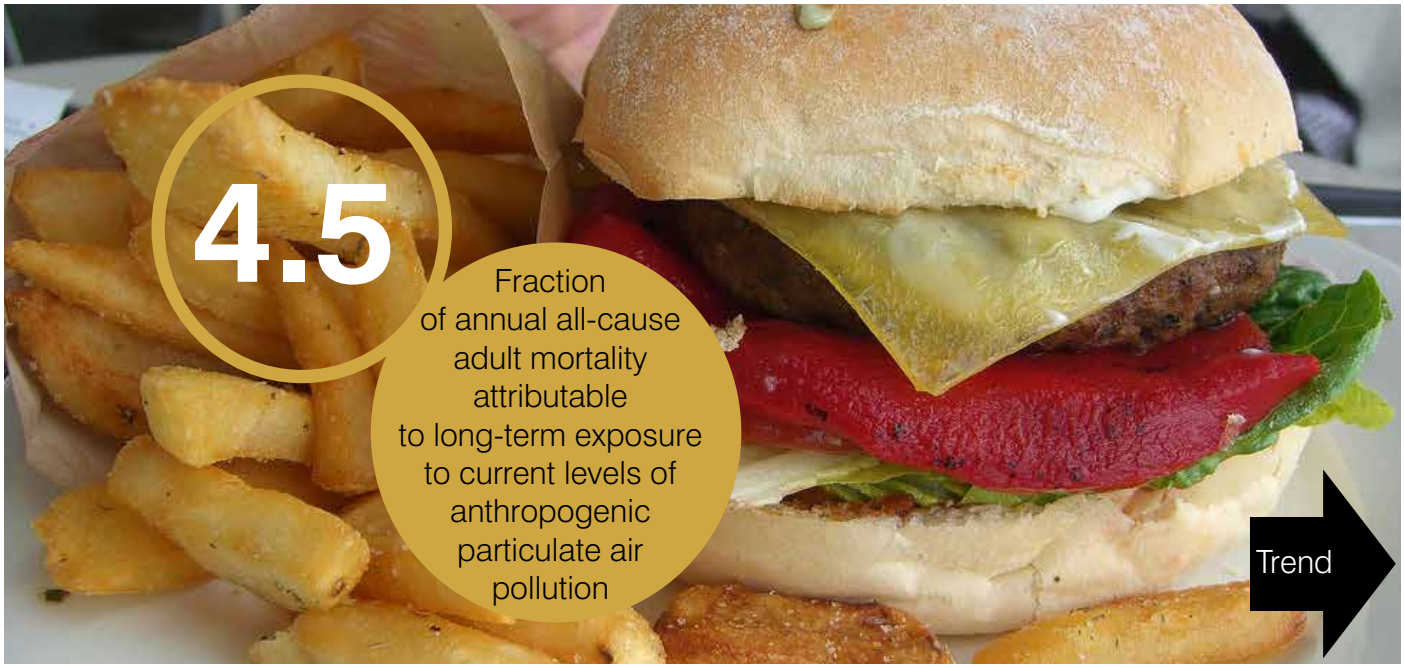
- addressing food insecurity in Doncaster
- promoting healthy food and lifestyles
- supporting local communities to eat well
- embedding healthy attitudes to food into the internal culture of the council
- boosting the role of food in the local economy

A food poverty alliance is also being set up to address food poverty, a leading cause of diet-related ill health and we are exploring the adoption of Sugar Smart in the borough.



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

A hot food takeaway review has been developed to provide evidence to support the consideration of health impacts for planning applications. There is the opportunity to include a policy in the developing Local Plan to restrict the proliferation of hot food takeaways and restrict the opening of them within the vicinity of secondary schools.



Evaluate local approaches with South Yorkshire Fire and Rescue (SYFR) to promote fire safety and address falls including enhanced home safety checks

A steering group supported by a variety of partners has resulted in SYFR delivering a Safe and Well service which includes advice and support relating to fire, crime safety, aging well and falls. The visits are focussed on the most vulnerable with referral pathways established for further support. In support of the introduction of the Safe and Well visits, SYFR has become an accredited centre for the delivery of the Royal Society of Public Health (RSPH) level 2 qualification in health improvement and over 100 staff across Doncaster have now received this training and qualification with other additional training scheduled for future dates.

The Safe and Well pilot was independently evaluated between Sept 2016 and March 2017, resulting in a number of recommendations. These recommendations are currently being reviewed and continued engagement with staff and partners within Doncaster is taking place in order to embed Safe and Well visits. Further partnership work has also taken place though initiatives including the 'To Save A Life' and the 'Fakes Cause Fires' campaigns. Adwick Fire Station at Quarry Lane, Woodlands, hosts a memory cafe as part of a new partnership between SYFR and the Alzheimer's Society. The events, held once each month on a Thursday afternoon, provide an opportunity for people living with dementia and their carers to meet in a safe, managed environment and to take part in activities to promote mental and physical wellbeing, such as games and health walks.

REAL life stories

Reducing preventable health conditions by removing illegal products

The Doncaster Trading Standards Service enforces the sale of tobacco, nicotine inhaling products, alcohol and solvents in line with national legislation. Between April 2016 and April 2017 the team successfully removed over 169,640 cigarettes and 54kg of hand rolling tobacco from premises across Doncaster.

The seized products are unacceptable for a number of reasons:

- They may not display the important health warnings about the dangers of smoking that help to deter people. There is clear evidence that the health warnings carried on tobacco packaging increases consumer knowledge about the health consequences of smoking, and helps to change consumer behaviour
- Some of the products are dangerous as they do not self-extinguish when not being smoked, this is a legal requirement that reduces the risk of deadly fires
- The low prices that illicit tobacco is sold for may encourage underage smoking.

With the changes in the laws around nicotine inhaling products the service has also made proactive inspections to ensure traders are aware of their obligations. Prior to the investment by Public Health in the Trading Standards Service, illicit tobacco and alcohol were on open sale within the borough. This is no longer the case and some businesses have been dissuaded from continued sales.

REAL life story

Reducing preventable health conditions by improving air quality

The Doncaster Council Pollution Control team has a duty to deliver actions across the council that improve air quality within an Air Quality Action Plan. As part of this, the team delivers a number of projects:

- Daily public air quality broadcasts on social media inform the public about the levels of air quality and provide advice during particularly poor episodes. This serves to potentially reduce the harmful effects on vulnerable individuals and the need to seek healthcare
- ECO stars- a heavy goods vehicle fleet emission reduction scheme that encourages cleaner fleet operations across Doncaster
- The Fuelling Change campaign aims to promote alternative fuels and addresses the uncertainty that surrounds them for both the public and local businesses. As part of the campaign Doncaster Council has an electric car available to promote and familiarise the public and council employees with electric vehicles.

Making the link between education, work and health at North Bridge

At the council's North Bridge depot, the Street Scene and Highways team has a number of Health Champions. Their role is to promote the benefits of healthy lifestyle choices, both in the workplace and at home.

The Health Champions initiative means that employees now have access to a wider range of information which has empowered them make to healthier choices and in the recent More Minutes initiative over 60 employees at North Bridge took part. On the day they received fruit and a free day's membership at a local gym.

As a result of the work of the Health Champions and the high level of engagement at North Bridge participation levels in future health campaigns are likely to increase further.

TACKLE unfairness and health inequalities

Last year six recommendations were made to tackle unfairness and health inequalities make the link between health and work stronger and ensure that economic growth benefits everyone. Progress against those is reported below.

Adopt a 'Health in all Policies' approach

A Sector Led Improvement peer review of the Public Health function was undertaken in 2017 and the council was commended for how embedded the function is following its transfer from the NHS in 2013. Health implications will be included in all corporate reports and the Health Impact Assessment process for major developments has been agreed. The Local Government Association delivered 'health training' open to all Doncaster elected members in May 2017.

Make a strategic shift to prevention through the Doncaster Place Plan

Prevention and demand management approaches are recognised across the six areas of opportunity in the health and care place plan (intermediate care, complex lives, first 1001 days, vulnerable adolescents, unplanned and emergency care and dermatology). Partners have commissioned 'Doncaster Talks' to understand what motivates local people in keeping themselves healthy and what the key barriers are. This approach will give more local insight into the drivers of behaviour and support future service planning.

Empower people and communities to take control of their own health and if services are required involve people in co-designing the services

The Community Engagement Framework sets out the importance of engaging people in decision making and acknowledging the different roles this can take, from information giving and consultation to co-production and citizen power. Further work on the strategy will set out how the council will approach the agreed policy statements:

- We will listen and understand
- Doncaster people will inform our policy and we will keep people informed
- We will be inclusive and act with purpose
- We will make the most of what already exists in communities and where possible increase community capacity

There is a key role residents and communities can, and are, playing in contributing to the achievement of our strategic priorities as set out in the Doncaster Growing Together prospectus.

Improve data capture, sharing and reporting so that services can become more seamless and based on insight to address inequalities in access and outcomes

A new vision for Business Intelligence in the council has been agreed, which puts evidence based decision making at its centre and reflects an intent to use a range of tools and techniques to inform our understanding of communities, people and how services are responding. This is being driven at a leadership level of the council where managers are being asked to consider their contributions as data owners, and how data can be better shared, mixed and interpreted to reach deeper insights.

Work is progressing to consider how to create an integrated intelligence function between the council and Doncaster Clinical Commissioning Group, this integrated approach could include gathering evidence and insight to support health and care integration.

At a strategic level, Team Doncaster launched the first ever State of the Borough assessment on 21 September 2017 alongside the Doncaster Growing Together strategy at Full Council. For the first time, this pulled together one strategic assessment of people and place, with measures taken from the Outcomes Framework.

This sits above, and complements existing assessments such as the Joint Strategic Needs Assessment, and will enable specific assessments to 'go deep' into any subsequent questions the strategic State of the Borough assessment prompts.

Report back on the health needs assessment for Black and Minority Ethnic (BME) Groups

Under the guidance of the Health and Wellbeing Board a number of actions have been progressed to further understand the health needs of Doncaster's BME populations. This BME needs assessment in 2017 identified two priority areas:

- The health of new migrants/arrivals
- The mental health needs of the BME population

A series of focus groups with sections of the BME community have taken place and the recommendations arising from these focus groups are being checked with participants. A method to look at the prevalence of health conditions in BME groups, their access into services, the completeness rates for treatment and the impact of treatment has been developed. The first health conditions being tested are depression and anxiety.

Continue to move beyond integration to population health systems and budgets

The Doncaster Place Plan sets out six 'areas of opportunities' where integration of service delivery should improve the quality of care, improve individual health and wellbeing and also reduce the required financial investment. Doncaster Council and the Clinical Commissioning Group are exploring the establishment of more formal joint commissioning approaches.

Successful integration should also demonstrate improvements in population outcomes and in time allow budgets to be allocated to agreed population segments and increasingly moved to focus on preventative approaches that contribute to reducing demand.

REAL life story

Reducing inequalities in health within Doncaster communities

The Green Space Network is a group of volunteers and partners co-ordinated by Street Scene and Highways operations. The network participates in regular voluntary projects such as litter picking, horticultural activities and fund raising. Tools, bin bags and hi-visibility clothing are supplied on request for volunteers to get involved.

As well as improving the environment for others, taking part in the network actively encourages a healthier lifestyle and an increase in health and well-being as a result of using Doncaster's outdoor spaces. This 'health by stealth' approach reduces the inequalities across communities and the number of volunteers supporting the network continues to grow across the borough.

CONCLUSIONS and recommendations

I hope you can see that despite on-going reductions and changes in public service finances there are still examples of innovative and impactful approaches that improve and protect the health of Doncaster people. As the real life stories indicate these approaches arise from within local communities, or jointly with the council and partners. The best of these approaches are where the state is 'an extension of the community' not 'a replacement for the community'. These gains are hard won, yet given the current financial situation are fragile and could be lost. The impact of these initiatives needs to be more systematically captured to ensure that we are making enough progress to impact health outcomes which can take years to change. I have revised the wording of two of the building blocks and whilst the four building blocks are still relevant and need continued focus an additional focus should be brought on sustainability and resilience.

Recommendations for 2018

1. Give every child the best start in life

I am pleased with the progress on implementing the early help strategy, the focus on the first 1001 days of a child's life and developments in schools focussing on mental health, physical activity and a curriculum for life.

I would like to see this focus continue but would also like partners to consider the potential impact of Adverse Childhood Experiences on Doncaster children and their families and what might be done to prevent these avoidable experiences.

I expect Doncaster's Children, Young People and Families Board to take this recommendation forward.

2. Make good growth our watchword for economic development

Local social value approaches together with adoption of the minimum wage are starting to benefit Doncaster people. The establishment of Great North Energy and cheaper energy tariffs should be good for local people too. The delay in recommissioning the work programme across the Sheffield City Region is disappointing, but we must take advantage of the trial of Individual Placement Support to show how local involvement in work and health can have similar impacts to the local involvement with work and skills. Workplaces should be a key place for health improvement and health protection and we must not be out off by national decisions on the workplace charter.

Community organisations are contributing to wider community development and their part in the foundational economy needs to be emphasised as part of 'good growth'. Collectively these approaches signal a strengths based approach which must support vibrant and thriving communities. I expect Doncaster Growing Together and the work theme in particular to take this forward.

3. Improve healthy life expectancy through preventing disability

A good start has been made by Get Doncaster Moving and Delicious Doncaster, however, now is the time to accelerate these approaches. The importance of the local plan together with good local intelligence to support healthy streets and environments is becoming more important following recent debates nationally and locally about hot-food takeaways and gambling premises. The development of the safe and well checks by SYFR is a good news story but does highlight the need to make sure tobacco control and substance misuse programmes are being implemented as effectively as possible.

There is still further work to do to place the work on improving air quality at the heart of planning and development as opposed to being on the periphery.

I expect Doncaster's Health and Wellbeing Board to take this forward.

4. Tackle unfairness and health inequalities

Embedding the health in all policies approach should reduce unfairness and tackle inequalities. The council should consider a Local Government Association facilitated Sector Led Improvement self-assessment later in the year. Community engagement, development and capacity building should be a focus for all partners in order to deliver the aspirations of Doncaster Growing Together. Collection and sharing of data should be reviewed in light of the new General Data Protection Regulations and the new Borough Strategy. The learning from the BME health needs assessment and subsequent work should inform approaches to other dimensions of health inequality starting with gender.

Fairness by itself is not enough and Doncaster should look at becoming as inclusive as possible and translate it's strengths in logistics and connectivity for business to connectivity and inclusion for local people and communities. I expect Doncaster's Health and Wellbeing Board to take this forward.

Build a sustainable and resilient borough

Doncaster, its people and the place, has responded well to a wide variety of challenges and changes in its recent past. However, Doncaster should explore the possibility of 'future-proofing' itself from future environmental, social and economic changes. Protecting the borough from poverty should be as much of a public health priority as protecting it from polio. Doncaster Growing Together provides a good basis for drawing together interdependent change programmes for the medium term and should help prevent unintended consequences or perverse outcomes from these multiple change programmes. However longer term planning along the lines of the United Nations Sustainable Development Goals for 2030 is much weaker. Whilst some individual programmes exist (e.g. reducing the likelihood and impact of flooding, or resilient design), there are obvious gaps where there is either no obvious approach or the approach is too short term.

The work on the new local plan describing a vision and a framework for the future development of Doncaster, addressing needs and opportunities in relation to housing, the economy, community facilities and infrastructure – as well as a basis for safeguarding the environment, adapting to climate change and securing good design will be increasingly important, as well as how the local plan fits with developing neighbourhood plans. There may be benefits in a collective approach to addressing physical, social and economic challenges and this could be based on long term health and/or economic scenarios. In the first instance NHS partners should review and update their Sustainable Development Management Plans, local supply chains should be reviewed and the South Yorkshire Passenger Transport Executive should work with local councils to increase sustainable transport and active travel.

I expect to develop some proposals and solutions to this in 2018.

REFERENCES

Doncaster Growing Together - www.doncaster.gov.uk/services/the-council-democracy/doncaster-growing-together

Early Help Strategy - www.doncaster.gov.uk/services/schools/early-help-what-is-it-in-doncaster

Local Transformation Plan - www.doncasterccg.nhs.uk/wp-content/uploads/2017/11/Doncaster-LTP-2017-20-updated.pdf

Place Plan - www.doncasterccg.nhs.uk/wp-content/uploads/2016/10/Doncaster-Place-Plan.pdf

Starting Well Strategy - www.teamdoncaster.org.uk/ChildrenFamilies

We're keen to hear your views and feedback on this report.
Please get in touch at:
Director of Public Health
Doncaster Council
Civic Office
Waterdale
Doncaster
DN1 3BU
Email: PublicHealthEnquiries@doncaster.gov.uk
Twitter: @Doncaster_PH
www.doncaster.gov.uk

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 15th March, 2018

Subject: Better Care Fund (BCF) – Use of Earmarked Reserve

Presented by: Dr R Suckling

Purpose of bringing this report to the Board	
Decision	
Recommendation to Full Council	
Endorsement	X
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		No
Finance		Yes
Legal		Yes
Equalities		Yes
Other Implications (please list)		No

How will this contribute to improving health and wellbeing in Doncaster?
The Doncaster Place Plan is the strategic driver for the integration of a wide range of health and social care services across the public, private and community and voluntary sector. The BCF is being utilised to deliver the Doncaster Place Plan.

Recommendations
The Board is asked to:- Consider the BCF spend plan and provide comments, prior to the report being considered at Cabinet on 27th March, 2018.

This page is intentionally left blank

Doncaster Council

Report

Agenda Item No. 10b
Date: 15th March, 2018

To the Chair and Members of Doncaster Health and Wellbeing Board

BETTER CARE FUND (BCF) – USE OF EARMARKED RESERVE

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Rachael Blake Nigel Ball Nuala Fennelly	All	Yes

EXECUTIVE SUMMARY

1. The Doncaster Place Plan is the strategic driver for the integration of a wide range of Health and Social Care services across the public, private and community and voluntary sector. It sets an ambitious agenda for reform, integration and delivery, with a strong focus on creating a person centred, whole system, increasingly preventive and localised health and social care system. This is a major undertaking and an urgent one. The aim of the plan is to respond to demand and funding pressures in health and social care, but with a laser like focus on improving user experiences, life chances and outcomes for Doncaster people.

2. Local health and care partners have developed the plan to address the three major challenges of the health and wellbeing gap, the quality gap and the finance gap. The joint vision is:

   Care and support will be tailored to community strengths to help Doncaster residents to maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed

3. The overall aim of the plan is to create more targeted and programmed arrangements for joint commissioning and collaborative delivery to secure integrated delivery of health and social care. This is especially focused on a number of key transition points in people's lives where joined up investment and delivery is needed most – referred to as 'Areas of Opportunity'.

4. The strategic context for Better Care Fund (BCF) investment is now the Doncaster Place Plan. The BCF is one of the most ambitious programmes ever introduced across the NHS and local government. The BCF encourages integration by requiring CCGs and local authorities to enter into pooled

budget arrangements and agree integrated spending plans, which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

5. This is being supported by the development of the wider adoption of joint commissioning, as indicated by the recent Cabinet agreement of Memorandum of Understanding between the Council and DCCG. Work is currently under way to develop this into a Joint Commissioning Agreement, for specific consideration early in 2018/19.

6. The report details the spending plan for the joint BCF non recurrent earmarked reserve of circa. £8.5m and sets out the joint decision making governance with the Doncaster Clinical Commissioning Group (DCCG). The report is due to be considered by Cabinet on 27th March, 2018 and will seek approval to draw down the balances for 2017/18, agree the plan for future years and delegate decision making arrangements.

EXEMPT REPORT

7. The report does not contain any exempt information.

RECOMMENDATIONS

8. The Board is asked to consider the non-recurring BCF spend plan (earmarked reserve) and provide comments. Cabinet will be asked to approve:
    i. The spending plan for the non-recurring BCF earmarked reserve as set out in the report; and
    ii. Delegate detailed spending decisions for the implementation of the Doncaster Place Plan £3m, other Integrated Functions £0.777m and unallocated balance £0.672m, to the Director of People in consultation with the Chief Finance Officer and relevant Portfolio Holder.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

9. The future joint commissioning arrangements will contribute to improved health and wellbeing for Doncaster residents. Doncaster residents should expect to be supported to maintain their independence as long as possible and also see a more integrated seamless response from health and care partners should they require services.

BACKGROUND

10. Previous years health and social care grant funding, which became the Better Care Fund (BCF), was agreed to be carried forward to support the joint transformation and integration agenda. The fund was agreed to be carried forward within the Council's earmarked reserves and, although it does not formally form part of the formal BCF Pooled Funding Agreement, it is jointly managed between the Council and DCCG. At 1st April 2017 the balance was £8.52m. The table below sets out the latest spending plan with estimated allocations from 2017/18 to 2020/21.

Workstreams	Plan £000s	Forecast Spend Plan 2017/18 £'000s	2018/19 £'000s	2019/20 £'000s
Schemes confirmed and approved:				
RDASH/SYH - residential contract variation	500	293	207	
Doncaster People Focussed Group	46	46		
Schemes confirmed requiring approval:				
RDASH/SYH - residential contract variation	134	134		
Integrated Functions - £1.5m total planned spend:				
Transformation Director (incl. temp cover)	293	74	114	105
CYP areas of opportunity development support extension	40	tbc		
Legal advice	40	35	5	
Complex Lives	150		75	75
Innovation Partner	200	25 tbc	125	50
Other Integrated Functions	777		tbc	
Customer Insight	140	140		
Place Plan:				
Intermediate Care - transformation & service re-design	840		840	
Allocation for other areas of opportunity	3,000		tbc	tbc
Integrated Digital	328	tbc		
Delayed Transfers of Care - capacity in Steps, Home 1st and Positive Steps Unit	194		164	30
Healthtrax	50	50		
Balance Remaining	**1,788**			
Schemes pending confirmation				
Provider Alliance Development	20		20	
Healthy Homes	642		321	321
Workforce Development - care homes	454	tbc		
Development Workshops				
Balance Remaining	**672**			

Further work is required on the schemes pending final confirmation, specifically Healthy Homes and Workforce development. The fund will be managed flexibly and spend on specific initiatives will be monitored and varied where required in accordance with the Joint Commissioning Governance detailed in the report.

11. As Cabinet is aware, the Government's ambition, facilitated through the BCF, is to establish integrated health and social care across the country by 2020. We have formally agreed a joint BCF plan with the DHSC and MHCLG in October 2017 (for 2017/18 and 2018/19). 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.

12. **Integrated Functions** – the Council and CCG have agreed that non-recurrent BCF of £1.5m would be needed for transformation and transitional costs such as 'dual running' in developing the integrated functions. The funding has been allocated as follows:
    a. **Director of Transformation including temporary support** – the Health & Social Care System Transformation Governance Group has recognised the need for transformation capacity, to take forward the Areas of Opportunity across health and social care commissioners

and providers in Doncaster. Transformation capacity has been provided by Ernst & Young and this came to end in October 2017. A Director of Transformation has been appointed, starting in post on 26 February as a 2 year fixed term post to drive delivery of the plans created by Doncaster partners with Ernst & Young. Elements of the post have been covered on a temporary basis for approximately 6 months to make sure that progress is made during recruitment and as the new Director settles in.

b. **Innovation Partner** – The Doncaster Place Plan is at the heart of the "Doncaster Caring" theme of the ambitions reforms of Doncaster Growing Together, the four year borough strategy focussing on key reforms for the borough. With the step change in public service reform comes the opportunity to bring forward innovative approaches to tackling to complex societal problems and Team Doncaster is seeking an innovation partner to support this. Some areas of work, namely associated with the Caring Theme and Learning Theme, have benefited enormously from a range of innovation and design partners who have brought new ways of working and modern methods to the table. These include:

    - Co:Create
    - The Design Council
    - Eclipse Experience
    - The Innovation Unit
    - The Open Data Institute
    - UsCreates

    Each of the contracted or partnership work so far has had an element of training and capacity building within it to ensure that Doncaster staff are upskilled in different approaches. We are seeking an innovation and insight partnership to provide challenge and support to Team Doncaster services and organisations by bringing on board innovation frameworks and modern methods to support the public service reforms in Doncaster Growing Together.

c. **Complex Lives Staffing** – to fund the Sex Worker Support Service from 1 April 2018 for two years to 31 March 2020 to secure existing roles and maintain continuance of the service. This work is integral to the integrated work across health and other partners and significantly contributes to the place plan priorities, Complex Lives in particular and links directly to early intervention to reduce non-elective admissions and will benefit from the support of the established Complex Lives Alliance partnership delivery model.

d. **Other Integrated Functions** – £777k will spent on other costs associated with integrating Council and DCCG functions; this will include infrastructure set up, development work and new roles, such as Project Mangers. The investment is required at the point of change, i.e. Programme establishment costs, in order to make future savings. The money is not for funding core services. Detailed business cases will be produced to support the investment, providing sufficient information for the decision; clearly identifying the benefits, any future savings that will be generated from the investment and explaining the costs to be incurred. The funding will be drawn down as required to progress integration over a number of years until the funding is exhausted. It is proposed that the specific details on how this funding will be spent i.e. whether the expenditure will be incurred

on infrastructure or additional temporary posts, will be delegated to the Director of People in consultation with the Chief Financial Officer and relevant portfolio holder, following joint agreement between the Council and DCCG (detailed below under Joint Commissioning Governance).

13. **Customer Insight** – Doncaster Talks. The Doncaster Place Plan describes our joint focus over the next five years, building upon the existing body of work and local plans already in place. In line with the five year forward view, the aim is to further develop out of hospital services and to foster community resilience, so that we can better support people and families, provide services closer to home and reduce demand for hospital services. Early help & prevention has been identified as one of the key areas of focus on as a partnership in the borough. At the core of this is a shift towards more intensive and all age locality based working and the idea of there being 4 key hubs in the borough around which activity is organised.

    The neighbourhood model to be developed should be supported by localised, system commissioning; this means service design being support by insight, and analysis of the ambitions, outcomes and needs of the different localities. This will allow for greater targeted resource in the right area at the right time, which in turn will result in qualitative benefits for residents and reduced demand on inappropriate secondary services.

14. **Doncaster Place Plan Areas of Opportunity** – During 2016, work accelerated around the Doncaster Place Plan, which describes the vision for and proposes the future state of health and social care services in Doncaster. The Doncaster Place Plan aims to address the three major challenges of the health and wellbeing gap, the quality gap and the finance gap, through the integration of a wide range of Health and Social Care services across the public, private and community and voluntary sector. It includes the following areas of opportunity:

    a. Starting Well – aiming to drive further integration in commissioning and delivery of support health and social care support for children and families, with an initial focus on the 'first 1001 days' through pregnancy up to age 2;

    b. Vulnerable Adolescents – aiming to drive further integration in commissioning and delivery of support for young people at risk of poor outcomes in their adolescent years. This will include a specific initial focus on prevention of young people needing tier 4 services, including issues around mental health and drugs and alcohol;

    c. Complex Lives – focused on people whose lives are affected by a combination of homelessness, rough sleeping, drug and alcohol addiction, mental ill health, poor physical health – often connected to childhood trauma or other major life events;

    d. Intermediate Care – focused on promoting faster recovery from illness, preventing unnecessary acute admissions and premature admission to long term residential care, and supporting timely discharge from hospital – with a focus on maximising independent living;

    e. Urgent & Emergency Care – focused on helping people who need urgent care to get the right advice in the right place, first time and ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities. This involves strengthening connections between all urgent and

emergency care services;

f. Dermatology – focused on a change in delivery setting for some dermatology services from acute to community where it is safe to do so. This will test a key dimension of the Place Plan approach, which can both deliver more preventive, accessible services to residents and offer transferable lessons to other areas of opportunity;

g. Learning Disability – focused on improving independence and quality of life for people with learning disabilities. Within this there are a number of crucial transition points which can determine outcomes and demand and costs on the system – notably the transition from childhood to adult services.

15. £3.8m has been earmarked in the non-recurrent Better Care Fund to deliver the ambitions of the Doncaster Place Plan (detailed above). This will provide vital funding and cover all spans of ages from maternity care to support for people in their older years.

    a. **Overall Doncaster Place Plan (£3.0m)** – This will be drawn down as and when required to deliver the Doncaster Place Plan vision over a number of years until the funding is exhausted. Types of expenditure items will include providing additional capacity 'fire power' needed, piloting new approaches to service delivery, any dual running of services required to achieve transformation. It is proposed that the specific details on how this funding will be spent i.e. whether the expenditure will be incurred on dual running in a particular area of opportunity e.g. providing additional accommodation in the relation to complex lives or building a team around the area of opportunity to drive the delivery and inject a quicker pace, will be delegated to the Director of People in consultation with the Chief Financial Officer and relevant portfolio holder, following joint agreement between the Council and DCCG (detailed below under Joint Commissioning Governance). Again detailed business cases will be produced to support the investment, providing sufficient information for the decision; clearly identifying the benefits, any future savings that will be generated from the investment and explaining the costs to be incurred.

    b. **Intermediate Care (£0.8m)** – Rapid Response Pathway and Community Intermediate Care – extension of funding for a further 12 months to facilitate further transformation of intermediate care and wider system redesign as part of Doncaster Place Plan. This builds on the initial business case approved in October 2016 and funded from BCF. It will:

        - Facilitate the ongoing transformation of intermediate care services, delivery of the Doncaster place plan and the Doncaster Caring Together outcomes framework.
        - Enable the test projects to further evolve into new ways of working, achieve further efficiencies and sustainability and further improved patient experience and quality of care.
        - Allow for double running and further testing while the redesign of the bed base continues and resource can be released to fund recurrent costs in community intermediate care.

16. **RDaSH residential contract variation** – the contract with RDaSH to sustain the residential care services they provide for people with learning disabilities and to enable a service review process. This was taken as a separate Cabinet report and was agreed on 7th November, 2017. Since then it has been clarified that this value requires increasing to take into account additional CCG costs. These total £134k and are also proposed to be funded from the non-recurrent BCF in 2017/18.

17. **Integrated Digital Care Record** - A project to develop a proof of concept for an integrated Digital Care Record (iDCR) for Doncaster health and care services is already underway. The project aims to develop a shared record for a key pathway within Intermediate Care initially joining up client records across five health and social care systems in order to serve as a proof of concept for the development of a full iDCR for Doncaster in the future. Context and case for change:
There is a national requirement for all Health and Social Care records to be digital, real-time and interoperable by 2020 (Personalised Health and Social Care 2020) and Doncaster's Local Digital Roadmap outlines how local health and social care partners will work together to achieve this. "Our vision for the health and care community of Doncaster is to join up information across care pathways and settings so that health and care practitioners have easy access to all the information they need to provide high quality, safe and effective services. IT services will be interoperable to allow practitioners access to information in all care settings." Page 5. Doncaster Local Digital Roadmap- June 2016. Joining up electronic care record systems is also a key enabler for delivery the Doncaster place plan and the 'Doncaster Caring' domain of the Mayor's strategy for the borough (Growing Together).

18. **Delayed Transfer of Care (DToC)** - there has been a significant increase in the number of delayed hospital discharge days over the past year for social care. One of the main reasons for the increase in delayed discharges is due to 'waiting for a care package' which at present can range from 16 to 20 days. These care package delays are also causing a bottle neck within the short term enablement service 'steps' as an increasing number people are waiting in excess of 6 weeks to transfer over to mainstream domiciliary services.
Current practice is undoubtedly having a knock on effect on patient flow across the hospital system as Steps are often blocked and often have to refuse referrals coming direct from the hospital. When looking at the issues presented, some of these challenges have come about as a result of the changes introduced in 2016 when the Council entered into a new 10 year domiciliary care contract with 4 Strategic Lead Providers (SLP's) and whilst these Lead Providers are continuing to build their capacity it is anticipated that it will take up to 12 months before the services are fully able to respond the proposal was to put in place an interim 12 month bridging arrangement within STEP's, which will allow them to pick up any outstanding domiciliary care packages in the first instance until the SLP's have capacity to take them over.

19. **Healthtrax** – DMBC and Doncaster CCG have worked collaboratively on a joint pilot of healthtrak, a business intelligence and decision support tool that integrates and analyses data from health and social care and presents it via interactive and intuitive on-line dashboards. The healthtrak solution enables the partnership to integrate health and social care data. The new contract was essential for the partnership to retain access to key business intelligence from integrated health and social care data. The partnership has made a considerable investment into the Healthtrak project.

20. **Other Joint Transformation and Integration requirements** – to remain flexible £672k is to be retained for potential bids to further progress joint transformation. This will be allocated following the production of a detailed business case which justify why the investment is required and clearly sets out the implications. It is proposed that the specific details on how this funding will be spent will be delegated to the Director of People in consultation with the Chief Financial Officer and relevant portfolio holder, following joint agreement between the Council and DCCG (detailed below under Joint Commissioning Governance).

Joint Commissioning Governance

21. There are clearly defined governance arrangements in place for Joint Commissioning between the Council and DCCG. This is through the Health & Social Care Joint Commissioning Management Board (JCMB) and Joint Commissioning Operational Group. The JCMB sets the work programme for strategic joint commissioning activity and plays a vital role in the development, implementation and oversight of joint commissioning arrangements. The terms of reference for the JCMB include:

    a. The JCMB is responsible to the Council Cabinet and NHS Doncaster CCG Governing;

    b. The JCMB will consult with and share information with the Doncaster Health and Wellbeing Board;

    c. The duties of the JCMB include;
        i. Agree strategic development priorities for joint commissioning activity
        ii. Agree the areas of opportunity to be the focus of joint commissioning and delivery
        iii. Coordinate the work programmes including monitoring progress
        iv. Agree the commissioning strategies relating to each area of opportunity
        v. Oversee management of the pooled budgets (including BCF) approaches to support the joint work.
        vi. Share wider transformation agendas to ensure an overall awareness across the health and social care economy
        vii. Escalate decisions to DMBC Cabinet and NHS Doncaster CCG Board as required

    d. There are delegations from JCMB to the newly formed Joint Commissioning Operational Group (JCOG) for operational decisions in relation to joint funding including the Better Care Fund (BCF);

    e. Membership of the JCMB includes;
        i. Chief Executive (DMBC) Jo Miller (Chair – revolving)
        ii. Chief Officer (CCG) Jackie Pederson (Chair – revolving)
        iii. Director of People (DMBC) Damian Allen
        iv. Commissioning Lead (DMBC) Learning and Opportunities Leanne Hornsby
        v. Commissioning Lead (DMBC) Adults – Denise Bann
        vi. Director of Public Health (DMBC) - Rupert Suckling Assistant
        vii. Director of Finance DMBC - Steve Mawson
        viii. Clinical Chair (CCG) – Dr David Crichton
        ix. Chief Financial Officer (CCG) Hayley Tingle

x. Director of Strategy and Delivery (CCG) - Anthony Fitzgerald
Chief Nurse (CCG) – Andrew Russell
xi. Strategic Clinical Lead (CCG) – Dr Nick Tupper
xii. Portfolio Holder (DMBC) – Rachel Blake
xiii. Lay Member (CCG) – Linda Tully
xiv. Additional members may be co-opted to the committee for durations and purposes as deemed appropriate by the JCMB members; and

f. The JCMB meets 6 weekly, with papers circulated in advance of the meeting.

22. The BCF and iBCF investment strategy is currently being reviewed and will be updated accordingly. This will re-establish the investment principles, in line with the Doncaster Place Plan, ensuring the funding is targeted and delivering the transformation. The process for receiving, evaluating and recommending any new bids will also be updated; aligned to the Joint Commissioning governance arrangements detailed above and ensuring transparency of decisions. The projects currently being funded from BCF and iBCF will be evaluated and quality assurance reporting introduced to provide a robust indication of progress. It is envisaged that this will involve quarterly reports to be submitted for individual schemes detailing progress.

OPTIONS CONSIDERED

23. Various schemes have been considered by the previous Transformation Coordination group (TCG) which previously managed the operational activities financed by the Better Care Fund (TCG is due to be merged with the Joint Commissioning Operational Group and functions transferred as detailed above).

REASONS FOR RECOMMENDED OPTION

24. The allocations detailed are recommended following joint discussions between the Council and DCCG.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

25.

	Outcomes	**Implications**
	Doncaster Working: Our vision is for more people to be able to pursue their ambitions through work that gives them and Doncaster a brighter and prosperous future; • Better access to good fulfilling work • Doncaster businesses are supported to flourish • Inward Investment	Improving health & social care in Doncaster can play a major role in the creation of an economically active and thriving population. The all age focus of the use of BCF to support integration of health and social care integration work will play a major role in this.
	Doncaster Living: Our vision is for Doncaster's people to live in a borough that is vibrant and full of opportunity, where people enjoy spending time;	Access to quality and modern health and social services plays a major role in the wider offer of Doncaster as a place to live, work and enjoy a good quality of life.

	• The town centres are the beating heart of Doncaster • More people can live in a good quality, affordable home • Healthy and Vibrant Communities through Physical Activity and Sport • Everyone takes responsibility for keeping Doncaster Clean • Building on our cultural, artistic and sporting heritage	
	Doncaster Learning: Our vision is for learning that prepares all children, young people and adults for a life that is fulfilling; • Every child has life-changing learning experiences within and beyond school • Many more great teachers work in Doncaster Schools that are good or better • Learning in Doncaster prepares young people for the world of work	Improving health & social care in Doncaster can play a major role in enabling young people and adults fulfil their potential in educational terms. The all age focus of the use of BCF to support integration of health and social care integration work will play a major role in this.
	Doncaster Caring: Our vision is for a borough that cares together for its most vulnerable residents; • Children have the best start in life • Vulnerable families and individuals have support from someone they trust • Older people can live well and independently in their own homes	The proposals for use of BCF are central to creating the flexibility and transformation required to deliver the ambitions of the Caring element of the Place Plan.
	Connected Council: • A modern, efficient and flexible workforce • Modern, accessible customer interactions • Operating within our resources and delivering value for money • A co-ordinated, whole person, whole life focus on the needs and aspirations of residents • Building community resilience and self-reliance by connecting community assets and strengths • Working with our partners and residents to provide effective leadership and governance	The proposals to use BCF to deliver service transformation, including cross cutting capabilities such as workforce development can play a major role in delivering the connected council ambitions.

RISKS AND ASSUMPTIONS

26. Any risks identified regarding the specific areas of expenditure will be detailed in the business cases and fully considered prior to implementation.

LEGAL IMPLICATIONS [NJD Date 22/02/18]

27. Section 1 of the Care Act 2014 places a number of duties on the Council to promote an individual's wellbeing.

28. Section 3 of the Care Act 2014 states that the Council must ensure that care and support provision is integrated with other health provision and health related provision where it will promote the wellbeing.

29. Section 6 of the Care Act 2014 states that the Council must co-operate with each of its partners and each relevant partner must co-operate with the Council in exercise of their respective function relating to adults with needs for care and support.

30. Section 1 of the Localism Act 2011 gives the Council a general power to do anything that an individual may generally.

31. The Council and DCCG have identified that the future need for joint commissioning is key to more integrated, preventative and localised delivery of services where this can improve outcomes for Doncaster residents and reduce demand for acute, costly services. Achieving this requires a joint approach to planning and investment of resources between the Council and DCCG.

32. Legal advice on the duty under section 149 of the Equality Act 2010 will be provided as required in future reports.

33. Further legal advice and assistance will be required throughout the delivery of services utilising the BCF monies as detailed within this report.

FINANCIAL IMPLICATIONS [HJW Date 22/02/2018]

34. These are included in the main body of the report.

HUMAN RESOURCES IMPLICATIONS [Officer Initials BT Date 27/02/2018]

35. At this moment in time there are no apparent HR&OD & Communications interventions necessary, although both Service Areas are fully aware of and represented in the many facets of the overall Doncaster Place Plan.

    Any staffing implications and/or significant developments will be communicated at an early stage to staff and Trades Unions through the established channels within the Council's Industrial Relations Framework.

    In addition other modes of communication will cascade relevant updates through the Adults Transformation and Corporate Communications teams as appropriate.

TECHNOLOGY IMPLICATIONS [Officer Initials PW Date 27/02/18]

36. There are specific technology implications at this stage. Digital & ICT are already involved in a number of the projects/schemes outlined above and must continue to be consulted in relation to future technology requirements arising from the spending plan and ongoing transformation, seeking approval from the ICT Governance Board, as necessary.

HEALTH IMPLICATIONS [Officer Initials Dr Victor Joseph Date 27/02/18]

37. Health and social care has got the potential to contribute to 25% of health status of population. The use of Better Care Fund, which fosters collaborative working between the Council and Doncaster CCG intends to use the fund to improve better ways of delivering both health and social care with synergistic effects. The use of the funds is built on Place Plan, which is a joint plan of local health and social care partners. The impact of the use of this fund will need to be built into the relevant project areas in order to monitor their benefit to the health of the people of Doncaster.

EQUALITY IMPLICATIONS [FT Date 22/02/18]

38. The Council must consider and have due regard to the three aims of the general equality duty when developing and implementing any spending plan. A due regard assessment will be carried out on the individual areas of spend identified prior to implementation and the weight given to the general duty will depend on how that area of work affects discrimination, equality of opportunity and good relations.

CONSULTATION

39. The non-recurrent BCF spending plan has been considered by senior managers at both the Council and DCCG.

BACKGROUND PAPERS

40. Doncaster Place Plan, Cabinet 13th December, 2016
http://doncaster.moderngov.co.uk/ieListDocuments.aspx?CId=131&MId=2420&Ver=4

To sign a Memorandum of Understanding (MOU) with Doncaster Clinical Commissioning Group (CCG) that establishes shadow joint commissioning arrangements to take forward the areas of opportunity in the Doncaster Place Plan, Cabinet 28th November, 2017
http://doncaster.moderngov.co.uk/documents/s13578/Cab%20281117%20rp7%20MOU%20Cabinet%20covering%20report%20v4%20Final.pdf

REPORT AUTHOR & CONTRIBUTORS

Faye Tyas, Head of Financial Management
01302 862606 faye.tyas@doncaster.gov.uk

Steve Mawson
Chief Financial Officer & Assistant Director of Finance

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 15/03/2018

Subject: Better Care Fund Q3 Return

Presented by: Dominic Armstrong

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

Implications		**Applicable Yes/No**
DHWB Strategy Areas of Focus	Substance Misuse (Drugs and Alcohol)	No
	Mental Health	No
	Dementia	No
	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?
This report provides an overview of the information submitted to government as part of the statutory return on BCF performance. The BCF itself contributes to preventing unnecessary hospital admissions, reducing delayed transfers of care and enabling people to stay at home for longer.

Recommendations
1) The Board is asked to: Note the progress against planned spend, the national conditions, performance indicators and wider integration of health and social care.

This page is intentionally left blank

Doncaster Council

Report

Agenda Item No: 10c
Date: 15 March 2018

To the Chair and Members of the Health and Wellbeing Board

BETTER CARE FUND QUARTER 3 UPDATE

Relevant Cabinet Member(s)	Wards Affected	Key Decision
All	All	No

EXECUTIVE SUMMARY

1) This report provides an update on the quarter three position of the Better Care Fund (BCF).

2) The Better Care Fund is one of the most ambitious programmes introduced across the NHS and local government. It encourages integration by requiring CCGs and local authorities to enter into pooled budget arrangements and agree integrated spending plans, which seeks to join-up health and social care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

3) There are a number of national BCF conditions that the partnership must meet and four key BCF national indicators must be monitored and reported against. Each quarter the partnership submits a statutory return that provides details of performance against the national indicators and the local BCF Plan. At the end of January 18 the report for quarter three was submitted. This report provides an update on the quarter three position as reported in the statutory return with updated data and information where appropriate.

4) Key points from the quarter 3 return are that the partnership fully meets all of the national conditions for BCF and we are on track to meet the targets set out for the four areas.

5) We are currently forecasting a small underspend of £11K (mainly relating to vacancies) against the BCF plan.

6) The Q3 BCF return also includes a maturity assessment of the Council's current status in relation to implementing a "High Impact Change Model," (HICM) a national initiative to improve flows of patients in and out of hospitals and to address issues relating to Delayed Transfers of Care (DToC). There are eight transformational change strands within the HICM. Good progress is being made in this area with plans in place or established for all of the eight strands within the HICM.

EXEMPT REPORT

7) The report does not contain any exempt information.

RECOMMENDATIONS

8) That the board notes progress against planned spend, the national conditions, performance indicators and wider integration of health and social care.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

9) The Better Care Fund (BCF) is a key resource to enable health and social care integration and transformation of current services. Doncaster residents should expect to be supported to maintain their independence as long as possible and also see a more integrated seamless response from health and care partners.

BACKGROUND

10) The BCF encourages integration by requiring CCGs and local authorities to enter into pooled budget arrangements and agree integrated spending plans, which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

11) The Government's ambition, facilitated through the BCF, is to establish integrated health and social care across the country by 2020. The partnership has formally agreed a joint BCF plan with the Department for Health and Social Care and Ministry of Housing Communities and Local Government in October 2017 *(for 2017/18 and 2018/19)*.

12) In Doncaster the BCF is an important vehicle for integration and a key resource that will enable us to transform current services and deliver efficiencies to ensure that we can meet the increasing challenges of rising demand and an ageing population.

13) There are a number of national BCF conditions that the partnership must meet and four key BCF national indicators which must be monitored and reported against. Each quarter the partnership submits a statutory return that provides details of performance against the national indicators and the partnerships local BCF Plan. At the end of January 18 the report for quarter three was submitted. This report provides an update on the quarter three position as reported in the statutory return as well as an update on our

forecast spend.

Update on forecast spending plans for the Better Care Fund (BCF).

14) The BCF is to transform health and social care services so that people are provided with better integrated care and support. It aims to help manage the pressures across the health and social care systems and improve long term sustainability of services in the context of demographic changes and on-going pressures on core budgets for health and social care services.

15) The BCF sets out a number of national conditions that must be delivered by each local plan. For 2017/18 those national conditions are:

a) Plans must be jointly agreed

b) NHS contribution to adult social care is maintained in line with inflation.

c) Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care.

d) Managing transfers of care

16) Beyond this, there is flexibility in how the Fund is spent over health and social care services, but there needs to agreement how this spending will improve performance in the following four metrics:

a) Delayed transfers of care;

b) Non-elective admissions (general and acute);

c) Admissions to residential and care homes; and

d) Effectiveness of reablement.

17) Appendix 1 sets out the 2017/18 plan and forecast spend. Overall we are forecasting a small underspend of £11k mainly relating to vacancies. Any underspend will be carried forward within the non-recurring BCF reserve.

Performance Against the National BCF Conditions and Indicators

18) The partnership submitted the quarter three BCF statutory return at the end of January 18. The return includes an assessment of the extent the partnership is meeting the national conditions for BCF, an assessment of performance against the four BCF national indicators; and an assessment of performance against the agreed targets within the local BCF Plan. It also includes an overall assessment of performance against the local BCF Plan for integrating health and social care. A summary of the quarter 3 position reported in the statutory return is as follows:

a) National Conditions for BCF

The partnership fully meets all of the national conditions for BCF as follows:

- There are jointly agreed plans in place for working towards health

and social care integration.

- There is agreement on the planned financial contribution from the CCG to social care in line with the BCF Planning Requirements.
- There is agreement to invest in NHS commissioned out of hospital services in accordance with the national conditions.
- Plans are in place and improvement activity is taking place to manage transfers of care.
- Additionally, the Council has a signed off and legally binding section 75 agreement in place that governs the pooling of BCF monies between the Council and CCG.

b) National BCF Performance Indicators

The overall assessment of performance for all of the four national BCF indicators is that they are all on track to meet the planned target for the quarter. Appendix 2 provides details of performance trends for each of these indicators from December 16 to Dec 17. Key points for the indicators are as follows:

i) **Non-elective admissions:** There has been good progress with the number of non-elective admissions consistently remaining below the target from March 17 onwards. Notably for the 9 months up to December 17, non-elective admissions are 4% below the BCF target and 1% below the corresponding period in 2016.

ii) **Admissions to care homes:** This is on track to meet the planned target. There has been a significant reduction in admissions over the last 2 years and this has resulted in the lowest number of people in residential care for many years.

iii) **Reablement:** The percentage of people remaining at home after hospital discharge has improved year on year for the past 3 years. In the 9 months to December it has increased by 2.7%. This means that just over 81% of people are now remaining at home which is in line with our 82% target. Key challenges remain around building community capacity to provide additional support to enable people to remain at home and the capacity of homecare providers.

iv) **Delayed Transfers of Care (DTOC):** Doncaster health and social care partners are working effectively together to reduce Delayed Transfers of Care. Since November the daily rate of delays has been below the national target. The draft upload for January suggests that this improving trend is continuing.

c) High Impact Change Model

The Q3 BCF return includes a maturity assessment of the partnership current status in relation to implementing a “High Impact Change Model,” (HICM) a national initiative to improve flows of patients in and out of hospitals and to address issues relating to Delayed Transfers of Care. A project manager has started to work across health and social care to implement the high impact change model. The council has worked with the CCG and providers to establish a steering group to

oversee the implementation, with a number of working groups established to drive change forward.

Key priorities have been identified and short term initiatives have been agreed to review the hospital discharge process, develop proposals for a swoop team to proactively challenge and discharge people from hospital beds and strengthen our 7 day working arrangements within the hospital. The project manager and business lead are also working with the hospital to work up proposals for a Homefinder role to reduce delays into our care homes.

d) Progress against local plan for integration of health and social care

The partnership is required to report on key areas of progress in delivering the local BCF Plan to enable the integration of health and social care. Significant work has taken place in this area to move towards Doncaster's vision for integration. This includes:

- The development of a suite of draft agreements: System Partnership Agreement, Commissioning Agreement, Provider Agreement which are expected to be well developed by 1 April 2018.

- Governance mechanisms are also being reviewed to ensure that joint commissioning decisions can be made via a joint committee with delegated authority.

- Six "Areas of Opportunity" have been identified and agreed as the first areas to test the local Accountable Care Partnership approach; namely Intermediate Care, Complex Lives, Urgent Care, Dermatology, Starting Well, Vulnerable Adolescents and LD is also under consideration.

- Integrated provision models are already being tested in intermediate care (joint working between council and Rdash reablement teams) .

IMPACT ON THE COUNCIL'S KEY OUTCOMES

19)

	Outcomes	**Implications**
	Doncaster Working: Our vision is for more people to be able to pursue their ambitions through work that gives them and Doncaster a brighter and prosperous future; • Better access to good fulfilling work • Doncaster businesses are supported to flourish • Inward Investment	None
	Doncaster Living: Our vision is for Doncaster's people to live in a	None

	borough that is vibrant and full of opportunity, where people enjoy spending time; • The town centres are the beating heart of Doncaster • More people can live in a good quality, affordable home • Healthy and Vibrant Communities through Physical Activity and Sport • Everyone takes responsibility for keeping Doncaster Clean • Building on our cultural, artistic and sporting heritage	
	Doncaster Learning: Our vision is for learning that prepares all children, young people and adults for a life that is fulfilling; • Every child has life-changing learning experiences within and beyond school • Many more great teachers work in Doncaster Schools that are good or better • Learning in Doncaster prepares young people for the world of work	None
	Doncaster Caring: Our vision is for a borough that cares together for its most vulnerable residents; • Children have the best start in life • Vulnerable families and individuals have support from someone they trust • Older people can live well and independently in their own homes	None
	Connected Council: • A modern, efficient and flexible workforce • Modern, accessible customer interactions • Operating within our resources and delivering value for money • A co-ordinated, whole person, whole life focus on the needs and aspirations of residents • Building community resilience and self-reliance by connecting community assets and strengths • Working with our partners and	None

	residents to provide effective leadership and governance	

RISKS AND ASSUMPTIONS

20) N/A

LEGAL IMPLICATIONS

21) No Legal implications have been sought for this update paper.

FINANCIAL IMPLICATIONS

22) No Financial implications have been sought for this update paper.

HUMAN RESOURCES

23) No HR implications have been sought for this update paper.

TECHNOLOGY IMPLICATIONS

24) No Technology implications have been sought for this update paper.

HEALTH IMPLICATIONS

25) No Health implications have been sought for this update paper.

EQUALITY IMPLICATIONS

26) No Equality implications have been sought for this update paper.

REPORT AUTHOR & CONTRIBUTORS

Dominic Armstrong, Programme Manager
Jacqui Scott, Project Manager

01302 735999
dominic.armstrong@doncaster.gov.uk

Dr Rupert Suckling Director or Public Health

Appendix 1: BCF Forecast spend

Project No.	Project Lead	Commissioning Lead	BCF Workstream	Plan 2017/18 £'000	Forecast Spend 2017/18 £'000	Variance 2017/18 £'000	Plan 2018/19 £'000
1	Anthony Fitzgerald	CCG	Community Aids and Adaptations	2,061	2,061	0	2,349
2	Anthony Fitzgerald	CCG	Carers Support Services & Breaks	844	844	0	844
3	Anthony Fitzgerald	CCG	COPD Early Supported Discharge (RDASH)	40	40	0	40
4	Anthony Fitzgerald	CCG	Dementia Services (RDASH)	2,019	2,019	0	2,019
5	Anthony Fitzgerald	CCG	Liaison Schemes (RDASH)	260	260	0	260
6	Anthony Fitzgerald	CCG	Care Home Liaison (RDASH)	244	244	0	244
7	Anthony Fitzgerald	CCG	Other Schemes ie Alzheimers & S256 contracts	205	205	0	205
8	Anthony Fitzgerald	CCG	Clinical Services Review Community based services - Mex Mont re-design (RDASH)	1,144	1,144	0	1,144
9	Anthony Fitzgerald	CCG	Assessment Unit Health Staffing	302	302	0	302
10	Anthony Fitzgerald	CCG	Single Point of Access	473	473	0	473
11	Anthony Fitzgerald	CCG	Respite Services (RDASH)	1,302	1,302	0	1,302
12	Anthony Fitzgerald	CCG	Discharge Schemes inc Early Supported Discharge	834	834	0	834
13	Anthony Fitzgerald	CCG	Bed Based Intermediate Care (RDASH)	3,418	3,418	0	3,419
14	Anthony Fitzgerald	CCG	Mental Health Crisis Services (RDASH	2,022	2,022	0	2,022
				15,168	**15,168**	**0**	**15,457**
1	Clare Henry	DMBC	Falls Development Programme (Age UK)	50	50	0	50
2	Lisa Swainston	DMBC	Round 2 Innovation Fund (Having a Good Day)	20	20	0	0
3	Fay Wood	DMBC	Community capacity and well- being support / social prescribing	225	180	-45	240
4	Nick Germain	DMBC	Well North Project	262	265	3	167
5	Fay Wood	DMBC	Community mobile day service / borough wide	125	125	0	125
6	Fay Wood	DMBC	Dementia mobile day services	45	45	0	45

7	Vanessa Powell Hoyland	DMBC	Winter Warm	99	99	0	85
8	David Eckersley	DMBC	Phase 1 Review officers	50	40	-10	0
9	Rosemary Leek	DMBC	Dementia Friendly Communities programme	18	18	0	0
10	Rosemary Leek	DMBC	Enhancement of Dementia support services (Alzheimers dementia café's)	77	77	0	77
11	Rosemary Leek	DMBC	The Admiral service (making space)	88	88	0	88
12	Louise Shore	DMBC	Hospital based Social Workers	209	150	-59	213
13	Fay Wood	DMBC	Home from Hospital (Age UK)	50	50	0	70
14	Collette Taylor	DMBC	Direct Payment Support Unit and Business Support Unit temporary staffing	116	101	-15	118
15	Alan Wiltshire	DMBC	Integrated health and social care information management systems - (Caretrak)	50	50	0	50
16	Rosemary Leek	DMBC	Dementia Advisor (Peer Support pilot)	0	0	0	0
17	Sarah Sansoa	DMBC	Telecare Strategy	119	140	21	150
18	Rachael Thompson	DMBC	HEART	531	531	0	542
19	Rosemary Leek	DMBC	Dementia ccg post fully BCF funded	5	5	0	0
20	Rosemary Leek	DMBC	Dementia Advisor (Age uk)	32	32	0	32
21	Rachael Thompson	DMBC	STEPS / OT service	1,334	1,452	118	1,510
22	Louise Shore	DMBC	RAPT	108	69	-39	110
23	Rachael Thompson	DMBC	(Positive Steps) Social care Assessment Unit	1,650	1,691	41	1,724
24	Louise Shore	DMBC	Hospital Discharge Worker	27	26	-1	28
25	Rachael Thompson	DMBC	SPOC/One Point 1	90	65	-25	92
26	Debbie John-Lewis	DMBC	Intermediate Care and support strategy	170	170	0	170
27	Fay Wood	DMBC	Mental Health - Doncaster Mind	156	156	0	245

28	Fay Wood	DMBC	Mental Health - Changing Lives	105	105	0	0
29	Patrick Birch	DMBC	PMO (Programme Management Office and Development)	177	177	0	181
30	Andy Collins	DMBC	Alcohol Safe Haven	15	15	0	0
31	Karen Tooley/ Ian Campbell	CCG	Doncaster Intermediate Health & Social Care – Phase 3- testing the model	600	600	0	0
32	Patrick Birch	DMBC	Procurement of a strategic partner to support DMBC and partners across the Doncaster Health and Social Care sector to deliver the Doncaster Place Plan.	500	500	0	0
33	Fay Wood	DMBC	Information and advice kiosks	0	0	0	0
34	Vanessa Powell Hoyland	DMBC	Healthy homes healthy people	13	13	0	0
35	Fay Wood	DMBC	Disabled Go	35	35	0	8
36	Lisa Swainston	DMBC	Dev & Enhancement of vibrant provider market	15	15	0	0
37	Simon Marsh	CCG	Integrated Digital Care Record Pilot – Consultancy Support	0	0	0	0
38	Griff Jones	DMBC	Adults Health and Wellbeing – Creative Options for Learning Disability service users	0	0	0	673
39	Griff Jones	DMBC	CLS Community lead support	0	0	0	500
			UNALLOCATED			0	10
				7,166	**7,155**	**-11**	**7,302**

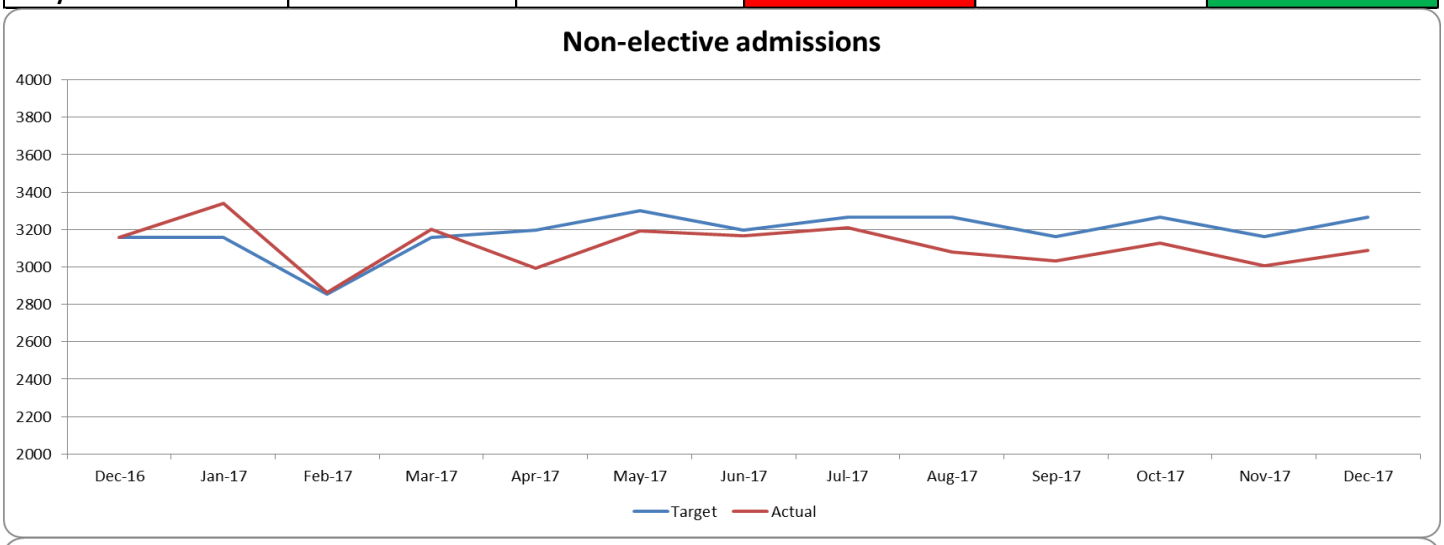
Minimum CCG Contribution TOTAL	**22,334**	**22,323**	**-11**	**22,759**

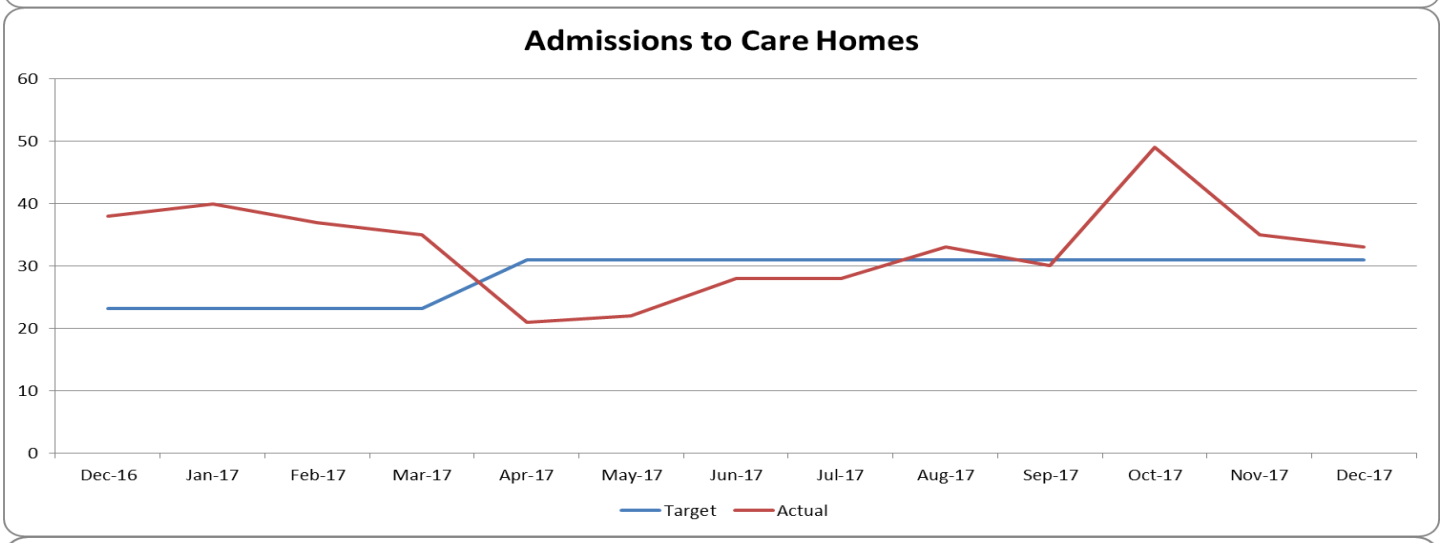
1	Keith Sinclair	DMBC - DFG	Disabled Facilities Grants - capital funding	2,118	2,118	0	2,272

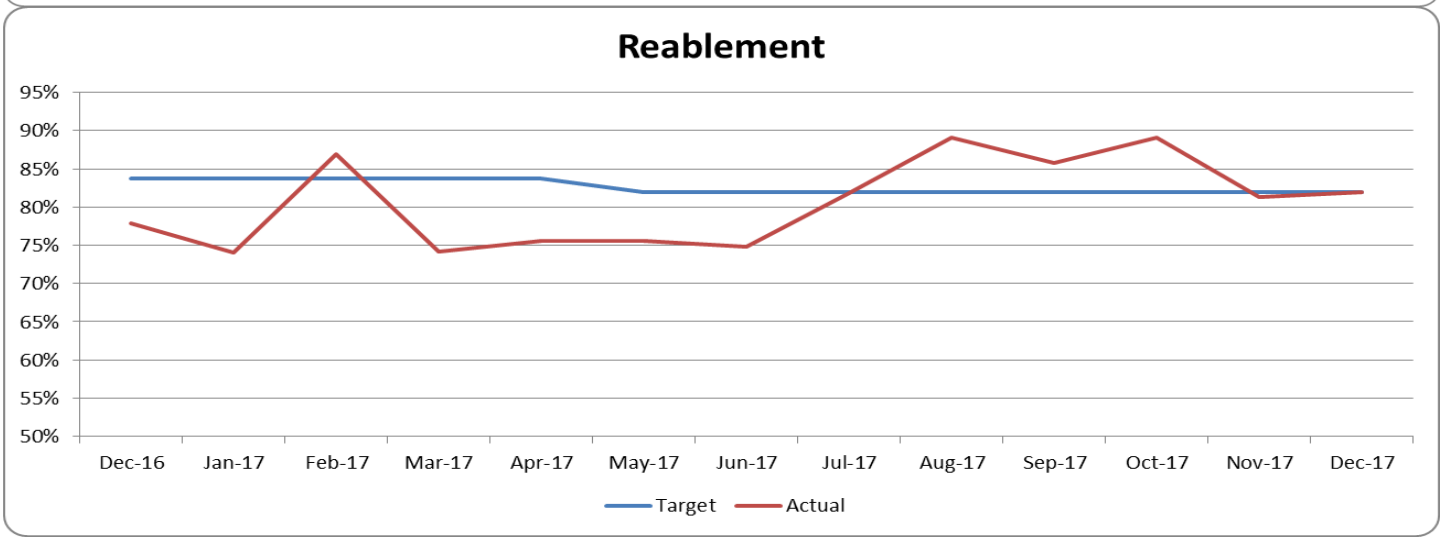
Appendix 2:

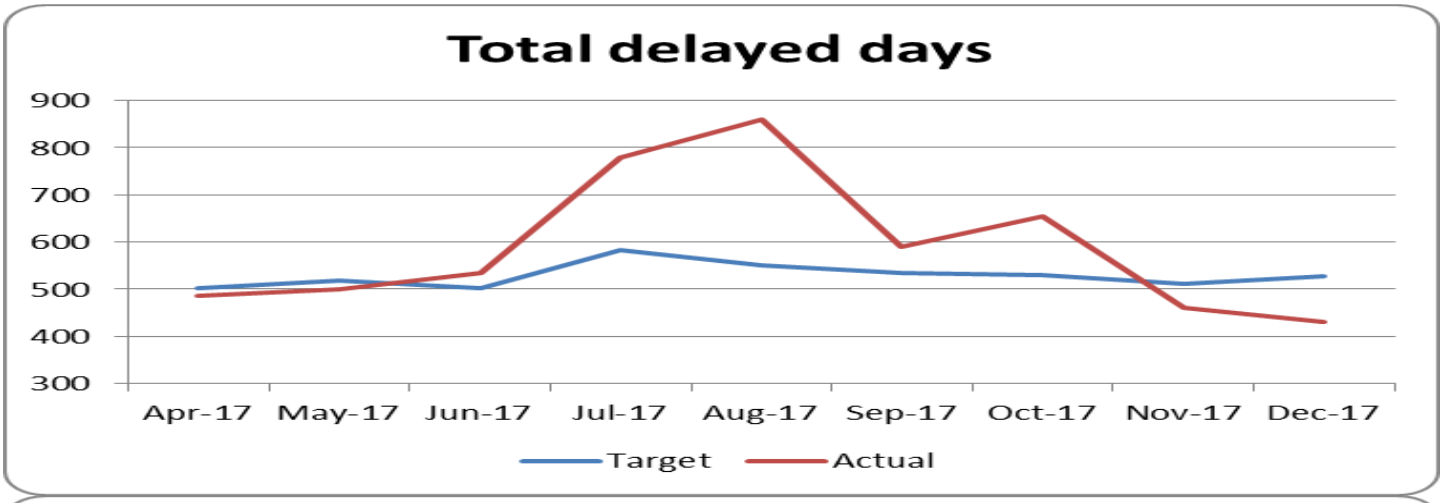
Performance against national BCF indicators

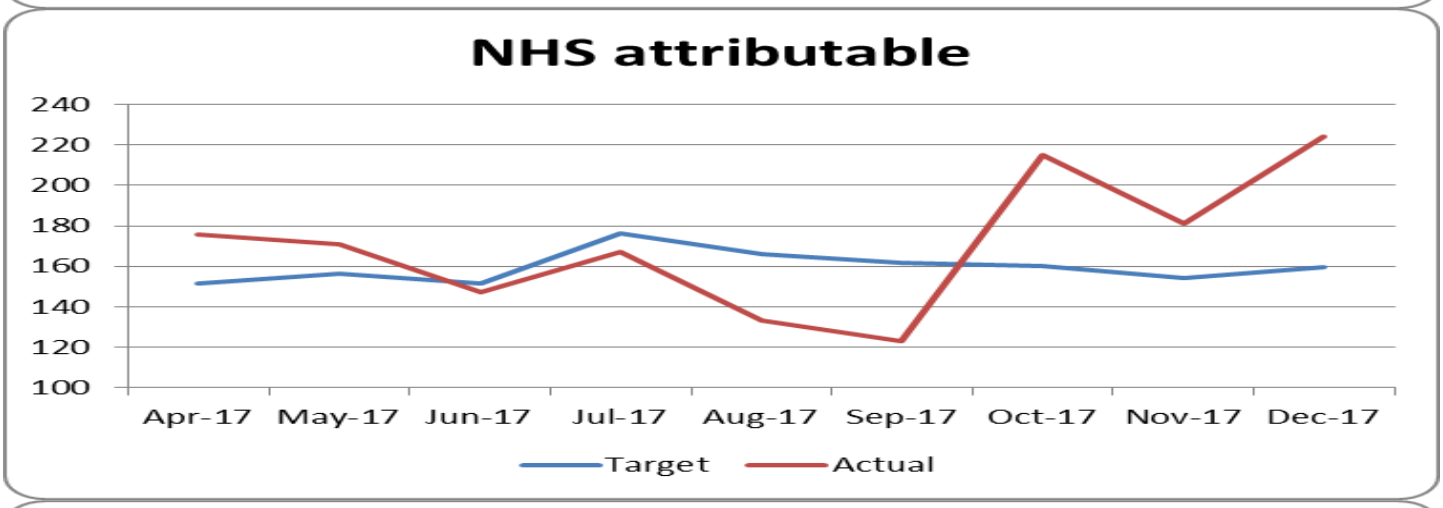
	2017-18 target YTD	2017-18 actual YTD	Var.	2016-17	Var.
Reablement	82%	81.01%	-1.21%	78.88%	2.70%
Admissions to care homes	278	279	0.27%	298	-6.38%
Non -elective admissions	29079	27892	-4.08%	28225	-1.18%
Delayed Transfers	4759	5285	11.05%	5360	-1.40%

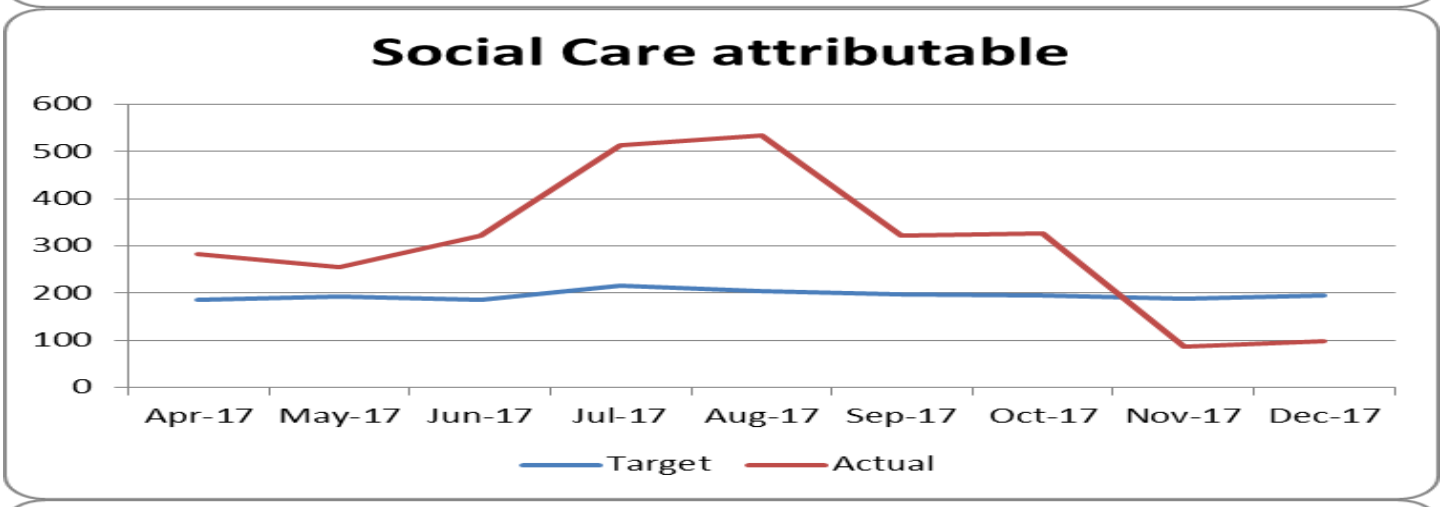


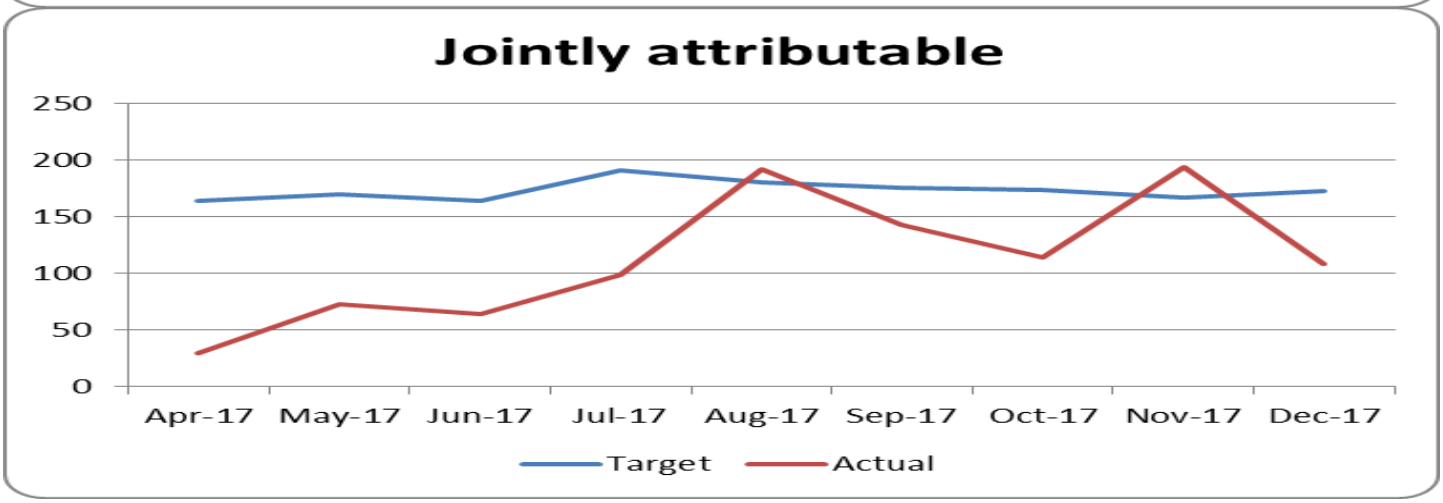





Total delayed days
900
800
700
600
500
400
300
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Target
Actual


NHS attributable
240
220
200
180
160
140
120
100
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Target
Actual


Social Care attributable
600
500
400
300
200
100
0
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Target
Actual


Jointly attributable
250
200
150
100
50
0
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Target
Actual

Doncaster Council

Doncaster
Health and Wellbeing Board

Date:15/03/18

Subject: Doncaster Suicide Prevention Plan

Presented by: Helen Conroy/Sarah Smith

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

Implications		**Applicable Yes/No**
DHWB Strategy Areas of Focus	Substance Misuse (Drugs and Alcohol)	
	Mental Health	yes
	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?
Delivery of a range of actions to prevent suicides and improve responses to suicide.

Recommendations
The Board is asked to:- Endorse the local plan.

This page is intentionally left blank

Doncaster Council

Report

Agenda Item No. 11
Date: 15/03/18

To the Chair and Members of the
HEALTH AND WELLBEING BOARD

DONCASTER SUICIDE PREVENTION LOCAL ACTION PLAN 2017-2020

EXECUTIVE SUMMARY

1. All areas in England are required to have a multi-agency suicide prevention plan in place which will contribute to the target to reduce suicides by 10% nationally set out in the *Five year forward view for mental health.* The national suicide prevention strategy has provided a framework for the development of a local action plan which is presented to the Health and Wellbeing Board for endorsement.

   Using feedback from a local conference in January 2017, Doncaster has developed in collaboration, a local action plan which sets out clear objectives with targeted actions, in line with the National Suicide Prevention Strategy. This local action plan is attached as an appendix.

   The multi-agency Suicide Prevention Group, chaired by Dr Seddon of Doncaster CCG, meets quarterly to oversee the delivery of actions contained in the local action plan.

   Also in 2017 Public Health England published guidance for local areas to adopt the 'Prevention Concordat for Better Mental Health' with the expectation that local areas publish their plans for mental health prevention improvement during 2018. It is planned that the Health and Wellbeing Board workshop scheduled on 5 July focusses this development.

   Doncaster and Bassetlaw ICS has applied for approximately £500K ICS wide suicide prevention transformation monies from NHS England, with the result of the bid mid known by mid-March. If successful, the monies will be targeted at reducing risk in men, and self- harm.

EXEMPT REPORT

2. No

RECOMMENDATION

3. That the Health and Wellbeing Board endorses the Doncaster Suicide Prevention Local Action Plan 2017-2020.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4. That a range of actions are delivered to prevent suicides and improve responses to suicide.

BACKGROUND

5. The local action plan adopts the themes of the eight short term actions recommended in the *Local suicide prevention planning – A practice resource*[1], **(***https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan),* and an additional area – 'data and intelligence'.

   The 9 areas for action in the local plan are therefore:

   - Reducing risk in men
   - Preventing and responding to self- harm
   - Mental health of children and young people
   - Acute mental health care
   - Tackling high frequency locations
   - Reducing isolation
   - Bereavement support
   - Data and intelligence

OPTIONS CONSIDERED

6.
- Follow national guidance regarding the plan format
- Devise an alternative local format
- Do nothing

REASONS FOR RECOMMENDED OPTION

7. For Doncaster's local plan to be in line with national guidance.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

8.

	Outcomes	**Implications**
	Doncaster Working: Our vision is for more people to be able to pursue their ambitions through work that gives them and Doncaster a brighter and prosperous future; • Better access to good fulfilling work • Doncaster businesses are	None

[1] https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

	supported to flourish • Inward Investment	
	Doncaster Living: Our vision is for Doncaster's people to live in a borough that is vibrant and full of opportunity, where people enjoy spending time; • The town centres are the beating heart of Doncaster • More people can live in a good quality, affordable home • Healthy and Vibrant Communities through Physical Activity and Sport • Everyone takes responsibility for keeping Doncaster Clean • Building on our cultural, artistic and sporting heritage	The Suicide Prevention local action plan will contribute positively to these outcomes.
	Doncaster Learning: Our vision is for learning that prepares all children, young people and adults for a life that is fulfilling; • Every child has life-changing learning experiences within and beyond school • Many more great teachers work in Doncaster Schools that are good or better • Learning in Doncaster prepares young people for the world of work	The Suicide Prevention local action plan will contribute positively to these outcomes.
	Doncaster Caring: Our vision is for a borough that cares together for its most vulnerable residents; • Children have the best start in life • Vulnerable families and individuals have support from someone they trust • Older people can live well and independently in their own homes	The Suicide Prevention local action plan will contribute positively to these outcomes
	Connected Council: • A modern, efficient and flexible workforce • Modern, accessible customer interactions • Operating within our resources and delivering value for money • A co-ordinated, whole person, whole life focus on the needs and aspirations of residents	None

	• Building community resilience and self-reliance by connecting community assets and strengths • Working with our partners and residents to provide effective leadership and governance	

RISKS AND ASSUMPTIONS

9. The target of a 10% reduction may not be achieved. The plan will be delivered within existing resources.

LEGAL IMPLICATIONS [Officer Initials NJD Date 26th February 2018]

10. There are no specific legal implications associated with this report. The Council has a vital role to play in suicide prevention and the production of a suicide plan will document how this Council intends to contribute to suicide prevention.

FINANCIAL IMPLICATIONS [Officer Initials HJW Date 22/02/2018]

11. There are no financial implications arising as a direct result of this report. There is a discretionary budget available if required for minor associated spend such as communication and awareness materials.

HUMAN RESOURCES IMPLICATIONS [Officer Initials BT Date 19/02/2018]

12. There are no apparent HR implications within this particular Report as Doncaster's Local Suicide Prevention Action Plan 2017-2020 will be coordinated on behalf of the authority's relevant Public Health team in collaboration with external partners.

TECHNOLOGY IMPLICATIONS [Officer Initials PW Date 21/02/18]

13. There are no anticipated technology implications in relation to this report.

HEALTH IMPLICATIONS [Officer Initials HC Date 16.02.18]

14. Suicide is one of the most common causes of death amongst middle aged men. There is an impact on individuals' families and communities which the local plan addresses in line with national guidance.

EQUALITY IMPLICATIONS [Officer Initials HC Date 16.02.18]

15. The group most significantly affected by suicide are middle aged men.

CONSULTATION

16. Approximately 80 delegates from a range of professional backgrounds and interest groups were invited to a Doncaster suicide prevention conference in January 2017. The delegates were consulted on the content of the local action plan, which therefore reflects local concerns and priorities.

REPORT AUTHOR & CONTRIBUTORS

Helen Conroy, Public Health Theme lead (vulnerable people)
01302 734571 helen.conroy@doncaster.gov.uk

Name & Title of Lead Officer
Rupert Suckling Director of Public Health

This page is intentionally left blank

Doncaster Suicide Prevention Local Action Plan

2017-2020

Prepared by **and On behalf of the Doncaster Suicide Prevention Group and all its members**

Sarah Smith

Improvement Co-Ordinator (Improving Lives Team– Public Health (Doncaster MBC)

Sarah.smith2@doncaster.gov.uk

Table of contents

1. National Context relevant to suicide prevention

Around 13 people take their own lives in England every day[1] and there were 14,429 deaths from suicide in England between the two years 2013 & 2015[2] although the true figure is likely to be higher. Suicide is preventable and a leading cause of years of life lost.

The latest National Strategy for England *Preventing suicide in England: a cross-government outcome strategy to save lives*[3] was published in 2012 and builds on the achievements of the early strategy published in 2002. The 2012 strategy sets out two objectives and six key areas for action:

Strategy Objectives:

- A reduction in the suicide rate in the general population in England: and
- Better support for those bereaved or affected by suicide.

Six key areas for action:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

The recent review of the national strategy by the Health Select Committee[4] made five key recommendations for improving the national strategy for England. Both the national strategy and the Mental Health Taskforce's report to NHS England, *The five year forward view for mental health*[5] set out the need to develop both local suicide prevention strategies and actions plans to reduce suicide. The Mental Health Taskforce also recommends that there be a national ambition to reduce the suicide rate in England by 10 per cent by 2020/21 and for every local area to have developed a multi-agency suicide prevention plan.

In order to track national and local progress, the data for suicide as an indicator was included within the Public Health Outcomes Framework[6] (PHOF). Local approaches to identify gaps would need further development.

2. The current position in Doncaster

In 2016, Doncaster underwent a refresh of the membership for the Suicide Prevention Group (SPG) and agreed to host a conference in early 2017. The membership of the group now includes a much wider range of representatives working with adults, children and young people. The aim of the

[1] ONS. Suicides in the UK in 2014. London: Office for National statistics; 2016
[2] Public Health England - Healthier Lives https://healthierlives.phe.org.uk/topic/suicide-prevention/comparisons#par/E92000001/ati/102/iid/41001/sexId/4/gid/1938132762/pat/102
[3] www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
[4] www.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf
[5] https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view?gclid=CLrK57vSstACFQXnGwodYo0ENA
[6] http://www.phoutcomes.info/

conference was to explore current practice in Doncaster on approaches to suicide prevention and discuss and explore the eight short term actions recommended in the *Local suicide prevention planning – A practice resource*[7]. It was also agreed by the SPG that an additional area – 'Data collection and monitoring' would be explored in order to achieve the 6th key action of the strategy. Local intelligence can provide an evidence base for action and the means to monitor and review progress which is crucial in order to monitor progress locally.

2.1 Doncaster's Suicide Audit 2013 - 2014

The audit of suicides in Doncaster took place in 2015 with the aim of understanding the context of suicide within the borough. The summary of findings is as follows:

- The rate of suicide/injury and undetermined remained in line with the data supplied by the Office of National Statistics (ONS)
- Of those who took their life
    - 84% were males
    - 27% were aged between 51-60 years old
    - 100% were White British
- Out of the 37 deaths reviewed, most occurred within the Balby area under the postcode: DN4
- Risk factors
    - 19% unemployed and 16% retired
    - 2 were under investigation of the police due to the serious allegations made against them
    - 5 individuals had recently experienced martial breakdown
    - 3 individuals prior to their deaths reported they had financial worries
- Methods
    - 48% died by hanging/strangulation with the next most common method being intentional overdose
    - 65% died in their own home with the next most common place being at a friend or relatives home

.

[7] https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

2.2 Development of the multi-agency action plan

All areas in England will be required to have a multi-agency suicide prevention plan in place by 2017 which will contribute to the target to reduce suicides by 10% nationally set out in the *Five year forward view for mental health.* The national suicide prevention strategy has provided a framework for the development of the local action plan.

PHE developed a suite of supporting documentation and guidance to aid and support local areas to develop strategies and action plans. These include:

- Local Suicide Prevention Planning – A practice resource
- Preventing suicide in public places – A practice resource
- Identifying and responding to suicide clusters and contagion – A practice resource

Using feedback from the conference in January, Doncaster has developed in collaboration, a local action plan which sets out clear objectives with targeted actions, in line with the National Suicide Prevention Strategy focusing on the eight short term actions with the additional action for supporting research, data collection and monitoring which is an important component.

2.3 Accountability and Governance

The SPG reports to the Health and Wellbeing Board, Health Protection Assurance Group and Doncaster Safeguarding Children's Board on a quarterly basis.

3. The challenge ahead

There were 81 deaths by suicide in Doncaster in the period between 2013-2015 and 80% (n65) of those were male, with just 20% (n16) female. The highest suicide rate in England is among men aged 45-49 and Doncaster currently has a higher suicide crude rate of 22.4 for those aged between 35 – 64 years: per 100,000 (5 year average) compared to England value of 20.5. In addition to this, Doncaster also has a higher crude rate for those aged 65+ than both regional and England value.

There are marked differences in suicide rates according to people's social and economic circumstances and suicide risk reflects wider inequalities. There are specific groups of people at risk of suicide and specific factors such as misuse of alcohol and drugs and suicide bereavement that will increase risk. There are also other population risk factors such as social isolation and significant life events such as Divorce, bereavement and employment status. Doncaster recorded nearly 32,000 marital breakups in 2011 and a higher proportion of households occupied by a single person aged 65 or over. The number of those who self-reported their wellbeing with a: low satisfaction, low worthwhile, low happiness and high anxiety score are much higher than the England value. [8]

Previous episode of Self Harm are the strongest identified predictor of suicide and from April 2016 – January 2017 there were nearly 600 emergency admissions with a recorded cause of injury of 'Intentional self-poisoning and Self-injury'.

[8] http://fingertips.phe.org.uk/profile/suicide

An audit of suicides/open/narrative verdicts is due to start early January 2018 which will include the 3 previous years as recommend by PHE: using a three year period is much more robust and statistically significant and will allow for a detailed analysis and be able to benchmark accordingly.

There are plans to adopt a suicide review process (Real-time suicide surveillance) which will be similar to the child deaths, drug related deaths and learning disability reviews once the 2018 audit has been completed. This system enables consideration of interventions required after a death has occurred where the circumstances suggest suicide in advance of the coroner's conclusion.

4. Local action plan – 9 Areas for Action

1. Area for action: Reducing risk in men

Objective	Action	Specific Outcome	Lead Responsibility
Increase awareness of and the response to the higher risk of suicide in men	Localised sustained suicide awareness (of increased risk of male suicides) campaign	Improved level of awareness of the general public of suicide susceptibility in men	Public Health Team/Clinical Commissioning Group/Aspire
Improve the skills of prison staff who work with the male prison population	To deliver a Training package targeted at prison staff - SafeTALK	Improved recognition and response to male prisoners who are vulnerable	Prisons Estates/Public Health Team

2. Area for action: Preventing and responding to self-harm

Objective	Action	Specific Outcome	Lead Responsibility
Improve data collection on self-harm at A & E	Identification of self-harm at A & E (coding)	Increase awareness of self-harm incidences/prevalence within Doncaster	CCG/DBH
To avoid people in crisis being sent home without follow up from A & E	Develop a formal protocol for referral from A & E into specialist service	Ensure continuity of specialist treatment for people in crisis	CCG/DBH/SPG/RDASH
Improve skills of education staff who work with young people	To deliver a training package targeting educational staff SafeTALK & ASIST training	Improve signposting into specialist service from educational establishments	Public Health

To provide a resource for YP which addresses self-harm issues	Promote the Respect Yourself website to educational settings	Improve awareness of Respect Yourself website in educational settings	Public Health
Improve skills of all frontline staff who may encounter self-harm	Target frontline staff with SafeTALK training	Improve signposting and response to self-harm	Public Health

3. Area for action: Mental Health of Children & Young People

Objective	Action	Specific Outcome	Lead Responsibility
Improve skills of all frontline staff who may encounter mental ill-health in children and young people	Target SafeTALK training offer to educational establishments – Engage System	Improve the ability of staff to work with children and young people's mental health issues	Public Health/Rotherham Doncaster and South Humber Trust

4. Areas for action: Treatment of depression in Primary Care

Objective	Action	Specific Outcome	Lead Responsibility
To reduce access to the means of suicide – safer prescribing	To promote safer prescribing practice of analgesics and antidepressants by GP's within Doncaster	Decrease the level of unnecessary prescribing of analgesics and antidepressants Safer prescribing Policy	Clinical Commissioning Group
To reduce access to the means of suicide	To promote safe storage of medication in the home	Improve home safety of stored medication and the safe disposal of old medication	Suicide Prevention Group/Local Pharmacy Committee

Support is available at the earliest possible stage	To develop Early Intervention suicide prevention services for Doncaster.	Early Intervention services are available for those contemplating suicide	DMBC
To reduce the pressures of health and crime related harms on A & E services	To promote the Safe Haven bus in Doncaster Town Centre during spring and summer	Reduce health and crime harms of alcohol	Public Health Team/Dr Nikki Seddon

5. Area for action: Acute mental healthcare

Objective	**Action**	**Specific Outcome**	**Lead Responsibility**
Support the development of a safe place for people in crisis	Support the development of the crisis cafe (crisis care concordat)	There is an alternative safe space for people in crisis	CCG/Better Care Fund

6. Area for action: Tackling high frequency place

Objective	**Action**	**Specific Outcome**	**Lead Responsibility**
Please refer to actions in local priority 9 – no one high frequency location in Doncaster			Public Health Team

7. Area for action: Reducing Isolation

Objective	Action	Specific Outcome	Lead Responsibility
There is access to services which reduce social isolation	Support the development of social prescribing across Doncaster borough	People can access services to reduce isolation via their GP	DMBC & CCG
Increase awareness of the impact of social isolation	Develop loneliness and isolation as a theme in campaign (see action 1)	People can access social prescribing via their GP/ Pharmacy/Community Nurse	Public health

8. Area for action: Bereavement Support

Objective	Action	Specific Outcome	Lead Responsibility
To commission an element of service for bereavement support	To develop a specification for DMBC tender on bereavement support as an element of early intervention/mental health support.	Availability of local bereavement support to bereaved people	DMBC
To improve awareness of availability of bereavement support services	To develop a z card to provide signposting for bereavement support services for adults and children	Availability of an up-to-date information resource	Suicide Prevention Group/Public Health

9. Area for action: Data and intelligence

Objective	Action	Specific Outcome	Lead Responsibility
Effective response to suicide contagion and clusters	To develop a suicide database to assist in identifying contagion and suicide clusters	Rapid and accurate identification of contagion and suicide clusters based on robust local data	Public Health Team
An effective response to suicide contagion	Assess the effectiveness of suicide /contagion emergency response protocol	An effective suicide contagion protocol is in place and monitored	DSCB/Public Health/Suicide Prevention Group
To systemically monitor and review local suicide occurrences	Maintain an up to date profile of suicides for suicide audit purposes	There is an understanding of the profile of local suicides	Suicide Prevention Group

Appendix 1:

Doncaster Suicide Prevention Group

TERMS OF REFERENCE

1. **Role/Purpose**

The role and purpose of the multi-agency Suicide Prevention Group is to provide a channel of communication to plan, direct and coordinate activity tailored to local needs that will lead to a reduction in suicide in the population of Doncaster, including support to those bereaved or affected by suicide.

2. **Objectives**

The objectives are:

To regularly review the national strategy and its recommendations and monitor their implementation
To report to the Health and Wellbeing Board, actions being taken and progress towards achieving recommendations
To identify and promote good practice in relation to suicide prevention
To agree a local action plan
To agree a work programme
To share local intelligence that will be used to inform the work programme.
To learn lessons from local experience and act on them
Oversee that interventions are culturally competent and able to meet the different cultural needs of all communities in the area.
Oversee interventions are evidence based, efficient, effective and economic and thereby offer good value for money.

3. **Working Principles**

Equality – the group will ensure that it promotes equality in all its work and will be active in ensuring its work is meeting the needs of the full diversity across the whole community.

Accountability – the group will support the interests of all its members and work in an open and transparent way, with good communication between partnership members and their membership organisations/sectors.

Respect/Co-operation – the group will aim to achieve its objectives through co-operation and collaboration whilst recognising, respecting and reflecting difference.

Partnership – the group will affect its work through the development and maintenance of strong and effective partnership working.

Time constraints – the duration of the meeting will not extend beyond one and half hours.

4. **Membership & Quoracy**

Membership of the group will include representatives from:

- ASPIRE Drug & Alcohol Services
- Coroner's Office
- Doncaster & Bassetlaw Hospital (DBH) NHS Foundation Trust
- Doncaster Children's Trust
- Doncaster College
- Doncaster Metropolitan Borough Council (DMBC) - to include Public Health / Children's / Adults and Communities / Communications / Education)
- Healthwatch Doncaster
- Independent and Voluntary Sector (MIND, Samaritans, Riverside, Rethink, Changing Lives)
- NHS Doncaster CCG Commissioning Support
- Prison Service
- Probation Service
- Network Rail
- Rotherham Doncaster & South Humber (RDASH) NHS Trust
- South Yorkshire Fire & Rescue
- South Yorkshire Police

The GP who leads on the Mental Health at Doncaster CCG will Chair the meetings. A deputy chair will be a member of the public health department.
The group may co-opt other members on an ad hoc basis as appropriate.

There must be 3 other members in addition to Chair or Deputy Chair in attendance for the meeting to be quorate.

If attendance is not possible apologies will be forwarded and a representative will be sent.

5. **Conflict of Interest**

Members must declare any actual or potential personal interests they have in any item on the agenda or as they arise during a meeting

6. **Governance & Accountability / Reporting Arrangements**

The group will be accountable to the Health and Wellbeing Board, Health Protection Agency and Doncaster Children's Safeguarding Board and will produce reports on its progress and actions at quarterly intervals.

7. **Frequency & Format of Meetings**

Meetings of the group shall normally be quarterly and will not last longer than 1.5 hours. Additional meetings may be convened as necessary to address specific items. Dates of meetings will be set in advance and members advised of the dates

8. **Review of Terms of Reference**

The group will review the Terms of Reference yearly

This page is intentionally left blank

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 15.03.2018

Subject: Pharmaceutical Needs Assessment 01.04.2018 - 31.03.2021

Presented by: Nasar Ahmed

Purpose of bringing this report to the Board	
Decision	X
Recommendation to Full Council	
Endorsement	
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		Yes
Legal		Yes
Equalities		Yes
Other Implications (please list)		

How will this contribute to improving health and wellbeing in Doncaster?
This Pharmaceutical Needs Assessment (PNA) assesses the local needs in relation to pharmaceutical services across the borough and identifies any gaps in that provision. The Health and Wellbeing Board has the responsibility of producing PNAs in accordance with the National Health Service (NHS) (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

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

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

Recommendations

The Board is asked to:-

1. APPROVE this Pharmaceutical Needs Assessment.

Doncaster Council

Doncaster Health and Wellbeing Board

Pharmaceutical Needs Assessment

(2018 – 2021)

Version: Final
Published: 1st April 2018

Acknowledgements

Thanks to the following individuals in helping compile the Pharmaceutical Needs Assessment:

Public Health, Doncaster Council
Nasar Ahmed Lucie Waugh Louise Robson

Strategy and Performance Unit, Doncaster Metropolitan Borough Council
Simon Noble Laurie Mott

Planning, Doncaster Metropolitan Borough Council
Jonathan Clarke Teresa Hubery

NHS England
Victoria Lindon Lee Eddell

Local Pharmaceutical Committee Representative
Nick Hunter

Doncaster Clinical Commissioning Group
Carolyn Ogle Kayleigh Wastnage

Neighbouring PNA Leads
Stephen Turnbull (Rotherham)
Rebecca Clarke (Barnsley)
Louise Brewins (Sheffield)

Contents

Executive Summary

This Pharmaceutical Needs Assessments (PNA) assesses the local needs in relation to pharmaceutical services across the borough and identifies any gaps in that provision. The Health and Wellbeing Board has the responsibility of producing PNAs in accordance with the According to the National Health Service (NHS) (Pharmaceutical and Local Pharmaceutical Services) Regulation 2013.
The report highlights the key findings of the mapping analysis, alongside the 60 days pharmacy stakeholder consultation which was undertaken from 24.11.2017 to 23.01.2018.

In conclusion, this PNA confirms that:

- On the whole access to pharmaceutical services is good.
- 87.2% of residents live within 1 mile of a community pharmacy.
- Nearly all GP practices are within 1km of a community pharmacy.
- There is a good coverage of pharmacies in poorer areas of Doncaster.
- Pharmacies offer brief lifestyle advice and are ideally placed to support the Public Health agenda.

Please be aware that the information contained in this report relating to service provision (opening times, services provided, housing developments etc.) was correct at the time of development, and is subject to future changes.

The final report was published in March 2018.

This PNA will be valid for three years from 1 April 2018 to 31 March 2021.

1. Introduction

PNA Introduction

Legislation requires that Health and Wellbeing Boards (HWBB) produce an assessment of the need for pharmaceutical services. These assessments (Pharmaceutical Needs Assessments or PNA) are due every three years. The last PNA was due on 1 April 2015 and a refreshed PNA is due on 1 April 2018.

PNAs describe:

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

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

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

Community pharmacies provide most of these services. There are other providers of pharmaceutical services and the PNA describes these where relevant. Assessment of pharmacy services in hospitals or in prisons are considered separately.

A range of organisations use PNAs to guide developments and commissioning intentions. NHS England is bound by regulations to consider the PNA for certain applications. Local Authorities and Clinical Commissioning Groups use the PNA to guide commissioning of services from pharmacies. The PNA is not a stand-alone document and organisations use other evidence in their planning. Other evidence includes Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies.

As part of developing PNAs a consultation must be undertaken for a minimum of 60 days. The regulations list those persons and organisations that must be consulted.

The PNA has to be approved by the HWBB. The HWBB includes representatives from the local authority, Health Watch and other relevant partners.

More information about Doncaster's HWBB can be found here: http://www.doncaster.gov.uk/services/health-wellbeing/doncaster%E2%80%99s-health-and-wellbeing-board

This PNA will be valid for three years from 1 April 2018 to 31 March 2021.

There is a range of legislation and regulation that specifies the development of PNAs and the information they must contain. This PNA complies with these regulations.

For more information see: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

2. Process for developing the PNA

2.1. Combined Approach

The Director of Public Health (DPH) in the local authority leads on the process and makes sure the PNA meets regulations.

The HWBBs are bound by the regulation to produce a PNA of their own. However, in order to make best use of limited resources the DsPH worked collaboratively across South Yorkshire on the elements of the PNA that would allow this.

This combined approach would only apply to the production of the 2018 refresh. It does not, at this stage, apply to the production of any supplementary statements. Any future collaboration is dependent on an evaluation of this approach and any changes to PNA regulations.

2.2. Governance

The DsPH agreed a project governance structure. A Public Health Specialty Registrar led the work on the combined approach supported by a Consultant in Public Health. PNA leads from each local authority agreed to act as a steering group. The South Yorkshire Local Pharmaceutical Network agreed to act as a stakeholder / reference group.

A core group was established consisting of representatives from the Local Pharmaceutical Committee, Doncaster CCG, Public Health and Strategic Performance Unit. The group has been responsible for the completion of the PNA and to ensure that the PNA exceeds the minimum requirements.

2.3. Scope

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

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

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

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

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

Emergency Hormonal Contraception, Needle Exchange and Palliative Care Drugs Services.

A pharmaceutical list includes the following:

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

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

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

2.4. Process

1. Mapping

Local leads gathered data from NHS England, local authorities and clinical commissioning groups. This data was collated into a single master spreadsheet detailing the following:

- Name / Contacts: Pharmacy name, lead pharmacist and contact details
- Geographical information: address, postcode
- Opening Times
- Advanced Services
- Commissioned Services

As we were looking to combine approaches we decided to use a single piece of software for the mapping of PNA data. This software is called SHAPE. SHAPE stands for Strategic Health Asset Planning and Evaluation. The Public Health England (PHE) Knowledge and Information Service manage the SHAPE tool. PHE have provided support to the South Yorkshire PNAs. SHAPE can layer geographical information with other indicators. SHAPE maps pharmacy locations against demographic information and indicators of health status and need.

2. Health Need

To identify health and pharmaceutical need the PNA uses a wide variety of data and information. These include the Joint Strategic Needs Assessments and other relevant strategies. The PNA uses these sources of information to assess current and future population size, measures of health and ill-health and other service provision.

3. Analysis

The current provision of pharmacy and pharmaceutical services was compared with current and potential future demographic and health needs.

4. Consultation

A 60 day consultation on the PNA was conducted. This consultation was sent to the list of stakeholders as defined by the regulations.

2.5. Equality Impact

The Public Sector Equality Duty (PSED) was introduced via the Equality Act 2010. It ensures Councils and other public bodies consider how different people will be affected by their activities and services.

The general duty (3 main aims) requires the council to have due regard to the need to:

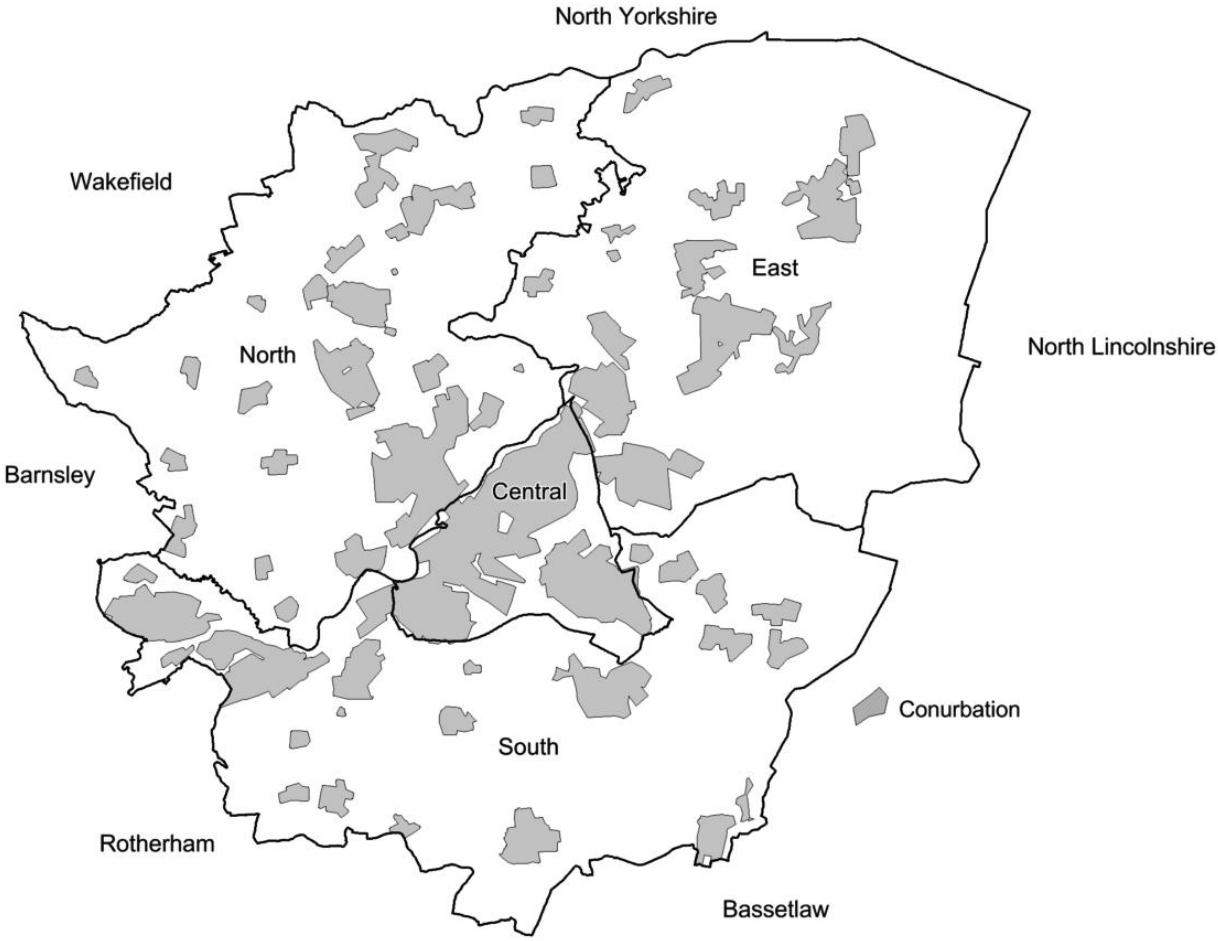
- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it

In accordance with the PSED at the outset of the PNA process the appropriate registration and paperwork was completed in accordance with the Doncaster Council Community Engagement Policy. An Equalities statement was completed and has been continually updated throughout the consultation process. This is available on request.

2.6. Localities for the Purpose of the PNA

The PNA uses the 4 neighbourhood areas defined by Doncaster Council and used by the majority of corporate partnerships (Central, North, East and South). These have roughly equal populations, ranging from approximately 71,000 in the North to 86,700 in the South. The PNA also takes account of pharmaceutical services outside the Borough provided by neighbouring areas – this is pertinent in the South and North which border Bassetlaw, Rotherham and Barnsley. The area beyond East is very rural and has no neighbouring pharmacies within a one mile radius of the border; however there is access to pharmaceutical services a little further afield in Crowle and Epworth (North Lincolnshire).

Map 1 – Doncaster Neighbourhood Areas



2.7. Consultation

A 60 day consultation on the document to the wider Doncaster community took place between 24.11.2017 and 23.01.2018. For this consultation all key stakeholders were consulted through online and email information methods. Copies were also circulated to neighbouring HWBBs for comment. List of key stakeholders can be found in Appendix 1.1.

Following the 60 day consultation, feedback on the document was received. These comments, our responses and any subsequent changes made to the document are listed in (Appendix 1.2).

2.8 Review Process

Doncaster HWBB will publish a revised assessment in three years unless there are significant changes to the availability of pharmaceutical services, in which case, a review will be considered. Assurances from partners will be sought on an annual basis if required, with accountability held by the Health & Wellbeing Board. Where changes to the availability of pharmaceutical services do not require a revision, the HWBB will issue a supplementary statement as soon as practical.

3. Population Demography

Doncaster is a diverse and vibrant borough. It is of medium size compared to other boroughs in Yorkshire and Humber, with a population of around 306,400 (2016, mid-year pop estimate). Some areas within the Borough are relatively affluent compared to the national average, though other areas are amongst the most deprived in the country. No Doncaster communities are free of lifestyle or social problems but some areas have multiple and persistent issues afflicting people across the life course.

3.1 Age Profile of the Population

Compared to the England average, it is estimated that Doncaster has a smaller proportion of adults aged 20 to 44 but has a higher proportion of people aged 45-69 and above (ONS, 2016).

The number of children and teenagers and the number of people aged 70 and above are similar to the national trend.

Table 1

Age Range	Doncaster pop %	England pop %
0-19	23.6	24
20-44	31.1	33.5
45-69	32.6	30.1
Above 70	12.8	12.3

Since 2001, Doncaster's population has increased by 6.4% (or 19,500 people) and is now estimated to be around 306,400 (ONS, 2016).

3.2 Future Age Trends

Doncaster`s population is expected to grow by approximately 1.8% - to 311,000 by 2030 (ONS, 2016).

Table 1 – Estimated Percentage change between 2017 and 2030 (ONS, 2016).

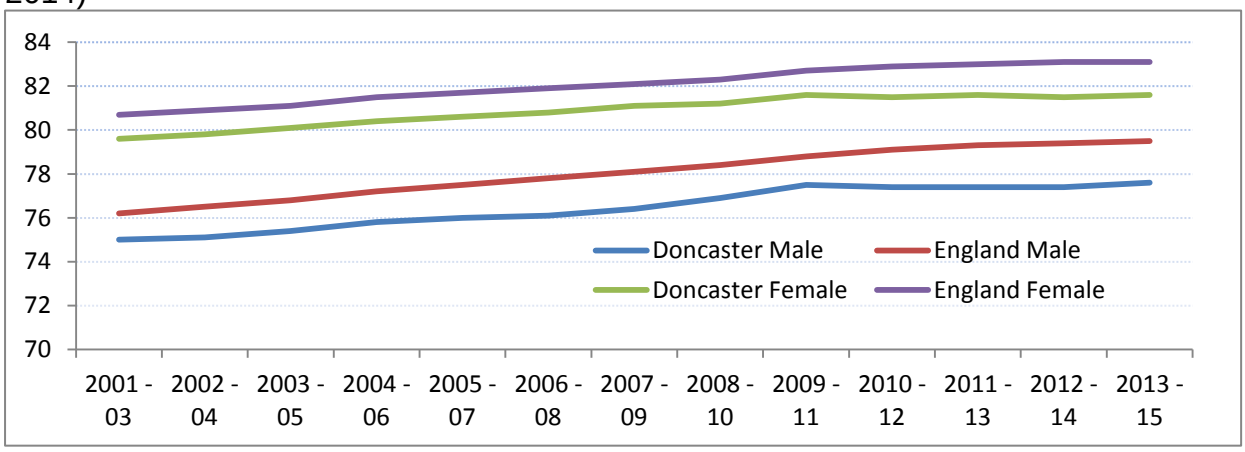
Age band	2017 pop	2030 pop	% change
0-14	55,069	52,064	-5.45%
15-24	33,203	34,478	+3.84%
25-34	40,705	34,977	-14.07%
35-44	36,462	40,360	+10.69%
45-54	43,214	36,471	-15.60%
55-64	38,845	39,013	+0.43%
65-74	31,995	37,210	+16.29%
75+	25,857	36,506	+41.18%

The largest increase (41.18%) is expected to be in the 75+ age band. Notably, there is predicted to be an increase in all age groups from 55 years and above. This increase in the age profile will have implications for health and social care services including pharmacies. The forecast also predicts a decrease in children aged 0-14 years.

3.3 Life Expectancy

Life expectancy at birth is 77.6 years for men and 81.6 years for women. Both are lower than the national average, though life expectancy has increased since 2001 in Doncaster for men and women. These increases mean more people in Doncaster will reach very old age and extreme old age, with associated health needs.

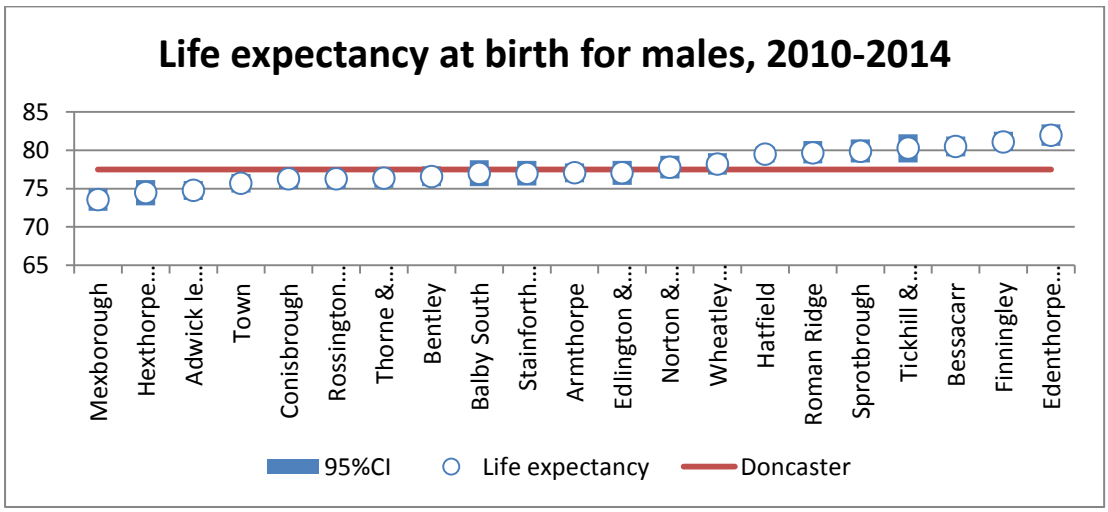
Graph 1 - Life expectancy gap for males and females (Public Health England (PHE), 2014)



3.4 Variation in Life Expectancy

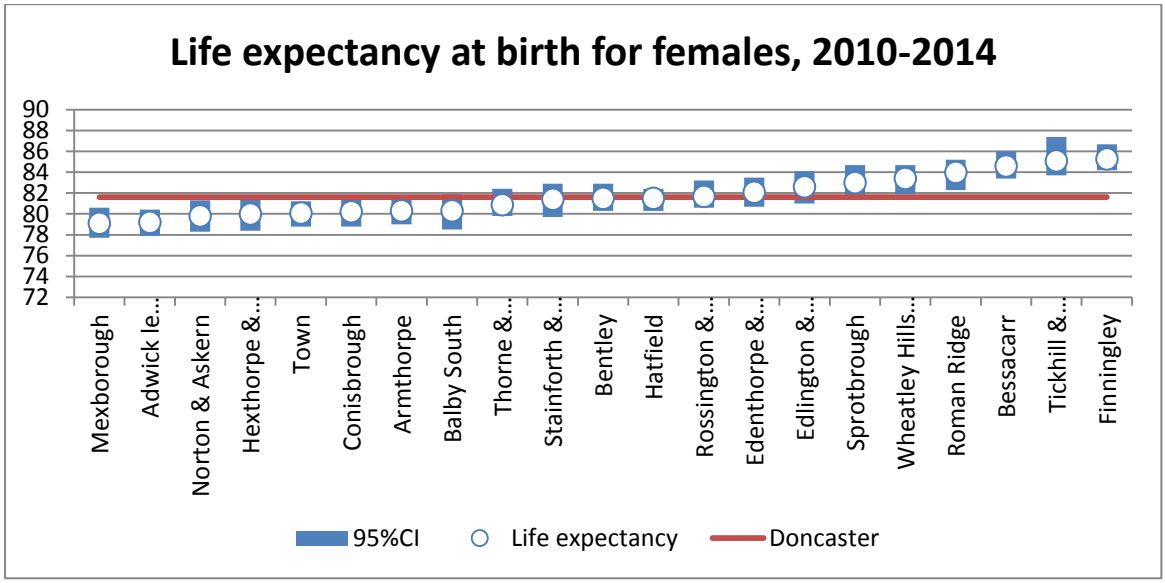
There is a variation in life expectancy within Doncaster. For males, there is an 8.4 year range from 73.6 years in Mexborough to 82 years in Edenthorpe and Kirk Sandall. For females, there is a 6.2 year range from 79.1 years in Mexborough to 85.3 years in Finningley.

Graph 2 - Life expectancy for males by Doncaster Electoral Wards (Doncaster Data Observatory, Electoral Ward Profiles 2010-14).



Compared to the Doncaster average, there is significantly lower male life expectancy in Hexthorpe, Central, Adwick le Street, Conisbrough and Mexborough Wards.

Graph 3- Life expectancy for females by Doncaster Electoral Wards (Doncaster Data Observatory, Electoral Ward Profiles 2010-14).



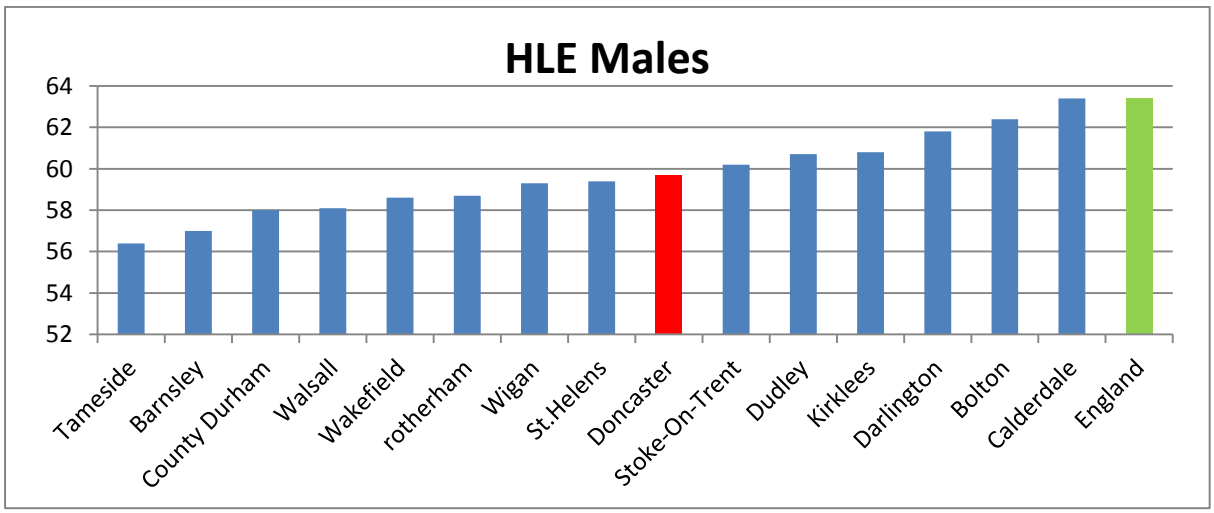
The female life expectancy in Mexborough, Central, Adwick, Norton and Askern and Hexthorpe wards is lower than the Doncaster average.

3.5 Healthy Life Expectancy

Both males and females in Doncaster have a lower healthy life expectancy compared to England average. The healthy life expectancy for both males and females is also lower when compared to the Yorkshire average. This means that people in Doncaster might spend the latter 20 years of their life without good health.

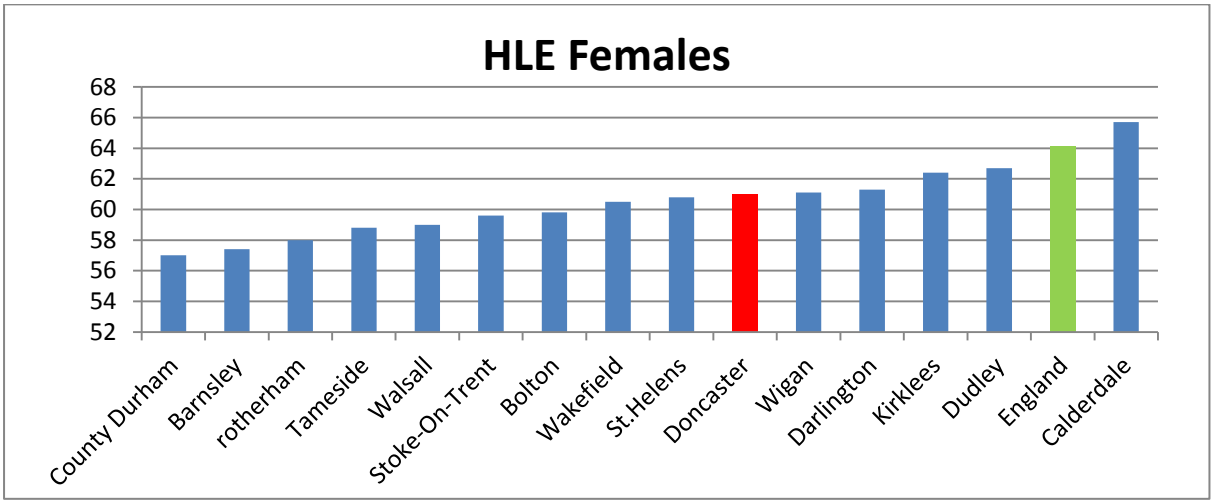
The graphs below compare healthy life expectancy in Doncaster to its Chartered Institute for Public Finance and Accountancy (CIPFA) nearest neighbours. Although, Doncaster Healthy Life Expectancy is higher than some areas it remains 3 to 4 years lower than Calderdale for both males and females.

Graph 4- Healthy Life Expectancy males (PHOF 2013-15).



On average, males in Doncaster experience ill-health from the age of 59.7. This is significantly lower than the national average of 63.4 years of age.

Graph 5 - Healthy Life Expectancy Females (PHOF 2013-15)



On average, females in Doncaster experience ill-health from the age of 61. This is significantly lower than the national average of 64.1 years of age.

The growing population and increasing life expectancy means more people will reach very old and extreme old age, with the associated health problems that result in low healthy life expectancy. Commissioners need to be prepared for increasing demand, to support older people to be a valued part of society, leading full and active lives for as long as possible, and to be cared for in the best possible way up to the end of their lives.

3.6 Disease Specific Populations

Generally, people in Doncaster experience higher levels of disease and ill-health compared to other areas. Compared to England as a whole, a high number of patients are registered with their GP for:

- Mental health conditions such as depression
- Circulatory conditions such as chronic heart disease, heart failure, stroke, hypertension and atrial fibrillation
- Chronic kidney disease
- Chronic obstructive pulmonary disease (respiratory disease) and asthma
- Diabetes
- Epilepsy

The table below gives a full breakdown of prevalence in primary care as measured by the Quality Outcomes Framework (QOF).

Table 2 – GP registered patients (Health and Social Care Information Centre (HSCIC), 2014).

	Doncaster register	Doncaster prevalence	England prevalence
Diabetes Mellitus	19,912	7.89%	6.55%
Epilepsy	2,413	0.97%	0.80%
Depression	20,520	8.24%	8.26%
Chronic Kidney Disease	15,163	6.09%	4.10%
Learning Disabilities	1,505	0.48%	0.48%
Osteoporosis	327	0.27%	0.31%
Stroke or Transient Ischaemic Attacks (TIA)	6,369	2.02%	1.74%
Hypertension	47,914	15.22%	13.81%
Chronic Obstructive Pulmonary Disease	8,444	2.68%	1.85%
Cancer	7,490	2.38%	2.42%
Mental Health	2,490	0.79%	0.90%
Asthma	21,030	6.68%	5.91%
Heart Failure	2,903	0.92%	0.75%
Palliative Care	848	0.27%	0.33%
Dementia	2,684	0.85%	0.76%
Atrial Fibrillation	6,265	1.99%	1.71%
Coronary Heart Disease	11,690	3.71%	3.2%
Cardiovascular Disease Primary Prevention	1,829	1.04%	1.07%

3.7 Ethnicity

In the 2011 Census, the Doncaster population was 91.8% White British compared with 85.5% for Yorkshire and Humber and 79.8% for England. Though less diverse than the regional and national average, the proportion has increased in recent years- In 2001 the population was 96.5% White British. The main other ethnic groups in Doncaster are detailed in the following table.

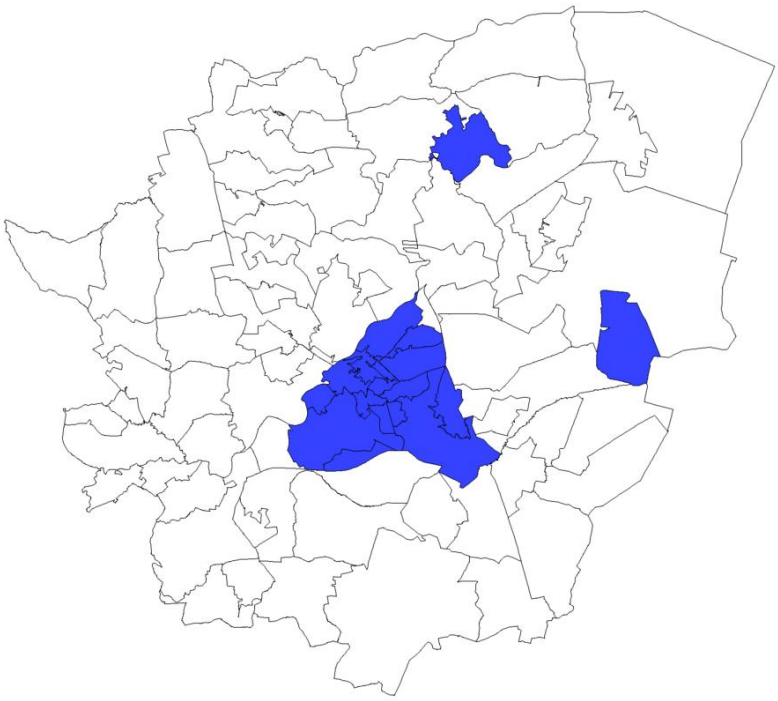
Table 3 – Minority ethnic groups in Doncaster (Nomis, 2013)

Ethnic Group	Person %
All categories: Ethnic group	302402
White: Total	95.2
White: English/Welsh/Scottish/Northern Irish/British	91.8
White: Irish	0.39
White: Gypsy or Irish Traveller	0.19
White: Other White	2.84
Mixed/multiple ethnic group: Total	1.09
Mixed/multiple ethnic group: White and Black Caribbean	0.46
Mixed/multiple ethnic group: White and Black African	0.14
Mixed/multiple ethnic group: White and Asian	0.29
Mixed/multiple ethnic group: Other Mixed	0.19
Asian/Asian British: Total	2.51

Asian/Asian British: Indian	0.61
Asian/Asian British: Pakistani	0.90
Asian/Asian British: Bangladeshi	0.03
Asian/Asian British: Chinese	0.37
Asian/Asian British: Other Asian	0.58
Black/African/Caribbean/Black British: Total	0.77
Black/African/Caribbean/Black British: African	0.43
Black/African/Caribbean/Black British: Caribbean	0.25
Black/African/Caribbean/Black British: Other Black	0.08
Other ethnic group: Total	0.35
Other ethnic group: Arab	0.08
Other ethnic group: Any other ethnic group	0.27

Overall Doncaster has low ethnic diversity though the map below shows there are diverse areas within the Borough. There are significant non-white British populations in the urban centre and surrounding areas, namely Balby (16%), Belle Vue (26%), Bennethorpe (18%), Hexthorpe (24%), Hyde Park (46%), Intake (16%), Lower Wheatley (37%), Town Moor (20%), and Wheatley Park (20%). There are anomalous hotspots in the North and East (HM Prisons and Braithwaite & Kirk Bramwith).

Map 2 - Significant non-white British populations (ONS, 2013a)



3.8 Language in Doncaster

96% of Doncaster's population (aged ≥3 years) speak English as their first or preferred language – compared to 94% across Yorkshire and Humber and 92% across England and Wales. 2.1% of people speak 'Other European' languages as a first or preferred language, of which 1.6% of people speak Polish.

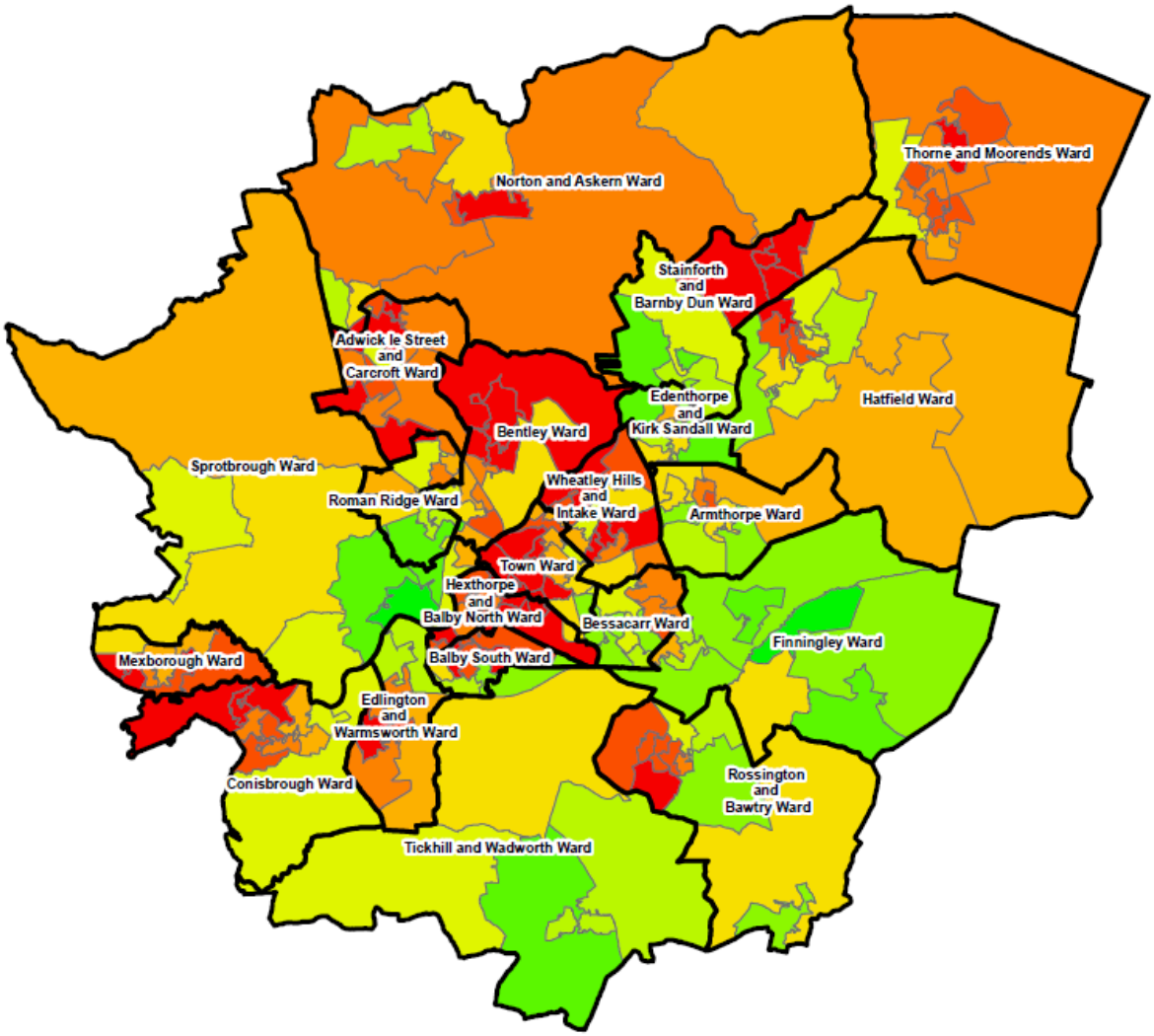
No other language accounts for half a percentage in Doncaster though 0.3% speak Urdu as a first or preferred language and 0.2% speak Punjabi as a first or preferred language (ONS, 2013b).

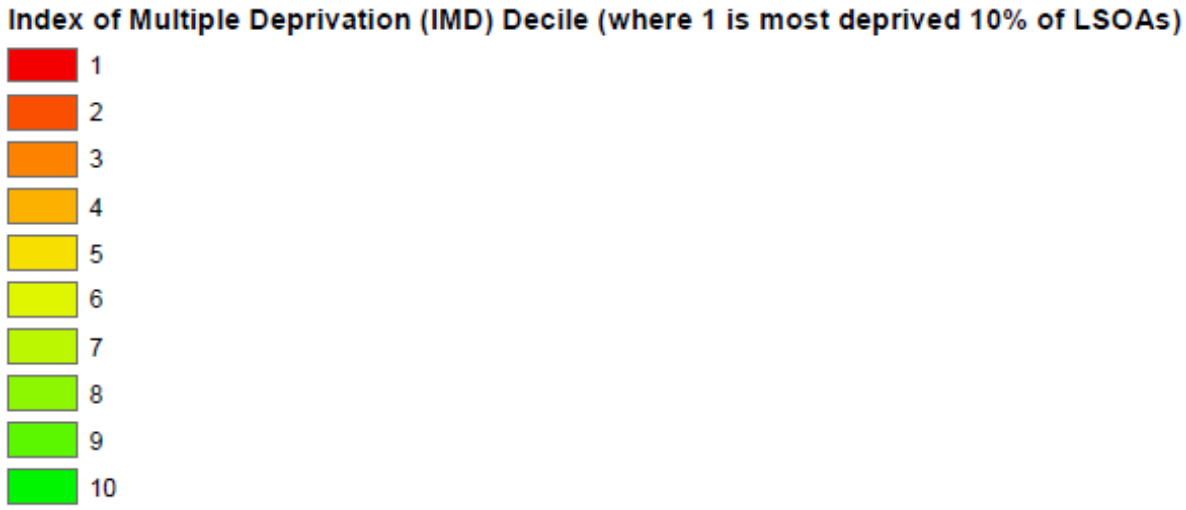
3.9 Deprivation

The Indices of Deprivation 2015 provides a composite measure of deprivation across multiple domains including income, employment, health and disability, education, skills and training, housing, crime and living environment (Index of Multiple Deprivation, 2015).

Doncaster has moved since the last PNA from 39th most deprived Local Authority to 48th most deprived of the 326 Local Authorities in England. However, there are concentrated areas of deprivation in all 4 corners of the Borough. Over 21% of the population in Doncaster are within the 10% most deprived in England.

Map 3 - Deprivation within Doncaster





4. Locally Identified Health Need

Local need is identified through the JSNA and the Health and Wellbeing Board Strategy (HWBS) for Doncaster. Priorities in the JSNA (identified from the Public Health Outcomes Framework) include:

- Overcoming challenges of an ageing population
- Reducing health inequalities
- Reducing number of elderly people living with above average levels of disability

Doncaster's Health and Wellbeing Board Strategy 2016-21

The Doncaster Health and Wellbeing Board Strategy 2016-21 has identified 4 key themes for development to improve health and wellbeing outcomes in Doncaster:

1. Wellbeing
2. Health and Social Care Transformation
3. Five Areas of Focus
4. Reducing Health Inequalities

The five areas of focus identified in the strategy are:

1. **Substance misuse (Drugs and Alcohol) -** Since 2011/12 the rates of alcohol-related admissions have increased further while the national rate has decreased, meaning the gap has widened further
2. **Obesity -** 74% of adults in Doncaster carry excess weight
3. **Children and Families -** Doncaster successfully delivered the first phase of the national Troubled Families Programme (locally known as Stronger Families)
4. **Dementia -** it is possible that the number of people in the borough aged over 64 living with dementia could increase from around 3,900 to almost 6,000 by 2030
5. **Mental Health -** If the national figures are applied to the Doncaster population then almost 55,000 people living in the borough have experienced some form of mental health problem

The Health and Wellbeing Board Strategy can be viewed from the link below: http://www.doncaster.gov.uk/services/health-wellbeing/doncaster%E2%80%99s-health-and-wellbeing-board

In addition, the 2011 Census showed that a high proportion of people in Doncaster:

- Report their health as 'bad' or 'very bad'
- Report having a disability that limits their everyday life
- Provide unpaid care, particularly those providing 50 hours or more per week

The Census also showed that, relative to the national average, a high number do not have access to a car, do not have qualifications and are economically inactive.

5. Current Pharmacy Provision and Services

In line with the HWBB's areas of focus, particular attention needs to be on those communities with the highest need and where there are gaps in provision – the following section will look at the provision across the Doncaster localities.

5.1 Pharmacy Demographics

Pharmacy contractors in Doncaster comprise of:

- 79 community pharmacies with:
    - 65 providers on 40 hour contracts
    - 11 providers on extended hour's contracts
    - 3 distance-selling providers/ internet pharmacies
- 1 appliance contractor
- 2 Dispensing General Practices.

An application for an extended opening hour's pharmacy has been approved at Hayfield Lane, Hayfield Green, Doncaster, DN9 3NB. The pharmacy is likely to open before the publication of this PNA.

Four maps in Appendix 2 present current pharmacy provision by geographic coverage (PHE, 2017).

At the time of the last PNA in 2015, there were 79 community pharmacies. The number of extended hour's pharmacies has reduced from 12 to 11 but the number of 40 hour pharmacies has remained the same. The number of Distance Selling Pharmacies has increased from 2 to 3 and the number of Dispensing General Practice has remained the same (Auckley Surgery and The Mayflower Medical Practice).

The NHS (Pharmaceutical and Local Pharmaceutical Services) regulations 2013 were amended in December 2016 by the introduction of Section 26A consolidations. The Section 26A consolidation is a merger of two pharmacy businesses that does not create a gap in the provision of pharmaceutical services. To date, there have been no Section 26A consolidations in Doncaster.

5.2 Pharmacies in Doncaster

Doncaster has a similar number of pharmacies per head of population compared to South Yorkshire and Bassetlaw and England as a whole. Central Neighbourhood has a higher rate of pharmacies per head of population compared to local and national averages. This is to be expected given the density of pharmacies in the town centre which people from whole of the borough travel to for work and leisure purposes. North and East Neighbourhoods have a similar rate to the overall average. South Neighbourhood is the most rural of the four areas and has a lower rate of pharmacies per head of population. However, Doncaster has two Dispensing General Practices, which are in the South (The Mayflower Medical Practice and Auckley Surgery).

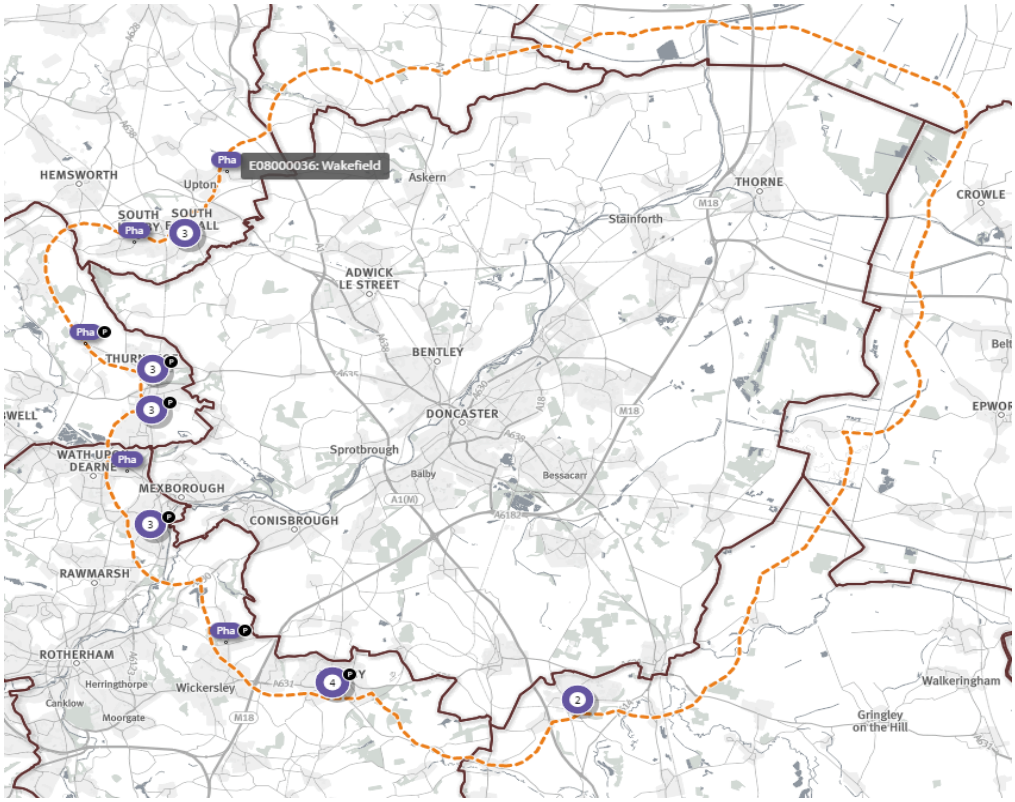
Table 4 – Pharmacy density for Neighbourhoods, Area Team and England (DMBC, 2017).

Pharmacies per head of population	Pharmacies	Population	No. per 10,000 population
South neighbourhood area	17	86,689	1.96
North neighbourhood area	17	71,440	2.37
East neighbourhood area	17	69,467	2.45
Central neighbourhood area	28	77,217	3.62
Doncaster	79	304,813	2.59

5.3 Access to pharmaceutical services around the HWBB boundary

Doncaster borders multiple neighbouring authorities so it is important to factor these into access to pharmaceutical services. Communities in the West and North also benefit from access to pharmacies in Bassetlaw, Rotherham, Barnsley and Wakefield authorities. There are no neighbouring pharmacies within a one mile radius of the border to the North East and East due to the rural nature of these areas, however there is some pharmaceutical provision a little further afield. The ratio of pharmacies per 10,000 people appears to be higher in the central neighbourhood area compared to South, East and North neighbourhood areas for Doncaster.

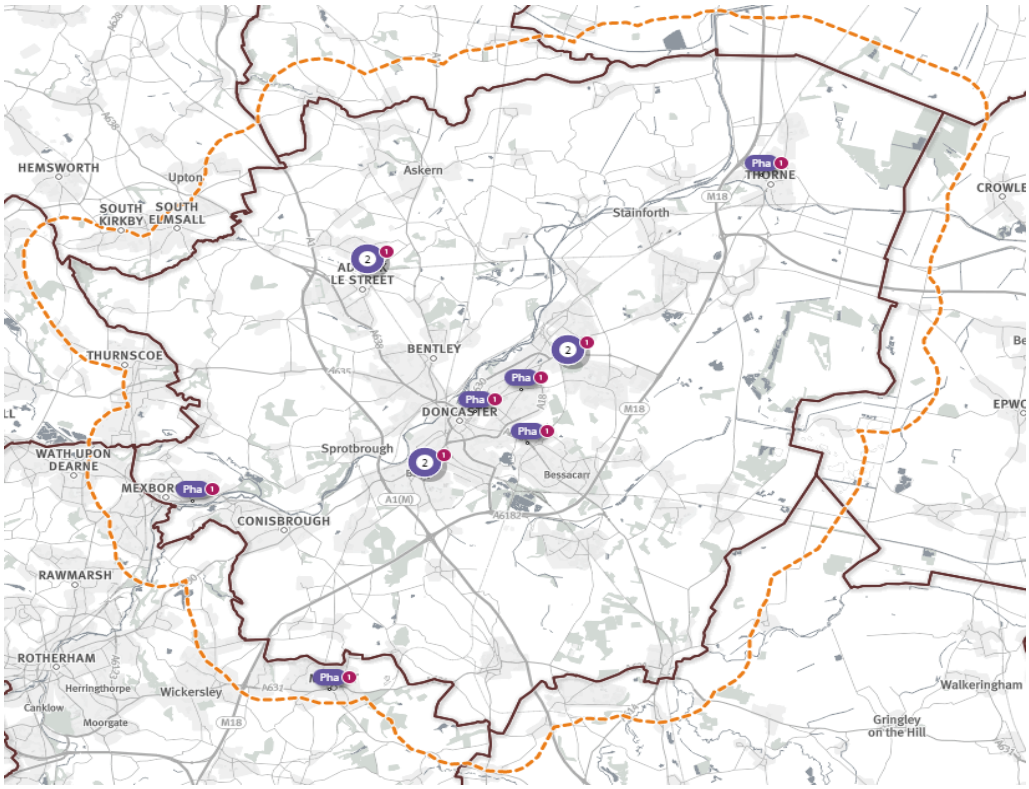
Map 4 – Pharmacy locations within 1 mile of Doncaster's border



5.4 Extended hour's Community Pharmacies

More than half of the extended hour's pharmacies in Doncaster are located in, or border, Central Neighbourhood. Access to the nearest extended hours pharmacy for most in the South (e.g. Rossington, Auckley) would be in Asda supermarket, Lakeside. Communities further out (e.g. Tickhill, Bawtry) could also access an extended hour's pharamcy across the border in Maltby.

Map 5 – Extended hour's pharmacy locations in Doncaster and within 1 mile radius of the border.



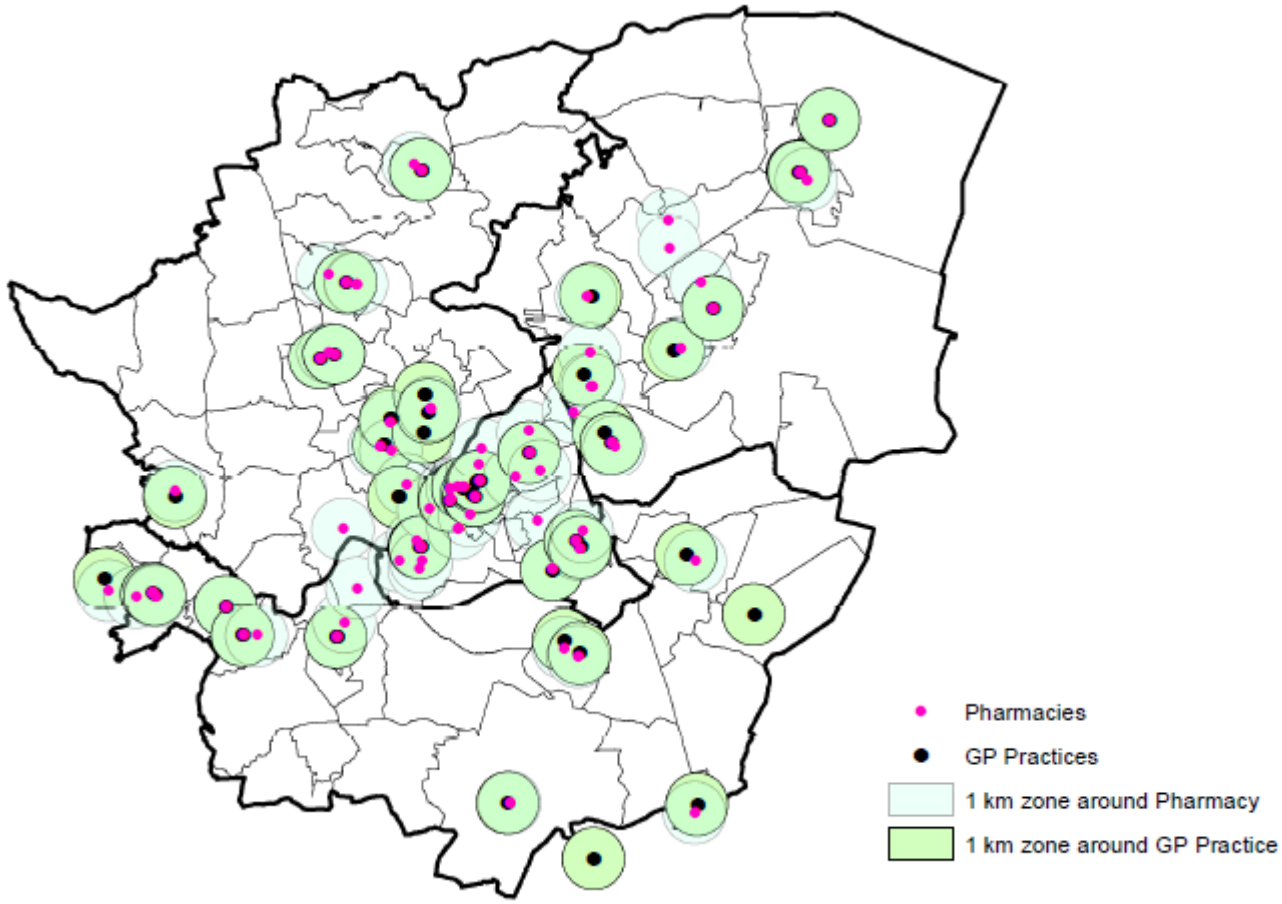
5.4.1 Services delivered by extended hour's pharmacies

Medicines use reviews, new medicines service and palliative care drugs services, inhaler technique, flu vaccination, minor ailment, supervised consumption and emergency hormonal contraception services are delivered by most of the extended hour's pharmacies. Pharmacy Urgent Repeat Medicine (PURM) service is available in six of the eleven extended hour's pharmacies. Needle Exchange service is available in three of the extended hour's pharmacies. In terms of setting, three of the eleven pharmacies are based in supermarkets. This will limit their opening hours on a Sunday to 6 hours.

5.5 Pharmacy correlation with GP practices

In Doncaster, pharmacies outnumber GP practices by approximately 2 to1 – there are 79 community pharmacies to 43 GP practices. Nearly all GP practices are within 1km of a pharmacy, or a 10 minute walk at average walking pace.

Map 6 – Locations of GP Practices and Pharmacies within Doncaster



6. Access to Pharmaceutical Services

An important part of the PNA is to assess how accessible pharmacies are to residents.

6.1 Geographical Access

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

6.1.1 Method

The method of calculating these measures has changed since the last PNA was published in 2015. The method now uses mapping software to assess access. This may give a better indication of access, particularly walking access than using a fixed radius around a pharmacy.

6.1.2 Results

Using the SHAPE access tool the following results have been calculated. To prepare these results consideration was also given the pharmacies outside of Doncaster that

could be reached within a 1.6km walk. 23 such pharmacies were identified within 1.6km of the Doncaster boundary. Of these only two pharmacies (both in Swinton, Rotherham) were close enough to improve access. However, those residents are already within a 1.6km walk of the McGill pharmacy in Mexborough. Thus, the overall access picture was not changed by pharmacies outside of the Doncaster border.

1. **Proportion of Doncaster residents within 1.6km (1 mile) walk of a pharmacy (including Dispensing GP Practices).**

Total population: 304,813 (PHE, 2017)

Number of residents within 1.6km walking distance: 265,782

Number of residents not within 1.6km walking distance: 39,031

Proportion of Doncaster residents within 1.6km (1 mile) walk of a pharmacy is therefore 87.2%.

2. **Proportion of Doncaster residents within 10 minute drive of a pharmacy.**

Total population: 304,813

Number of residents within 10 minute drive of a pharmacy: 304,813

Number of residents not within 10 minute drive of a pharmacy: 0

Proportion of Doncaster residents within 10 minute drive of a pharmacy is therefore 100%.

6.1.3 Discussion

The walking access measure shows a reduction in proportion of Doncaster residents within 1 mile walk of a pharmacy from 93% in the last PNA to 87.2%. This is due to the change in methods of analysis rather than a change in the population or pharmacy provision. This new method of analysing access does still have some methodological weaknesses which can bias the results. We will work with Public Health England to continue to improve this analysis as we believe that over time this will give a more accurate measure of access.

Access to pharmaceutical services in Doncaster is further improved through the three distance selling pharmacies and the delivery service provided by most pharmacies. Distance selling pharmacies provide a service to whole of England so fill a need where people don't have access to transport or cannot make the walk.

6.2 Access to pharmacies by opening hours

Table 5 – Number of pharmacies opening early, in the evening or at weekends.

	Early opening (≤8am)	Late opening (≥7pm)
Monday	4	14
Tuesday	7	14
Wednesday	7	14
Thursday	7	15
Friday	7	14

	Morning	Afternoon
Saturday	33	22
Sunday	10	

The proposed opening hours of the approved pharmacy at Hayfield Lane, Hayfield Green, Doncaster, DN9 3NB are; Weekdays 10.00-20.00, Saturdays 10.00-17.00 and on Sundays from 10.00-13.00. This will allow access to residents in the South neighbourhood area to pharmaceutical services on evenings and Sundays.

Access to a pharmacy on a Saturday morning is good throughout the borough. Four maps in Appendix 3 present opening hours by geographic coverage.

Weldricks at East Laith Gate is commissioned yearly on a needs basis by NHS England and Doncaster CCG, to ensure a pharmacy provision is available into the evenings, weekends and on Bank Holidays including Christmas day.

7. Pharmaceutical Services

7.1 Essential Services

Essential services are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contract (PSNC 2017). These include:

- Dispensing medicines
- Dispensing appliances
- Repeat dispensing
- Disposal of unwanted medicines
- Public Health (promotion of healthy lifestyles)
- Signposting
- Support for self-care
- Clinical governance

7.2 Advanced Services

Any pharmacy contractor may choose to provide Advanced Services. Currently, in Doncaster these includes; Medicine Use Reviews, New Medicine Services, Appliance Use Reviews, Appliance Customisation and Flu Vaccinations.

7.3 Locally Commissioned Services

Locally commissioned community pharmacy services can be contracted via a number of different routes and by different commissioners, including local authorities and Clinical Commissioning Groups (CCGs). Smoking cessation, needle exchange and supervised consumption are some of the Locally Commissioned Services in Doncaster.

Table 6 – Advanced services commissioned by NHS England

Commissioner	Service	Community pharmacy providers
NHS England	Medicine Use Reviews	69
	New Medicines Service	71
	Appliance Use Reviews	33
	Flu Vaccination	59
	NHS Urgent Medicines Supply	5
	Stoma Appliance Customisation	0

Table 7 – Local services commissioned by Doncaster Council Public Health and Doncaster CCG (direct and indirect).

Commissioner	Service	Community pharmacy providers
Doncaster Council Public Health	Emergency Hormonal Contraception	49
	Needle Exchange	16
	Supervised Consumption	73
	Smoking Cessation	33
Doncaster CCG	Palliative Care	39
	Minor Ailments	70
	Inhaler Technique	69
	Pharmacy Urgent Repeat Medicine (PURM) Service	54

At the time of writing the above data on the commissioned services is correct. However, from 1st April 2018 some of the services will be changing. The changes will be added to the supplementary statements which can be found on the following webpage:
http://www.doncaster.gov.uk/services/health-wellbeing/doncaster%E2%80%99s-health-and-wellbeing-board

Falls Risk Assessment service is no longer commissioned in Doncaster. At the time of the previous PNA, 49 pharmacies provided this service.

There has been an increase in number of pharmacies offering Palliative Care (11 to 39), Minor Ailment (27-70) and Inhaler Technique (50-69) services since the last PNA in 2015. Furthermore, there is a good coverage for PURM (54) and Flu

Vaccinations (59) services in the borough (Data for these was not available at the time of last PNA).

8. Geographic coverage of provision

This PNA does not consider prison or hospital pharmacies as they are commissioned through separate routes.

8.1 Advanced Services commissioned by NHS England

Medicine Use Reviews

The Medicine Use Reviews and Prescription Intervention service consists of accredited pharmacists undertaking structured adherence-centred reviews with patients on multiple medicines for long-term conditions. National target groups have been agreed in order to guide the selection of patients to whom the service will be offered.

Geographic coverage is high, as nearly all pharmacies across the borough offer Medicines Use Reviews service (Appendix 4, map 1).

New Medicines Service

A New Medicines Service provides support for people with long term conditions starting new medicine to help improve adherence; it is initially focused on particular patient groups and conditions.

Geographic coverage is high as 71 pharmacies across the Borough offer the New Medicine Service (Appendix 4, map 2).

Appliance Use Reviews

Appliance Use Reviews improve patient knowledge on the use of appliances (e.g. colostomy/urostomy bags, syringes etc) by resolving poor or ineffective use, and advising on safe and appropriate storage and disposal.

Less than half of the pharmacies offer Appliance Use Review (33/78) service in Doncaster. In the North neighborhood, some sizeable communities with health problems are more than 1 mile from an Appliance Use Review service – Askern, Woodlands, Highfields and parts of Bentley. However, most patients obtain their supplies and advice from Dispensing Appliance Contractors who provide services across a much wider geographic area (Appendix 4, map 3).

Flu Vaccination

Flu Vaccination is available every year to help protect adults and children identified at higher risk of flu and its complications. The risk groups identified include; people aged over 65 pregnant women , children and adults with an underlying health condition (such as long-term heart or respiratory disease) and children and adults with weakened immune systems (PSNC 2017b). The eligible list is currently awaiting changes to include paid carers.

Geographic coverage is high, especially when mapped against areas in Doncaster with poorer health. There are 59 pharmacies offering this service and residents who meet the criteria are also invited for a flu jab through their GP Practice (Appendix 4, map 4).

NHS Urgent Medicines Supply Advanced Service (NUMSAS)

The NHS Urgent Medicines Supply Advanced Service pilot is a new advanced service commissioned by NHS England with the aim of referring people directly from NHS 111 to a community pharmacy for urgent repeat prescriptions. It complements rather than replaces the Pharmacy Urgent Repeat Medicine (PURM) service which is a pharmacy walk-in service.

Three pharmacies in the South provide this service, (Conisbrough, Mexborough and Harworth). The service is also available in Thorne and Carcroft, There is no provision in the Central neighbourhood area. the number of pharmacies providing this service is likely to change if the pilot is permanently commissioned in the future.

Stoma Appliance Customisation Service

The Stoma Appliance Customisation Service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.

Patients access this service through specialist Dispensing Appliance Contractor (DAC) providers which operate over a wide geography.

8.2 Locally Commissioned Services

Palliative Care Drugs Service- commissioned by Doncaster CCG

The Palliative Drugs Service ensures appropriate access to a range of palliative care drugs in accessible locations across Doncaster, particularly in the out-of-hours period and when treatment is needed urgently.

Half of the pharmacies in Doncaster provide palliative care drugs service. At the time of the last PNA only 16 pharmacies provided this service and there was no provision in Bawtry, Tickhill and Rossington and Conisbrough in the South. However, this is no longer the case and geographic coverage is high when mapped against areas of Doncaster with poorer health (Appendix 4, map 5).

Needle Exchange Service- commissioned by Aspire

Needle Exchange Service allows injecting drug users to obtain hypodermic needles and associated paraphernalia at no cost. This reduces the risk of harm from disease such as HIV/AIDS and Hepatitis, which also benefits the health of wider society. Exchanges also offer the opportunity to sign-post users to treatment services.

Geographic coverage is good in Centre and South West of Doncaster, especially when mapped against areas in Doncaster with high crime rates. The service is commissioned from 16 pharmacies following an assessment of need (Appendix 4, map 6).

Supervised Consumption Service- commissioned by Aspire

Supervised Consumption Service aims to dispense and supervise the consumption of Methadone and buprenorphine/Subutex, a substitute used by people recovering from addiction to opiates such as Heroin.

Geographic coverage is high across the borough as nearly all pharmacies offer the Supervised Consumption Service (Appendix 4, map 7).

Inhaler Technique Service- commissioned by Doncaster CCG

Inhaler Techniques Service aims to improve the inhaler technique of patients with asthma and Chronic Obstructive Pulmonary Disease (COPD). Research shows that many patients use their inhaler incorrectly and this service provides additional advice by pharmacists who have undertaken additional training.

Geographic coverage is high across the borough, especially when mapped against areas in Doncaster with poorer health. There are 69 pharmacies in Doncaster which provide the Inhaler Technique Service (Appendix 4, map 8). The number of pharmacies providing this service has increased from 50 to 69 since the last PNA in 2015.

Minor Ailments Service- Doncaster CCG

Minor Ailment Service provides advice and support to people suffering illnesses such as colds, headaches, eczema and diarrhoea. Pharmacists can also supply a range of medicines to people without having to visit the GP for a prescription. The service also provides referral to other services where appropriate.

Geographic coverage is high throughout the borough as nearly all pharmacies offer this service (Appendix 4, map 9). There has been an increase in the number of pharmacies providing this service since the last PNA from 27 to 72 at present.

Smoking Cessation Service- Commissioned by South West Yorkshire Partnership NHS Foundation Trust (SWYFT)

The pharmacy Smoking Cessation Service allows members of the public to speak to a trained member of staff about quitting smoking. The trained staff can provide one-to-one behavioural support based on the National Centre for Smoking Cessation and Training (NCSCT) standard treatment programme and/or Nicotine Replacement Therapy (NRT) and Champix.

Less than half of the pharmacies offer smoking cessation service in Doncaster (33/78). Geographically, these services are concentrated in Centre, East and South West of Doncaster (Appendix 4, map 10).

Pharmacy Urgent Repeat Medicine (PURM) Service- commissioned by Doncaster CCG

The PURM service allows pharmacists to supply prescription only medicines to patients without a prescription in an emergency at the request of the prescriber or patient.

Geographic coverage is high, especially when mapped against areas in Doncaster with poorer health. There are 54 pharmacies which provide the Emergency Supply service in Doncaster (Appendix 4, map 11).

Emergency Hormonal Contraception Services- commissioned by TriHealth

The Emergency Hormonal Contraception is a pill that can be taken to prevent pregnancy in the event of unprotected sex, or where usual contraception has failed (for example a split condom).

Geographic coverage is high when mapped against Doncaster's most deprived areas. These are likely to be the areas of greatest need - there is a correlation between deprivation and issues such as unprotected sex, sexually transmitted infections and teenage pregnancy (Appendix 4, map 12).

This PNA has not analysed whether there are any areas where a Section 26A consolidation would create a gap in the provision of pharmaceutical services. Any such applications would need to be considered on a case by case basis. The SHAPE tool could be used to assess such applications.

8.3 Pharmacies and Public Health Campaigns

Community pharmacies are an easily accessible health care service within the wider community setting, and therefore are an ideal setting to promote healthy lifestyles messages. Pharmacies are required to participate in six public health campaigns at request of NHS England (NHSE), and with provision of materials for those campaigns.

Community pharmacies contribute to the Public Health agenda in a number of ways. They provide prevention and early intervention brief advice to support and help tackle health inequalities. This includes support and advice around:

- Stopping smoking- some pharmacies are commissioned by South West Yorkshire Partnership NHS Foundation Trust to provide structured advice and pharmacotherapy – List of services offered by the NHS stop smoking service can be viewed here: https://www.nhs.uk/Livewell/smoking/Pages/NHS-stop-smoking-adviser.aspx
- Brief alcohol and drugs signposting and lifestyle advice- Aspire commission substance misuse support by way of supervised consumption and needle exchange.
- Signposting
- Contraception and sexual health signposting and lifestyle advice-TriHealth also commission EHC service from a selection of pharmacies in Doncaster (Appendix 4, map 12).
- Delivering public health campaigns- as part of the essential services commissioned by NHS England.

Pharmacies are also encouraged to train staff on the principles of Making Every Contact Count (MECC) as part of the Healthy Living Pharmacies Level 1 criteria. Doncaster Public Health has developed a MECC e-Learning module focussing on five key areas; diet, smoking, alcohol, physical activity and mental wellbeing and has worked with the LPC to help pharmacies understand that every interaction is an

opportunity to deliver a health promotion intervention. The module is mandatory to anyone attending the leadership or the healthy living champions training.
Healthy Living Pharmacies aim to improve the health and wellbeing of the local people and help to reduce health inequalities by delivering, through community pharmacies, a broad range of public health services. This includes a stop smoking service, brief alcohol interventions, weight loss, treatment of minor ailments, contraception and sexual health and targeted medicine use reviews to meet local health needs.

Currently, there are 35 pharmacies in Doncaster that have been accredited as Healthy Living Pharmacies. The latest list of the Healthy Living Pharmacies can be found through the link below:

https://www.rsph.org.uk/our-services/registration-healthy-living-pharmacies-level1/register.html

The Department of Health introduced Quality Payment Scheme as part of the community pharmacy contractual framework in 2017/18 incentivises pharmacies to meet new quality criteria on patient safety, patient experience, public health, digital standards, clinical effectiveness and workforce (PSNC 2017c). It aims to widen the pharmacy role beyond dispensing to improving the quality of health care for patients while at the same time helping to ease demand on other areas of the health system.

In terms of workforce, pharmacies are encouraged to train staff as Dementia Friends. The Doncaster Dementia Action Alliance has worked in partnership with the Local Pharmaceutical Committee (LPC) and Centre for Pharmacy Postgraduate Education to deliver dementia awareness sessions for pharmacy staff on two levels. One aimed at all pharmacy support staff and the second being a more comprehensive session for pharmacists and pharmacy technicians, which included the dementia friends information along with more clinical information related to dementia care.

9. Future Impacts

9.1 Housing and Development

The development of significant quantities of new housing and the creation of job opportunities can have a major impact on the demand for pharmaceutical services. Doncaster's Core Strategy Development Plan Document, part of the council's Local Development Framework sets out a vision for the area, and key strategic objectives and strategic policies for development. This can be found here:

http://www.doncaster.gov.uk/services/planning/ldf-core-strategy-development-plan-document-dpd

It provides a planning framework for the 17 year period from 1st April 2011 to 31 March 2028 to deliver the vision and aspirations of the Borough Strategy. The Doncaster Core Strategy was adopted in May 2012 and identifies where employment opportunities and new housing will be located according to the Settlement Hierarchy within the adopted plan period up to the year 2028.

Table 10 - Possible future housing development sites in Doncaster with existing planning permission granted by Doncaster Metropolitan Borough Council (DMBC) for 100+ plots as at 1st April 2017. *

Area	Location	Approved number of dwellings (Total site capacity net units)	Remaining Number of dwellings	Planning Stage
Central	Hexthorpe	930	930	Permission had formally commenced but stalled before any completions and developer no longer implementing this scheme so doubts around deliverability and likely to require a fresh planning application in due course.
Central	Wheatley	600	600	Permission
Central	Waterdale	450	396	Started- Outline permission is for a large mixed use development, much of which has been developed (e.g. Council Offices; Cast Performance Venue; Civic Square etc). Therefore, 132 dwellings in total is a more accurate reflection.
Central	Lakeside	147	147	Not started
Central	Lakeside	151	135	Started
Central	Bessecar	1106	1007	Started
Central	Lakeside	303	37	Started
Central	Woodfield	323	55	Started
North	Woodlands	343	343	Permission
North	Askern	227	225	Started
North	Askern	220	220	Permission
North	Bentley	203	179	Started
East	Dunscroft	400	400	Permission
East	Stainforth	170	170	Not started
East	Stainforth	152	152	Not started
South	Mexborough	147	76	Started
South	Mexborough	215	39	Started
South	Rossington	1200	1162	Started
South	Auckley	450	205	Started
South	Edlington	375	375	Permission
South	Edlington	387	190	Started
South	Edlington	173	107	Started

South	Conisbrough Denaby Main	175	175	Not started

**Please note that this information was correct as of 31st March 2017 and will not be updated until 1st April 2018.*

Any future PNA reviews will need to be mindful of any unmet needs of newly established populations residing within future building programmes and make recommendations as appropriate.

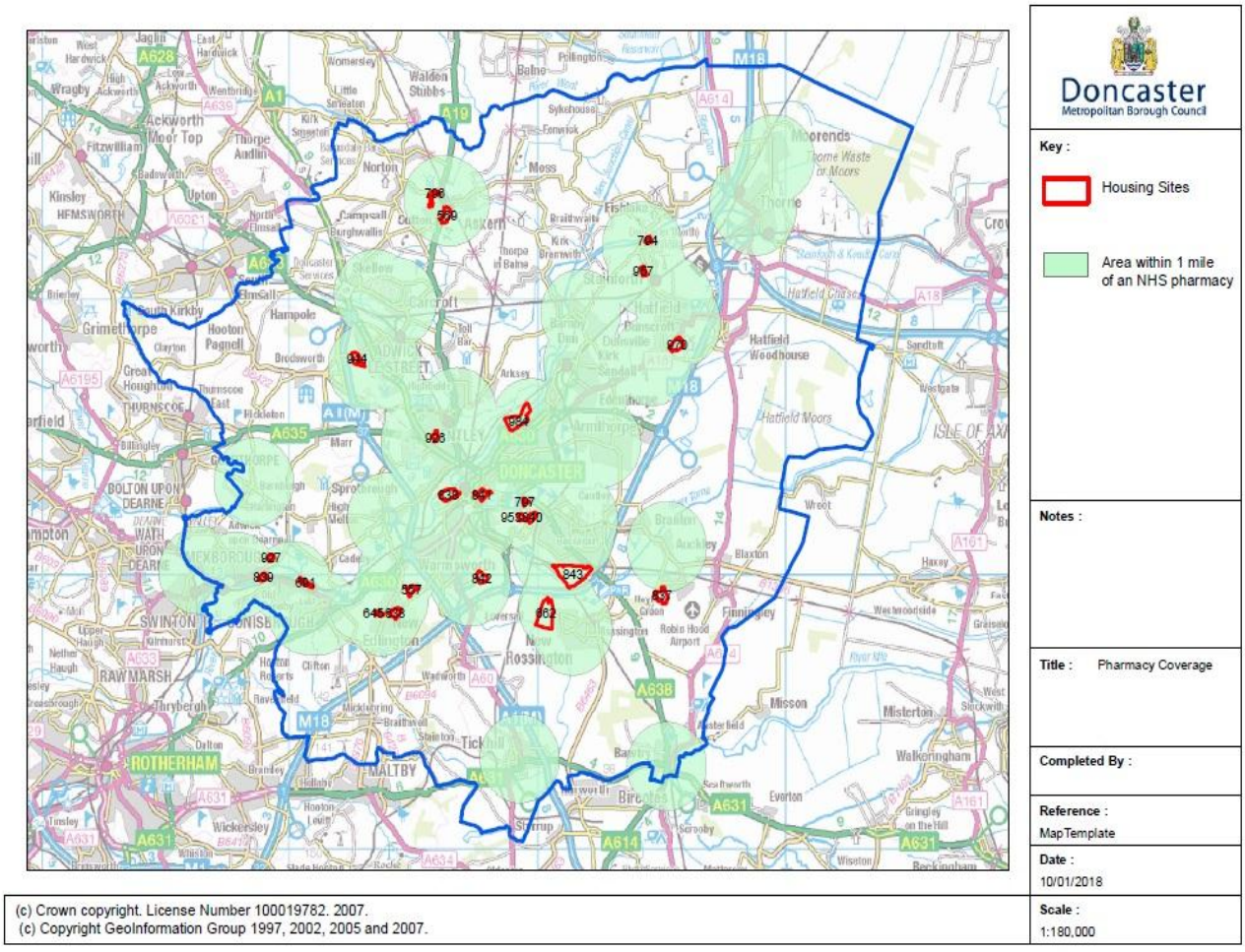
Various reports are produced to monitor the implementation of the council's Planning Policies.

The latest versions of these documents are available below:

http://www.doncaster.gov.uk/services/planning/monitoring-and-implementation

9.2 Pharmacy correlation with future housing development

Map 7- Housing developments within 1 mile radius of an NHS Pharmacy



Only one future housing development scheme is outside 1 mile radius of an NHS pharmacy. This is site at Hurst Lane/ Hayfield Green. However, as stated earlier in section 5.1, an application for an extended opening hour's pharmacy has been approved at Hayfield Lane, Hayfield Green, Doncaster, DN9 3NB. The pharmacy is likely to open before the publication of this PNA.

10. Conclusion

The outcomes of this PNA have confirmed that on the whole access to pharmaceutical services is acceptable.

In summary our analysis shows that:

- Doncaster has good access to pharmaceutical services with 87.2% of residents living within 1 mile of a pharmacy and all residents within 10 minute drive.
- Nearly all GP practices are located within 1km of a pharmacy.
- Geographic coverage of pharmacies is high, especially when mapped against areas of Doncaster with poorer health.
- Pharmacies offer brief lifestyle advice and are ideally placed to support the Public Health agenda.
- All approved future housing development are within 1 mile radius of an NHS Pharmacy.

References

Doncaster Data Observatory 2012. Doncaster Data Observatory Profiles; 2012 Electoral Ward Profiles.

Doncaster Metropolitan Borough Council (DMBC) (2017). Strategy and Partnership Unit. June 2017. Available at;

http://www.teamdoncaster.org.uk/doncaster-data-observatory

HSCIC, 2016. Health and Social Care Information Centre, Quality Outcomes Framework. Published 27.10.2016. Available at;
http://digital.nhs.uk/catalogue/PUB22266

Index of Multiple Deprivation, 2015. Doncaster Metropolitan Borough Council. Published 30.09.2015

Nomis, 2013.Ethnic groups by sex by age. Published 16.05.2013. Available at;
https://www.nomisweb.co.uk/census/2011/dc2101ew

ONS 2013a. Office for National Statistics, 2011 Census; Statistics on Ethnic Group (Table QS201EW). Published 13/02/2013. Available via;
http://www.nomisweb.co.uk/query/construct/components/stdListComponent.asp?menuopt=12&subcomp=100

ONS 2013b. Office for National Statistics, 2011 Census; Statistics on Main Language (Table QS204EW). Published 30/01/2013. Available via;
http://www.nomisweb.co.uk/query/construct/components/stdListComponent.asp?menuopt=12&subcomp=100

ONS 2016. Office for National Statistics Data: Annual Mid-Year Population Estimate 2016. Doncaster Demographics.

PHE 2015. Public Health England, Public Health Outcomes Framework Web-based Tool. Available at; http://www.phoutcomes.info/

PHE 2017. Public Health England, Strategic Health Strategic Health Asset Planning and Evaluation (SHAPE) Web—based Tool. Available at;
https://shapeatlas.net/place/

PSNC 2017a. Pharmaceutical Services Negotiating Committee, Services and Commissioning summary. Available at; http://psnc.org.uk/services-commissioning/

PSNC 2017b. Pharmaceutical Services Negotiating Committee, Flu vaccination-eligible patients groups. Available at; http://psnc.org.uk/services-commissioning/advanced-services/flu-vaccination-service/flu-vaccination-eligible-patient-groups/

PSNC 2017c. Pharmaceutical Services Negotiating Committee, Quality Payments. Available at: http://psnc.org.uk/doncaster-lpc/quality-payments/

Appendix 1 - 60 day Consultation Results

Consultation Phase 2 commenced on 24.11.2017 and ended on 23.01.2018. For this consultation all key stakeholders and the general public were consulted through online and email information methods. Communications teams in key organisations across Doncaster were asked to cascade the information and further copies were available through all the regular channels of communication. Hard copies were made available on request. Copies were also circulated to neighbouring HWBB's for comment.

1.1 Key stakeholders

Organisation	Contact Details
Sheffield City Council	Louise Brewins: Louise.Brewins@sheffield.gov.uk
Barnsley Metropolitan Borough Council	Rebecca Clark: RebeccaClarke@barnsley.gov.uk Barnsley Julia Burrows – juliaburrows@barnsley.gov.uk
Rotherham Metropolitan Borough Council	Stephen Turnbull: Stephen.Turnbull@rotherham.gov.uk DPH Rotherham Teresa Roche: Teresa.roche@rotherham.gov.uk
North Lincolnshire Council	Penny Spring: penny.spring@northlincs.gov.uk
Nottinghamshire County Council	Barbara Brady Barbara.Brady@nottscc.gov.uk
North Yorkshire County Council	Lincoln Sargeant: Lincoln.sargeant@northyorks.gov.uk
East Riding of Yorkshire Council	Tim Alison: tim.alison@eastriding.gov.uk
Wakefield Metropolitan District Council	Andrew Furber: afurber@wakefield.gov.uk
Neighbouring Health and Wellbeing Boards	Louise.Robson@doncaster.gov.uk
NHS England/ Doncaster CCG	Carolyn Ogle: Carolyn.Ogle@nhs.net
Local Pharmaceutical Committee (All Pharmacies)	Nick Hunter: nickhunter19@gmail.com
Rotherham Doncaster and South	Lynn Hall:

Humber NHS Foundation Trust	lynn.hall@rdash.nhs.uk
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Adam Tingle: Adam.Tingle@dbh.nhs.uk
Dispensing General Practices	Dean Eggitt: deaneggitt@hotmail.com office@doncasterlmc.co.uk
Local Medical Committee	Dean Eggitt: deaneggitt@hotmail.com office@doncasterlmc.co.uk
Healthwatch	Andrew Goodhall: andrew.goodall@healthwatchdoncaster.org.uk
Health and Wellbeing Board	Louise Robson: Louise.Robson@doncaster.gov.uk
Doncaster Children's ServicesTrust	Paul Moffat: Paul.Moffat@doncaster.gov.uk

1.2 Stakeholder Responses

Was the purpose and background of the draft PNA clearly explained?

	Count
No	0
Yes	2
Did not answer	0
Grand Total	**2**

Feedback	PNA Authors response

Was the information in the draft PNA clear and understandable?

	Count
No	1
Yes	1
Did not answer	0
Grand Total	**2**

Feedback	PNA Authors response
A few anomalies detailed below under question 8, but do not affect the PNA conclusion	Please see question 8.

Do you feel the PNA reflects pharmacy/chemist provision within the Borough?

	Count
No	0
Yes	2
Did not answer	0
Grand Total	**2**

Feedback	PNA Authors response
As far as I can tell, without local knowledge.	Feedback noted.
Mostly - a few comments include under question 8 below	Please see question 8.

Do you feel the PNA reflects the needs of the population in the Borough?

	Count
No	0
Yes	2
Did not answer	0
Grand Total	**2**

Feedback	PNA Authors response

Do you feel there are any unidentified gaps in service provision; i.e. when, where and which services are available?

	Count
No	2
Yes	0
Did not answer	0
Grand Total	**2**

Feedback	PNA Authors response

Do you feel there are any services that could be provided in community pharmacies in the future, which have not been highlighted already?

	Count
No	1
Yes	1
Did not answer	0
Grand Total	**2**

Feedback	PNA Authors response
Further support for COPD patients and other long term condition management. Falls risk assessment service should be recommissioned - modified to integrate better with other services. Commissioners should consider further need for a service to support pharmaceutical care plans for patients to reduce pressure on primary medical services and social care as part of the intermediate care pathway	This feedback has been noted and shared with commissioners.

Do you agree with the considerations within the PNA?

	Count
No	0
Yes	2
Did not answer	0
Grand Total	**2**

Feedback	PNA Authors response
The considerations relating to North Lincolnshire (I am completing this on behalf of the NLC H&WBB) relate to the services provided in the	This Feedback has been noted.

Epworth/Crowle area and these seem reasonable.	

If you have any further comments about the content of the PNA draft, please write them below.

Feedback	PNA Authors response
The PNA is clear and understandable with a clear exposition of gaps/needs. NLC recognise the shared dependency of services provided by pharmacies on the boundary with NLC.	This feedback has been noted.
1. There is no reference to the PNA consultation on DMBC website – in fact not even a reference to the 2018 PNA being drafted.	The Pharmaceutical Needs Assessment Guidance outlines the groups that we need to consult with irrelevant of any protected characteristics. For community oversight and to underpin the views of the public, Healthwatch Doncaster offered to share the consultation questionnaire with some of their members who represent a good cross-section of the community.
2. Reference to the "South" is too vague and should be more specific by defining an actual geographic area. Also, the reference needs to be qualified by referring to the South Locality / Neighbourhood where this is applicable. For instance not many would consider Mexborough to be "south" of the Borough.	This feedback has been noted and relevant changes have been made.
3. When it talks about accessing services across a border it mentions Maltby, which most people would struggle to find! While doesn't mention M&R Pharmacy in Harworth which in terms of patient	This feedback has been noted. This point refers to extended hour's pharmacy on map 5. The only extended hour's pharmacy within 1 mile radius of the border is in Maltby. Wording has been changed to reflect

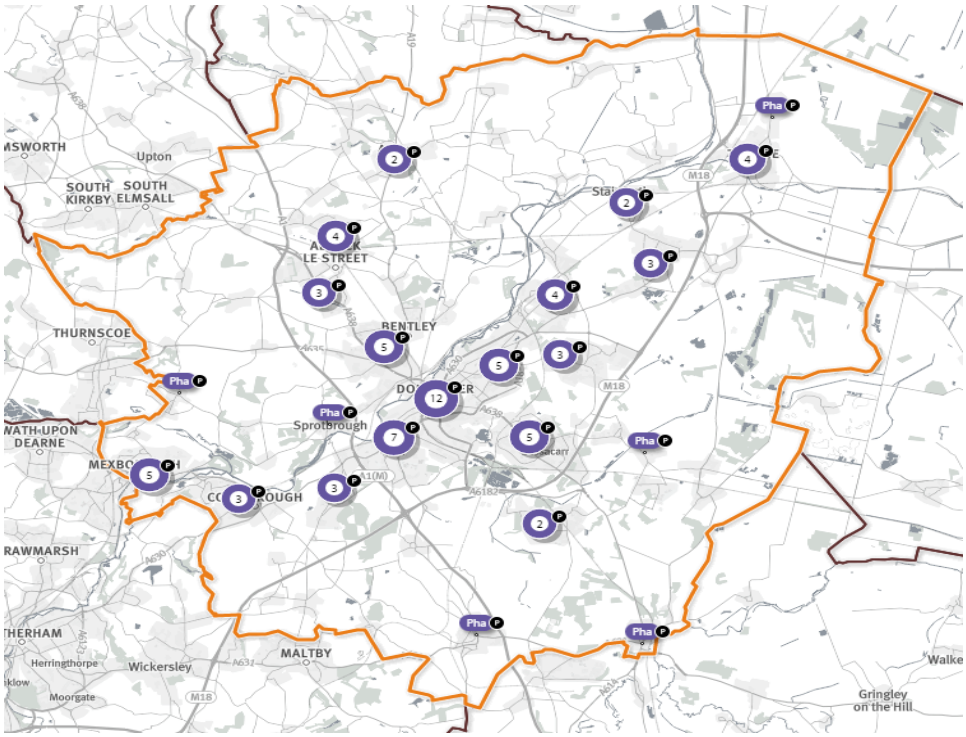
flows is a much more obvious choice from either Rossington or Bawtry?	this.
4. There is quite a lot of comment about 100 hour provision but no mention that this is not commissioned in any way (it is a feature of an historical exemption in the regulations) or that the majority have not been directed to provide services during these extended opening hours. While it is unlikely, it is possible, that all or at least some of the 100 hours pharmacies will close due to the DH funding squeeze (due to the higher operational costs of running a 100 hour pharmacy), potentially resulting in some areas being without extended pharmacy provision.	This feedback has been noted and the relevant changes have been made.
5. There is no mention that Weldricks at East Laith Gate has been commissioned, in line with other key extended hours pharmacies across SY to ensure a pharmacy provision is available into the evenings, weekends and on Bank Holidays including Christmas day – this should be referenced in the PNA	This feedback has been noted and the relevant changes have been made to section 6.2.
6. There doesn't seem to be any logic in the comments about extended hours provision in the South when looking at the maps the population of Askern, for instance, would have as much of a problem getting to Carcroft or Thorne as those in Rossington would getting to Asda or Harworth.	This feedback has been noted. Section 5.4 refers to Bawtry and Tickhill residents accessing out of hour's pharmacy. The nearest extended hour's pharmacy to these communities is in Maltby across the border or Asda at Lakeside, wording has been changed to reflect this.
7. Current national initiatives are considering reducing prescribing so although the population is getting older and potential for increased demands on traditional pharmaceutical services of dispensing current prescription	This feedback has been noted and relevant changes have been made in Executive Summary and section 10.

growth is zero and forecast for the next financial year is only 0.6% - i.e. way below population growth and what might be expected due to an aging population, because a factor of improved medicines optimisation to reduce waste and improve prescribing efficiency and hence demand on traditional dispensing services	
8. P19 – dispensing practices – seems like the 2018 PNA is capturing Bawtry and Blyth practice (Bassetlaw CCG) which was previously not included as the practice is primarily registered as Bassetlaw CCG and not with Doncaster CCG.	This feedback has been noted and relevant changes have been made to section 5.1.
9. Bullet 6.1.3 – aside from the Distance Selling Pharmacies providing deliveries most pharmacies provide a delivery service so any one with difficultly physically accessing a pharmacy premises should still be able to access pharmaceutical services.	This feedback has been noted and relevant changes have been made to section 6.1.3.
10. P27 – under NUMSAS reference to “emergency supply” should be “PURM”. Also, NUMSAS is a pilot and pharmacies providing is likely to change if the pilot is permanently commissioned.	This feedback has been noted and relevant changes have been made to section 8.
11. P28 – “No Pharmacies in Doncaster provide the Stoma Appliance Customisation Service” – patients access this service from specialist DAC providers which operate over a wide / national geography.	This feedback has been noted and relevant changes have been made to section 8.
12. P31 – HLPs – constantly increasing as pharmacies meet the criteria so probably worth referencing to the latest list on the RSPH website at https://www.rsph.org.uk/our-services/registration-healthy-living-	This feedback has been noted and relevant changes have been made to section 8.3.

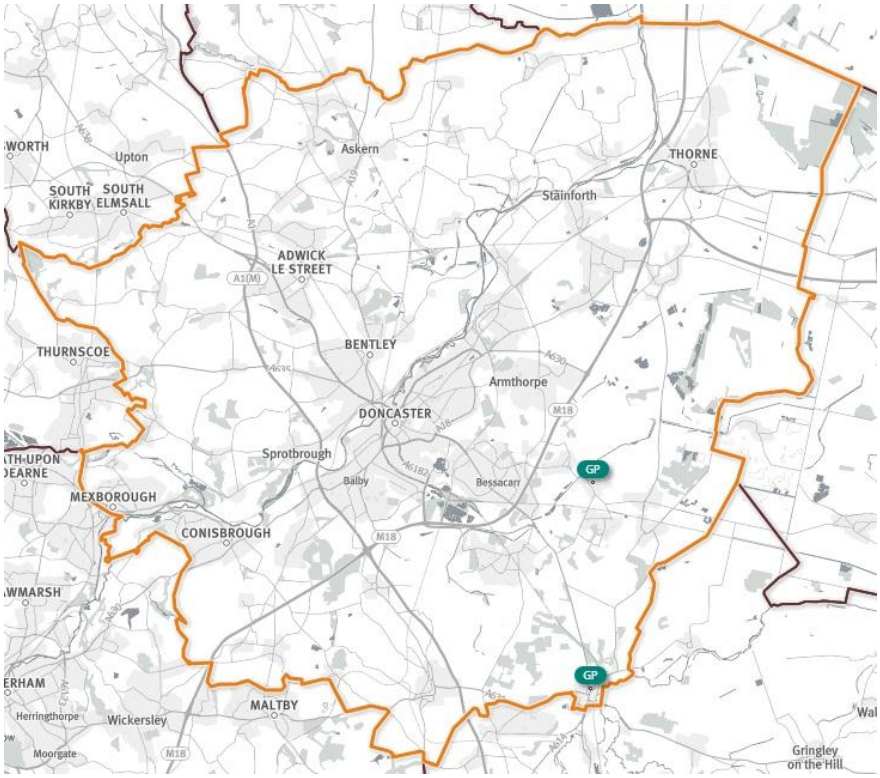
pharmacies-level1/register.html	

Appendix 2 – Current Pharmacy Demographics

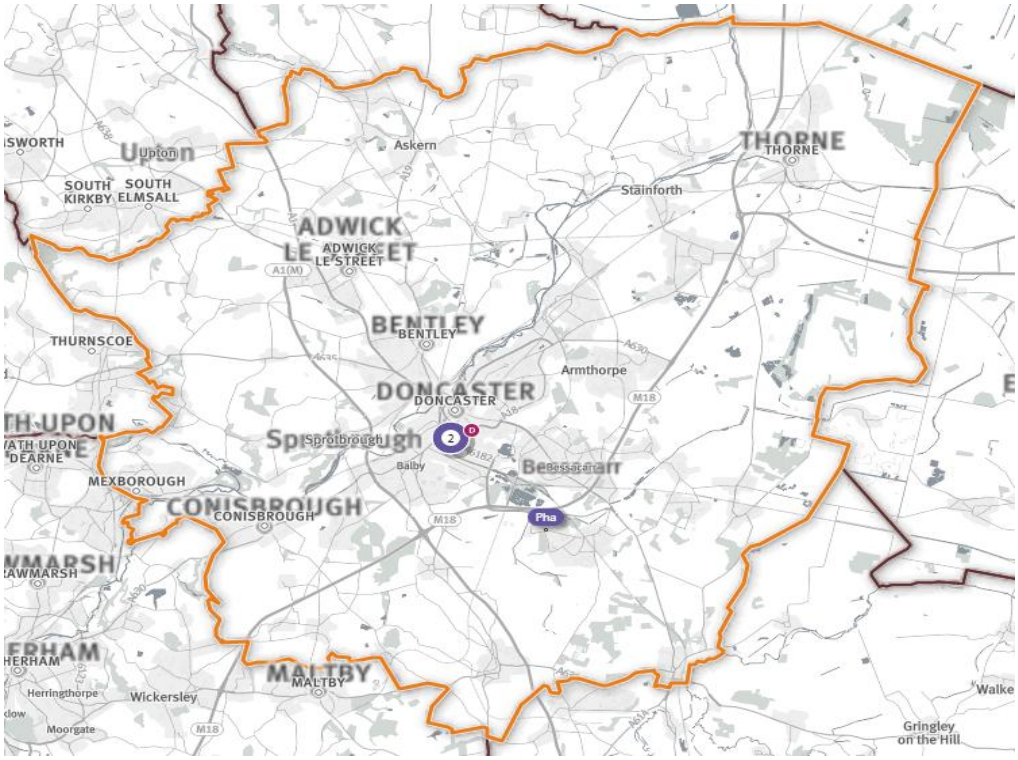
Map 1 – Community pharmacies by location.



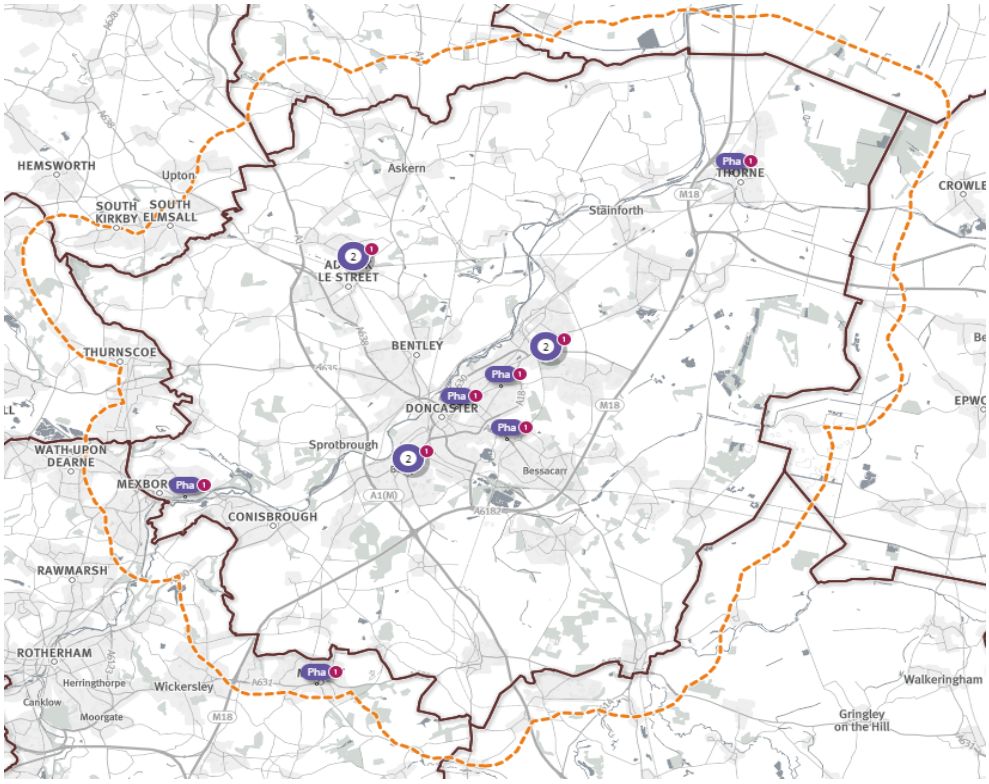
Map 2 - Dispensing GP practices by location.



Map 3 - Distance selling pharmacies by location.

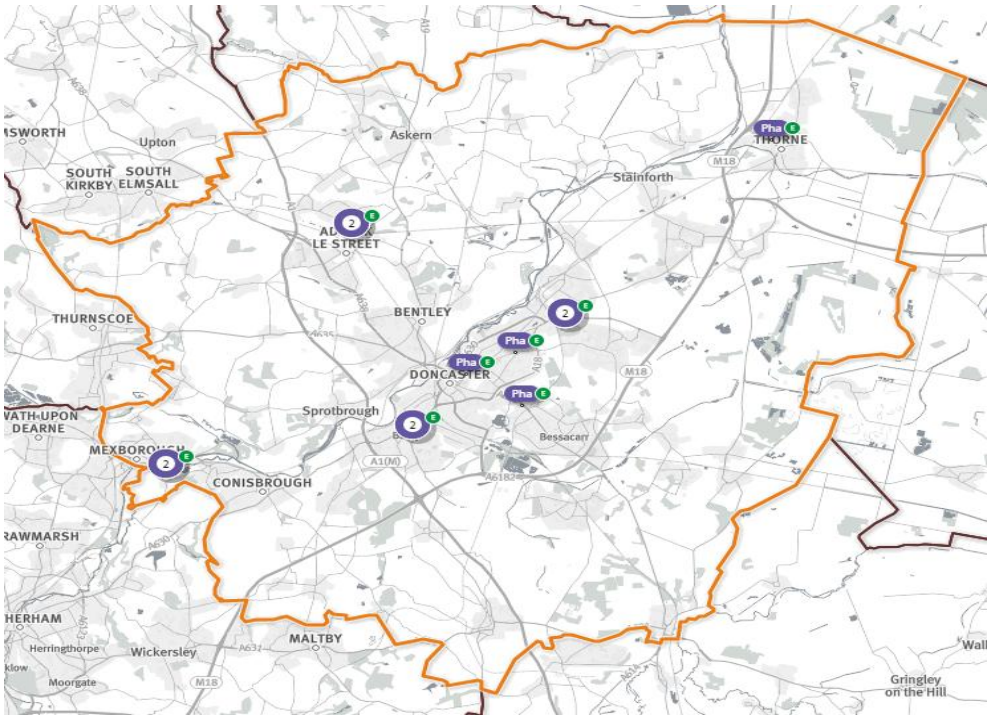


Map 4 – 100hr community pharmacies in Doncaster, plus bordering 100hr pharmacies.

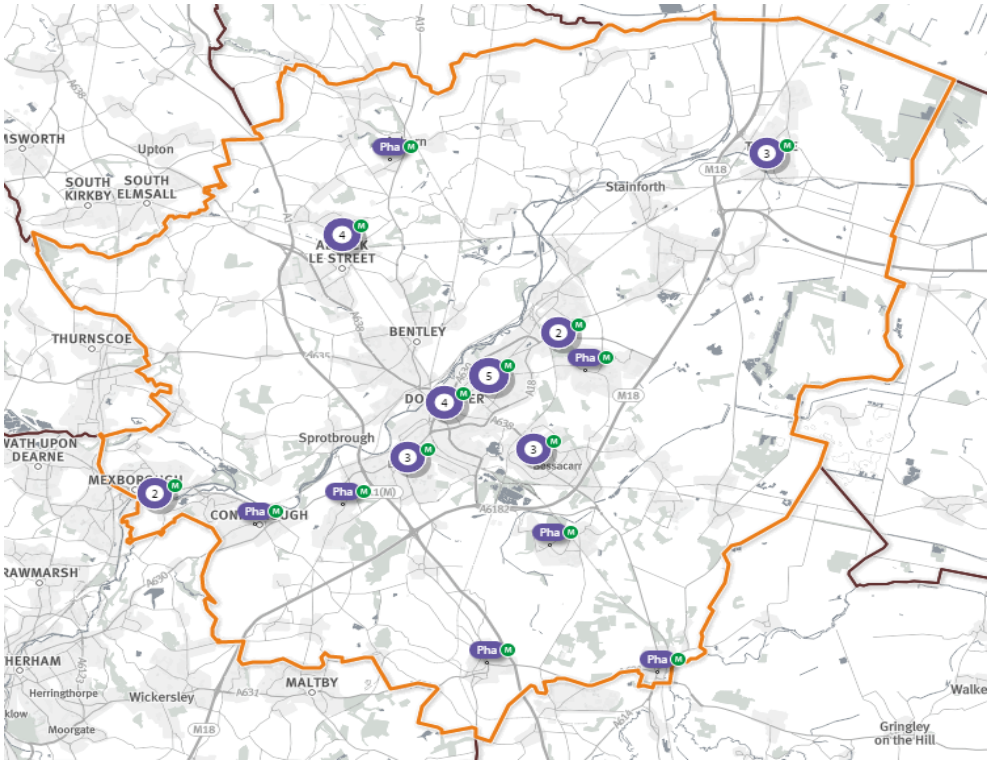


Appendix 3 – Opening hours by geographic location (maps)

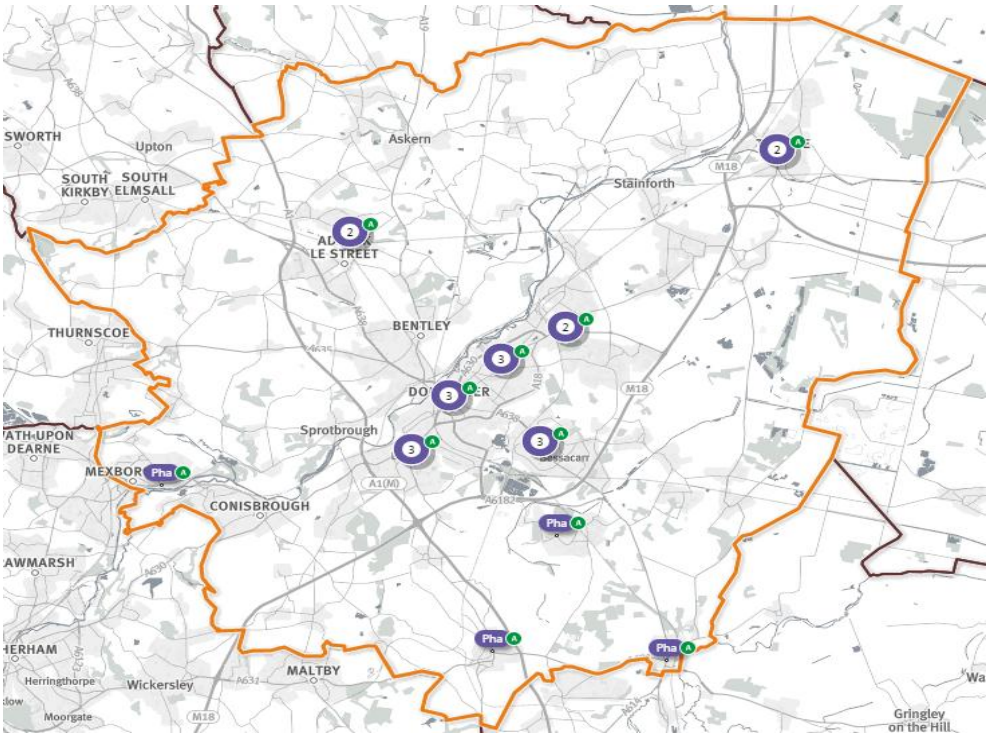
Map 1 - Evening opening.



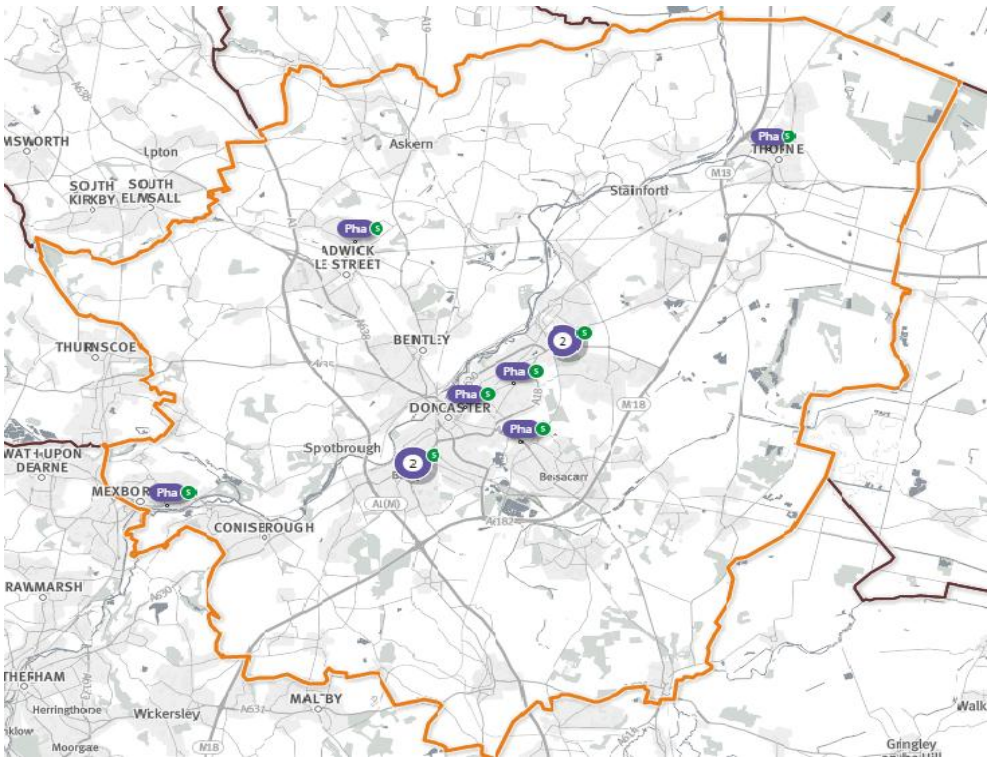
Map 2 - Saturday morning opening.



Map 3 - Saturday afternoon opening.



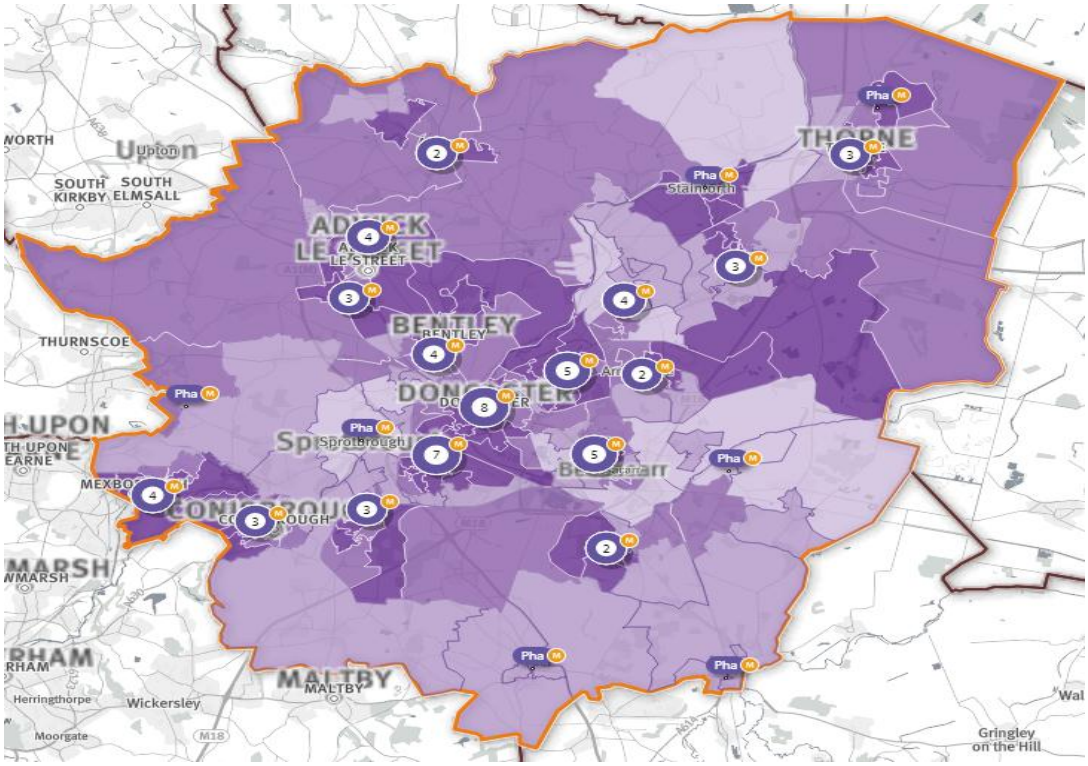
Map 4 - Sunday opening



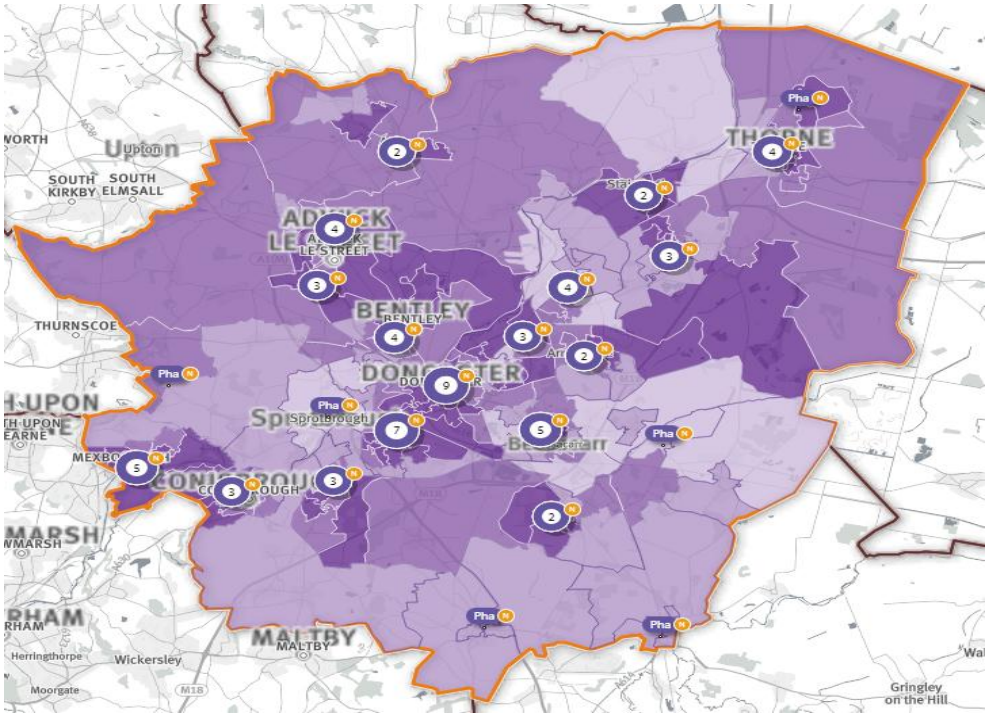
Appendix 4 - Geographic Maps of Pharmaceutical Services

Please note, the darker colours on the maps below represent areas in Doncaster with poorer health.

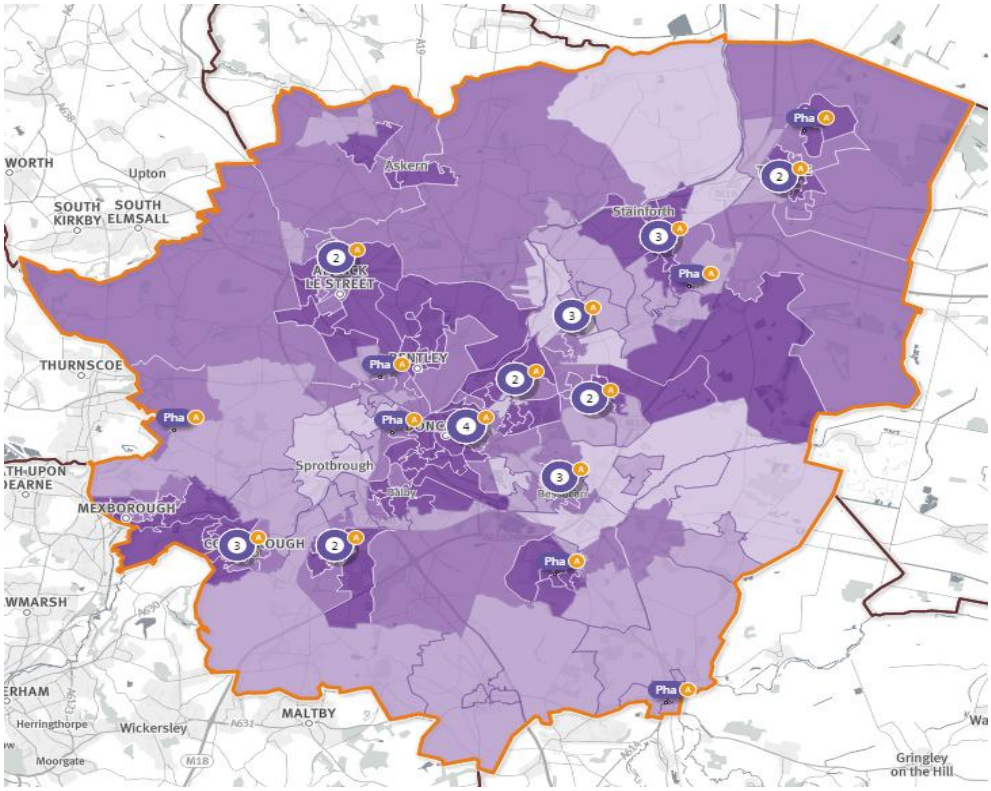
Map 1 – Medicine Use Review Services by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



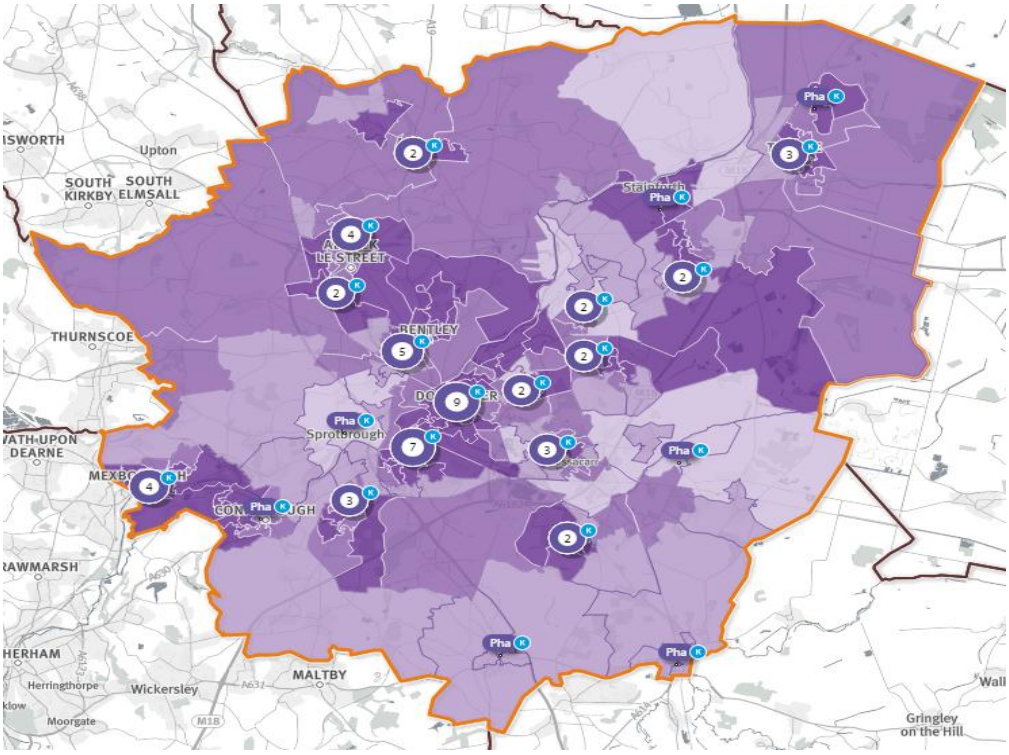
Map 2 – New Medicines Services by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



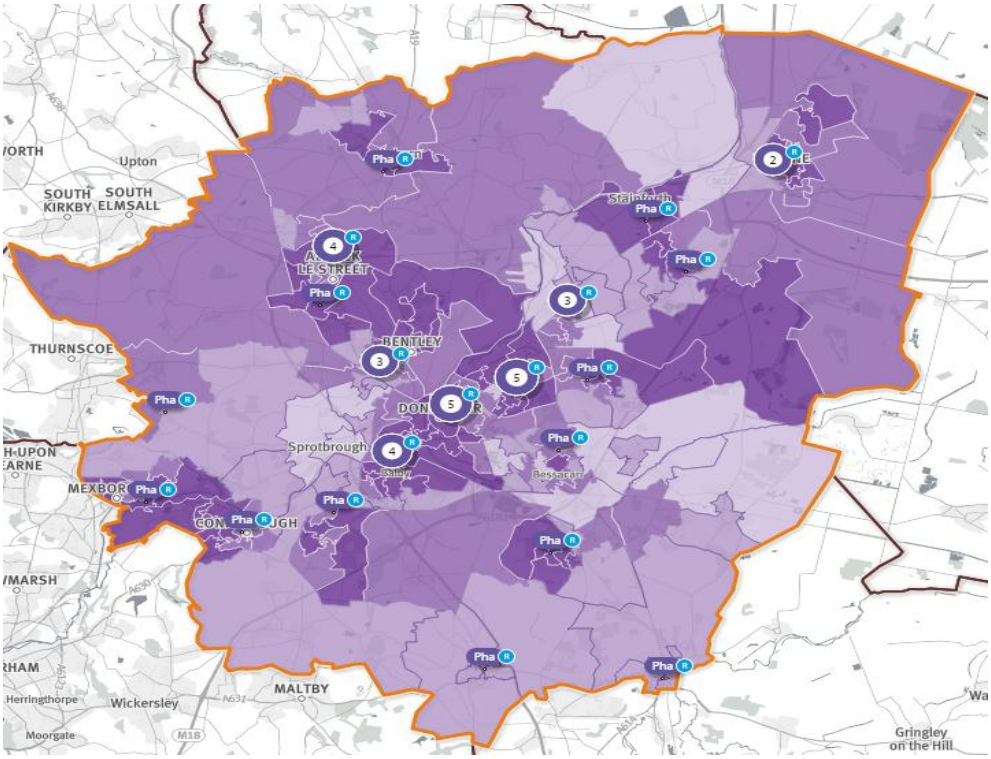
Map 3 – Appliance Use Review Services by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



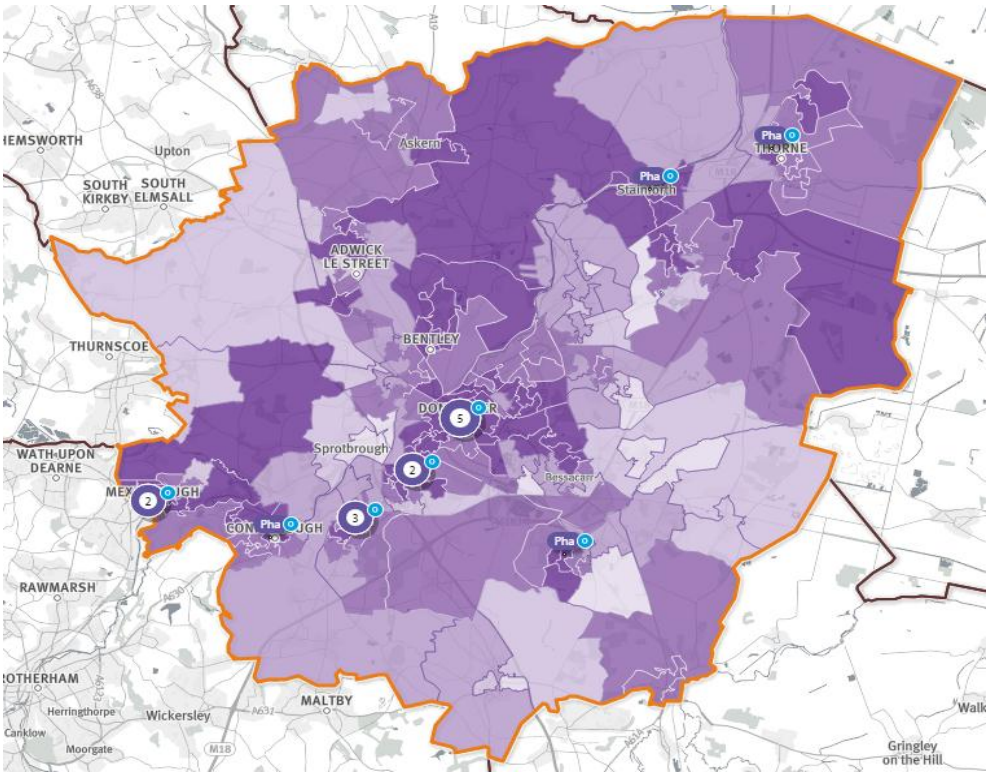
Map 4 - Flu vaccination services by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



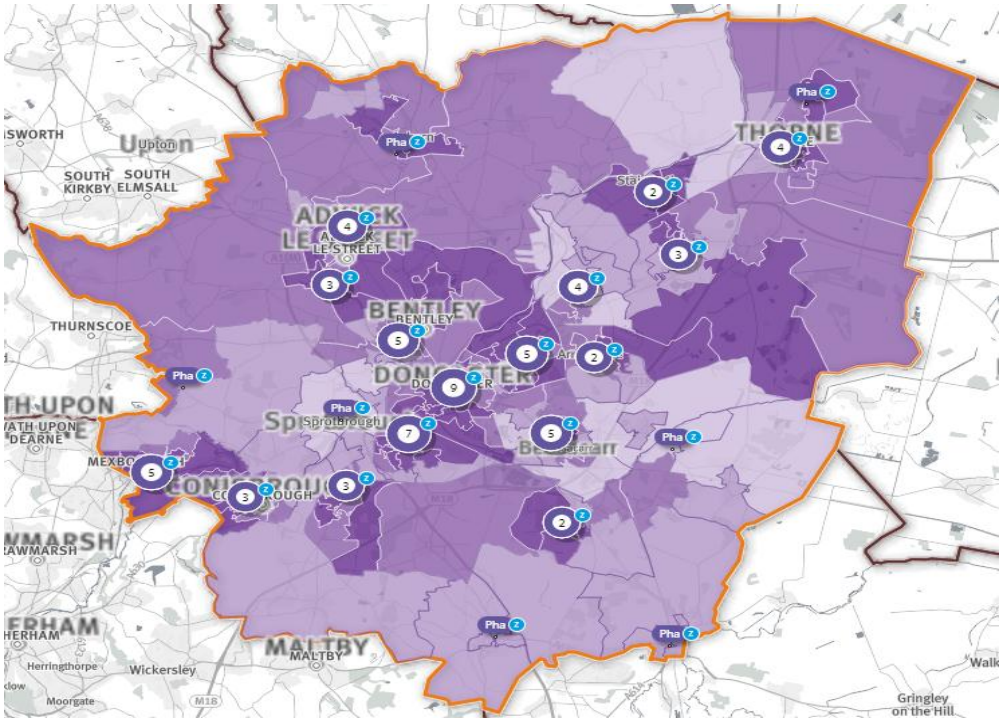
Map 5 – Palliative Care Drugs service by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



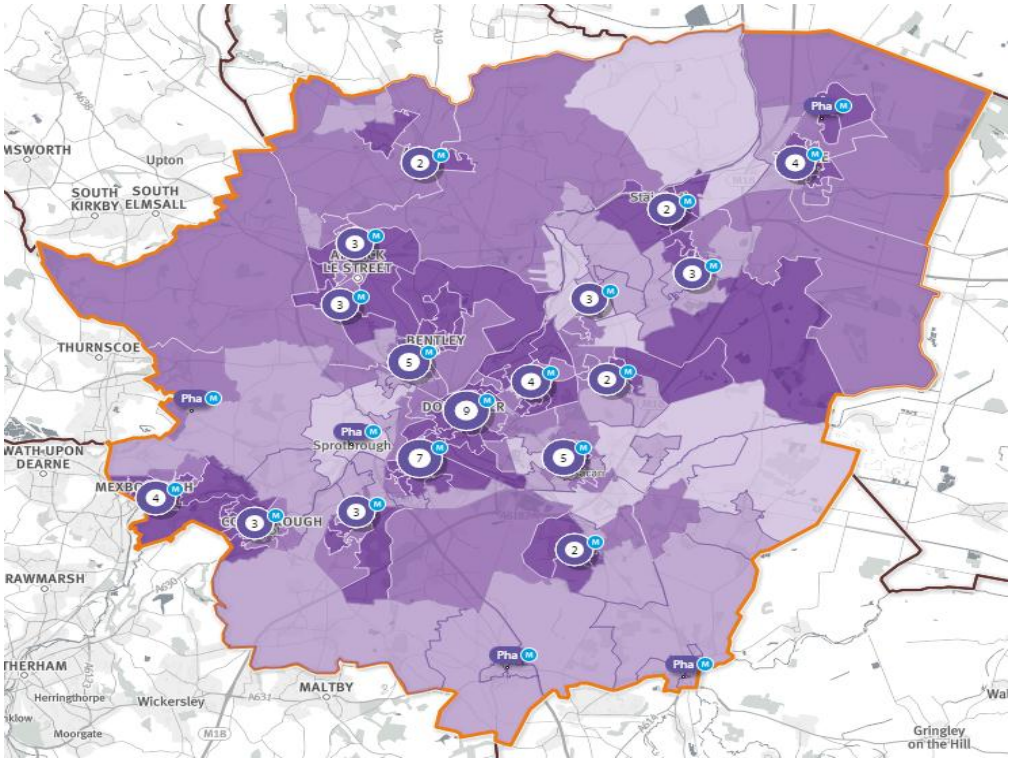
Map 6 – Needle Exchange Services by most deprived areas under the IMD 2015 Crime Deprivation Domain.



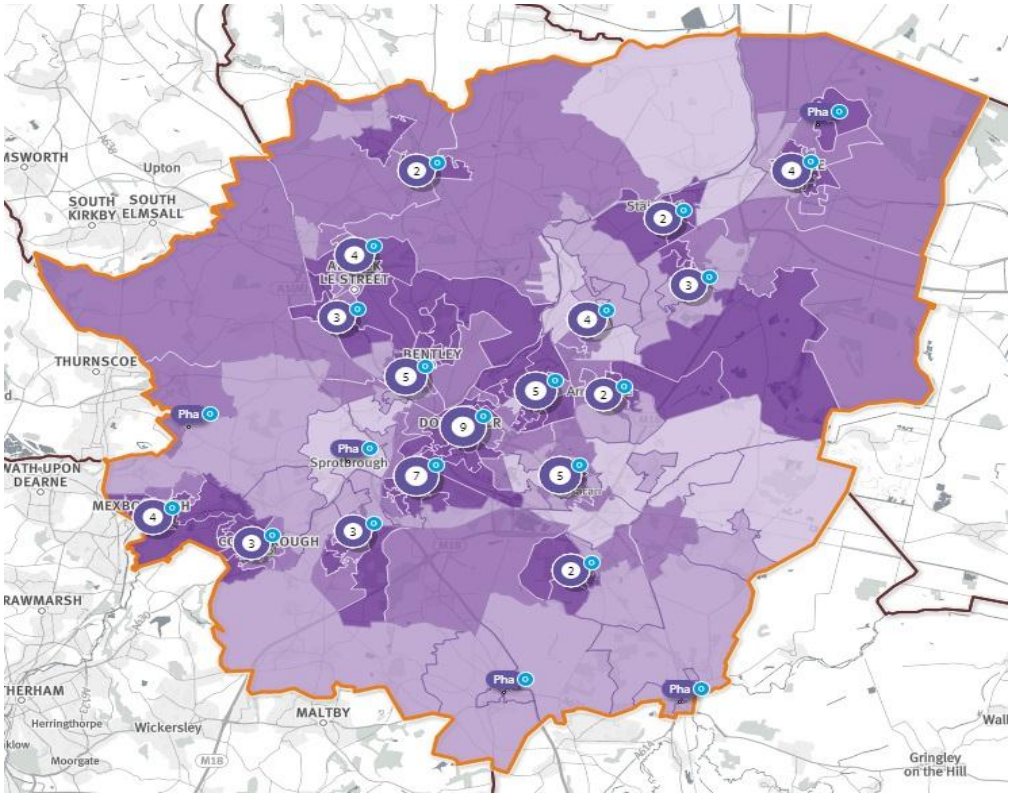
Map 7 – Pharmacies providing Supervised Consumption Services by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



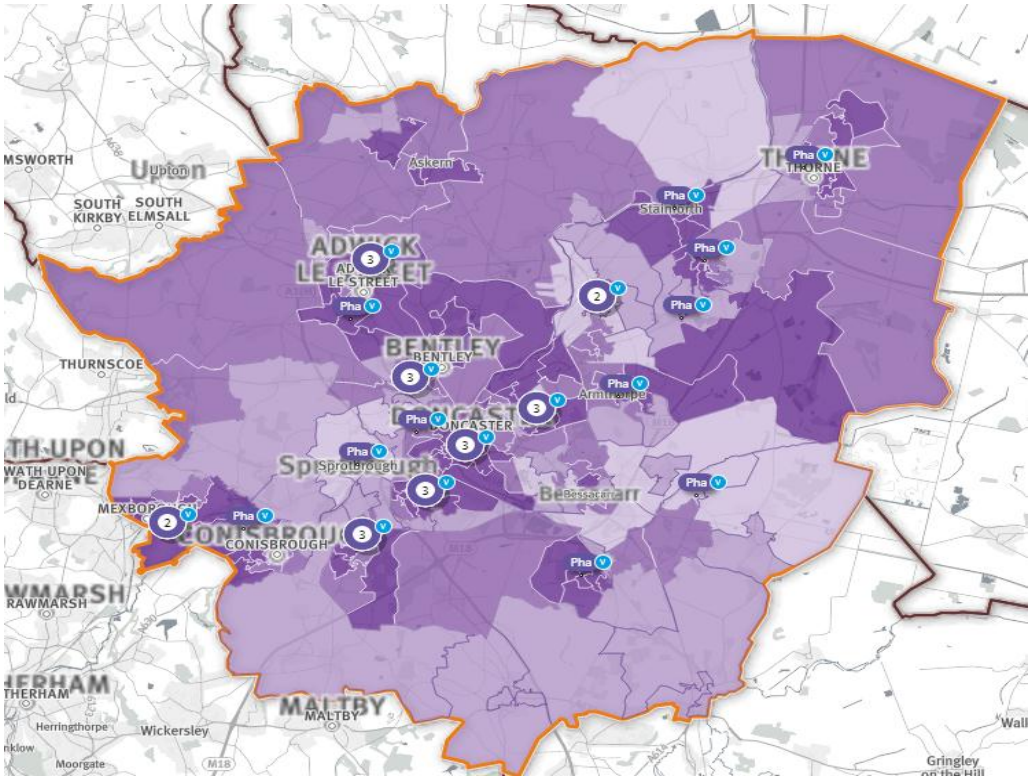
Map 8 – Inhaler Technique Services by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



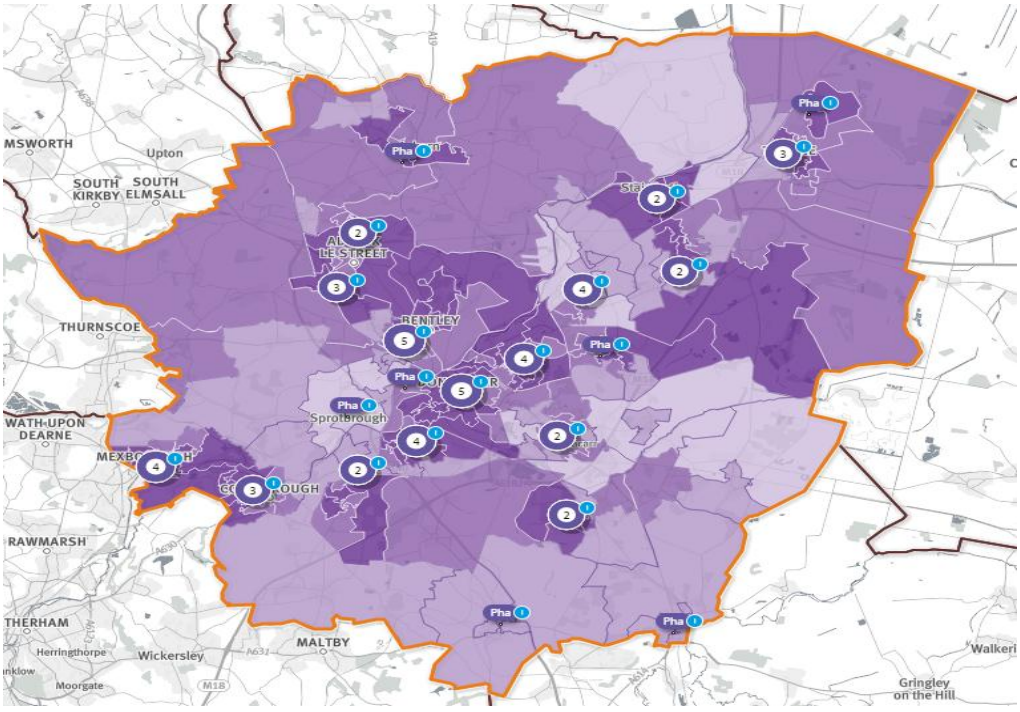
Map 9 – Minor Ailments services by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



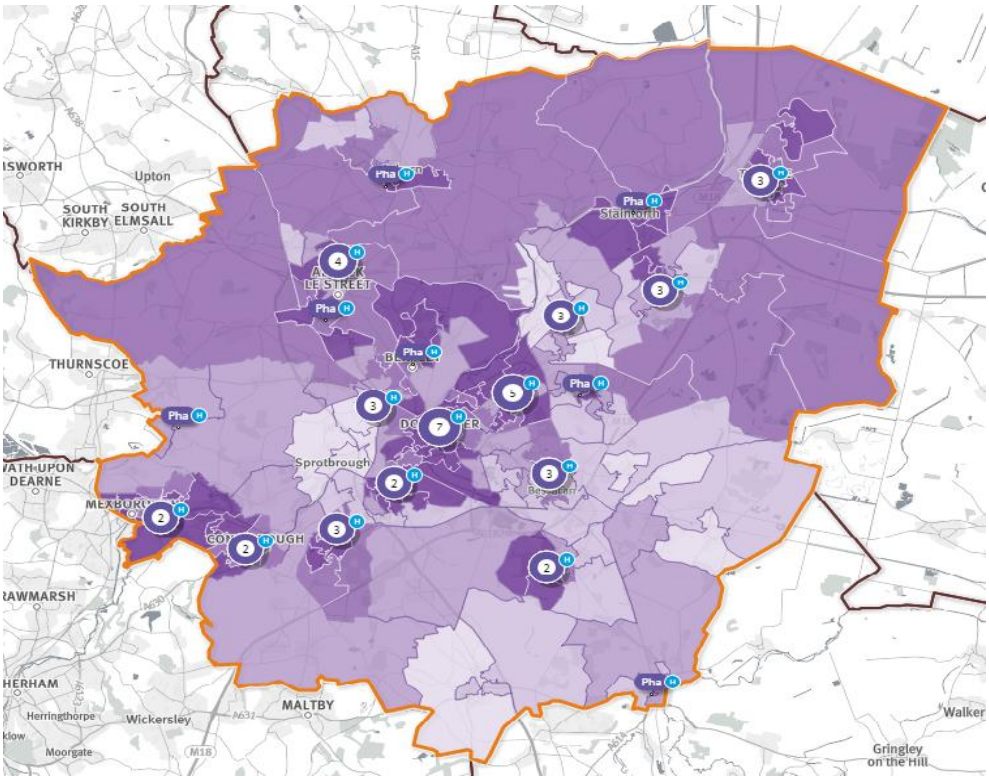
Map 10 - Smoking Cessation service by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



Map 11 - PURM services by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



Map 12 – Emergency Hormonal Contraception Services by most deprived areas under the IMD 2015 Health Deprivation and Disability Domain.



Appendix 5 - Changes made during consultation period

We also noted feedback and comments from colleagues and stakeholders who had not completed the above questionnaire. Through this feedback, relevant changes were made to the following sections:

1. Executive Summary
2. Section 5
3. Section 8
4. Section 8.3
5. Section 9.1
6. Section 9.2
7. Section 10

Doncaster Council

Doncaster
Health and Wellbeing Board

Date:15 March 2108

Subject: Affordable Warmth Strategy

Presented by: Vanessa Powell-Hoyland

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

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		x
Other Implications (please list)		

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

The strategy provides direction and a clear action plan for preventing people living in cold homes and reducing excess winter death incorporating the National Institute of Clinical Excellent recommendations. Once agreed the strategy will give guidance to partners and key holders and drive delivery of the Affordable Warmth program.

Cold homes and unaffordable fuel bills can lead to poor health for the most vulnerable people - pensioners, the long-term sick or disabled, and young children. Fuel poverty affects one in ten households in England. NICE guidelines have recommended that England's 152 Health and Wellbeing Boards commission local 'single point of contact' housing and health referral service

Recommendations
The Board is asked to endorse the proposed Affordable Warmth Strategy 2018-2021 presented in this paper.

Doncaster's Affordable Warmth Strategy 2018-2021

Contents

Foreword

Cold homes harm health. There is a growing knowledge and evidence base related to the direct negative impacts on morbidity and mortality of living in cold housing. We know for example that children, cold homes are associated with poor infant weight gain, slower development, worse asthma, and more hospital admissions. Adolescents are five times more likely to suffer multiple mental health problems. Adults particularly those who are vulnerable, suffer more heart disease, stroke and respiratory disease, their general health is worse and existing conditions are exacerbated by living in cold properties. Older people suffer worse mental health and higher mortality rates.

Living in cold housing can indirectly harm health. It affects children's educational attainment, emotional wellbeing and resilience, limits the dietary opportunities and choices people make and the impact of cold on dexterity leads to a higher risk of accidents and injuries.

Dr Rupert Suckling

Director of Public Health,

Doncaster Metropolitan Borough Council

Rupert.suckling@doncaster.gov.uk

Executive Summary

This Strategy sets out a partnership approach in Doncaster to achieving affordable warmth, setting specified actions to be taken by all partners. The purpose of this paper is to present a better understanding of fuel poverty within Doncaster including the consideration and recommendations from the “Fuel Poverty: how to improve Health and Wellbeing through action on affordable warmth report 2014” and the “Kings Fund”. The paper raises the issues about fuel poverty within Doncaster, covering the definition, the cause and effect and incorporates both direct and indirect impact that fuel poverty has on an individual’s health and the wider context, such as cold housing.

Our vision

“We want less people year on year to suffer from living in a cold home”

Introduction

"Affordable Warmth" means a household is able to afford to heat their home to the level required for their comfort and health. 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 there are an estimated 14,835 households in fuel poverty in Doncaster (Department for Energy & Climate Change, 2014) and this figure is rising (Public Health England, 2017). This has significant negative effects on these residents' health and well-being. For example, fuel poverty is a clear contributory factor in health issues such as excess winter deaths, respiratory diseases, falls and poor mental health (Butcher, 2014). Moreover, it has a significant impact on a range of other factors, such as the ability of young people to undertake homework effectively and individual's ability to manage their finances/debt effectively.

Cold homes, high health care costs, cold-related illnesses, excess winter deaths and housing in poor repair are the visible signs of fuel poverty and are impacting on many households in Doncaster, affecting the most vulnerable in our society. Families on low incomes are living in cold, damp homes and the elderly are struggling to heat just one room in winter. With fuel prices continuing to rise, the issues are set to continue. In addition according to Marmot, there is a clear social gradient in fuel poverty: the lower your income the more likely you are to be at risk of fuel poverty, fuel poverty is avoidable and it contributes to social and health inequalities (Marmot Review Team, 2011).

What is Fuel Poverty?

Fuel poverty is a term used to describe the inability of households to afford fuel consumption sufficient for domestic purposes, including the maintenance of comfortable heating standards and reasonable use of hot water, lighting and appliances.

Definition

The Low Income High Cost indicator (introduced in 2013), is the official fuel poverty indicator and classes a household as being in fuel poverty if its energy costs are above the average (median) for its household type and this expenditure pushes it below the poverty line (Hills, 2013). Using this definition 11.3% of the Doncaster population are classified as being in fuel poverty and Doncaster is ranked 13th out of 21 in Yorkshire and the Humber region.

Cause & Effect

Fuel poverty is associated with a range of additional adverse health outcomes; there are measurable effects of cold housing on adults' physical health, well-being and self-assessed general health, in particular for vulnerable adults and those with existing health conditions. With evidence that living in a damp cold home can have a 30% greater risk of admission to hospital or attendance at primary care facilities (National Institute for Health and Care Excellence, 2013). Marmot (Marmot Review Team, 2011) states that children that live in cold homes are more at risk of respiratory illness, low self-esteem and confidence and contributes to mental health

problems(Department of Health, 2016). Risk of suffering from a mental health issues quadruples in young people living in a cold home to those living in a home that has always been warm (Butcher, 2014). The effects of cold housing for children is varied and can contribute to low educational attainment, difficulties with emotional well-being and can decrease their food choices(Public Health England, 2012). It is also shown to contribute to low weight gain in infants under 3 years old, the physical health impacts most commonly experienced by those living in cold homes are circulatory diseases and respiratory illnesses.

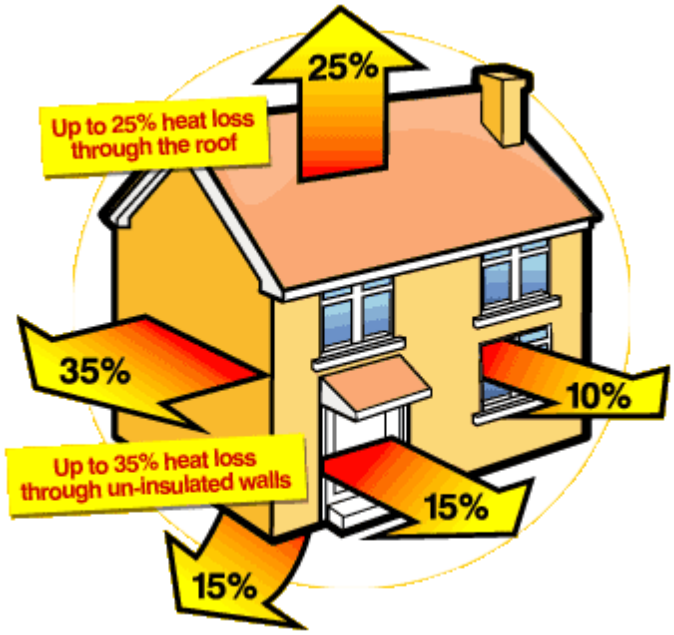
In a cold snap in a mild winter…

- Two days later there is a sudden rise in heart attacks
- Five days later there is a big rise in strokes
- Twelve days later there is a big rise in respiratory illness (DoH, 2008).

However there are a number of causes of fuel poverty which result in households not being able to afford sufficient warmth for health and comfort.

- Low household income and debt
- Inefficient heating systems
- Heating systems with high running costs
- Poor quality housing
- Access to affordable tariff and payment options
- Ill health / disability resulting in an increased demand for a warm home.

Energy Inefficient Homes



Fuel poverty often results in increased household maintenance and repair costs sending householders deeper into fuel poverty.

The associated negative impacts on the home will be increased condensation, dampness and mould growth as well as increased levels of dust mites which can exacerbate health problems.

Those most at risk

Those most vulnerable to fuel poverty and the impacts of cold, damp homes are:

- Older people – particularly those living on their own and/or in larger family homes
- Lone parents with dependent children
- Families who are unemployed or on low incomes
- Children and young people
- Disabled people
- People with existing illnesses and long-term conditions (physical and mental)
- Single unemployed people.

Excess Winter Deaths

Excess Winter Deaths are calculated by comparing the number of deaths in winter with a non-winter period:

EWM = winter deaths - average non-winter deaths

Currently a standard method for the calculation of EWM is used each year for England and Wales. This is referred to in the article as the 'ONS method'. This defines the winter period as December to March and compares it with the average of deaths occurring in the preceding August to November and the following April to July (Office for National Statistics, 2016).

Doncaster has a higher than national and regional average for excess winter deaths (EWD) which are calculated as the difference between the number of deaths during the four winter months (December to March) and the average number of deaths during the preceding autumn (August to November) and the following summer (April to July). Evidence suggests a strong link between EWD and cold homes. The UK as a whole has one of the highest EWD rates in Europe with thousands of people dying needlessly every year because of excessive cold temperatures in their homes. Countries which have lower EWD have more energy efficient housing. EWD are significantly more likely in private rented and owner-occupied homes, houses built before 1850 and damp houses.

Over the last five years there have been on average 26,000 EWD in the UK, locally within Doncaster in 2015/16 there was 230 EWD's. However not all EWD can be attributed to cold housing or low indoor temperatures: according to the World Health Organisation, between 30% and 50% of EWD can be attributable to cold indoor temperatures. People living in the coldest quarter of homes have a 20 per cent greater risk of dying than those in warm homes (Marmot Review 2011). Older people living on their own with existing illnesses and chronic conditions, poor mobility and in poor quality, harder to heat housing are most vulnerable to dying in winter (Roche

2010). The majority of EWDs occur amongst people aged 75 and over (Roche, (2010).

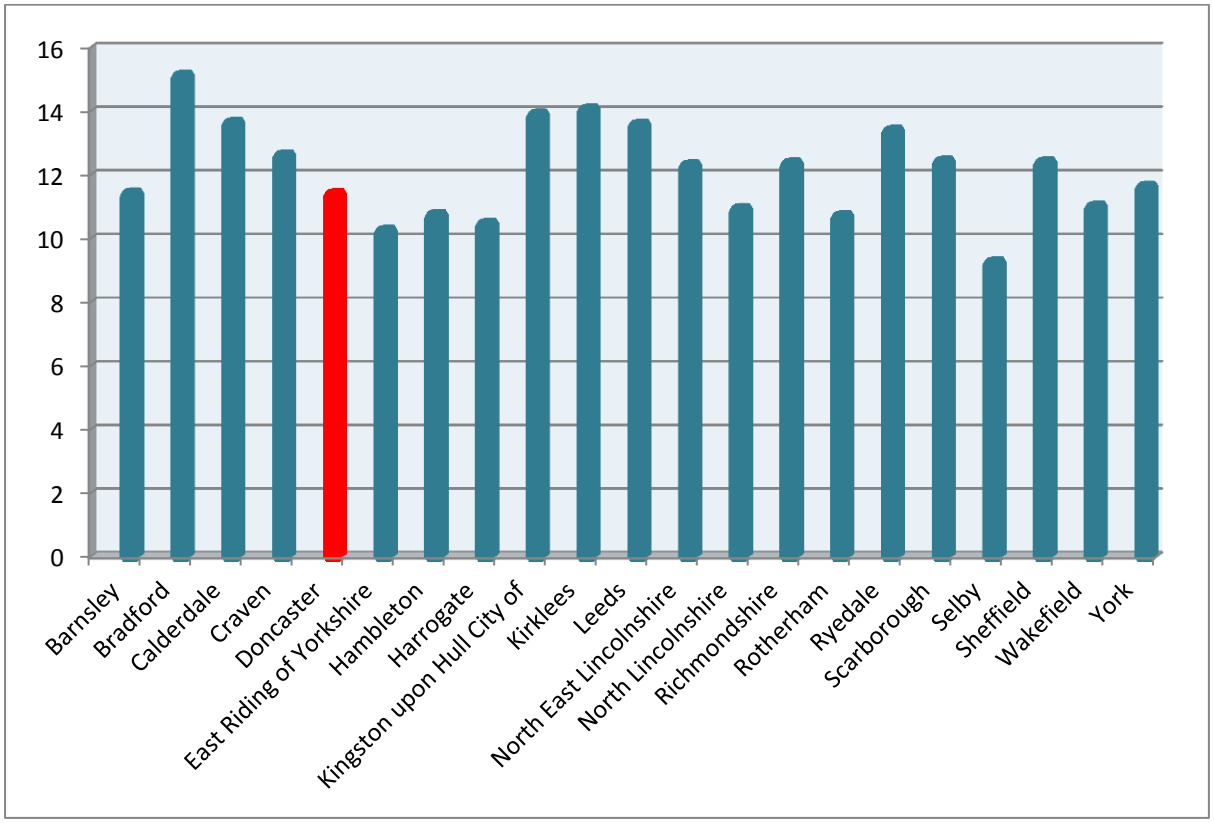
Many health conditions are aggravated by the cold, and often people with disabilities are unable to keep active during the winter months. People with disabilities have on average a 25% higher cost of living due to additional needs such as mobility, aids and care. For many, moving to a more energy efficient home is not an option as it will need to be adapted for their needs (Energy Bill Revolution, ND).

Fuel poverty can worsen people's health conditions, which in turn impacts on the demand for health and social care services. It is also likely to lengthen recovery times of people with certain conditions and make existing problems worse. There are the mental health effects of living in a cold home too, from stress and anxiety through to more severe mental health issues.

Where are we now?

11.3% of the Doncaster population are classified as being in fuel poverty and Doncaster is ranked 13th out of 21 in Yorkshire and the Humber. The following chart use sub-regional fuel poverty statistics from the Department of Energy and Climate Change.

Figure 1



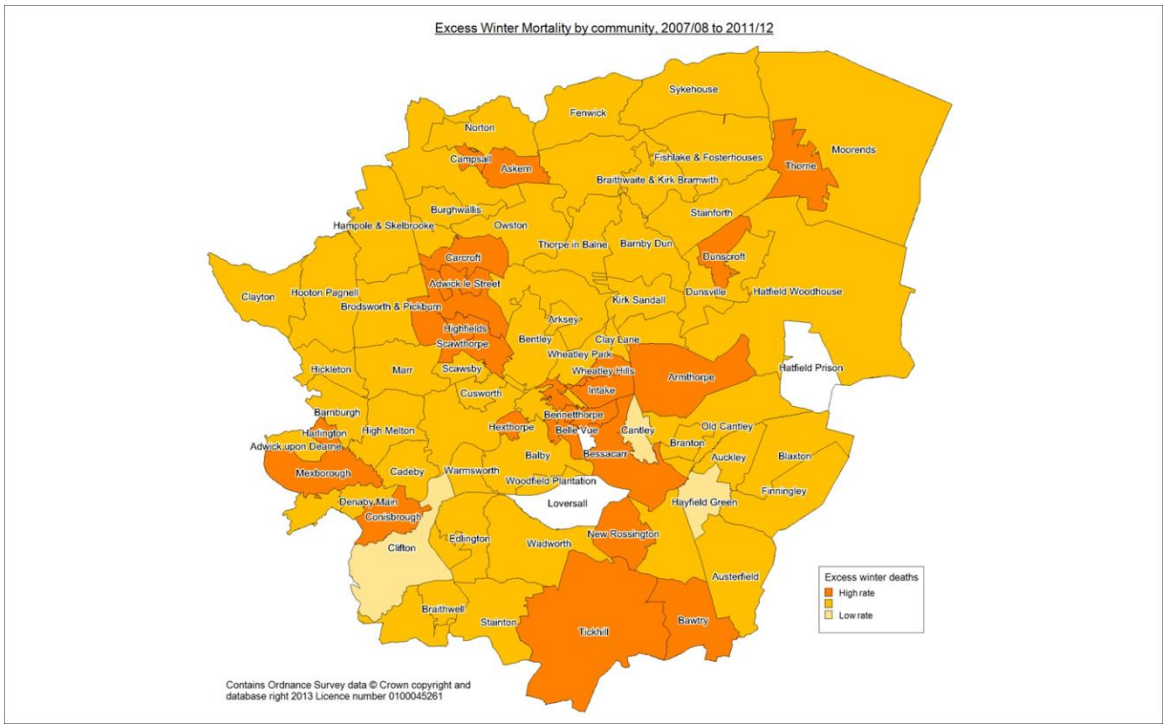
Local Evidence

There were an estimated 24,300 excess winter deaths (EWDs) in England and Wales in the 2015/16 winter period. This represents an excess winter mortality index of 15%; that is 15% more deaths occurred in winter compared to the non-winter months In 2015/16 Doncaster had 230 excess winter deaths, therefore on each day during the winter months, about two Doncaster people die of conditions made worse by cold. The most affected communities within the Doncaster borough were;

- Town Centre
- Hyde Park
- Lower Wheatley
- Hexthorpe
- Highfields

The map below highlights most affected communities within Doncaster.

Figure 2

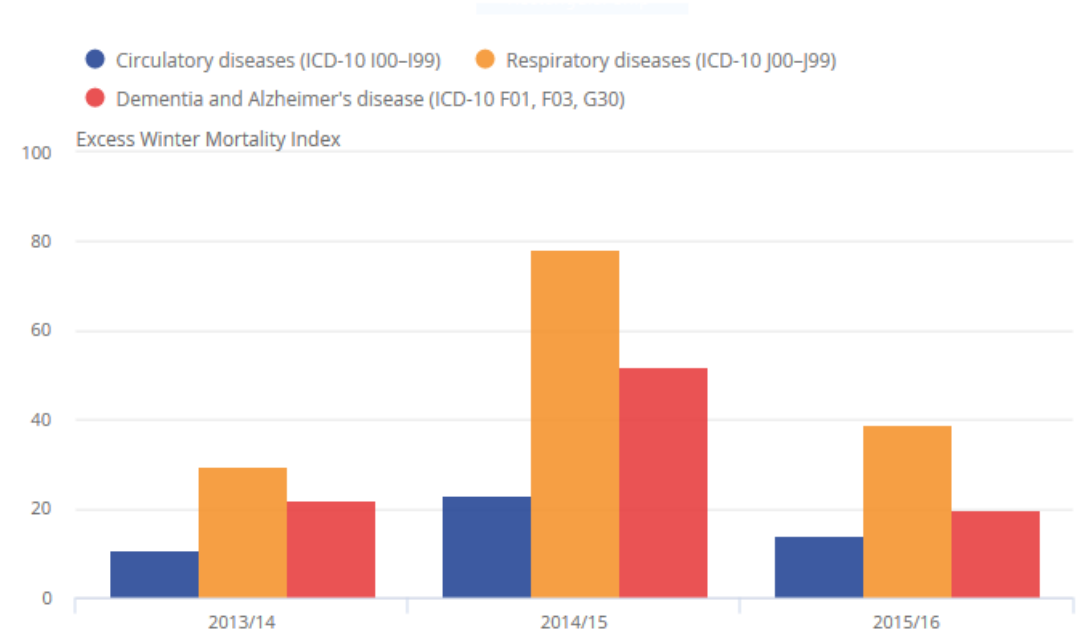


Respiratory diseases caused most excess winter deaths

As shown in Figure 3, respiratory diseases remained the most prominent underlying cause of excess winter deaths, this cause of death category had a EWD index of 41% in 2015/16. This means that there were 41% more deaths from respiratory deaths in the winter months than there were in the non-winter months. Although this is a decrease from the 2014/15 period this is still greater than the 30% reported in

the 2013/14 period. The 8,600 excess winter deaths from respiratory diseases accounted for over a third of all winter excess winter deaths (35%, 8,600 of 24,300 deaths). Pneumonia accounted for the largest proportion of these deaths but the prominence of this cause category is also likely related to the relationship between EWM and a range of bacterial and viral respiratory pathogens including influenza.

Figure 3



Source: Office for National Statistics

Traditionally interventions to reduce fuel poverty have focused on older people and people with ill health; however this conflicts with recent studies which have identified equally vulnerable groups that would benefit from interventions. These vulnerable groups include: people with conditions affected by living in cold damp homes: respiratory, cardiovascular, mobility and mental health. The Warm and Well Family Research undertaken in Doncaster in 2012 highlighted that families with young children are at risk. Moreover, Hills review 2013 highlighted that one of the groups at high risk of fuel poverty are those on low income who are single-person households of working age, due to lack of targeted interventions with this at risk group in the past.

Warm and Well Families Research

The Public Health Team have been working in partnership with Sheffield Hallam University and Public Health Rotherham to deliver a research study to examine the experience, knowledge, beliefs and values of adults living in households with young

children in keeping warm at home. The study consists of 36 interviews with families and the measurement of indoor house hold temperatures and was performed in the winter of 2012/13. The information gained is being used to develop social marketing keeping warm interventions for winter 2014/15 this will include four pen portraits that will support professionals to deliver targeted interventions.

The different data revealed a range of themes which explain the complex world within which families operate and the barriers they encounter in relation to keeping warm. Key themes included:

- Contextual factors e.g. type of home and income
- Social factors e.g. the nature and quality of social contact and support
- Behaviours e.g. the behaviours and coping strategies of families employed to keep warm and manage household budgets
- Attitudes and beliefs, including fear of debt, priorities and beliefs regarding asthma, cold and health
- Knowledge and awareness of cold household temperatures, heating systems, getting help and trusted sources of information.

Full report available at
http://shura.shu.ac.uk/7905/1/Doncaster_Final_Report_March_2014.pdf

Doncaster currently offers a wide range of low level interventions to tackle fuel poverty issues. These include:

DMBC Energy Team offer a range of support to reduce energy consumption, the number of cold homes in Doncaster, fuel poverty, carbon emissions, and help households save money, by:

- Promoting the Mayoral priority "The Big Power Switch" joining local residents together to increase their buying power and negotiate a better deal on their energy
- Working with Energy Companies to deliver their government obligations to improve the energy efficiency levels of privately owned housing
- Delivering large scale thermal improvement programmes to make Council owned housing energy efficient
- Proactively targeting the most vulnerable communities to provide 'one to one' energy saving advice and grants assistance
- Continuing to improve the quality of housing and reduce the number of poor quality, energy inefficient homes
- Improve the quality and management of private rented housing and work in partnership with private landlords to make best use of the sector to meet local housing demand.

Affordable Warmth
The affordable warmth work consists of a variety of pathways to identify and support vulnerable people during the winter period. We have identified geographic concentrations of fuel poverty, excess winter deaths and assessed those at risk using Doncaster's Joint Strategic Needs Assessment and Community Profiles intelligence.

Winter friends training is offered to frontline staff and volunteers that supports vulnerable people, the training covers spotting the signs of living in a cold, damp home, fuel poverty, energy measures and emergency planning. The Public Health Team and Energy Team offer small micro grants of £500 to the top twelve areas within fuel poor communities to able them to deliver creative community sessions which provide information, advice and guidance on keeping warm and well during the winter months.

The Public Health Team have produced winter friends information packs which leaflets with advice and tips on how to prepare for the cold weather, fuel poverty advice, contact numbers for key organisations and temperature cards to give to individuals to highlight a healthy temperature within their home.

Winter Warmth Toolkit
The winter warmth England Toolkit has been used to produce a variety of resources for both managers and frontline staff to provide consistent messages to encourage people to stay warm and healthy in winter. We have encouraged staff and organisations to utilise the tools by promoting the toolkit on various websites, through the Hotspots training and via our local networks. Over the past four years over 300 front line staff were trained to spot the signs of people living in a cold home and to refer on to services within Doncaster.

A six month communication action plan has been produced, delivering a variety of methods to raise awareness of fuel poverty and issues during the winter. Doncaster Public Health Team coordinates a multi-agency steering group that manages and governs all the winter warmth work.

Where do we want to be?

Doncaster MBC is committed to tackling fuel poverty and the many health issues faced by a significant number of households. A range of aims and objectives have been developed, designed to assist with the alleviation of fuel poverty, delivering affordable warmth and ensuring that the benefits of energy efficiency measures are brought to the attention of all households. This will involve accurate targeting of the people who most need support and assistance to tackle fuel poverty and reduce health inequalities, working along with the energy team to provide energy efficient housing.

Doncaster MBC will aid the implementation of the affordable warmth action plan with the support of a local partnership, this will be a is a non-statutory body that brings together the different parts of the public, private, voluntary and community sectors, to acts as steering group. They will provide governance and direction for all activities within the affordable warmth action plan and work together to identify opportunities, to share best practice and support joint initiatives.

Doncaster MBC is committed to reducing fuel poverty and increase the energy efficiency of housing across Doncaster as part of Doncaster's Corporate Plan. With aims to target Doncaster's most vulnerable households by gather an agreed set of data to identify who is at most at risk of cold related illness and therefore establishing what support is required.

We will incorporate the considerations and recommendations from the recent "fuel poverty: how to improve health and wellbeing through action on affordable warmth report 2014 by collectively working with all partners on the affordable warmth action plan. This strategy has been developed in partnership with a number of key agencies that work closely with the Council St Leger Homes, DMBC Strategic Housing, Professional Buildings Maintenance (PBM), Doncaster West Development Trust (DWDT), Department of Work and Pensions (DWP) DMBC and Community Libraries.

All partners are committed to improving access to affordable warmth solutions for all Doncaster residents. We have involved representatives from different community groups so that there is a greater first hand understanding of what fuel poverty means and what residents want the council and partners to do. We consulted on this strategy by undertaking a fuel poverty workshop with all key partners.

Action Plan

This Affordable Warmth plan sets out our joint approach to tackling Doncaster's' fuel poverty, with clear aims and objectives.

Priorities	Action
Improve awareness and understanding of fuel poverty for residents, in all tenures.	To define fuel poverty locally and within a national context
	To have an annual Affordable Warmth programme of public events
	To develop awareness of Affordable Warmth through social media and traditional methods
	Develop and implement an Affordable Warmth behavioural change programme
	To offer a co-ordinated delivery approach to reduce the number of people living in a cold home
	"Winter Friends" training for front line staff, enabling then to identify and signpost where necessary
Develop a shared understanding of the problem and local need through a robust Joint Strategic Needs Assessment (JSNA)	Mapping of Partnership activities
	Investigate the role of winter friends
	Gather evidence (Case Studies etc.) from partners relating to positive outcomes and achievements
Increase the energy efficiency of Doncaster's private housing stock.	To address Doncaster's "hard to treat" private sector properties
	Affordable Warmth programme to link with DMBC's Housing Strategy 2014-2024
	Affordable warmth programme to link with both private sector and social housing

Maintain and develop Doncaster's Affordable Warmth Referral System	Identify current up to date data relevant to AW in Doncaster
	Continue to deliver and develop Doncaster Winter Friends AW referral system
	Annual summary of training conducted and its impact on referrals
Reduce the number of people that are fuel poor in Doncaster	To reduce the number of people that are fuel poor by incorporate income maximisation, health and energy advice
	Communication with organisations where conflicting information exist
	To continue to promoting financial inclusion, by maximise opportunities and improve quality of life during difficult times
	Work with DWP around training for frontline staff on Universal Credit.
	Challenge Fuel suppliers on pre-payment meters
Ensure the co-ordination and development of Doncaster's Affordable Warmth Strategy	Develop monitoring and evaluation systems for the strategy and action plan

References

Butcher, J. (2014) 'Fuel Poverty: How To Improve Health and Wellbeing Through Action on Affordable Warmth. A guide to delivering action on fuel poverty for public health professionals, health and wellbeing boards, and local authorities in England'

Department for Energy & Climate Change (2014) *Sub-regional fuel poverty 2014 data*

Department of Health (2016) 'The Cold Weather Plan for England Protecting health and reducing harm from cold weather'

Hills, J. (2013) 'Getting the measure of fuel poverty Final Report of the Fuel Poverty Review of fuel poverty Fuel Poverty Review'

Marmot Review Team (2011) 'Health Impacts of Cold Homes and Fuel Poverty'

National Institute for Health and Care Excellence (2013) 'Excess winter deaths and morbidity and the health risks associated with cold homes'

Office for National Statistics (2016) *Excess winter mortality in England and Wales: 2015/16 (provisional) and 2014/15 (final)* [Online]. Available at https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/excesswintermortalityinenglandandwales/2015to2016provisionaland2014to2015final (Accessed 19 June 2016)

Public Health England (2012) *Keep Warm Keep Well*, [Online]. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/254859/Keep_Warm_Keep_Well_2013_WEB_FINAL.pdf Accessed 16/06/2016

Public Health England (2017) 'Public Health Outcomes Framework Summary for Doncaster'

Roche, T. (2010) How to reduce the risk of seasonal excess deaths systematically in vulnerable older people to impact at population level.

This page is intentionally left blank

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 15 March 2018

Subject: Doncaster Talks – an approach to insight led policy, practice and service design

Presented by: David Ayre – Head of Service, Strategy & Performance Unit

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

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

How will this contribute to improving health and wellbeing in Doncaster?
The Doncaster Talks insight report provides actionable insight about the habits, motivations and behaviours of Doncaster residents pertaining to their health. Using a mixture of ethnography, face to face engagement and an online platform with nearly 200 residents signed up, the findings represent a step change in our ability to focus on early help and prevention, resulting in a service and/or support that is better tailored to the needs of residents. Ultimately, it allows us as public sector partners to focus on 'what matters to them, not what is the matter with them'.

Recommendations
The Board is asked to:- • Note the findings of the research • Endorse the approach to insight generation and application for further work • Note the suggested prototypes as ways of testing potential solutions

I learned there that I could achieve things - that even when things looked difficult, I had the strength and capabilities to respond, learn, and get stuff done

My motivations? My kids

Conisbrough, with its castle and church, is a favourite place with many happy memories attached

My GP practice is brilliant, the hospital is great, it makes it a lot easier not to worry about things when medical services are so good

There is a lot to do such as art classes at the local library yoga children's pre school activities and very good bus links to and from Doncaster to thorne and Moorends

There is a lot to do such as art classes at the local library yoga children's pre school activities and very good bus links to and from Doncaster to thorne and Moorends

My village has a real sense of community and you can't go very far without seeing a familiar face

There was nothing for me where I lived, so I moved to Doncaster to have a better prospect of finding a job

Doncaster Talks

A customer insight report for Team Doncaster

uscreates

Contents

Executive summary

Executive summary

What's in the report

This report documents a piece of research and engagement carried out for Doncaster Metropolitan Borough Council and Doncaster CCG. By reaching over 200 Doncastrians across 100 days, this project has provided an effective way of understanding the motivations and barriers that exist around improving the health and wellbeing of people who live in the borough.

It provides the foundation for all partners involved in the Team Doncaster Place Plan to take a more insight-led approach to the design, commissioning and improvement of services, and to enabling and encouraging a greater number of community-led initiatives to improve health outcomes.

What we did

Research for depth: Ethnographic research with residents of Doncaster to gather rich qualitative data on health behaviours

Research for breadth: An online platform - Doncaster Talks - and associated campaign to drive interest in the project to generate evidence on healthy behaviours

Building capability: Training staff in analysing different kinds of data and using this to inform service re-design & commissioning, with a focus on early intervention/prevention

91%
of participants expressed an interest in taking part in Doncaster Talks in the future

Over half
of participants reported making positive behavioural changes

Executive summary

The impact

Simply by being involved in this project - by sharing stories of their lives and what contributes to their health and wellbeing via the Doncaster Talks platform - residents have reported making positive behavioural changes. This was true for over half of the platform participants (i.e. 55% [55 participants] who completed the end of project survey) Changes included:

- Exploring more green space in the Borough
- Joining a weight-loss group
- Joining a gym
- Volunteering with the elderly to tackle loneliness
- Commitment to focus on mental health as much as physical health

“Doncaster Talks” provides the borough with an innovative and effective model to use in gathering insight, crowdsourcing ideas, and engaging with residents that can be adapted and scaled - 91% of participants expressed an interest in taking part in the future.

What we found out

Discovering the why behind the what

Why are current public health campaigns around smoking not working?

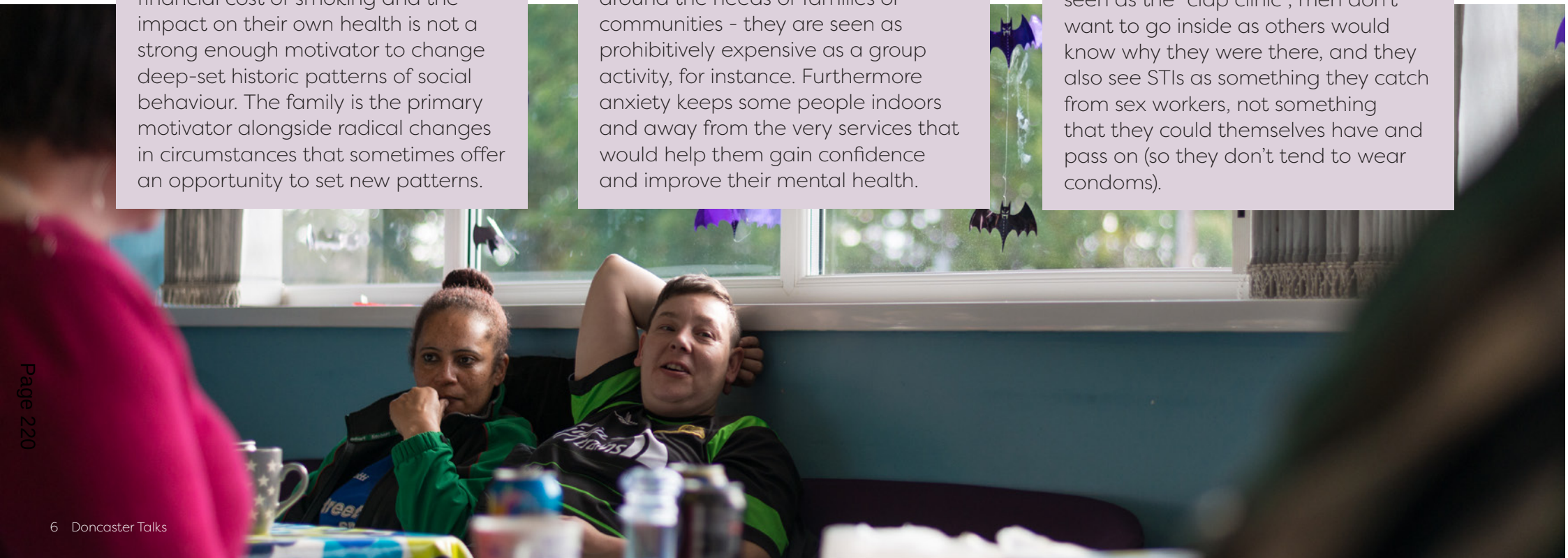
Because for people in Doncaster the financial cost of smoking and the impact on their own health is not a strong enough motivator to change deep-set historic patterns of social behaviour. The family is the primary motivator alongside radical changes in circumstances that sometimes offer an opportunity to set new patterns.

Why don't some people use public leisure facilities and take more exercise?

Because services are not aligned around the needs of families or communities - they are seen as prohibitively expensive as a group activity, for instance. Furthermore anxiety keeps some people indoors and away from the very services that would help them gain confidence and improve their mental health.

Why are men over 40 not using sexual health services?

Because the sexual health service is seen as the "clap clinic"; men don't want to go inside as others would know why they were there, and they also see STIs as something they catch from sex workers, not something that they could themselves have and pass on (so they don't tend to wear condoms).



Understanding and acting on "resilience" in Doncaster

In order to improve health outcomes, reduce health inequalities in the borough, and take a more preventative approach to health, Team Doncaster needs to embed a strategic approach to building resilience in its population.

This research has helped to understand what "resilience" means for Doncaster, how it currently plays out in people's behaviours, and how it could be nurtured and increased to help improve health outcomes.

The two most powerful factors that impact on the resilience of an individual, family or community in Doncaster are their openness to change and their connectedness.

Openness to change

Doncaster should be proud of the toughness of its residents, and their capacity to absorb the shocks of difficult circumstances or events, their histories, and the history of the borough. It has, however, encouraged a kind of South Yorkshire "grit", which shows itself through deep-set and longstanding unhealthy behaviours, occasional inflexibility in responding to changing circumstances, mistrust in some health professionals, and an acceptance that "things are the way they are". All of these have become a barrier to making positive changes to live a healthier life.

Connectedness

The most critical factor in increasing health and wellbeing in the borough will be maintaining and improving people's connection to others. The Doncaster Talks community has shown the value of bringing people together to share ideas and engage in an aspirational conversation about the future of where they live. It has provided ideas for service improvements, insight about barriers to health improvement, and a vehicle for connecting people in a shared endeavour. On average, participants gave it a rating of 8.8/10.

To improve people's health, therefore, partners across Doncaster must work together to:

1. Increase people's openness to change - turning "grit" into "aspiration" by repositioning health messages, building more trust in different kinds of health professionals, and reframing services around that which motivates people - namely family and community.

2. Help people become connected and maintain connection with others through targeting resources where social connection is at risk, tackling the kinds of mental health challenges that keep people distant from support services and supporting community-level infrastructure that holds people together.

Using the Insights

This report provides examples of how to increase people's openness to change and maintain a sense of connectedness across the borough. In addition, it offers challenges to Team Doncaster partners to tackle in the short and medium term.

This report has produced personas - composite pictures of Doncaster residents - for use in the development of service improvements, campaigns, new interventions, and in understanding communities. Each persona tells the story of someone with a different level of resilience - they are more or less connected to their communities, and are open to change in different ways. They are tools for all partners across Team Doncaster to use in the development of new services, in making service improvements, and in understanding their communities.

Background

Background

Our brief

Doncaster Metropolitan Borough Council and Doncaster CCG commissioned service design and innovation agency Uscreates to undertake customer insight research to inform the work of the Doncaster Growing Together Partnership. The brief had three components:

1. Generating actionable insight.

2. Training staff in tools and techniques for engaging with different kinds of data and insight.

3. Generating public awareness of and interest in positive health and social care choices.

As a result of this project, it was hoped that the design and commissioning of services would be more routinely informed by insight generated from different kinds of rich data. This would enable better targeted resources to ensure Doncaster becomes healthier, with a focus on prevention.

This research was also an opportunity to find new ways of empowering residents, as part of the project itself, and also in the recommendations that flowed from it.

Background

The local picture in Doncaster

Doncaster Growing Together is a partnership across the borough that brings together organisations from health, social care and public services. The partnership is focused around four themes:

- Learning
- Working
- Living
- Caring

Whilst cutting across all four themes, this research is primary focused on helping achieve the aim of the "caring" theme: to encourage the whole health and care system to work together across one place and around the needs of people. Driven partly by financial pressure across the public services to deliver more for less, the Doncaster Place Plan describes a joint focus over the next five years. In line with the Five Year Forward View, the aim is to develop out of hospital services further and to foster community resilience, so that partners across the borough can better support people and families, provide services closer to home, and reduce demand for hospital services.

At the heart of this is a commitment to support residents to take responsibility for their own health and wellbeing. Across the Borough, there is a desire to find new solutions to old problems, as partners recognise that carrying on as before will not work.

This research has origins in the need to get to know the people of Doncaster better. Traditionally, that partnership has been data rich but insight poor: over-reliant on service data to inform thinking without being sufficiently grounded in the lived experience of residents. There is a recognition that teams across public sector organisations in Doncaster struggle to interpret the data adequately due to a lack of sufficient insight into people's motivations.

Team Doncaster has already developed neighbourhood profiles as part of its focus on getting to know communities better. The use of in-depth insight research contained in this report will provide the opportunity to significantly bolster this work and provide a clear steer for both commissioning and service design.

Background

Challenges and priorities - the turn to prevention

The Doncaster "State of Our Borough" report - the first of its kind in the area - provides a strong quantitative overview of the quality of life for people living in the borough.[1] It has not only given partners across the region a foundation on which to develop priorities, but also has opened up questions where the statistical picture may not tell the whole story.

- Life expectancy at birth remains below the national average. For males in Doncaster it is 59.7 and for females in Doncaster it is 61. The England average for males is 63.4 and for females it is 64.1.
- Emergency hospital admissions are high in Doncaster. The current rate is 12,311 per 100,000 population. The England average is 10,036.
- The percentage of the population who achieve 150 minutes of physical activity per week is low. In Doncaster the figure is 52.6%, and the England average is 57%.

Doncaster has identified "Early Help & Prevention" as one of the key areas of focus for the Growing Together Partnership to achieve the objectives in the State of Our Borough report.

The move to "Early Intervention, Prevention and Resilience" (EIP&R) is common across public sector bodies that are pursuing new models of operation which:

Seek to reduce the reliance on costly and overstretched acute health services
... by building a healthier community through behavioural insight-driven campaigns, moving treatment out into communities, increasing investment in outreach.

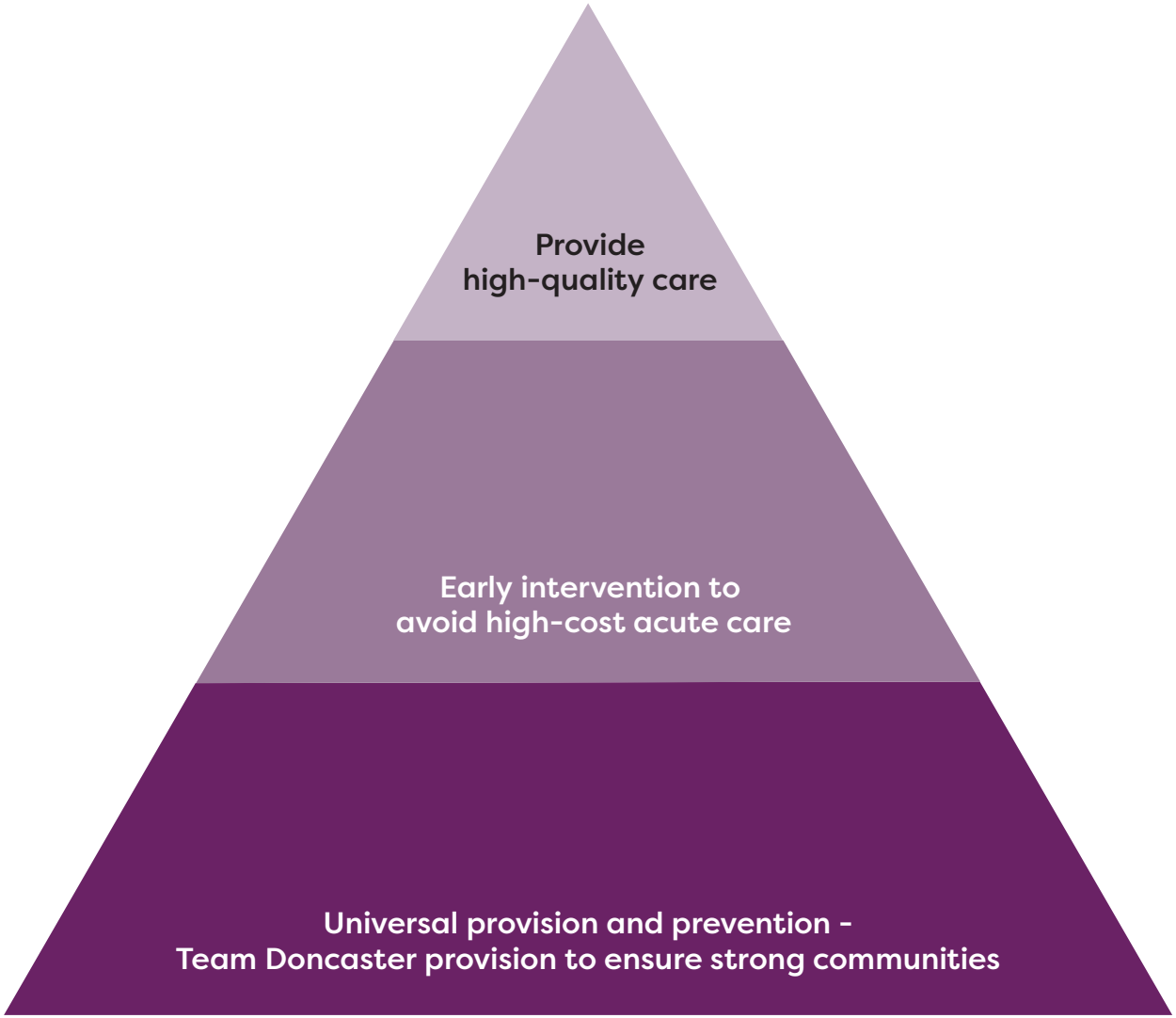
Prioritise the role of the communities and voluntary sector in tackling social problems
... by enabling and supporting people to act on their own initiative, opening up community assets, changes to planning processes, developing social-impact bonds and community partnerships, etc.

Reframe the role of "the public sector" from the providers of care and support at crisis points to those who can help build resilience
... by tackling the root causes of problems much earlier and targeting resources there.

This approach can be summarised using the diagram on the next page.

1. http://www.doncaster.gov.uk/services/the-council-democracy/state-of-the-borough

Prevention triangle



As part of its work to help the council move to a more preventative model in the London Borough of Islington, Uscreates developed four key principles. These are:

1. Start with what residents care about, not a service or professional viewpoint.
2. Aim to build positive assets and capability, not just reduce risks and harm.
3. Get to the root cause of problems, not just address immediate symptoms.
4. Help people to help themselves and those around them, not just provide a service.

These principles have helped frame Uscreates' work with local authorities across the UK (and have proved vital to this project).

What creates or supports resilience?

A central concept in a prevention and early intervention approach is resilience. Resilience is often described as an individual, personal quality - you either have it or you don't - but it is also supported by a range of external and internal protective factors:

Access to resources: whether that's the more well-off for whom bad decisions/mistakes have less of an impact, or the more savvy individuals who understand how to navigate support services.

Supportive relationships and social network: resilient individuals draw on the resources of friends, family, community, etc.

Mindset: some people see themselves as able to influence their fate, others as the victims of events. This is sometimes referred to as the locus of control – whether that is external or internal for individuals.

A s ense of identity and goals: having a sense of who you are and what you want to be and achieve helps people have direction, rather than being buffeted by events.

Stability: sudden changes in the reliability of accommodation, relationships, finance, etc. can cause crisis for people who have previously seemed resilient.

Role of experience: resilience is a property of having to deal with adversity: through trying and failing; through trying and succeeding. This helps people develop a sense of autonomy, agency and control.[1]

Understanding how these factors play out in a particular area - or for a particular individual, family or community - will give insight into how to build resilience in that place (and thus support a more preventative approach).

1. Health itself has a significant impact on resilience. If somebody is unable to access distant services because of their immobility, or if their mental health makes it difficult to take part in support programmes, their resilience will suffer. As improved health outcomes are a central aim of this report, it is not used as a resilience factor here.

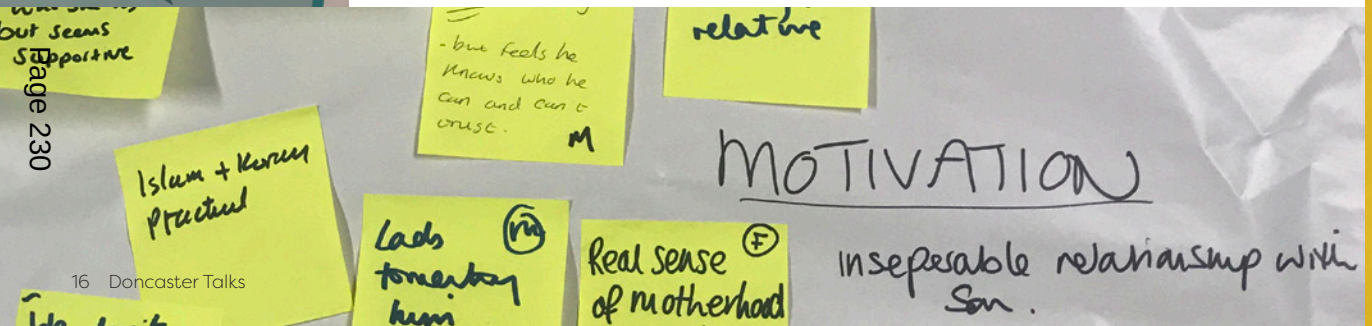
What we did

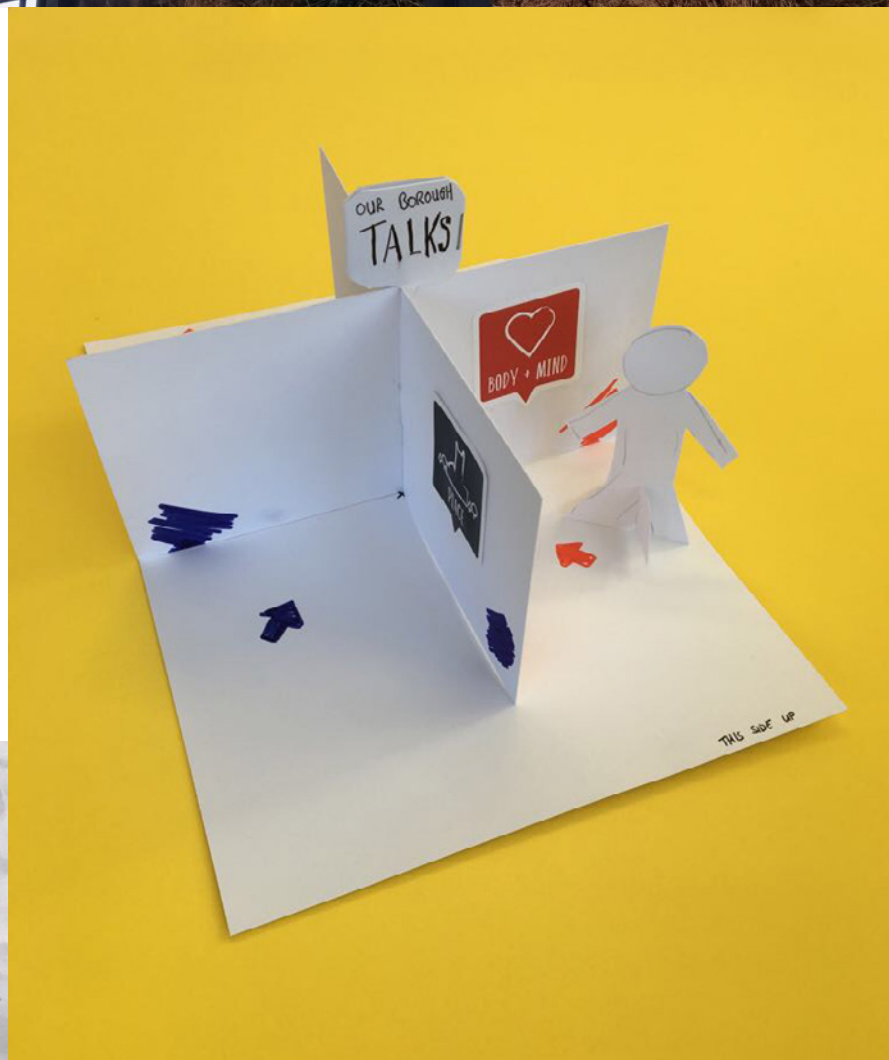
What we did

A design research approach

This project employed a design research approach - a human-centred qualitative method to gathering insight that helps inform the design and development of services.

The research was structured into two groups: ethnographic interviews and a digital engagement platform.





Research for depth: ethnographic interviews

Seven design ethnographies - half-day immersive interviews - were carried out with people living in the Metropolitan Borough of Doncaster. These interviews took place in cafes, homes and community centres, and researchers also travelled around the local area with participants to learn more about their lives and how living in the area impacted on their health and wellbeing.
The broad aim of these interviews was to understand the behaviours, motivations and barriers that exist around health and wellbeing in the borough.

In addition to increasing understanding of patterns and trends in the borough, Doncaster MBC and Doncaster CCG wanted ethnographies to focus on specific health conditions and behaviours that are prevalent, or for which uptake of services is a challenge. These were:

- Teenage pregnancy.
- Smoking (and smoking whilst breastfeeding).
- Dementia or Alzheimer's.
- Drug and alcohol abuse.
- Men's sexual health.

The council and CCG also wanted the ethnography sample to include:

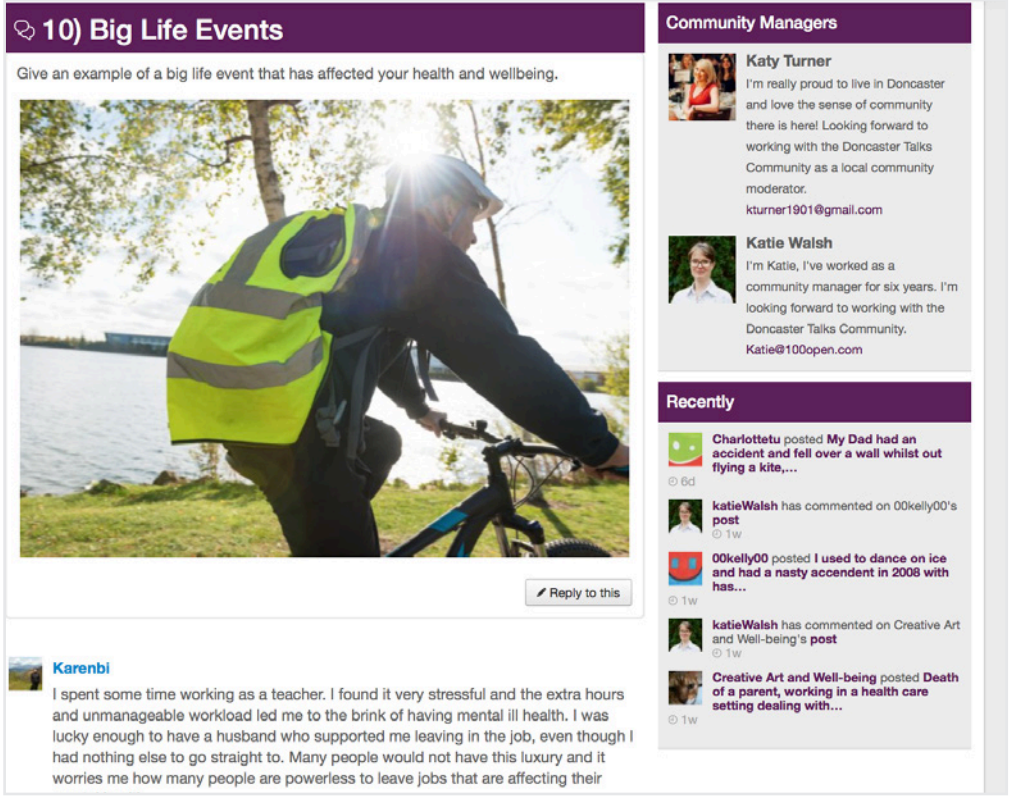
- Residents from across the borough, who lived in both urban and rural settings.
- At least one BAME participant.
- Participants of different ages spanning adolescence to old age.[3]

Participants were recruited through a mixture of partnership referral by particular services and "street" recruitment (where researchers flyered across the borough). The Doncaster Talks campaign (see below) was also used to recruit ethnography participants.

The interview questions were grouped around three themes:

People: understanding the role of others in shaping health and wellbeing, and driving behaviours and outcomes.
Places: understanding how living in different parts of Doncaster has an impact on health and wellbeing.
Things: understanding the role of infrastructure, resources and services on people's health and wellbeing.

3. During project development, it was decided not to interview any participants under 18, but to discuss previous experiences of teenage pregnancy with those who were over 18.



Research for breadth: online engagement platform

In addition to curating the depth of insight that came from design ethnographies, Uscreates (in partnership with 100%Open) set up and managed an online engagement platform: Doncaster Talks.

Doncaster Talks was a forum in which people from the borough responded to 16 broad questions about their health and wellbeing, and shared stories about their lives or ideas about how to improve health outcomes in the area. They also responded to surveys, reflected on some statistical data about the borough, and gave feedback on their experience of taking part. We were particularly interested in learning how this method of engagement had prompted them to make changes themselves.

Recruiting people to Doncaster Talks

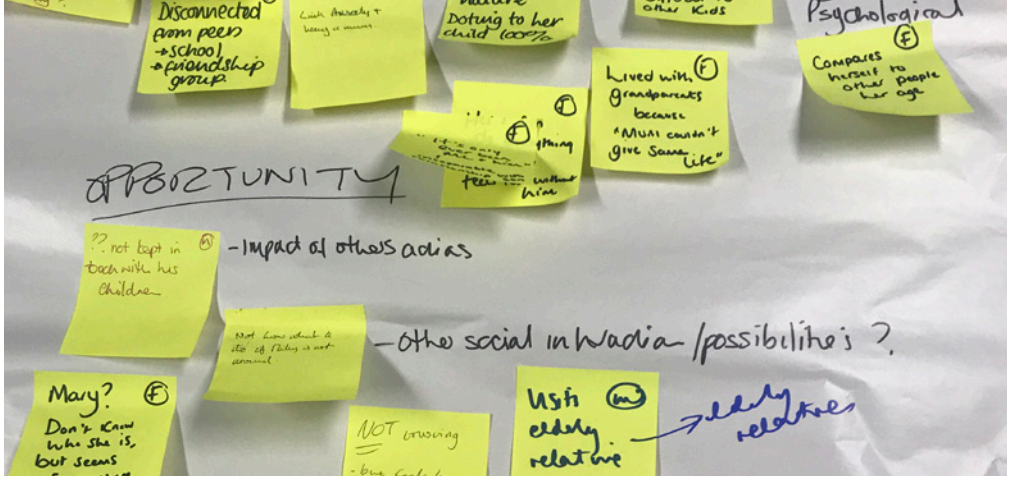
Uscreates ran a short recruitment campaign through local health partners and the press. A mobile recruitment structure was toured to four local venues to engage residents in the project and encourage them to sign up to the platform. The research team used this opportunity to ask some of the platform questions to people who visited the recruitment structure, attempting to reach as broad a range of residents as possible and canvas the views of people without access to a computer.

Examples of campaign material

Newspaper advert

Social media images

Leaflet



How we analysed the data

Staff from Doncaster MBC and the CCG undertook preliminary analysis of the first ethnography transcripts as part of their capacity building programme (see below). During these sessions, four overarching themes emerged, each of which seemed to have a significant positive or negative effect on the health and wellbeing of people living in Doncaster and the surrounding borough. These themes were finalised during a workshop between Uscreates and 100%Open as:

Services

Connections

Mind and Body

Place

These four themes became the guiding framework for future analysis of the ethnography transcripts, and were used as a way of grouping tasks and questions on the Doncaster Talks platform.

Capacity building

As part of this project, teams from the council and the CCG attended five capacity -building workshops, exposing them to the tools and techniques of design research, behavioural science and service design. At each stage of the design process, staff were using the outputs of this research project - analysing the ethnography transcripts, engaging with the material on the Doncaster Talks Platform, and developing prototypes using some of those insights.

Staff were also able to influence the kinds of questions asked on the platform. For example, after reading two ethnography transcripts where trust of services seemed to be a barrier to changing health behaviours, staff were able to develop an activity around trust of services on the platform. Moreover, having identified a significant theme around intergenerational health, the team asked platform participants to share stories of who had most contributed to their health and wellbeing, and why, and also set up a conversation around giving health advice to the next generation.

Findings

"Many years ago I bought me a home,
To settle, to thrive and never to roam.
A nice little area, friendly and clean,
My terraced house all snuggled between
Great neighbours who went out of their way,
That's how everyone was back in the day.

After 30 some years I've seen some things alter,
Less families, less community, my feelings have faltered.

But at the end of the day with all of its warts
I love where I live, my home is my fort."

Poem by Doncaster Talks participant

Findings

Place

A sense of belonging

A diverse borough, full of different identities

Living in "Donny" holds significant meaning for people, and place plays a strong role in residents' sense of identity. However, this meaning is as diverse and multifaceted as the borough itself. People who live in or close to Mexborough or Thorne do not identify with Doncaster, but with their own town or village. In fact, they often identify against Doncaster (as they feel it is "different"). In some cases, framing our research around "Doncaster" was met with suspicion or indifference - the place holds little meaning for some people. However, people who have lived in the area for the whole of their lives tend to be more open to talking about Doncaster as a wider area (people who played sport in Doncaster as children, for example).

Pride

People are proud and protective of Doncaster, and challenge stereotypes that it might be run-down or undesirable. For some this extends to feeling proud about what is bad about where they live. An ethnography participant said to us: ***"it's a shit hole, but it's my shit hole".***

This research has identified how there could be more aspriation in the population about where people live, and about whether the future could be better in their area, their family life, or their health.

Pride in the here and now, no matter how good or bad, is arguably a characteristic of the area: some might call it a particular kind of South Yorkshire "grit". Understanding how to mobilise that pride and turn "grit" into "aspiration" should be a primary focus of Team Doncaster as a route to improving the health outcomes of their population. Some platform participants told stories of how they were able to do this. When asked "Who has most contributed to your health and wellbeing", many people said "myself".

"Everything I've ever done in terms of health has been due to my own implementation, from foods to exercise, to mental wellbeing. My parents were smokers/drinkers, their natures were largely sedentary. I developed a love of activity as a child and I'm still trying to be active despite my declining health."

LISTEN IN…

On Doncaster Talks, people shared many examples of well-connected communities in which people "look out" for each other, help their neighbours, and take a collective responsibility for their wellbeing, safety, and the appearance of the neighbourhood.

Key characteristics of communities that are well-regarded by the residents include:

- Places where there is easy access to high-quality open space.
- Places where anti-social behaviour is under control.
- Places where rubbish is regularly cleared and the wider environment kept clean.
- Places with access to amenities that are close.
- Places that are well connected by public transport to larger places with amenities.

"My village has a real sense of community and you can't go very far without seeing a familiar face. There's nice places to eat and some little shops, it would be nice to see further investment in the area to make community areas like the parks and green spaces more appealing."

"My street now is clean and quiet. It's full of friendly honest people. People not only smile at each other but remember everyone's names and ask after each other. People go around to elderly neighbours to see if they're okay, they take the bins out for them, de-ice the cars. We pop around and cut each other's hair in exchange for fixing the printer or loaning a book. Little kiddies draw pictures for you and post them through the letterbox. I have a trio of nursery-age boys who stop outside my house to wave at my cats!"

"I love the village I live in, it has a real sense of community spirit. If I'm doing any jobs outside, such as cutting the grass or sorting my fencing out, everyone stops for a chat. The kids are friendly and I feel my cats are safe, too."

Residents seemed to accept that there is a limited role for public agencies in maintaining community spirit, and recognised a change taking place in how people interact with their neighbours in a modern, fast-paced world. Some recognise the positive role of the voluntary sector in this regard, including the Denaby Family Hub, the Stainforth and Scrawthorpe Rethink Groups, the Alzheimer's Society, and the Talking Shop for mental health all mentioned. One man made a suggestion regarding specific people in the community who should be targeted as agents for change:

"I'm not convinced that any outside agency can alter what seems to be happening in our local neighbourhoods. Ultimately we are all in such a rush, feel that we don't have enough hours in the day, have our own family obligations to meet, and somehow in the middle of this the neighbourliness disappears or comes a very poor second. The most active member of our street died last year. There was standing room only at his funeral in the local church, much to the vicar's dismay (as he had only printed a handful of service leaflets). This neighbour had retired some twenty years ago, and spent most of his day helping other people in the local community with odd jobs, walking their dogs, and so on. I think that in today's climate, the best group to target for building a sense of community is the newly retired, as they will be used to being active and might welcome the element of involvement and rewarding relationships."

"I think when your neighbourhood is busy with dog walkers, joggers, and other people using the streets, it's one way of winning back your streets from the bad element who then become the minority."

The changing landscape

The shadow of the past

As with people's physical and mental health (see below), place and the past cast long shadows in Doncaster. A majority of people spoken to as part of this project - both ethnography participants and on Doncaster Talks - had lived their whole lives within the borough. For some, the area still holds the emotional baggage of industrial decline, particularly for people in their 50s and 60s. The discussions on Doncaster Talks frequently became conversations about the way things were, or about changes that had taken place several decades before.

"As for the neighbours, this is a former pit village area of the town and, as such, everybody knows everyone else."

This particular element of the past is a significant part of the collective identity of Doncastrians, and the quote above illustrates the way in which it is often presented by residents. It is framed with both positive and negative connotations. People speak of the negative impact of the loss of the pits, and the loss of the social connections that were formed around them.

"That's why people round here voted against Europe. Don't underestimate the impact that the miners' strike is still having here...I can't put into words how bitter that was, and how many families it tore apart. I know people who were left with debt from that time, and they are still paying it off. It created bitterness, which is a void, and that void was filled by drugs."

However, people also see this collective sense of belonging to a shared past as something that still binds communities, and that is an asset to the area.

Open space

Residents of Doncaster see the value of open space and fresh air, with participants across the research citing ease of access to the countryside as one of the most positive aspects of living in the borough. Highlights include the Lakeside, Humberhead Heartlands, Sandall Park and Cusworth Hall, and the Yorkshire Wildlife Park. However, there are many participants in this research who are more isolated as a result of ill health or anxiety, and - as such - do not experience or recognise this positive aspect of living in the borough.

Air quality

Residents on the platform cite pollution in the town centre as a barrier to their being healthy. Air quality in the town is part of a wider narrative for residents around the lack of safe shared space for cyclists and motorists, and the friction this creates between cyclists and other road users.

Housing

The increase in local population due to new housing developments is a cause of concern for residents.There is anxiety about how health services will be stretched, impacting on health outcomes, and that growth will put pressure on some fragile community connections which are already under strain. Residents also shared examples of where housing developments had eaten into open space used for exercise:

"Quite a lot of new builds popping up that are sadly taking away areas to walk dogs, but people do need homes."

There are positive stories to be told about this change, too:

"I live in Armthorpe. Our street is made up of council homes, now mostly bought by the council tenants, one or two have been sold on to others. I think it's a very nice place to live, with friendly neighbors and a community spirit. I have lived here for over thirty years now and have seen a lot of changes to the village. When we moved here it was around the time of the miners' strike, not a great time for a pit village. People who lived here then said the village would die without the pit, but it thrived, I think because of its link to the motorway. Lots of new housing has been built and this has made it a much larger village than it once was, it has lots of different shops, a library, banks and supermarkets, and is a busy place - but still seems to keep its small village style of community spirit."

Crime and feeling safe

For some, the quality of their place is being affected by antisocial behaviour. The material quality of their town or village centre does impact on their wellbeing:

"I live in a lovely street, but in a village that is getting worse. We don't have a large supermarket. Most of the shops have closed down, empty houses are burnt nightly. Police station has closed down. I don't go into my village anymore, I drive to a different town to shop and I think that is sad ... a few people spoiling it for others,"

The centre of Doncaster remains a "no go" area at night for many people, owing to anti-social behaviour (particularly drug use) and a rise in homelessness. There is a strong correlation between pride in the physical fabric of the environment and people's wellbeing, and the reverse is also true (lack of pride = low mental wellbeing).

"...it still seems to keep its small village style of community spirit."

What parts of the borough make you feel good and why?

Town

Some great bars and restaurants. Doncaster brewery is a local business that provides a real social service with folk music afternoons, book clubs, German lessons and a ukulele club

Wheatley Hills and Intake

I love the wild flowers that the council put in the areas that you drive past, it all looks so beautiful and inspired me to plant my own small wild flower seeds, I have harvested some and given them to my grandchildren to plant at school

Armthorpe

I live here, my street is wonderful and friendly. My in-laws are here too

Edenthorpe and Kirk Sandal

I recently moved to Edenthorpe and really like it. The Tesco Field (athough needs work) is a great green space for children and the local facilities are really good

Sprotbrough

Really nice canal walk and countryside to walk round to relax and unwind, kids love the riverside walks also

Hatfield

There is a lot to do such as art classes at the local library yoga children's pre school activities and very good bus links to and from Doncaster to thorne and Moorends

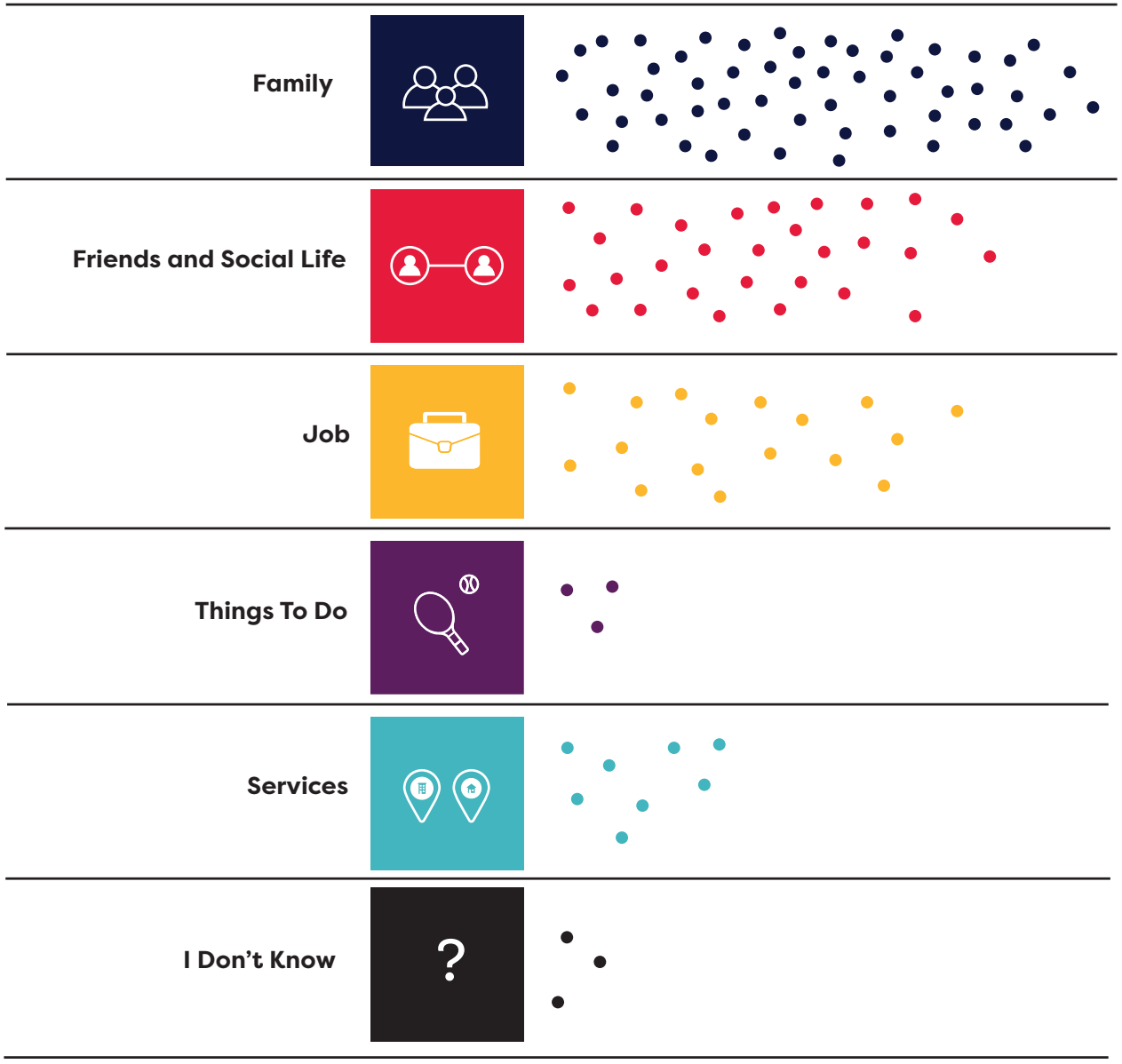
Rossington and Bawtry

Rossington is buzzing with young people and the area feels safe

Conisbrough

I love history, so Conisbrough, with its castle and church, is a favourite place with many happy memories attached

What keeps you in Doncaster?
If you moved to Doncaster what brought you here?



My family came from India in 1947 to Doncaster, We are a large family with all my father side of the family all living and born in Doncaster since they arrived

I have chosen this as I am not originally from Doncaster but have made a nice network of friends through my childrens school and am quite happy

There was nothing for me where I lived, so I moved to Doncaster to have a better prospect of finding a job

Events like Doncaster comicon and Doncaster video game market held in places like Doncaster dome

My GP practice is brilliant, the hospital is great, it makes it a lot easier not to worry about things when medical services are so good

CHALLENGE BRIEFS

To **Doncaster Metropolitan Borough Council and the CCG:**

1. As services are integrated through the Place Plan, **how can we** maintain sub-local identities as the borough becomes more connected and services are integrated?

2. How can we raise collective aspiration around health by capitalising on people's strong sub-local identities and the shared identity of the past? How can we use community-level outcomes to drive behaviour?

To **All Team Doncaster partners:**

3. How can Team Doncaster partners collaborate around resident-identified metrics such as the five metrics of good places to help target resources for improvement or intervention? How could this help progress the borough towards outcomes based budgeting?

To **Doncaster Metropolitan Borough Council:**

4.How can we capitalise on a wish to open closed shops and utilise empty space so that communities are able to organise and manage initiatives to: a) improve the fabric of communities; b) increase wellbeing; and c) promote positive health outcomes?

Findings

Mind and body

Unhealthy behaviours

Self awareness and aspiration to be healthier

Residents of the borough understand the impact of their unhealthy behaviours and habits. They understand that smoking kills, that eating too much sugar is bad for them, and (for example) that the red traffic light on the side of a packet of food means the contents are high in saturated fat.

People in Doncaster aspire to be healthier or maintain their health, particularly our ethnography participants (the majority of whom are living with some kind of health condition). For example, young women who had smoked whilst pregnant with their first child wanted to quit during their next pregnancy and be able to breastfeed. A woman with dementia wanted to maintain her quality of life as the disease worsens. Often, however, this sense of aspiration is framed around other people. For most, their ambitions for health focus on their whole family unit, or on their capacity to‘“keep doing things”, rather than being about themselves and their own health outcomes.

Passive to current behaviour

Residents who talk about unhealthy behaviours often present themselves as somewhat passive to those behaviours. They frame their ill health around external drivers, rather than around their own internal motivations. For example, eating sugary foods is explained by the ‘“addictive”’ qualities of sugar, and being ‘“out of control”’. Skipping meals (a common topic on the

Oditata turitat iiscipi dernatum fuga. 4

online platform, particularly amongst women with children) was caused by stress from work, making meals for others, or not having enough time. The exception to this is drinking alcohol, which is framed as a more active choice because it tastes nice, or provides a social focus that they enjoy. During discussion on the Doncaster Talks platform, the biggest "barrier" to being healthy - by far - was the plethora of fast food outlets in the town centre and their ease of access/affordability (an *external* driver).

Again, what has gone before is often used to explain the unhealthy behaviours of today. For example:

"When I was a child, I was forever sent to my room without dinner, sometimes for three or four days in a row. It's become a habit that I still do to this day where I can go a week without eating, then binge."

It is not just childhood experiences that shape unhealthy behaviour in this way. One bad experience (perhaps of a service) will set residents' attitudes in place for the long term, compounding unhealthy behaviours. For example:

"I don't go to the dentist because she was horrible and made me feel like I am a bad person for having stains on my teeth."

Life events

As the shadow of the past is strong, moments of crisis or change can set unhealthy and healthy behaviours for the long term. Many platform participants shared examples of when their "grit" had helped fixed positive patterns of behaviour following significant events:

"I was let go at my job.....and immediately afterwards went into hospital for major surgery. During recovery I decided it was time to reinvent myself. With the support of friends I managed to make a small start on starting a business. Years later I am the director of a marketing agency. I am always grateful for being fired...and the perfect storm that ensued. It made me galvanise myself and take the opportunity to do what I had always wanted to do. Sometimes when things are safe we can think there is no other alternative...it takes a "crisis" to change our thinking and increase our courage. It took me ages to recover but I was buoyed by the idea that I had plans and ideas. Hope is more powerful than we sometimes think."

Perceptions of ill health

People in Doncaster often judge themselves to be healthier than they would be considered to be by health professionals. What would be considered rather severe examples of co-morbidities are accepted as normal. This normalising effect of being surrounded by ill health is compounded within families, particularly where there is no alternative role model. Moreover, whole families that are healthy tend to be healthy together.

Ethnography participants were chosen because they were living with particular kinds of conditions or were interacting with particular services. In the majority of cases, they were living with co-morbidities that were having a marked impact on their quality of life. Yet they did not see themselves as being unhealthy, or worse off than others. For example, an underweight woman with multiple health challenges told the researcher:

"***I feel there's always someone worse off, more ill, poorer, not as strong... What does "healthy" mean? Not drinking, not smoking. Helps with the healthy mind, it's what you're putting in to your body. I'd say my mental health [is] more important. Though with the physical that is important because it's harder to hide it. Important to hide as don't want people to judge, or to feel sorry for me. When people know there's something up, that changes how they look or speak. I don't do sympathy, giving or taking it. Any normal person wouldn't know I had SPD – when your hips fall apart. Had to wear a belt and stuff to keep them there when pregnant. Painful walking, laying down. Having physio for it at hospital."***

What do you think is your worst health habit? Why do you keep doing it? What would make you stop?

28

Sugary food and drink

"Prices going up has definitely reduced my sugar consumption, so increased prices."

11

Drinking

"I do like a few cans of lager every night. I do not feel this is a problem but I think my wife disagrees. I do not feel unhealthy from this as i feel it helps me relax and i would not drive when i have had a drink."

8

Smoking

"I think for me it is a case of finding the strength to go cold turkey and having the willpower to stick to it. I don't know if there is any incident that could occur that would make me stub out my fag and never have another because it has never happened."

23

Eating too much

"Once I start overeating I can't stop. It's a kind of an addiction in its way. I use food when I happy, sad, bored as a reward."

11

Skipping meals

"I often skip meals due to my job and child (always seem to care for everyone else first)."

8

Watching too much tv

"Being disabled I'm limited on what I can do and I have an unhealthy relationship with food."

8

Ordering takeaways

"I like the taste of them and sometimes I just can't be bothered to cook! Would take a lot to make me stop, I do exercise after all and I gave up the demon cigs about five years ago."

6

Not going to the dentist

"I don't go to the dentist because she was horrible and made me feel like I am a bad person for having stains on my teeth "

13

Spending too much time on your phone

"As for my smartphone, if there were more things to do on doncaster I would be more inclined to go out."

● Amount of people

Mental health and physical health

Mental and physical health are closely aligned for the residents of Doncaster. Stress at work and other kinds of anxiety are fuelling unhealthy behaviours and act as a barrier to engaging with services.

Stress at work

Across the research, stress at work was raised as a common cause of low mental wellbeing. One ethnography participant was previously stressed in his high-pressure public sector job, drinking at least a bottle of wine each night as a coping mechanism, and not exercising. This resulted in him seeing his GP at least once a month for general feelings of ill health. Owing to the strong financial situation of his family and his wife's high salary, he was able to leave work early and gain support to manage his mental health better via his GP. He took the opportunity to assess his life "in the round", and take a preventative attitude to his health, rather than simply waiting to see his doctor whenever he was ill. However, this freedom to leave work so young is not common in Doncaster, and many people working through their 50s will not have the opportunity to assess their lives in this way until retirement much later.

Doncaster has a high proportion of jobs in the (much-stretched) public sector, where workplace wellbeing is low. Mental health charity Mind recently surveyed 12,000 employees across the nation in public and private sectors. Nearly double the number of public sector respondents said that their mental health was poor when compared with their peers in the private sector (15% versus 9%)[2]. Stress and anxiety due to work - and coping with this through alcohol and unhealthy food - risks becoming a significant challenge for the borough when trying to prevent ill health and reliance on expensive services in the future.

...but classic British tradition is denial. Too proud to ask for help, or hold out the laurel branch. It's typical.

The stigma surrounding mental health

As is common across the UK, Doncastrians recognise the stigma attached to talking about mental health - particularly the difficulty of making that first approach, or telling somebody else that you have a problem and might need help. One platform participant put it well:

"We all know when we have the blues or when someone else has. Bartenders tend to have a knack for these things, but classic British tradition is denial. Too proud to ask for help, or hold out the laurel branch. It's typical. Most of us tend to isolate ourselves as not only do we feel sanctuary in our own homes but we can hide our problems."

Anxiety as a barrier to engaging with services

Anxiety" is a common term used by participants - anxiety about leaving the house, anxiety about taking part in healthier activities, anxiety about social connections, and anxiety about walking through the town at night. From this research it is the most common form of mental health condition identified by people who live in Doncaster. For one ethnography participant, social anxiety (for which she was receiving treatment) was a clear and present barrier to improving physical health. She told us:

"My daughter wants to go jogging, but I said I would have to do it in the early morning so nobody is around."

See http://hrmagazine.co.uk/article-details/workplace-wellbeing-worse-in-the-public-sector

LISTEN IN…

Participants on the online platform were asked to share ideas about how to encourage people to talk more about their mental health, manage work-based stress better, and reach out to those who are isolated owing to anxiety. Most suggestions were around peer-led support, focusing on the first point of contact with someone else, and making that experience as positive as possible. Here are some of their ideas:

- Online "meet-ups" for people who need a first contact point that isn't face to face before reaching out to people or services.
- Open mental health workshops for all.
- Greater focus on mental health in the workplace through mental health "mentors".
- Local cafes encouraged to sign up to a "one hour a week mental health open house" for people to come and talk about their problems with some friendly faces.
- A way of encouraging people to go a bit further than just asking "how are you?"; instead, they need to feel confident to ask "how are you *emotionally*?" or 'how are you in *yourself*?

Men's health

Doncaster faces challenges around men's use of sexual health services. This was specifically raised as a challenge that data alone was not able to fully explain. When discussing the potential barriers to use of these services, one participant explained how:

"It's the "clap clinic". People know where it is, and what it is. No men I know would use the clap clinic. It's for people with HIV."

This point of view represents a common barrier to the use of sexual health services; the perception that existing services lack privacy, anonymity, and are located somewhere with a strong local reputation. However, the challenge appears to go deeper. The same participant explained how none of his peers - men in their 40s and 50s, both married and unmarried - would use a condom during sex. The only exception to this, he suggested, would be during a trip abroad, and with a sex worker (where the risk is seen as higher). This suggests that:

- The prevalence of sexually transmitted infections in Doncaster is not well known, particularly amongst this age group;
- The risk is externalised - men would protect themselves when having sex with someone who they perceive to be particularly high risk; and
- Men in Doncaster do not perceive themselves or their behaviour as being risky.

Being active

Cycling

Cycling is seen as an affordable and enjoyable way of staying healthy, but a perceived lack of infrastructure and fears around safety, pollution, traffic, and the behaviour of other road users puts off beginners. This may be a perception issue, as other "seasoned" cyclists have explained how easy it is to cycle in Doncaster because of all the high-quality cycle paths and open space (although even regular cyclers agree that it feels unsafe to cycle at rush hour as part of their commute).

"Maybe a media campaign that tells the story of a few local cyclists and talks about their experiences on the roads of Doncaster. We could make a video of someone's mum talking about how they worry about them and asking other road users to keep them safe..."

Leisure facilities

Residents report that there are plenty of leisure facilities in Doncaster, but some see them as unaffordable for families, with limited opportunities for young people to exercise with their family and some challenges around timing of family-oriented classes. The following comment is indicative of a common viewpoint shared on the Doncaster Talks platform and highlighted through our research: that what is being offered in the way of leisure isn't quite matching with the needs of residents:

"I've approached DCLT a couple of times asking them to offer a family membership card specifically for swimming. Rotherham, for instance, offer one at £39 for the month but with DCLT I have to pay for us all separately and it costs £60 a month without including my husband."

CHALLENGE BRIEFS

To **Doncaster Metropolitan Borough Council Public Health:**

5. How can we design a public health campaign campaign around encouraging people to make the first approach in talking about mental health - it could be called "...and how are you in yourself?"

To **Doncaster Metropolitan Borough Council Strategy Unit:**

6. How can we engage local employers to see workplace mental health as a priority in the borough and enable holistic assessments of people's health and wellbeing earlier?

To **All Team Doncaster partners:**

7. How can we identify those who are isolated through anxiety and support them in making connections so they are able to participate in healthier activities?

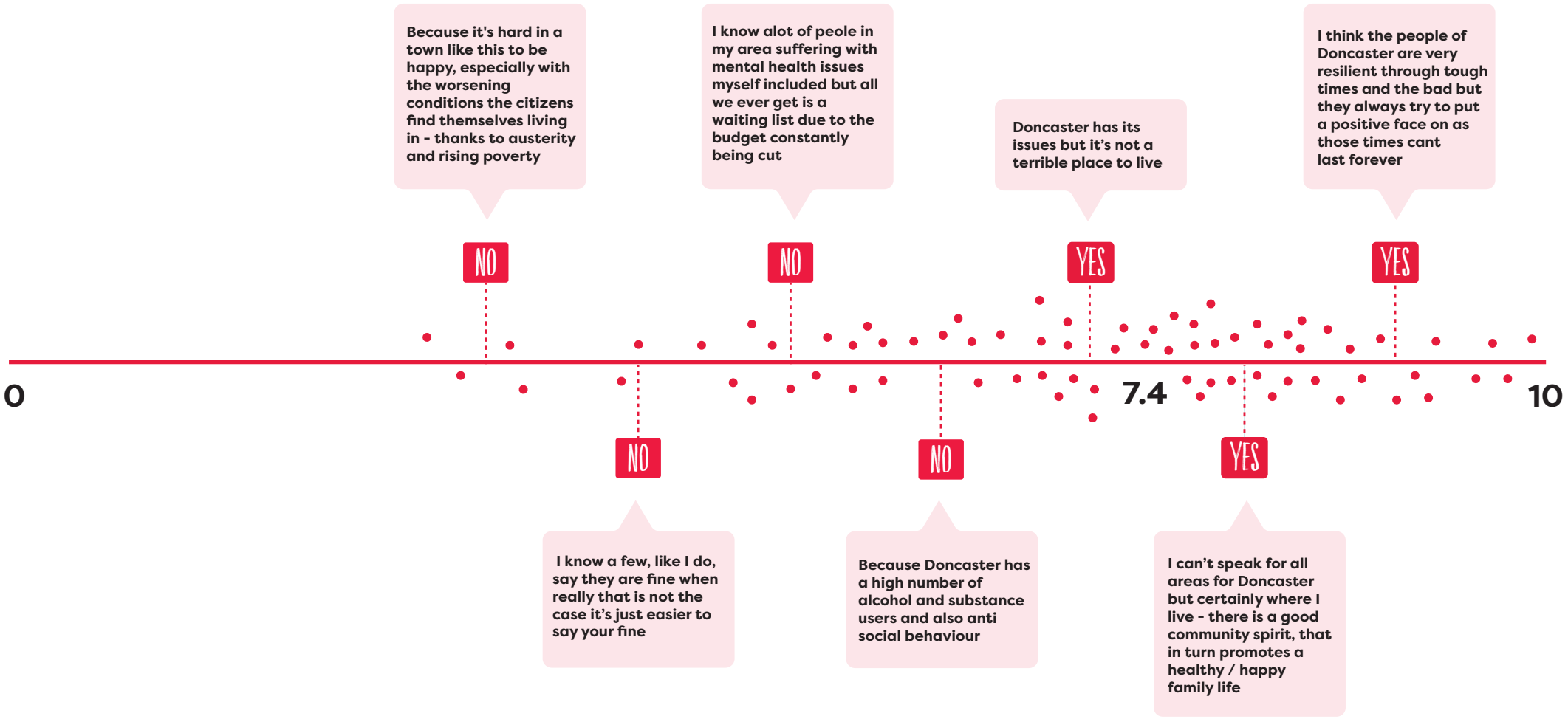
To **Doncaster Metropolitan Borough Council Public Health:**

8. How can we design a sexual health service that better meets the needs of men, alongside a campaign that explains the particular risk to that age group and promote 'condom use'.

To **Doncaster Metropolitan Borough Council Public Health:**

9. How can we design and commission leisure services so they better meet the financial constraints and time pressures of families? How can we promote cycling to beginners in a way that tackles barriers of safety, traffic and pollution?

Doncaster has a happiness rating of 7.4 out of 10. Do you think this is accurate?



What's your happiness rating? Plot it on the line

Findings

Connections

Family and friends

For the people of Doncaster, an individual’s health and wellbeing is deeply connected to the health and wellbeing of others. This is revealed through residents prioritising the health of family members above their own, and through reliance on the presence of and motivation from close family to stay healthy or make a change.

Prioritising the health of others

Particularly for women with children, this research has surfaced a pattern of prioritising the health of others above one’s own.

“My motivations? My kids. Motivated to do everything for them. I used to play football and rugby as a child, my parents never came to matches, didn’t support it much. A lot of what motivates me is my upbringing, doing better for them. Don’t have motivations about myself, all about other people really.”

Of course, this attitude to life is not uncommon. However, this kind of complete externalisation of motivation does have direct implications for the health and wellbeing of the individual. This ethnography participant barely ate throughout the day, keeping energy levels up with crisps and cups of tea. Her devotion to her kids also affected her wellbeing. For example, she told us:

"My kids – they've almost made me worse though, they've made me more scared of things because I don't want to not be here for the kids. But then I don't want to grow grey and old either. Even just being in hospital for one day for a melanoma to be removed, the house goes to a tip and falls apart! Can't allow myself to be ill, to be unwell."

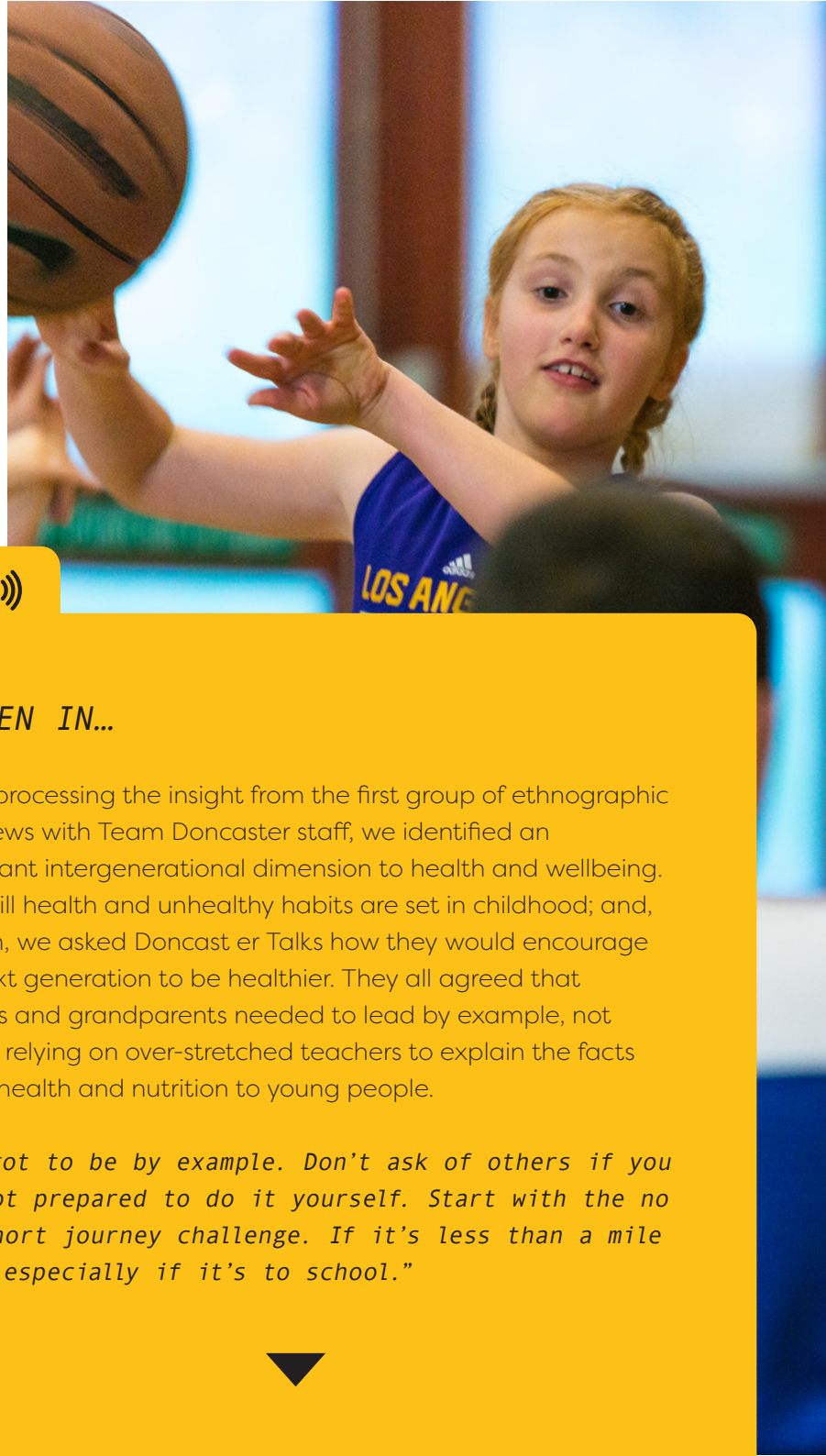
Her approach to wellness is to simply "not allow" herself to be unwell - rather than eating a healthier diet or giving up smoking. These kind of motivational drivers should have an impact on the tone and framing of all kinds of interventions from new services to public health campaigns. There should focus given to both working within and reflecting this mindset, but also explaining challenging when professionals come up against it.

Wellbeing contained in the health of others

One ethnography participant had the dates of her five children and two step-children's birthdays tattooed onto her arm, so she wouldn't forget them. Her tattoo is a metaphor for how much residents of the borough bind their health and wellbeing to that of others. This can be a source of great support, but it also creates risk in the population if those connections to others were to be lost (for example, one ethnography participant relies heavily on her husband to keep mobility as her dementia worsens), or if individuals were required to make changes to their health and wellbeing that were not connected to others (and so were not motivated to do so).

For some, the family remains the primary driver of staying healthy, and also the motivator during periods of ill health or times of stress:

"Moving home, having children, looking for work, working in stressful and busy environments - all can provide joy and stress at different levels. Personal resilience and support mechanisms have ensured none of these have impacted too badly on my health."



LISTEN IN…

When processing the insight from the first group of ethnographic interviews with Team Doncaster staff, we identified an important intergenerational dimension to health and wellbeing. Often, ill health and unhealthy habits are set in childhood; and, as such, we asked Doncast er Talks how they would encourage the next generation to be healthier. They all agreed that parents and grandparents needed to lead by example, not always relying on over-stretched teachers to explain the facts about health and nutrition to young people.

"It's got to be by example. Don't ask of others if you are not prepared to do it yourself. Start with the no car short journey challenge. If it's less than a mile walk, especially if it's to school."

"I think for kids it definitely starts with the adults in their life leading by example! Forming early habits is key, like eating a piece of fruit with meals, things like that, but I think these things should definitely not be made to feel like work, or being "taught" at all. Walks don't have to be about walking for example, they can be about exploring, finding new things and places. I think the best exercise to get kids into is the stuff that is a) fun and b) lacks a competitive element, which can make kids who aren't athletic feel bad."

"I think one thing we can do is target pubs, restaurants and many other eating establishments. Something I despise is the children's menu. When I was young there wasn't adult food or children's food, just food. On a children's menu the most healthy items you are likely to see are peas or baked beans. The rest of the food is usually high-calorie, fat-laden fast food. Even if these foods don't appear on the adult menu they are there for children. Do away with the child's menu and encourage healthy eating alongside adults."

"We need to teach our teenagers life skills. When I left school I had no idea how to run a home, about bills, credit rating, etc. This has caused stress due to debts and not understanding how these things work. I massively think that diet and stress causes so many health-related issues that this should be looked at in school and if we prepare the next generation and teach them some life skills then they are more likely to be healthier."

Local connection

The decline of the mining communities has been accompanied by a similar decline in the community assets that sat alongside - community centres, working men's clubs, etc. These spaces provided contact between families, enabled people to look out for each other, and often curbed the excesses of heavy drinking. A collective responsibility for health behaviours was contained within the working men's clubs, and without that physical and social space, such collective responsibility has been lost.

People in the borough also feel that this has contributed to an increase in loneliness, something that concerns residents - and something which several of our platform participants had themselves experienced. Loneliness diminishes aspiration to be healthier, and compounds unhealthy behaviour (particularly drinking, poor diet, and exercise).

LISTEN IN…

We asked the Doncaster Talks participants how they would combat loneliness in the borough. Here are some of their ideas:

- The Great Doncaster Bake-off - a bake and share event for people to come and share what they have.
- Make and share events -people bring a dish of some kind to share at a community venue, and prizes are awarded for the best!
- Open house - opening up interesting community venues that are normally closed at a particular time of day and that people may not usually visit.
- Volunteers in the Frenchgate Shopping Centre with badges on to indicate they are available to chat if people feel like it.
- Language exchange - people invited to come and talk to someone in a different language, helping to build skills and community cohesion.
- Reducing the cost of public transport to get out of isolated villages.
- A community-based "board game cafe".
- Inter-generational penpals - scheme where school children write to isolated older people, perhaps coordinated between schools and libraries.
- Talking benches in parks - particularly designed for people to stop and chat to each other.
- Supporting GPs to signpost towards community activities for those who are isolated.

Q: Which of these ideas would you choose to prototype in the borough?

CHALLENGE BRIEFS

To **Doncaster Metropolitan Borough Council Public Health:**

10. How can we demonstrate that being healthy yourself is better for your children and that it is important to role model these behaviours?

To **Doncaster CCG:**

11. How can we develop a risk stratification approach that includes an individual's reliance on others, both practically and emotionally, and target interventions accordingly?

To **Doncaster Metropolitan Borough Council and CCG:**

12. How can we develop, commission and enable interventions and services that maintain geographic connection using the public, voluntary and communities sectors?

To **Doncaster CCG:**

13. How can we systematically engage with the health and wellbeing of the family "unit" at all stages of interaction with 'public services'?

To **Doncaster Metropolitan Borough Council Strategy Unit:**

14. How can we design and support the Working People's Club of 2020?

Findings

Services

Trust

This research has identified how residents place trust in different parts of the health and care system in Doncaster. In summary:

- A majority of residents who participated in this project do, on the whole, trust acute care and recognise positive experiences.
- Residents trust those who intervene at a point of crisis more than those who intervene to help prevent ill health or a crisis.
- Residents trust professionals in what might be considered ‘high status’ roles more than others (e.g. trusting GPs more than practice nurses).

Oditata turitat iiscipi dernatum fuga. 4

LISTEN IN…

The issue of "trust" was discussed on the online platform. When asked if they always trusted the advice of health professionals, 64% of platform participants responded yes and 46% responded no. Their reasons for not trusting health professionals included:

- Negative experiences in the past.
- No continuity of care, and having to relay information to different health professionals.
- A perception that - owing to GPs being overstretched - they were not receiving their GP's full attention, that the doctor was always rushing to see the next patient or had their eyes "glued" to the computer during appointments.

This correlates with previous DMBC research on people experiencing complex lives, and suggests that - in fact - lack of trust is more widespread and should not only be considered in conjunction with "complex" cases. Lack of trust in others was a common theme across the ethnographic participants. Negative experiences with a service in a particular place had a significant influence on someone's ongoing relationship to all services in that place. Platform participants shared similar experiences and opinions. Negative experiences are internalised and become part of the mindset of that individual or within that family unit.

Trust and praise for acute care

Despite some negative impressions regarding facilities in local hospitals, residents reported positive experiences of the NHS in general, and were full of praise for senior clinicians who treated elderly relatives - for example:

Crisis versus preventative

Services that intervene with an individual at the point of crisis are trusted to a much greater extent than those which are universal or preventative.

For example, participants trust their drug rehab service or intensive crisis support (such as Doncaster Changing Lives). However, trust is more varied for larger or impersonal services with authority to intervene in people's lives (such as "the council" or "social services" or "schools". Additionally, this lack of trust is set in place early, and difficult to change - ethnography participants spoke of negative experiences with services in the past, particularly as children, and as a result they were now mistrustful of other, similar services. One participant had moved from a nearby area following challenging experiences, and now saw all services from that area in a negative light. The local area "brand" - that of "Doncaster Council" - has weight, and seeps between services, which in turn are not seen in isolation (i.e. a negative experience of one part of the local authority service in an area will then affect residents' perceptions of other services in that area, even if they are delivered or commissioned by a different agency). The sub-local brands, such as Thorne or Mexborough, are yet to hold traction in understanding service delivery, something which should be explored (see "Place").

Senior versus junior

Participants spoke of not trusting messages that were being relayed from practice nurses to GPs. One ethnography participant identified a reluctance in others to fully engage with practice nurses or receptionists, something which he saw as a major barrier to their taking control of their health. This man could name all the staff in his local health centre, and had seen the benefits of sharing his health information with all staff. They were able to offer advice on making lifestyle changes or on the likely cause of small niggles. The attitude of other participants in the research towards healthcare professionals other than doctors may be a barrier to their accessing the right kind of helpful (and preventative) support.

CHALLENGE BRIEFS

To **Doncaster CCG:**

15. How can we increase the brand association of services with those of sub-local areas that resonate most with the population?

To **Doncaster CCG and Doncaster Metropolitan Borough Council:**

16. How can we recreate the trusting relationship with acute / crisis services in more preventative or community-based interventions. **How can we** make a community facility feel like a hospital to give reassurance to residents?

To **Doncaster Acute Service providers:**

17. Without undermining frontline preventative services, **how can we** encourage trusted professionals to promote coordinated messages about prevention?

To **All Team Doncaster partners:**

18. How can we raise the profile of professionals other than GPs who have a more preventative role in improving health?

Conclusions

Conclusions

Resilience in Doncaster

In order to improve health outcomes and provide a more effective system of health and social care across Doncaster, partners will have to work together in a more preventative way, often intervening earlier - or playing a convening role - to enable community-based bottom-up services to thrive.

Preventing ill health is enabled by building resilient communities, families, and individuals, and earlier in this report are detailed different factors which influence resilience.

1. Mindset.
2. Sense of identity and goals.
3. Supportive relationships and social networks.
4. Stability.
5. Access to resources.
6. Role of experience.

It is vital that Team Doncaster embrace a shared understanding of resilience in the borough and take steps towards achieving it. This section of the report will provide the foundation for that, by synthesising insights according to these six factors, recommending how the borough should act in relation to each one. Challenge briefs found across this report are also grouped below according to the six factors.

Mindset

There are two interrelated aspects of a resilient mindset in a family, community or individual that can feel contradictory:

- A sense of **toughness, strength** and the ability to absorb shocks or difficult events.
- Flexibility of mindset, agility, and the skills and confidence to be able to adapt to those shocks and change course.

In Doncaster, people show resilience in relation to (1) - they have the strength to deal with the difficulties of life, and are proud of it.

However, this strength of mindset can become a barrier to (2) - their toughness reveals itself as inflexibility, and a lack of confidence to try new things or being open to changing behaviours (South Yorkshire "grit").

Team Doncaster should encourage flexibility of mindset and openness to change, whilst maintaining the strength and toughness for which the area is so deservedly proud. This is most likely to be achieved through people **experiencing** something different for themselves and their families, rather than by being told what to do by a public sector body.

See challenge briefs: 2, 5, 10, 13, 17, 18

Sense of identity and goals

People in Doncaster have a strong sense of identity: either as people from Yorkshire; or part of a family; or being from Mexborough, for example. Often, identity is shared across a family, or is invested wholly in other people (such as children or a partner). Their goals are for the health and wellbeing of their whole family unit or community rather than for themselves. Identity is also strongly influenced by the past and by specific events. These events can be personal (such as a relationship breakdown) or collective (such as the closure of a large employer).

Team Doncaster should prioritise a "collective" approach to intervening across health and social care to better mirror the way in which people understand their identity and health goals: as connected to their wider family or community. This will be a route to building greater aspiration towards better health outcomes and improving their own environments. This approach could include giving greater consideration to how interactions are designed - through care planning, outcomes-based budgeting, risk stratification, and impact evaluation - and in prioritising where and how to intervene.

See challenge briefs 1, 2, 3, 4, 8, 10, 13, 15

Supportive relationships and social networks

Supportive relationships and social networks are a primary driver of wellbeing in Doncaster. However, there is an impression that a lot of emphasis and pressure is placed on individual family relationships, for which the future is uncertain. There is appetite, however, for greater connection across communities, something that is particularly visible in villages across the borough.

Team Doncaster should learn from villages in the borough to encourage greater social connection in urban areas and support interventions that expand and maintain social connection. They should also systematically identify where and for whom social connection is at risk of being undermined and provide infrastructure to enable this to thrive.

See challenge briefs: 2, 4, 5, 6, 7, 8, 11, 14

Stability

Many people living in Doncaster lead complex lives, and wish for a greater degree of stability in, although there is also a stubborn acceptance that “things are the way they are”. Changes in the area have meant that people needed to respond with flexibility, although some have not been able to do so.

Team Doncaster should continue its work targeting families living with complex lives, and provide support to grow their aspirations for improving the community.

See challenge briefs: 3, 6, 11, 12

Access to resources

Doncaster is a borough with a wide range of incomes and stubborn health inequalities. Resources of open space and leisure are plentiful in the region, but there is misalignment between the needs of families and what is on offer. Additionally, there are resources available to all - particularly in the community and primary care - which are not being used by those who would benefit most due to mistrust and misalignment.

Team Doncaster should promote the skills and expertise of those who deliver preventative health, such as practice nurses. This message should be carried by those in senior positions in acute care to capitalise on where trust currently exists in the system. They should also align public health resources (such as leisure facilities) to the needs of families and communities (as part of the collective approach outlined under the "Sense of identity and goals" section).

See challenge briefs: 1, 2, 4, 7, 8, 9, 11, 12, 16

Role of experience

The role of experience in Doncaster is twofold:

- With many people, a negative experience can fix unhealthy habits and make them hard to shift ("things are the way they are").
- Experiencing the positive effects of a change in lifestyle can be enough to fix that change for the long term.

Team Doncaster should prioritise campaigns around health improvement that focus on the emotional motivation of life events - births, marriages, moving house, new job, recovery from illness - and target moments of change to disrupt experience and change habits. This could include more systematic reflective activities with people when they do engage with services at a significant moment, or following a severe bout of ill health.

See challenge briefs: 15, 16, 17, 18

Conclusions

A segmentation model

The Doncaster resilience strategy should use a segmentation model as a framing tool. This was developed in partnership with the Doncaster team.

We have found that the **mindset of openness to change** - which is compounded by other resilience factors such as the role of experience and a sense of identity - and **connectedness to supportive relationships and social networks** are the most important drivers of this , so have developed a segmentation model that uses these characteristics.

Segmenting the population in this way helps to focus different kinds of interventions or improvements on the most relevant and impactful behavioural characteristics of that group.

The two characteristics chosen for a segmentation model should enable and encourage commissioners, service providers, strategists and other professionals to understand their population according to which behaviours or characteristics are having the greatest impact (both positive and negative) on their desired behavioural outcome.

Openness to change

This research sought to understand how to encourage various kinds of changes: changes in behaviour; changes in reliance on or attitude to services; changes in awareness of community support; and changes in the understanding of the system of health and care across the borough. Deep-set behavioural patterns and habits have been identified, which have remained unchanged for decades. They are framed around family history, the history of the borough, or specific life events; and they create, in some people, a resistance to change, acceptance of the way things are, and little aspiration for things to be different. In others, this is not the case, and their “grit” is revealed through aspiration for different circumstances, or being flexible to changing circumstances, taking opportunities as they appear.

Connectedness

Health and wellbeing in Doncaster is driven through connection (or lack of it). Social and family networks are a source of support, encouragement, and identity, as well as key enablers sustaining levels of wellbeing. For those who are isolated and do not have a network of support outside of their immediate family (such as a child or partner), their health and wellbeing is limited. Also, connectedness is a significant risk fact if lost or reduced.

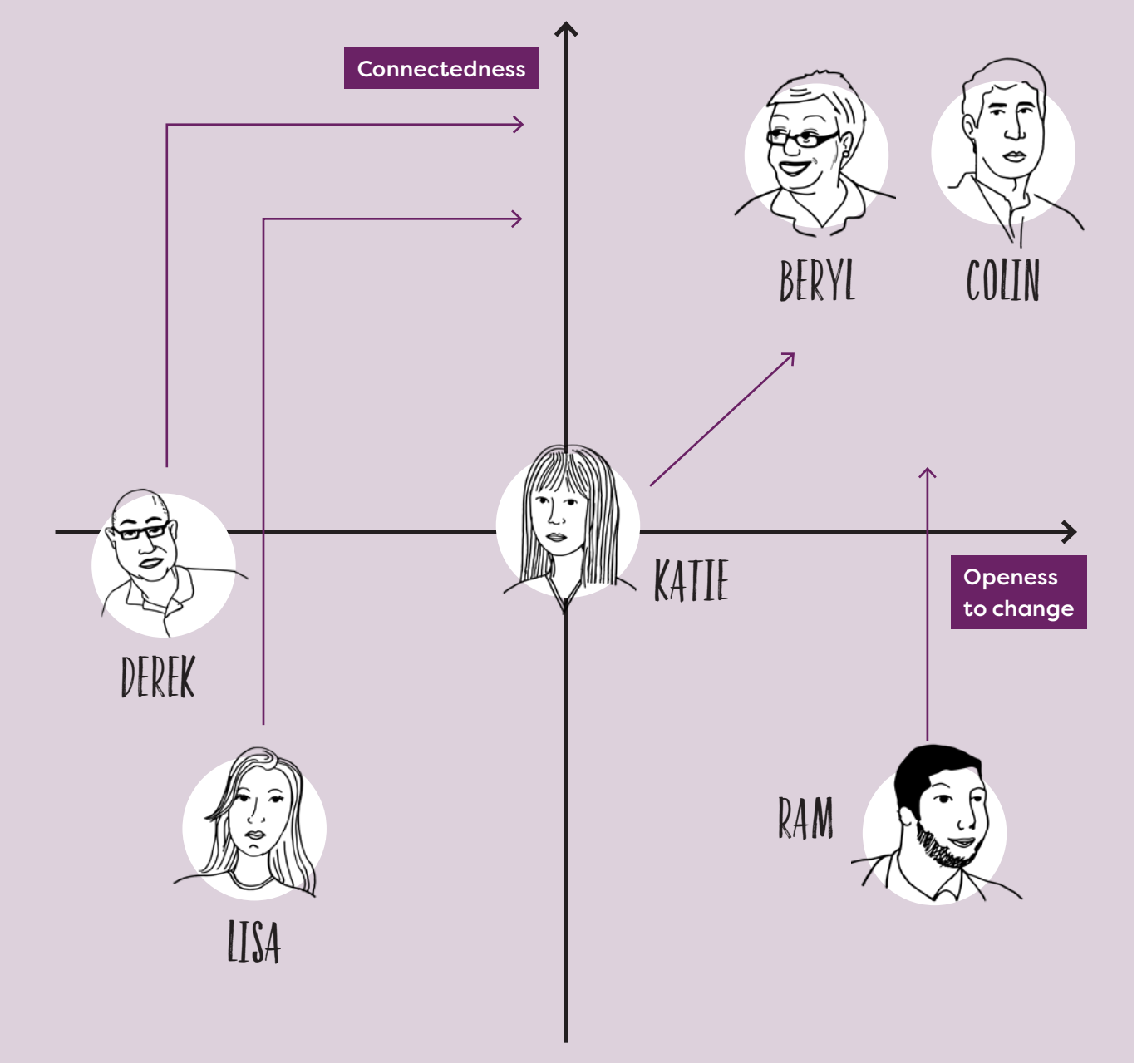
Using the segmentation model

The Doncaster resilience strategy should use the segmentation model as a framing tool for designing/encouraging interventions. In order to improve health and gain resilience, a strategy should be to increase and maintain people's connectedness to others, whilst encouraging an openness to change.

For those who are not open to change, it is unlikely that they will quickly become more open without having first gained greater connection to others - either through their family or via their community.

For those who are open to change, gaining connections will help enable and motivate them to do this.

The sequence of interventions for individuals, families and communities should therefore follow as indicated on the diagram:



Conclusions

Personas

These personas are composite stories of people who live in Doncaster. Their experiences, behaviours and motivations represent a cross section of individuals who took part in this research.

Personas are used as a synthesising tool in the design process. They anchor the creative process in insights, and help inform policy development, service improvement, and the generation of new ideas. They also help us to see the potential impact of policy decisions and the development of services from the perspective of the people who use them, by focusing on one person's experience of that service. We design interventions for a persona, and constantly check that we are meeting their needs. A set of personas also helps us design for a variety of behaviours and needs, and not just those of one person.

Personas have been created that sit across the segmentation model.

DEREK, 58

Occupation: Derek no longer works because of his multiple health conditions - he was a security guard for 15 years

Immediate family: Married to Claire and has five children (not with her). Between them they have 12 grandchildren. Two of the grandchildren live with them at home.

Where in the borough: Town centre

Health conditions: Multiple: the most severe is COPD, but has had two mild strokes and a heart attack

Key resilience factors: Mindset; sense of identity and goals; role of experience

Derek's family are all from Doncaster and the surrounding area. He was born in the area but left as a young man. He has moved to different parts of the country and moved back to Doncaster seven times.

"It's like people say: it's a shithole. Yeah it is, but it's my shithole. I won't leave because 1) it's my shithole and 2) it's my kind of people. I know who to trust and know who not to trust. I am not a trusting person, I am NOT a trusting person."

Derek likes to tell stories: stories about his family, about who is no longer talking, about who split up with whom, and about his children and grandchildren. These stories go way back - to arguments in the 1970s, to illnesses he had when he first started working, to his wanting to be in the army as a child. His obsession with the past extends beyond his family:

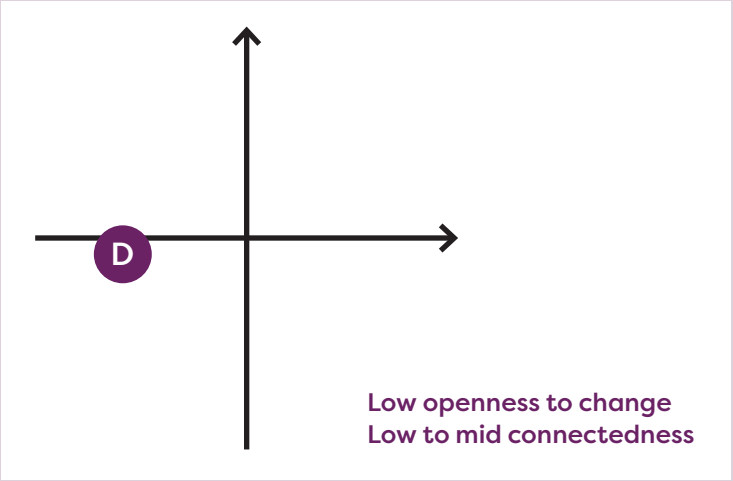
"I've got an obsession with history, whether it be true history or things about....my nana were into history of the royal family, you know like way back? And I download films and a good part of my catalogue is films, you know, like Henry VIII... D'you know what they call me at home? Wiki, Wikipedia, cos that's my bible - if I'm watching a film and I can't remember a bit, I will use Wikipedia to cross reference."

Derek has a very a clear moral sense, something which he takes pride in. He owes everything to being brought up by his aunt and uncle: he has never smoked, never taken drugs, and never been in trouble with the police. He says:

"You should never hit a woman; argue with a woman, by all means argue with a woman, but do not hit. Hit a door, you can replace a door, you put a hole in that door today, council will come and put a new door up. What ya lost? If she gets into ya head, and women will, knock shit out of the wall...you'll hurt yourself. And I instilled that into me kids."

He is no longer physically active; and, owing to his multiple health conditions, cannot walk far. Over the past two decades he has had a heart attack, two strokes, and is now living with COPD. He doesn't like hospitals but he has to "put up with them", and they give good care. He's been there so long, the receptionists know who he is, and always say "Hi Derek, I got ya!" when he arrives.

He tries to keep his brain active by reading, watching television and playing his PlayStation. He sometimes plays pool at the nearby pool hall.



LISA, 22

Occupation: Doesn't work

Immediate family: Partner Tariq, son James, another on the way

Where in the borough: Town centre

Health conditions: Bad oral health, smokes

Key resilience factors: Mindset; sense of identity and goals; role of experience

Lisa is pregnant with her second child with her partner Tariq. She moved to Doncaster from a nearby town, and lives in a privately- rented flat in the centre of the town. Because she is away from her family (out of choice) she is rather isolated, and doesn't have many friends.

Moving away from home had been a priority for her after some challenging experiences - people she knew had been in trouble with the police and the whole area didn't feel safe. She's excited to be starting a new life in a different place.

She is trying to stop smoking, (and particularly not to smoke whilst she's pregnant). She smoked when she was carrying James, but was scared when she heard stories that having one cigarette is like blocking the umbilical cord for three3 seconds. So she's using a nicotine spray from the chemist, and it seems to be working.

Lisa had a difficult time at school. She says that she didn't really attend school at all after the age of about 14. She's tried to go back, but always found it made her anxious (an anxiety she still experiences on a day-to-day basis). She tried to talk to teachers about it, but she didn't feel believed when she said she found things difficult. This experience has made her mistrustful of services.

"It just didn't feel comfortable...I just feel...I struggled with reading and writing. We had to read out in most of the lessons and I just didn't see the point in embarrassing myself. I got fed up to the point when I just didn't go. When I tried to go back I'd missed so much, so I didn't sit my GCSEs. When I was in juniors I kept telling my teachers that I couldn't read and they paired me with someone a bit older but that didn't help. To be honest, nobody believed it. I just got fed up and thought there's no point anyway."

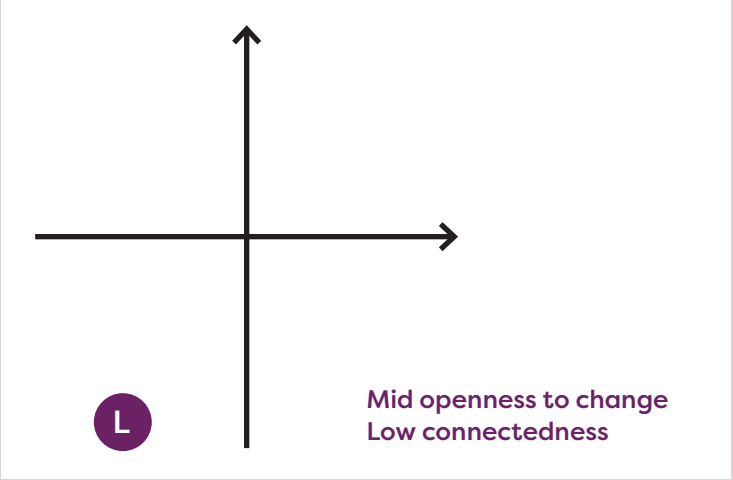
She does have ambition to be healthier, as well as trying to stop smoking, but she says that time can be a barrier.

"I'd like to eat a bit healthier. Just time really stopping me -, like today, I was in town this morning so I didn't know how much time, so got him McDonald's. He usually only has one a week, usually on a Thursday, and he gets a toy as well on a Thursday."

She says that she sometimes cooks meals for her and Tariq, but more often she finds it stressful. She tries to stick to meals she knows how to cook as she once tried a chilli but it didn't work well. HoweverAlthough, she now gets bored of having the same thing, and prefers the variety of a takeaways, and how easy it is to order one. She's trying to change because she doesn't want James and her new baby to be eating the same way she does. She used to make a little fry-up at the weekend and on weekdays he'd have cereal and toast. But she's started moving to fruit and yogurt in the morning.

She is excited about having a new baby and wants to have a successful family life, although money is a concern for her. She also wants to be able to get out of the house more, and hopes that she can gain confidence to make new friends in Doncaster:

"I don't really think about the future much, I take every day as it comes. All kids grow up and do well and achieve what they want to achieve. Hopefully Tariq and I will still be together. Childhood made me not look too far ahead, not expecting things to go a certain way and then get disappointed. I think it's a very horrible world we live in, it's just full of idiots. Everybody wants to hit everybody, nobody gets on. There's all that war and stuff, it's not a very nice place to live in."



RAM, 41

Occupation: Warehouse worker

Immediate family: Separated from his wife, two daughters who live in the South of England with their mother.

Where in the borough: Town centre

Health conditions: Recovering drug user

Key resilience factors: Access to resources; supportive relationships and social networks; role of experience

Ram was born in Nepal, lived in Hong Kong, and then came to the UK around ten years ago. Both his parents also moved to the UK and live nearby in the borough; as does his brother. Ram moved to Doncaster six months ago to be closer to his parents as he goes through treatment, but he plans to stay afterwards.

He is a recovering heroin addict, and has been taking methadone for 15 years. He feels that it was much easier to self-medicate in Hong Kong, so arrived in the UK to a system where he wasn't able to take as much methadone (or as regularly) as he had before. He is now trying a full detox, so has taken a break from work to get clean.

He has been able to work through most of his life, taking roles in various industries: from construction, to food manufacturing, to his current role in a warehouse. Because of zero-hour contracts, he's been able to take time out for more intensive treatment if he needs it.

"I never stopped working because I am a workaholic or something; like, even if I'm sick, I will keep going. Unless I can't wake up, otherwise I take painkillers and go to work."

He has a difficult relationship with the mother of his children. His drink and drug use was the cause of their breakdown. He began taking drugs because they was readily available and helped him maintain his pace of life. Even though his wife is not nearby, their history remains a source of anxiety. The shadow of their relationship breakdown still affects his wellbeing. He says "that's the past thing, that can really be bad".

He is pleased to see that his daughters are doing well, and wants them to achieve more than him:

"I want them educated well, they have options...I was working in labour most of the time, it's [a] good salary but it's not good for your health. I can feel it in my back now; in my bones, when I lift something, there is pain that was never there before."

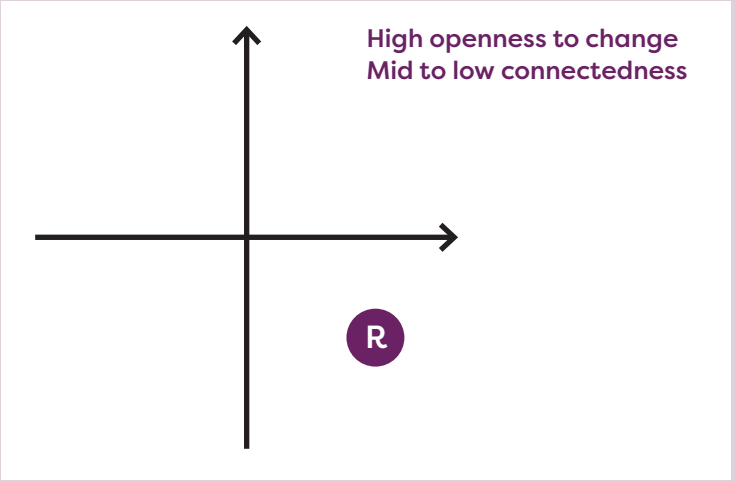
He has enjoyed living in Doncaster - he enjoys the open spaces, the access to good recovery services where they do lots of activities, and the people who live near to his parent's home. He loves gardening - for himself, his family and his neighbours. He grows vegetables, flowers and fruit:

"The neighbours where I live, they are very, very helpful for me. There are two old ladies, their husbands have died, and one lady next to me, she who is 53 and she never married. They really, really support me: I do gardening and things for them, and when I'm not there they look after my parents, my mum especially."

His parents are getting unwell, particularly his mother. This makes him anxious, and he finds it difficult to sleep. He's also concerned about how this will affect his recovery. When these issues fly around in his head at night, he takes painkillers to try and sleep.

He has developed one strategy for coping with this challenge: mindfulness. He uses an app on his phone and, after 10 or 15 minutes, he sleeps better.

"I want to be free in a good way. This time I have to really be careful. If my body can hold it then I will do it."



BERYL, 79

Occupation: Retired teacher

Immediate family: Married to Ron, has two children who don't live locally

Where in the borough: Village

Health conditions: Early-onset Alzheimer's, but otherwise her general health is good

Key resilience factors: Mindset; access to resources; stability

Beryl lives in a bungalow with her husband Ron. They moved to the Metropolitan Borough of Doncaster 30 years ago for Ron's work, and have settled in the area very happily. Their two children (and grandchildren) both live in the South of England.

"How old do I feel? It depends on the time of day! Feel younger than 79, feel 55 or 60 inside."

Beryl was diagnosed with early-onset Alzheimer's two years ago. At first it was frightening, and she had contradicting advice from specialists about the likely pace of her disease. However, on the recommendation of her doctor, 18 months ago she joined the local Alzheimer's support group run by the Alzheimer's society. She believes it has been instrumental in maintaining her quality of life.

She goes to activities and meet-ups sometimes as often as four times a day. There are between 30 and 60 people who attend from all over Doncaster, and the activities vary from week to week - coffee mornings, musical events, talks, etc.

Beryl and Ron also have lots of friends that they see regularly. Very rarely does a day pass when they don't see friends, go for coffee, or take a run into Derbyshire:

"Life would be dead without it, it's very uplifting. See the friends a lot. We go once a month to a pub for lunch with another group of friends. Lots of help at the pub to help us out with the carvery, and we get a reduced rate on it."

She particularly enjoys getting out into the countryside, or going to places where there are lots of families and it's busy, such as Langold Lake. It always lifts her up to see lots of children playing.

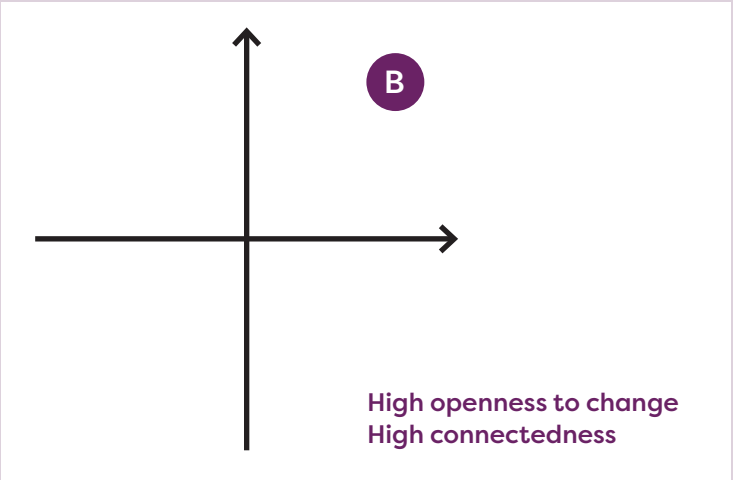
Beryl has always been a good cook, and has maintained her healthy lifestyle since being diagnosed. She says how she does what she is told with her diet.

"I make my own muesli: sunflower seeds, pumpkin seeds, oats, apricots. It's a very healthy breakfast, and I try to eat well. Ron loves boiled eggs from a chap who has chickens, or a slice of toast covered in Manuka honey. We've always eaten well, we never buy ready meals, or frozen meals. Lots of fish and fresh veg. We love tapas, too."

The doctors tell her that she's doing everything right. She's motivated to keep on being healthy so that she and Ron can maintain the quality and richness of their social life - she doesn't want to become isolated owing to any kind of ill health. She used to be quite an active person and loved swimming. She used to go on a Saturday morning when the baths opened at 6am, and stay until 9am.

She admits, however, that she now depends 100%On her husband, particularly to get from place to place. This makes her nervous as there are no buses in the village any more.

"No problem with asking someone for help. I can't drive, if Brian couldn't also, then I don't know what we'd do. It would be a mess. We've tried to get the bus back but we can't convince them. There's a main road that a bus runs down, just the end of our road. Could just run in but the local council, they'll listen and take notes but that's as far as it goes."



COLIN, 52

Occupation: Semi retired, does odd jobs for people, former prison manager

Immediate family: Wife of 30 years, Karen. Two daughters and five grandchildren

Where in the borough: Small town

Health conditions: Physical health is good, some mental health troubles

Key resilience factors: Mindset; access to resources; stability; role of experience

Colin lives in a bungalow with his wife Karen, ten minutes' walk from the house he grew up in. His two daughters live five minutes' drive away, and they are a tight-knit family. Until 18 months ago, Colin worked in a senior position in the Prison Service, but decided to leave his work and focus on being at home to help his daughters, who both have children. He still does the occasional piece of gardening work and has finally got himself a white van: "I've always wanted one, but Karen refuses to be driven around in it!"

Colin left his job because of his health - the stress he was experiencing from the high-pressured environment was driving him to drink alcohol to excess and eat unhealthily. He has now cut out almost all sugar, and drinks only on special occasions. He also goes to the gym, walks, and plays golf.

"It's a mortality thing: my mother was diagnosed with terminal cancer 2 years ago, but she's still with us because she looks after herself, eats well, doesn't drink."

He is Yorkshire through and through, and most of his male relatives have spent time in the uniformed professions. His father was a senior fireman, as is his brother, and Colin went into the army as a 16 year-old and trained as an engineer. He had to leave prematurely because of an injury, but explains how much he owes to the training he received as a teenager in the army - he feels this training gave him the chance to develop his resolve, inner strength and the capacity to adapt.

"I learned there that I could achieve things - that even when things looked difficult, I had the strength and capabilities to respond, learn, and get stuff done. My parents instilled that in me, too. So when I had to leave the army, I knew that I'd be able to shift jobs and do something new."

When he left the army he found new jobs in the chemicals sector that were suited to his skills. When that sector began to be uncompetitive, and the companies started to close down, he shifted again and started working in prisons, where he stayed until the end of his career. He's aware that lots of other men of his age didn't respond so well to the industrial changes in the area.

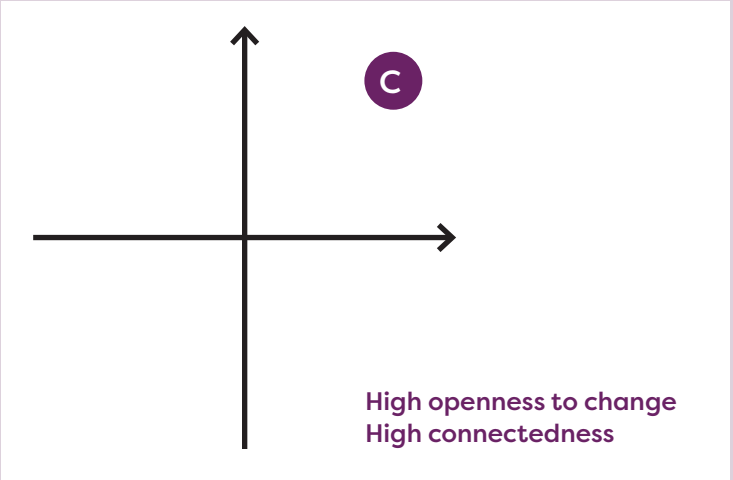
He has been motivated by wanting to live comfortably and to provide for his family. He isn't sure that this is a common motivation anymore.

Having previously visited his GP regularly whilst at work to address ongoing health niggles, he now sees his relationship with his practice much more holistically - he goes in and takes advantage of different kinds of preventative health checks, and often doesn't need to talk directly to the doctor. He thinks that people in the area take their health services for granted:

"People think that it's the job of their GP to be at their beck and call, but no - it's their job to diagnose. If you don't need to be diagnosed with anything, but just need medical attention or support or advice, the nurses are there for you, and they're much better at it sometimes! They can help you find new ways of doing things, new strategies for being healthy."

He has a real fondness for his area, but doesn't like to see so much of the town centre boarded up and the old working men's clubs closed down.

"When we'd go in there as lads, you didn't know people's names, but you knew their families and that they knew yours. So if there was any trouble, you knew it would get back to your parents. Everyone looked out for each other, even if we didn't speak!"



KATIE, 35

Occupation: Nurse in the Doncaster Royal Infirmary

Immediate family: Husband of 10 years, Phil. Two daughters aged 11 and six.

Where in the borough: Village

Health conditions: Physical health is good, but she is slightly overweight.

Key resilience factors: Stability; access to resources; role of experience

Katie was born in Doncaster, trained as a nurse in Manchester, and returned to the area to be closer to her family. She had her first daughter with her childhood sweetheart, Phil, when she was 24, and her second after they were married. They bought a house together, and are both focused on paying off the mortgage so they can give stability to their family. This is how Katie's been brought up. Particularly strong are the influences of the men in her life: her Dad always told her to look after her money. She doesn't have a credit card and she refuses to take out loans.

"My dad and grandad are very important to me. They both led me down the aisle when I got married. I always show my kids that picture so they know where they came from."

They both work very hard - Katie is a successful nurse in the busy DRI and Phil is a plumber with his own successful business. All their friends still live in the area, but since they all got married and starting living in different parts of the borough, they see each other less and less. Katie used to go out in Doncaster with her friends, or they would all get a taxi to Sheffield for a nice meal, but she can't remember the last time that happened.

Often it's Phil who gets home first, and Katie comes back a bit later, sometimes just in time for dinner.

"I always try and cook healthy food, but sometimes you just don't have the time. We both work, so there isn't much time in the evenings, and I don't always have the energy."

Katie doesn't really think about her own health. She thinks about her kids and about her husband. She says, "I'm well when my kids are well." She visits the doctors fairly regularly - as her youngest daughter has asthma - but doesn't seem to go for herself. She takes the girls in whenever they feel poorly.

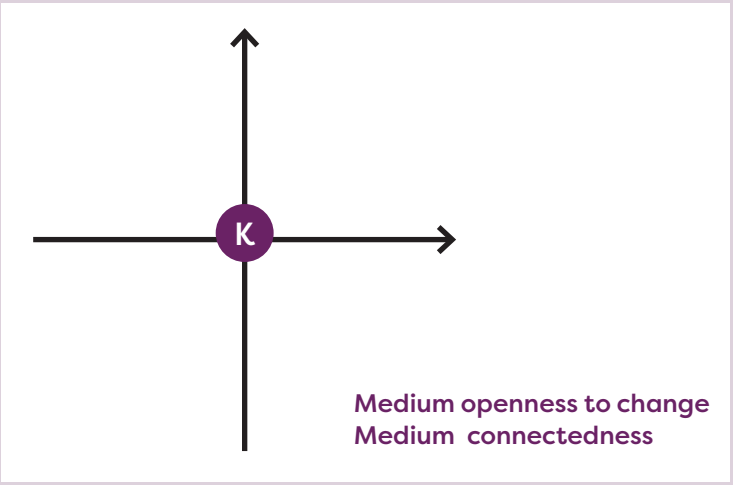
"It's so hard to see a GP, and I hate having to repeat everything three times to the receptionists, then the nurse, then the doctor. I just don't trust that anybody is really listening until I get in front of the doctor, and even then he's staring at his computer."

She allows herself a cigarette and a glass of wine when the kids have gone to bed after a busy week: "wine o'clock". Sometimes she does this after a busy weekday, too.

Her daughters aren't particularly sporty, and she finds it hard to find the right kinds of activities for them. They often go to the Lakeside at weekends, but the girls seem more interested in shopping and going to the restaurants than walking around the lake.

For the first time in her life, Katie isn't that happy with her weight:

"I've been putting weight on. It's stress, mainly. And at work there isn't time to eat so we sometimes just have a Kit Kat for energy. My oldest wants to lose weight, too. I took her to a young person's gym class, but it was so expensive, and the instructors didn't pay much attention to them. They just left them to it, so it wasn't worth the money. There are other mums in my village who want to take their kids swimming - but the cheaper classes are always at difficult times, and for a family of five like mine to go, it's so expensive."



Assessment of the “Doncaster Talks” platform

Use of platform

The Doncaster Talks platform offered a new way of engaging with people who live in the borough. Its usage provides valuable insight for the Team Doncaster partners with regard to different forms of digital engagement, as well as its potential as a tool:

a) To gather insight.
b) To generate ideas.
c) To gain feedback; and
d) To promote and encourage healthier behaviours.

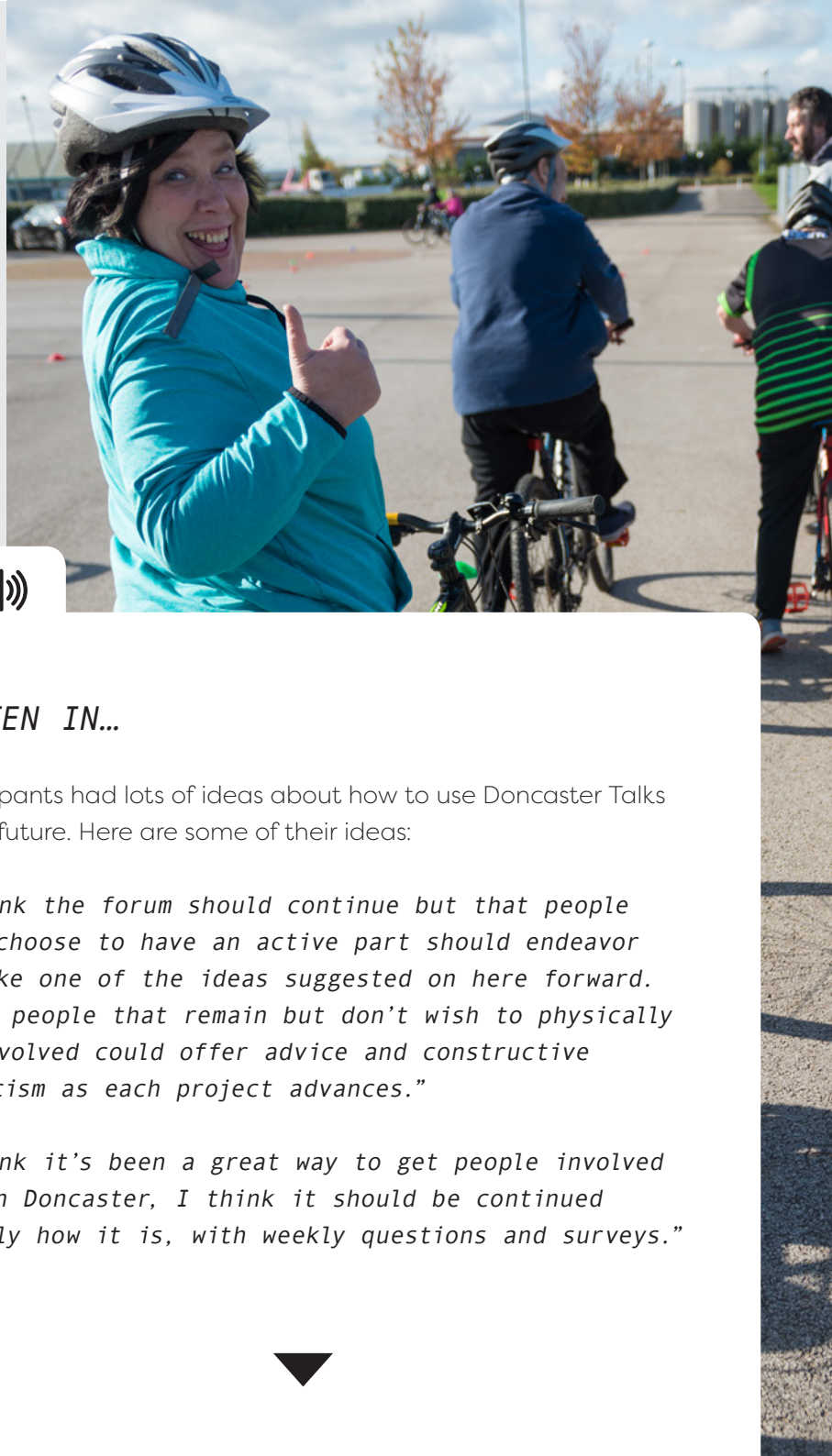
As part of engaging in the platform, participants completed a short survey to reflect their experience.

91% of people said they would be interested in taking part in the platform if it were to continue into 2018.

Participants rated their experience of taking part in the platform from one to 10. The average score was 8.8/10.

In order to ensure an active and engaged online community, participants were incentivised to take part. If they completed all 16 activities, they received an Amazon voucher worth £30. This amount reduced depending on how many activities people took part in.

We asked participants if they would have continued to use the platform even if they were not incentivised to do so. 53% said they would. 16% percent said they wouldn’t. 32% said they were not sure. Understanding the specific motivations of that undecided 32% would be crucial to deciding on the future use of a Doncaster Talks-style platform without incentives.



LISTEN IN…

Participants had lots of ideas about how to use Doncaster Talks in the future. Here are some of their ideas:

“I think the forum should continue but that people that choose to have an active part should endeavor to take one of the ideas suggested on here forward. Other people that remain but don’t wish to physically be involved could offer advice and constructive criticism as each project advances.”

“I think it’s been a great way to get people involved within Doncaster, I think it should be continued exactly how it is, with weekly questions and surveys.”

"I think the forum could be used as a sounding board when the council (or anyone else) are thinking about starting a new club or event, so that they could 1) get an idea of whether people would be interested or not and 2) help to develop and improve the idea by asking for people's feedback."

"Many fine suggestions have been submitted to Doncaster Talks. It is important that they reach the influencers in the borough; councillors, the mayor, constituency MPs, NHS managers, and leaders of social care, housing and business. So two main ideas: 1) publish an analysis of the most significant ideas in every forum possible - the press, business journals, circular letters, websites, etc.; and 2) keep up the momentum - a new question every month with a small incentive (perhaps an annual £5.00 voucher for those who complete 10 out of 12), with a brief summary of the results sent to the list above. Above all, don't lose the momentum already built up!"

8.8

was the average score given (out of 10) to the platform

Reflections on the platform

Some aspects of the Doncaster Talks platform proved challenging, and should be considered before future investment in digital engagement.

Digital literacy

Throughout this project, the research team were aware of those with limited et access at home to the facilities provided on site by the council. One option to address the lack of digital literacy or digital access would be to coordinate facilitated use of the platform in group settings. This would, of course, deny people the opportunity to interact with moderators or other community participants. The platform could also become a route to gaining digital skills as it was easy to navigate and use.

The Dub platform

The Doncaster Talks platform used an “off-the-shelf” platform called “Dub”. Dub was chosen because it was well placed to serve as a research tool. It has built-in functionality for surveys, sharing and commenting on photographs; and producing heat maps. It is also easy to store, download and analyse the data produced.

That said, the platform has limitations. The visual style is fixed, and there is limited flexibility around the look, feel and the user experience. This did not appear to affect the numbers engaging on the platform; however, if it were to be designed for seldom-heard groups, further UX research and testing would be required to ascertain if the Dub platform were accessible and enjoyable for those groups.

In addition, participant sign up to the Dub platform creates unavoidable pain points. The platform moderation team at 100%Open were required to manually process applications, and participants had to visit two different web addresses for sign-up and participation. This undoubtedly impacted on the numbers of people who were initially interested in taking part but then did not complete any activities.

Resource intensive moderation

For online platforms such as this to be successful, there needs to be regular high-quality facilitation and moderation. This was provided by 100%Open and members of council staff. For a high-intensity project such as this, it required daily responses to ensure that each person’s contribution was acknowledged and engaged with. This had a positive effect on the quality of insight gathered, as moderators were able to ask the why question in relation to people’s stories. Without this kind of active moderation, the quality of the insight generated from the platform would certainly suffer.

Insight generation versus idea generation

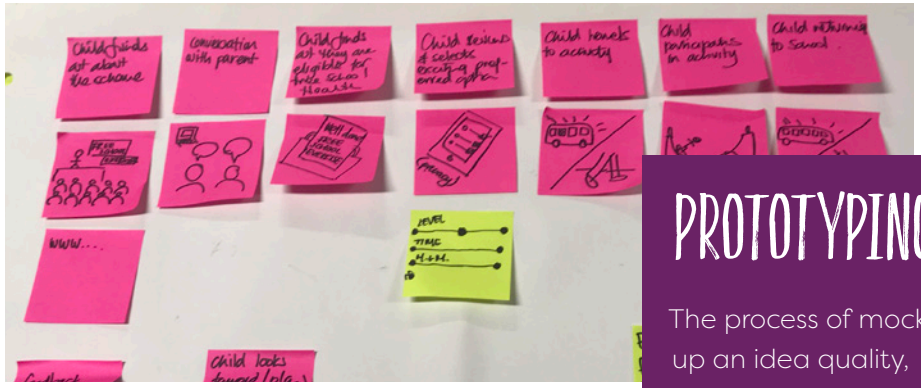
This project used Doncaster Talks to generate insight and ideas. Typically, an insight question asked people to share a story about their life, e.g. “Who has contributed most to your health and wellbeing”. An idea question asked them to solve a problem, e.g. “How would you encourage people to talk more about mental health”. Insight questions were answered more easily and generated higher engagement. The idea questions produced some good ideas, but much that was similar. Moreover, responses to insight questions were all of equal usefulness to the project (this is the nature of gathering insight), which was not the case for the idea questions (necessarily, some ideas were better than others). In addition, some people responded to insight questions with ideas. There is potential in using such platforms for idea generation, but the experience of Doncaster Talks suggests that this would be better framed around insight and personal experience first.

Using these insights and tools

Using these insights and tools

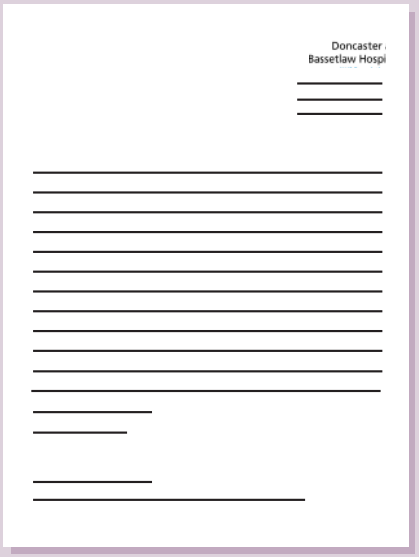
"How can we" questions are written throughout this report. They are challenge briefs that will help Team Doncaster develop ideas for service improvements or new interventions that might address some need identified in the research. They will also help achieve the ambitions for resilience outlined in the previous chapter.

Here we take four of these briefs and prototype what a new intervention might look like in response to the insight generated in this report.



PROTOTYPING:

The process of mocking up an idea quality, with minimal resources, to assess its viability, desirability and feasibility



Men's sexual health

Community leisure pass

Working people's club for 2020

Trust campaign

TRUST CAMPAIGN

PROTOTYPE 1

Without undermining frontline preventative services, **how can we** encourage trusted professionals to promote coordinated messages about prevention?

RESILIENT FACTORS:

Mindset

Role of experience

WHO IS IT FOR?

Derek

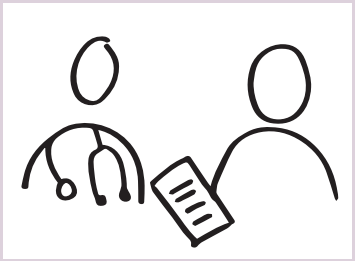
Lisa

WHAT THE INSIGHT IS TELLING US:

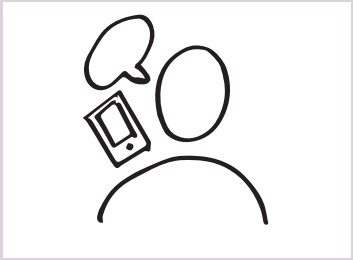
People in Doncaster trust professionals working in acute health settings and are less trusting of those closer to the community who currently play a greater role in prevention.

DEREK'S STORY

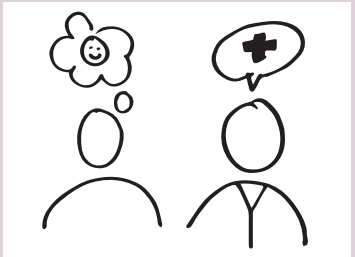
Derek sees a campaign poster in his local shop in Thorne.



At an appointment at the health centre a week later, his doctor hands him a campaign leaflet.



Next time Derek books an appointment, he requests to see a community support worker.



The following week he sees a community support worker and still feels reassured about his health.

MEN'S SEXUAL HEALTH SERVICE

PROTOTYPE 2

How can we design a sexual health service that better meets the needs of men, alongside a campaign that explains the particular risk to that age group and promote condom use.

RESILIENT FACTORS:

Sense of Identity and Goals

Access to resources

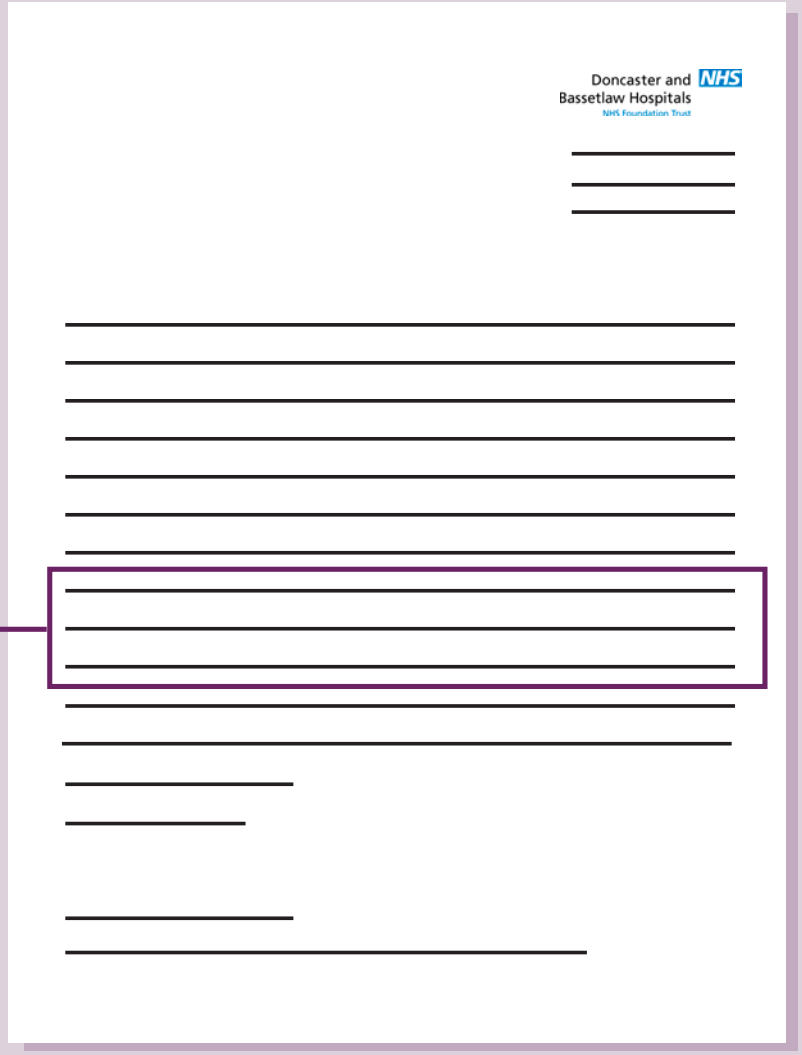
WHO IS IT FOR?

Colin

WHAT THE INSIGHT IS TELLING US:

Men are not using sexual health services because they do not want to be seen to visit somewhere that is explicitly known as a sexual health clinic. Moreover, men externalise sexual health as something that they do not have to take responsibility for, and would only wear a condom when having intercourse with a sex worker.

..."During this health check we will examine your cholesterol levels, blood sugar, and also check for other conditions such as asthma, heart disease and sexually transmitted infection such as chlamydia or gonorrhea...."



This prototype involves including a sexual health check in the general health checks that are already delivered in the borough for men of the target age. Men would be informed via letter that the health check is being offered, and that a sexual health test would be included as part of the test, but it would not be prioritised, or be the main focus.

PROTOTYPE 3

How can we raise collective aspiration around health by capitalising on people's strong sub-local identities and the shared identity of the past? How can we use community-level outcomes to drive behaviour? How can we design and commission leisure services so they better meet the financial constraints and time pressures of families?

RESILIENT FACTORS:

- **Mindset**
- **Sense of Identity and Goals**
- **Access to resources**
- **Supportive relationships and social networks**

WHO IS IT FOR?

Katie **Beryl**

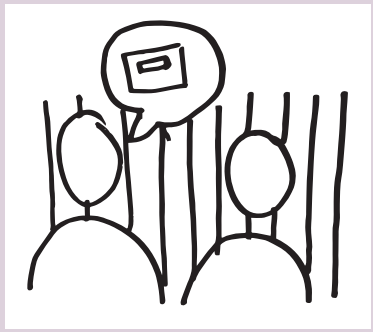
COMMUNITY LEISURE PASS

WHAT THE INSIGHT IS TELLING US:

Leisure services are not always well designed to suit the needs of families. They are perceived to be expensive, or not open at the right times. There are also strong community-level identities that are not being used as motivators for healthier behaviours.

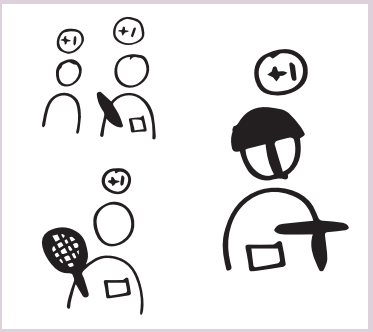
KATIE'S STORY:

Katie sees campaign poster for a community leisure pass at the hospital where she works.



Katie suggests to her friends at the school gates that their families should team together to get a community leisure pass. Together they recruit more members. Teams with more members and a wider age range receive a bigger discount on the pass.

Like all teams using the pass, Katie's team has a profile page where they can see what activities are available, set goals, track achievements and recruit new members who are looking for a team.



The more exercise a team member does, the more points and rewards the team receives. The team has a collective responsibility to encourage each other to use the leisure pass. This creates a healthier and happier community.

PROTOTYPE 4

How can we capitalise on a wish to open closed shops and utilise empty space so that communities are able to organise and manage initiatives to a) improve the fabric of communities; b) increase wellbeing; and c) promote positive health outcomes?

RESILIENT FACTORS:

Supportive relationships and social networks

Access to resources

Sense of Identity and Goals

WHO IS IT FOR?

Ram

Lisa

WORKING PEOPLE'S CLUB 2020

WHAT THE INSIGHT IS TELLING US:

There is appetite in communities to reinvigorate places of connection to encourage people to be healthier together. Collective responsibility for health should be encouraged. People also feel disheartened by a lack of development in town and village centres, which is having an effect on their mental wellbeing.

MEX LADIES WIN BOROUGH CUP

The Mexborough Working Ladies have won the Doncaster Borough football cup - the first time one of the new wave of "Working People's Clubs" has won a borough-wide sports competition.

The Mexborough Working People's Club was the first of the new wave of clubs to open in the borough following the council's new planning priorities in 2018. It has fast become the focal point for the local community. At a time when areas across the country bemoan lack of connection between generations, here is a place where people look out for each other, where socialising involves more than just drinking alcohol. Club member, Lisa, comes with her son at least once a week:

"Before I joined the club I didn't have many friends in the area. Everyone was so friendly, and now my son has joined the under-10s football team, we're always here. Definitely worth the membership fee!"

Acknowledgements

We're very grateful to everyone who played a role in this project, but especially to all the people of Doncaster who took part in research, either as ethnography participants or through the Doncaster Talks platform.

Special thanks to our partners 100% Open for all their work on the Doncaster Talks platform, and particular thanks to Katie Walsh for managing the platform moderation.

Thanks also to:

- Colleagues from communications teams across organisations in Doncaster for their support in promoting the platform, and helping recruit for ethnography participants
- Rupert Suckling, David Ayre and the strategy and performance team at Doncaster Counci
- Steph Cunningham and the communications team at Doncaster Council
- Jonathan Briggs at Doncaster CCG
- The hard working group of Council and CCG staff who undertook co-analysis with the Uscreates team
- Katy Turner for platform moderation
- Paul Chesters and the facilities team at the Doncaster Civic building
- Claire Scott the community teams at Doncaster Council
- Glen Smith at Mexborough Library
- Alyson Bryan at the Martinwells Centre
- Jenny Vaughn and the staff at Thorne Library
- Martin Toole and his van
- Our fantastic photographer, Jamie Bulb
- Bob Martin at Danum Eagles Basketball Club
- Kelly Hicks at the People Focus Group
- Mary Ellis at Changing Lives Doncaster
- Saroj Verma at the Doncaster Ethnic minority Regeneration Partnership
- Sandra Crabtree at the Friends of Sandall Park

This report was written and designed by Uscreates,
a service design agency specialising in health and wellbeing.

For more information please visit www.uscreates.com

February 2018

This page is intentionally left blank

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 15 March 2018

Subject: Report of the Steering Group and Forward plan

Presented by: Dr Rupert Suckling

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

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

How will this contribute to improving health and wellbeing in Doncaster?
This report provides an update on the Joint Strategic Needs Assessment 2017/18, the Motor Neurone Disease Charter and the minutes from the last two South Yorkshire and Bassetlaw, Sustainability and Transformation Partnership, Collaborative Partnership Board meetings. It also provides a forward plan for the Board.

Recommendations
The Board is asked to:- NOTE the report, DISCUSS and AGREE the forward plan.

This page is intentionally left blank

Doncaster Council

Agenda Item No. 15
15 March 2018

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.

EXEMPT REPORT

2. N/A

RECOMMENDATIONS

3. That the Board RECEIVES the update from the Steering Group, and CONSIDERS and AGREES the proposed forward plan at Appendix A.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4. The work programme of the Health and Wellbeing Board has a significant impact on the health and wellbeing of the Doncaster population through the Health and Wellbeing Strategy, the Joint Strategic Needs Assessment, system management and any decisions that are made as a result of Board meetings.

BACKGROUND

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 2018 and can report the following:

Joint Strategic Needs Assessment (JSNA) 2017/18

The Doncaster Joint Strategic Needs Assessment (JSNA) consists of a number of pieces of development work and analysis reflecting the increasingly dynamic nature of health and wellbeing analytics, but also how the JSNA relates to the State of the Borough and Doncaster Growing Together. Products include

- Health and Wellbeing Board outcomes framework
- BME Health Needs Assessment Mental Health analysis
- Data to support health and care integration including complex lives and Doncaster Talks
- Baseline data to inform the physical activity and sport strategy
- Updated community profiles
- Updated pharmaceutical needs assessment

All the above products will be available via the Team Doncaster website.

Work to develop the 2018/19 JSNA is beginning with a focus on scenario planning, supporting the place plan, locality working and assets to fulfil the 'state of health and wellbeing' requested at the previous Board meeting.

Motor Neurone Disease Charter

At Full Council the chair of the Health and Wellbeing Board announced that the Council was minded to sign up to the above charter and officers have been instructed to place a decision on the forward plan. Details of the charter are attached as an appendix and partners are asked to consider signing up to the charter too.

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership Collaborative Partnership Board

The minutes from the December 2017 and January 2018 meetings are attached for information.

Forward Plan

In light of the development of the outcomes framework the proposal is that the forward plan should be reviewed following the March performance report and a schedule of agenda items developed.

OPTIONS CONSIDERED

6. None

REASONS FOR RECOMMENDED OPTION

7. None

IMPACT ON THE COUNCIL'S KEY OUTCOMES

8.

	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 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

9. None

LEGAL IMPLICATIONS

10. No legal implications have been sought for this update paper.

FINANCIAL IMPLICATIONS

11. No financial implications have been sought for this update paper.

HUMAN RESOURCES IMPLICATIONS

12. No human resources implications have been sought for this update paper.

TECHNOLOGY IMPLICATIONS

13. No technology implications have been sought for this update paper.

EQUALITY IMPLICATIONS

14. The Pharmaceutical Needs Assessment has taken into account equalities issues as part of its development.

CONSULTATION

15. None

BACKGROUND PAPERS

16. 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

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2018/19

Date	Board Core Business		Partner Organisation and Partnership Issues	HWBB Steering Group Work plan
	Meeting/Workshop	**Venue**		

12th April 2018 (*please note change of date)	**Workshop**
	Loneliness and social isolation (tbc)
		Venue tbc	• 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
				• 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

14th June 2018	**Board meeting** • Outcomes Framework update • Health and social Care /BCF update • Information on performance measures for ACP • Annual update from the Children and families Exec Board • Learning Disability Partnership Update • Dementia update (tbc) • Drug and alcohol strategic overview and plan • HWBB Steering group (including carers covenant) update	Civic office 007a and 007b		
5th July 2018 ***Date/time may be subject to change**	**Workshop** Mental Health Concordat (tbc)	Venue tbc		
6th September 2018	**Board Meeting** • Outcomes Framework update • Health and social care/BCF update	Civic office rooms 007a and 007b		

	• Veterans update • Feedback from Culture and wellbeing workshop • HWBB steering group update			

2018 Health and Wellbeing Board: future meetings

14 June 2018 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

6 September 2018 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

15 November 2018 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster 15th March 2018 (Venue: Rooms 007a/00b, Civic Office, Waterdale, Doncaster)

Health and Wellbeing Workshop Dates – Topics/ venues to be confirmed

12th April 2018 9-12 noon Loneliness and Social isolation

*5th July 2018 10-3pm tbc (date/time may be subject to change)

4th October 2018 9-12 noon tbc

This page is intentionally left blank

mnda
motor neurone disease
association

CHAMPION THE CHARTER ON YOUR DOORSTEP

themndcharter

Achieving quality of life, dignity and respect for people with MND and their carers

The MND Charter is a statement of the respect, care and support that people living with motor neurone disease (MND) and their carers deserve, and should expect.

We believe that everyone with a connection to MND, either personally or professionally, should recognise and respect the rights of people with MND as set out in the Charter, and work towards the Charter's vision of the right care, in the right place at the right time.

About MND:

- MND is a fatal, rapidly progressing disease that affects the brain and spinal cord.
- It can leave people locked in a failing body, unable to move, talk and eventually breathe.
- A person's lifetime risk of developing MND is up to one in 300.
- It kills around 30% of people within 12 months of diagnosis, more than 50% within two years.
- It affects people from all communities.
- It has no cure.

Therefore, what matters most is that people with MND receive a rapid response to their needs and good quality care and support, ensuring the highest quality of life as possible and the ability to die with dignity. The MND Charter serves as a tool to help make this happen.

MND is a devastating, complex disease and particularly difficult to manage. We believe that if we get care right for MND we can get it right for other neurological conditions, and save public services money in the long run. But more importantly, we can make a positive difference to the lives of people with MND, their carers and their loved ones.

1 People with MND have the right to an early diagnosis and information

THIS MEANS:

- An early referral to a neurologist.
- An accurate and early diagnosis, given sensitively.
- Timely and appropriate access to information at all stages of their condition.

There is no diagnostic test for MND – it can only be diagnosed by ruling out other neurological conditions. People with MND can be halfway through their illness before they receive a firm diagnosis.

GPs need to be able to identify the symptoms and signs of a neurological problem and refer directly to a neurologist in order to speed up diagnosis times for MND.

Appropriate tests must be carried out as soon as possible to confirm MND. The diagnosis should be given by a consultant neurologist with knowledge and experience of treating people with MND[1]. The diagnosis should be given sensitively, in private, with the person with MND accompanied by a family member/friend and with time to ask questions. A follow-up appointment with the neurologist should be arranged soon after diagnosis.

At diagnosis people with MND should be offered access to appropriate information and should be informed about the MND Association. Appropriate information should be available at all stages of the person's condition in a language of their choice.

2 People with MND have the right to high quality care and treatments

THIS MEANS:

- Access to co-ordinated multidisciplinary care managed by a specialist key worker with experience of MND.
- Early access to specialist palliative care in a setting of their choice, including equitable access to hospices.
- Access to appropriate respiratory and nutritional management and support, as close to home as possible.
- Access to the drug riluzole.
- Timely access to NHS continuing healthcare when needed.
- Early referral to social care services.
- Referral for cognitive assessment, where appropriate.

People with MND may need care provided by health and social care professionals from up to 20 disciplines. This clearly needs co-ordination to work effectively. Co-ordinated care can improve the quality of life of people with MND and provide value for money for the NHS by preventing crises and emergency hospital admissions. The care should be co-ordinated by a specialist key worker with experience of MND who can anticipate needs and ensure they are met on time. Ongoing education for health and social care professionals is important to reflect advances in healthcare techniques and changes in best practice.

A third of people with MND die within 12 months of diagnosis. Early access to specialist palliative care[2] soon after diagnosis is therefore vital and should be available in a setting of the person's choice. Some hospices give preferential access to people with a cancer diagnosis. It is important that access is based on need, not diagnosis, so that people with MND have equitable access to hospice care. Hospices can

provide high-quality respite care, which can benefit both the person with MND and their carer.

As MND progresses, the respiratory muscles and muscles of the mouth and throat may be affected. People with MND may therefore need respiratory and nutritional support. It is important that these services are available as close to the person's home as possible so that travelling is minimised and support is available quickly.

In 2001 the National Institute for Health and Care Excellence (NICE) recommended riluzole as a cost-effective drug for people with MND. GPs can be reluctant to prescribe riluzole on cost grounds, despite its NICE-approved status, or to monitor for side effects during its use. However, it is vital that people with MND have ongoing access to this important treatment.

As the disease progresses, people with MND may need more intensive health care. It is important that people with MND have timely access to NHS continuing healthcare when they need it.

People with MND are likely to need help with getting up, washing, dressing and preparing food as the disease progresses. Access to social care services is therefore important to maintain quality of life. People with MND may also need access to cognitive assessment, as up to half of people with the disease experience changes in cognition.

3 People with MND have the right to be treated as individuals and with dignity and respect

THIS MEANS:

- Being offered a personal care plan to specify what care and support they need.
- Being offered the opportunity to develop an Advance Care Plan to ensure their wishes are met, and appropriate end-of-life care is provided in their chosen setting.
- Getting support to help them make the right choices to meet their needs when using personalised care options.
- Prompt access to appropriate communication support and aids.
- Opportunities to be involved in research if they so wish.

Everyone with MND should be offered a personal care plan[3] to specify what care and support they need. The plan should be regularly reviewed as the disease progresses and the person's needs change.

People with MND should be offered the opportunity to develop an Advance Care Plan[4] to make clear their wishes for future care and support, including any care they do not wish to receive. The plan should be developed with support from a professional with specialist experience and may include preferences for end-of-life care.

Some people with MND will need support to help them make the right choices to meet their needs when using personalised care options, such as personal budgets.

As the disease progresses, some people with MND will experience difficulty speaking. It is important that people with MND can access speech and language therapy to help them maintain their voice for as long as possible. However, as the disease progresses, people with MND may need access to communication aids including augmentative and alternative communication (AAC)[5]. The ability to communicate is a basic human right. For people with MND, communication support and equipment are vital in order to remain socially active and to communicate their wishes about their care, especially during hospital stays and other medical environments.

Many people with MND value the opportunity to be involved in research as it provides hope that one day an effective treatment will be developed. Everyone with MND who wishes to should be able to participate in research as far as is practicable.

4 People with MND have the right to maximise their quality of life

THIS MEANS:

- Timely and appropriate access to equipment, home adaptations, environmental controls, wheelchairs, orthotics and suitable housing.
- Timely and appropriate access to disability benefits.

People with MND may find their needs change quickly and in order to maximise their quality of life, they may need rapid access to equipment, home adaptations, wheelchairs and suitable housing. These needs should be anticipated so that they are met in a timely way. This is particularly true of wheelchairs which are important for maximising independence and quality of life.

People with MND need timely and appropriate access to disability benefits to help meet the extra costs of living with a disability. Information on appropriate benefits needs to be readily accessible in one place and easily understandable.

5 Carers of people with MND have the right to be valued, respected, listened to and well supported

THIS MEANS:

- Timely and appropriate access to respite care, information, counselling and bereavement services.
- Advising carers that they have a legal right to a Carer's Assessment of their needs[1], ensuring their health and emotional well being is recognised and appropriate support is provided.
- Timely and appropriate access to benefits and entitlements for carers.

Caring for someone with MND is physically and emotionally demanding. Carers need to be supported in order to maintain their caring role. Every carer should have their needs assessed and given timely and appropriate access to respite care, information, counselling and bereavement services. It is important to support the emotional and physical needs of the carer in a timely way so that they can continue their caring role.

Carers should also have timely and appropriate access to benefits and entitlements to help manage the financial impact of their caring role.

[1] Recomendation in the NICE guideline on MND.

[2] Specialist palliative care – palliative care is the active holistic care of patients with progressive illness, including the provision of psychological, social and spiritual support. The aim is to provide the highest quality of life possible for patients and their families. Specialist palliative care is care provided by a specialist multidisciplinary palliative care team.

[3] Personal care plan – a plan which sets out the care and treatment necessary to meet a person's needs, preferences and goals of care.

[4] Advance care plan – a plan which anticipates how a person's condition may affect them in the future and, if they wish, set on record choices about their care and treatment and/or an advance decision to refuse a treatment in specific circumstances so that these can be referred to by those responsible for their care or treatment (whether professional staff or family carers) in the event that they lose capacity to decide or communicate their decision when their condition progresses.

[5] Augmentative and Alternative Communication (AAC) – is used to describe the different methods that can be used to help people with speech difficulties communicate with others. These methods can be used as an alternative to speech or to supplement it. AAC may include unaided systems such as signing and gesture as well as aided systems such as low tech picture or letter charts through to complex computer technology.

"Many people with MND die without having the right care, not having a suitable wheelchair, not having the support to communicate.

We have got to set a standard so that people like us are listened to and treated with the respect and dignity we deserve.

We have got to stop the ignorance surrounding this disease and have to make sure that when a patient is first diagnosed with MND, they must have access to good, co-ordinated care and services.

One week waiting for an assessment or a piece of equipment is like a year in most people's lives, because they are an everyday essential to help us live as normal a life as possible and die with dignity"

Liam Dwyer, who is living with MND

For more information:

www.mndassociation.org/mndcharter

Email: campaigns@mndassociation.org

Telephone: 020 7250 8447

We are proud to have the following organisations supporting the MND Charter:

Royal College of General Practitioners

Association of British Neurologists

Royal College of Nursing

Chartered Society of Physiotherapy

College of Occupational Therapists

Royal College of Speech & Language Therapists

British Dietetic Association

MND Association
PO Box 246 Northampton NN1 2PR
www.mndassociation.org

Registered charity no 294354

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

8 December 2017

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Decision Summary

Minute reference	Item	Action
124/17	**CEO ACS Report** The Chair informed members that there is an ACS Development Day in London on Wednesday, 13th December 2017 and a report back will be given to members at the next Collaborative Partnership Board meeting or via e-mail. The priority focus areas together with a proposed management structure will be discussed at a workshop for CEO's in January and the proposed structure will be populated and implemented by April 2018.	The Chair W Cleary-Gray
125/17	**Integrated Operational Report** Richard Jenkins will be circulating information and requesting advice from the team regarding two issues one being the ownership of any breaches and the second being tariffs and the flow of money. The Chair requested the Cancer Alliance to report back to the Executive Steering Group or Collaborative Partnership Board with three or four sustainable proposals resulting from the scoping project.	R Jenkins L Smith
126/17	**Developing the ACS and Future Commissioning Arrangements** Will Cleary-Gray asked members to note that before becoming operational the ACS needs to complete an overarching strategy for 2018/19 in the next quarter. He added that the STP vision and strategy would also require refreshing.	W Cleary-Gray

127/17	**Workstream Priorities:** **Estates** Chris Edwards confirmed that the estates workstream needs to develop its strategy to enable it to deliver its priorities. He confirmed that the workstream would develop a strategy and priorities by the end of January 2018. **Digital/IT** Nicola Haywood-Alexander confirmed the workstream could move the priorities into actions in the next three months and it will populate the priorities with specifics by the beginning of 2018. **Medicines Optimisation** Idris Griffiths confirmed that the workstream would populate the priorities in time for discussion at the meeting in January 2018.	C Edwards N Haywood-Alexander I Griffiths
128/17	**Finance** The Chair requested Jeremy Cook to link in with Richard Jenkins (and others) regarding the analytical review as this linkage will provide information to enable him to highlight the four largest common opportunities across the system for 2018/19. The Chair highlighted that the top four large common opportunities identified from the analytical review will be discussed at the workshop in January 2018.	J Cook W Cleary-Gray
129/17	**Hospital Services Review** Alexandra Norrish informed members that there will be an interim report published on the website regarding the public engagement event held on the 6th December 2017.	A Norrish

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

8 December 2017

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw ACS	ACS Lead/Chair, Sheffield Teaching Hospitals NHS FT, CEO	✓		
Adrian Berry	South West Yorkshire Partnership NHS FT	Deputy Chief Executive		✓	
Adrian England	Healthwatch Barnsley	Chair	✓		
Ainsley Macdonnell	Nottinghamshire County Council	Service Director		✓	Anthony May CEO
Alison Knowles	Locality Director North of England,	NHS England	✓		
Alan Davis	South West Yorkshire Partnership NHS FT	Director of Human Resources	✓		Adrian Berry
Alexandra Norrish	South Yorkshire and Bassetlaw ACS	Programme Director – Hospital Services Review	✓		
Andrew Hilton	Sheffield GP Federation	GP		✓	
Anthony May	Nottinghamshire County Council	Chief Executive		✓	
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher		✓	
Catherine Burn	Voluntary Action Representative	Director		✓	
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer	✓		
Chris Holt	The Rotherham NHS FT	Deputy Chief Executive & Director of Strategy and Transformation		✓	
Des Breen	Working Together Partnership Vanguard	Medical Director	✓		
Diana Terris	Barnsley Metropolitan Borough Council	Chief Executive		✓	
Greg Fell	Sheffield City Council	Director of Public Health	✓		John Mothersole CEO
Frances Cunning	Yorkshire & the Humber PHE Centre	Deputy Director – Health & Wellbeing	✓		
Helen Stevens	South Yorkshire and Bassetlaw ACS	Associate Director of Communications & Engagement	✓		

Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer	✓		
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer	✓		
Jane Anthony	South Yorkshire and Bassetlaw ACS	Corporate Committee Administrator, Executive PA & Business Manager	✓		
Janette Watkins	Working Together Partnership Vanguard	Director	✓		
Janet Wheatley	Voluntary Action Rotherham	Chief Executive	✓		
Jeremy Cook	South Yorkshire and Bassetlaw ACS	Interim Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive		✓	
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Jo Miller	Doncaster Metropolitan Borough Council	Chief Executive		✓	
Julia Burrows	Barnsley Council	Director of Public Health	✓		
Julia Newton	NHS Sheffield CCG	Director of Finance		✓	
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive		✓	
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive		✓	
Lesley Smith	NHS Barnsley Clinical Commissioning Group	SYB ACS System Reform Lead, Chief Officer, NHS Barnsley CCG	✓		
Lisa Kell	South Yorkshire and Bassetlaw ACS	Director of Commissioning Reform	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive		✓	
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer		✓	
Matthew Groom	NHS England Specialised Commissioning	Assistant Director	✓		
Matthew Sandford	Yorkshire Ambulance Service NHS Trust	Associate Director of Planning & Development	✓		Rod Barnes
Mike Curtis	Health Education England	Local Director	✓		
Neil Taylor	Bassetlaw District Council	Chief Executive		✓	
Nicola Haywood-Alexander	South Yorkshire and Bassetlaw ACS	Digital Programme Director	✓		
Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		✓	
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Chief Operating Executive	✓		
Richard Henderson	East Midlands Ambulance Service NHS Trust	Chief Executive		✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS FT	Chief Executive	✓		

Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Acting Chief Executive		✓	
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		✓	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive		✓	
Roger Watson	East Midlands Ambulance Service NHS Trust	Consultant Paramedic Operations	✓		Richard Henderson
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health	✓		
Ruth Hawkins	Nottinghamshire Healthcare NHS FT	Chief Executive		✓	
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive	✓		
Simon Morritt	Chesterfield Royal Hospital	Chief Executive	✓		
Steve Shore	Healthwatch Doncaster	Chair		✓	
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		✓	
Victoria McGregor-Riley	NHS Bassetlaw CCG	Director of Primary Care		✓	
Will Cleary-Gray	South Yorkshire and Bassetlaw ACS	Sustainability & Transformation Director	✓		

Minute reference	Item	Action
120/17	**Welcome and introductions** The Chair welcomed members to the meeting	
121/17	**Apologies for absence** The Chair noted apologies for absence.	
122/17	**Minutes of the previous meeting held 10th November 2017** The minutes of the previous meeting were agreed as a true record.	
123/17	**Matters arising** **Workstream Priorities:** Primary Care At their last meeting the Collaborative Partnership Board did not approve the top 3 priorities for this workstream as presented. The workstream will be presenting their revised top 3 priorities to the Collaborative Partnership Board in January 2018. **Workforce** The top 3 priorities for this workstream were approved and Mike Curtis will be progressing the items identified i.e. the amendment of the strategy and drawing up the narrative required.	

	Finance Update: Jeremy Cook advised members that the Executive Steering Group approved the proposed allocation of the £3.2m uncommitted funds at their meeting on 21st November 2017. **Hospital Services Review** Alexandra Norrish said that she would talk to the communications team about the survey being circulated to the Joint Health Overview and Scrutiny Committee if it had not already been done. Post meeting update – The members of JHOSC had received communications on the review at its launch and been invited to share the survey link with their constituents. **To consider any other business** Dissemination of papers post CPB meetings. Will Cleary-Gray highlighted that the introduction of this system will help to ensure there is consistent communication across the ACS regarding the business going forward to Governing Bodies and Boards.	
124/17	**National Update** **CEO ACS Report** The Chair gave his Chief Executive Officer report to the meeting. This monthly report provides members with an update on: • The work on the ACS CEO over the last month. • A number of key priorities not covered elsewhere on the agenda. In addition to his report the Chair added the following updates: **Developing governance and resourcing to support the ACS strategic priorities** Ian Dalton, Chief Executive of NHS Improvement has said that NHSE/I need to give more clarity about governance and this is one of his key priorities to address. He also said there are semantics and differences in terminology used when referring to ACSs and this something that he will be addressing as the second wave of ACSs come on board in April 2018. The Chair highlighted that SYB STP had initially progressed work to develop itself into an ACS and is now exploring the development of its future governance arrangements. The Governance Group and Audit Chairs (one audit Chair from each place) had a workshop on 1st December 2017 to explore future governance arrangements, to ensure they are in place and that they will guarantee the ACS has consistent management,	

	cohesive policies, guidance, processes and decision-rights for a given area of responsibility, and proper oversight and accountability. The workshop was facilitated by Chris Ham, Chief Executive of the King's Fund. The Chair informed members that there is an ACS Development Day in London on Wednesday, 13th December 2017 and a report back will be given to members at the next Collaborative Partnership Board meeting or via e-mail. The Chair highlighted the priority focus areas for the SYB system working together in Phase 1, 2018/19 i.e. integrated ACS strategy and new regulation, workforce planning, financial strategy, SYAB ACS priorities, system transformation priorities, research, education and innovation, patient and public involvement, population health management. The priority focus areas together with a proposed management structure will be discussed at a workshop for CEO's in January and the proposed structure will be populated and implemented by April 2018. The Chair highlighted that the shadow phase (phase 1, 1st April 2018 to 31st March 2019) of the ACS could have two options regarding its management structure: • the creation of a senior structure of full time positions or, • the creation of a structure comprising of part time positions working at SYB ACS and the remainder of their week working in their substantive posts. The Chair stated that the ACS requires high-quality senior people to fill the positions in the proposed new management structure and it should also ensure there is good geographical representation across the five ACS areas. The Chair highlighted the following focus areas for the SYB ACS working together in phase 1: • building an integrated ACS strategy and new regulation - ensuring the structure is not another tier of management and that links the systems organisations and places through the ACS. • Workforce planning - having a senior HR leadership presence at a system level • Financial strategy - getting ready to deliver the control total from 1st April 2019 (not 2018). • System transformation priorities - the 45 priorities identified by our workstreams need to be focussed to 10-12 priorities for the ACS. This will be completed at the workshop in January 2018. • Research, education and innovation - there is £3.5bn in the recently launched UK Life Sciences Industrial Strategy that could be available to benefit the population of South Yorkshire and Bassetlaw. The ACS is keen to forge better links with industry to help in the creation of jobs in areas such as the advanced manufacturing, digital and in healthcare medical technology industry.	**The Chair** **W Cleary-Gray**

- Patient and public involvement - active public involvement to enable the ACS to evolve with public support and participation.
- Population Health Management – understanding the SYB population needs and inequalities to inform commissioning decisions and best use of funds to improve outcomes in areas such as childhood obesity, tobacco and alcohol cessation.

The Chair responded to a comment regarding the Autumn Budget and the requirement to reduce management costs by 15-20%. He said that the SYB ACS needs to change the way it delivers services to achieve savings and we need to work with NHSE/I, CCGs and hospitals to achieve this.

Will Cleary-Gray asked members to note that there are limits to the amount of transformational funding available for backfilling posts. The ACS will not be developing another tier of management in its structure therefore it needs to develop new ways of working. A management structure will be discussed and developed at the workshop in January.

Lisa Kell added that it is beneficial that Alison Knowles and her team from NHSE are linked with SYB ACS and can offer the ACS support regarding governance issues. The national team has also offered support to SYB ACS in creating a governance structure for the future ACS.

The Chair asked members to note that in the future governance of the ACS it is likely that the meeting arrangements will change as from April 2018. The Governance and the Audit Chairs groups are initially formulating the meeting structure required to proceed from 1st April 2018 and may engage with Ian Dalton in this work.

Autumn Budget 2017

The Chair highlighted that the Autumn Budget announced a further £2.8b of revenue funding for the NHS and added the maximum amount SYB would receive from the additional funding would be the fair share element which stands at 2.9%), which the following is a break-down by year.

2017/18 £9.7m

2018/19 £46.4m

2019/20 £25.1m

The Chair reminded members that it was the 70th anniversary of the National Health Service on 5th July 2018. The ACS should ensure that it is in a position to bid into any potential capital funding that may be made available in the 70th anniversary year.

	The Collaborative Partnership Board noted the update.	
125/17	**Integrated Operational Report** Alison Knowles referred to her paper (C) circulated with the agenda papers and highlighted that the report provides an interim view of performance across the ACS pending the development of the wider single assurance framework. She highlighted that South Yorkshire and Bassetlaw ACSs overall performance has improved with achievement of eight out of the ten national indicators (compared to seven in August). In a ninth area, (waiting time in A&E), the ACS achieved the expected in-year performance of at least 90% but did not deliver the national standard. The access to diagnostic tests within six weeks of referral remained below national standards. Richard Jenkins informed members that short term recommendations have been implemented for echocardiography and it is expected that these will result in positive traction towards the targets in 1-2 months. Extra capacity is being implemented to progress work required in echocardiography. He added that he will be circulating information and requesting advice from the team regarding two issues one being the ownership of any breaches and the second being tariffs and the flow of money. Lesley Smith added that the Cancer 62 day target has been achieved in September but October and November may not achieve the target. However, it should be noted that there are other sides to improvement that should be highlighted other than targets i.e. sharing learning and 'taking on' cancer from 1st April 2018. She added that the areas of traction are Upper GI, Head and Neck, Chemotherapy and Introducing a Faecal Immunochemistry Test in primary care for people with lower GI symptoms. The Cancer Alliance will be undertaking a scoping project and will be bringing back information relating to the above four areas of traction and their commissioning, provision and transformation. The Cancer Alliance will address what change is required in provision and commissioning going forward from 1st April 2018. The Chair requested the Cancer Alliance to report back to the Executive Steering Group or Collaborative Partnership Board with three or four sustainable proposals resulting from the scoping project. The Collaborative Partnership Board noted the current published performance against key national indicators for the South Yorkshire & Bassetlaw ACS.	**R Jenkins** **L Smith**

126/17	**Developing the ACS and Future Commissioning Arrangements** Will Cleary-Gray updated members regarding the development of the ACS and future commissioning arrangements. He asked members to note that before becoming operational the ACS needs to complete an overarching strategy for 2018/19 and then distill the information into the workstreams identified in the Memorandum of Understanding. He added that the STP vision and strategy would also require refreshing. The Hospital Services Review will report on its recommendations and the ACS need to be mindful that it meets the principles of the Hospital Services Review when drawing up its overarching strategy. He informed members that setting out the operational plan for 2018/19 and the development of an overarching strategy needs to be completed in the next quarter. The Chair highlighted that any financial implications of the Hospital Services Review recommendations should be affordable and sustainable. Sharon Kemp informed members that Local Authorities are keen to get involved in place based commissioning. She added that it is important for CEOs to be involved in place based commissioning as it feeds into local tariffs. The Chair thanked Will Cleary-Gray for his update.	**W Cleary-Gray**
127/17	**Workstream Priorities –** slides will be circulated to members after this meeting **Children's and Maternity** John Somers and Chris Edwards presented the Children's and Maternity workstream top 3 priorities for the Collaborative Partnership Boards approval as: • Improve quality and sustain access to surgery and anaesthesia care, network the provision. • Sustain children's acute care, through a network approach and new models of care. • Deliver Better Births in maternity care. John Somers spoke to the Children's element of the workstream priorities stating that the key drivers for the priorities were accessibility, shortage of paediatric nurses and a public consultation process.	

	He informed members that in relation to the first priority one to two children are involved in accessing the services on a monthly basis. The hospital sites involved are Pinderfield's General Hospital in Wakefield, Sheffield Children's Hospital NHS FT and Doncaster Royal Infirmary. As part of the project, peer reviews are currently being undertaken; these are challenging but are proving to be very useful. Three peer reviews have taken place and there are another three to be undertaken in January 2018. The children's surgery and anaesthesia services project has got traction for implementation to proceed in 2018/19. In relation to the second priority a managed clinical network has been established and this will be aligned with the Hospital Services Review (HSR) as their recommendations emerge (HSR recommendations will be published at the end of April 2018). New sustainable models of paediatric care are being investigated along with upskilling of community services to reduce the impact on secondary and specialist care. Chris Edwards spoke to the maternity element of the workstream priorities i.e. Better Births in maternity care. Maternity has been allocated £150k and there is a further £4m (of national monies) in the Memorandum of Understanding. The maternity plan has received good feedback from the national team. Maternity care consists of consultant led, midwife led and home birth services. Chris Edwards highlighted that there is a challenge to the workforce resulting from declining numbers of consultants and midwives in the maternity services. The Chair noted that a stock take is required at 'place'. This will enable the ACS to identify the areas that it should be involved in to make progress. Chris Edwards added that we require solutions to establish how we recruit and keep our workforce. Rupert Suckling highlighted that the key priorities identified for this workstream risked a disconnection from the vision of the children's and maternity workstream. We should be mindful that the vision of the workstream does not get left behind. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented. **Estates** Chris Edwards presented the Estates workstreams top 3 priorities for the Collaborative Partnership Boards approval as: • Develop an ACS estates strategy. • Detailed delivery plan for estates priorities. • Optimisation of high quality estate.	

	Chris Edwards informed members that the priorities have been developed with the Interim Director of Finance and the ACS Estates Workstream Lead using specific criteria. He said that the Sir Robert Naylor Review was published in April 2017 and it sets out the new NHS estates strategy focused on delivering improved care. However, the review was not very beneficial to the estates workstream as it is London centric and so the workstream is waiting for the Estates National Strategy to be published in December 2017 which could have an impact on the workstream. He highlighted that the workstream requires skills and resources to be put in place. He informed members that sites have been identified that address all the national priorities and in doing so will therefore attract funding. Alison Knowles highlighted that NHS estates and technology transformation funding (ETTF) is a multi-million pound investment (revenue and capital funding) in general practice facilities and technology across England and we should ensure that the capital links back to the ACS strategy so that estates attract ETTF funding. The estates workstream should note the process to acquire ETTF funding and the ACS can utilise the funds on its projects. A discussion took place regarding the outcome of the Hospital Service Review (HSR) and the need for the workstream to be aware of any implications for them resulting from the HSR recommendations. Chris Edwards informed the meeting that he sits on the Sheffield City Region Joint Assets Board and in this capacity he is aware of current and future initiatives and opportunities in this sector. Chris Edwards confirmed that the estates workstream needs to develop its strategy to enable it to deliver its priorities. He confirmed that the workstream would develop a strategy and priorities by the end of January 2018. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented. **Digital/IT** Nicola Haywood-Alexander presented the Digital workstreams top 3 priorities for the Collaborative Partnership Boards approval as: • The future ACS digital delivery framework. • Population health data and information requirements.	**C Edwards**

	• Interoperability – technical architecture and integrated care records. Nicola Haywood-Alexander gave a brief overview of the progress of the Digital/IT workstream. She added that the Digital/IT workstream would like to move to a more facilitative role regarding the sharing of data between NHS organisations. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented. Nicola Haywood-Alexander confirmed the workstream could move the priorities into actions in the next three months and it will populate the priorities with specifics by the beginning of 2018. **Medicines Optimisation** Idris Griffiths presented the Medicines Optimisation workstreams top 3 priorities for the Collaborative Partnership Boards approval as: • Efficient prescribing • Universally adopting initiatives and innovations • Implementing results of national consultation Richard Jenkins raised the point that there is significant duplication in the analysis of new drugs by individual hospitals and this requires addressing, we need a system that will analyse all new drugs on behalf of everyone in the SYB ACS footprint and in doing so save resources across the system. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented Idris Griffiths confirmed that the workstream would populate the priorities in time for discussion at the meeting in January 2018. The Chair thanked people for presenting their information at this meeting.	**N Haywood-Alexander** **I Griffiths**
128/17	**Finance Update** Jeremy Cook, Interim Director of Finance SYB ACS, presented his finance report to the meeting. The report informs members on a number of items e.g. Directors of Finance meetings and other general updates, the Autumn Budget and financial reporting. Jeremy Cook informed members that he will be discussing the opportunities of undertaking an analytical review across the ACS which covers operational productivity (providers), right care	

	(commissioners), getting it right first time (providers), medicines optimisation (commissioners) and menu of opportunities (commissioners). The Chair requested Jeremy Cook to link in with Richard Jenkins (and others) regarding the analytical review as this linkage will provide information to enable him to highlight the four largest common opportunities across the system for 2018/19. The opportunities should identify what should be done at an Accountable Care Partnership (ACP) level and what needs to be done at an ACS level to improve efficiency and effectiveness. The Chair highlighted that the top four large common opportunities identified from the analytical review will be discussed at the workshop in January 2018. The Collaborative Partnership Board noted the contents of the report. The Chair thanked Jeremy Cook for his report and for presenting the information contained therein.	**J Cook** **W Cleary-Gray**
129/17	**Hospital Services Review Update** Alexandra Norrish updated the group on progress on the Hospital Services Review (a copy of her presentation will be circulated to members). She said that the first cut and analysis will be produced in time to be discussed at the Hospital Services Steering Group meeting in January 2018. Alexandra Norrish informed members that there had been a very good and constructive public engagement event held on the 6th December 2017 and there will be an interim report published on the website regarding this event. Helen Stevens added that the public engagement element of the event had proved to be successful. The Chair thanked Alexandra Norrish for her presentation and attendance at this meeting.	**A Norrish**
130/17	**To consider any other business** There was no other business brought before the meeting.	
131/17	**Date and Time of Next Meeting** The next meeting will take place on 12th January 2018 at 9.30am to 11.30am in the Boardroom, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU.	

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

12 January 2018

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Decision Summary

Minute reference	Item	Action
6/18	**Public Health Dashboard** Lisa Wilkins agreed to liaise with Chris Edwards outside this meeting to discuss the evaluation work vis-à-vis the health and social prescribing indicators (step 1 of the next steps identified above). The Chair will meet with Helen Stevens to discuss the formulation of a successful intervention that SYB ACS could implement and promote in our shadow phase, this subject will be discussed at a future meeting. The Chair and Lisa Wilkins will discuss the level of clarity required in the development the public health dashboard.	Lisa Wilkins The Chair /Helen Stevens The Chair/Lisa Wilkins
8/18	**Communications and Engagement** The Chair requested Helen Stevens to produce a draft communication and engagement plan to share with members regarding the launch of the shadow ACS in April.	Helen Stevens
9/18	**Finance Update** A query was made regarding tranche one of winter monies vis-à-vis the control totals and Jeremy Cook agreed to gain clarification from the national team and report this information back to members.	Jeremy Cook
10/18	**Hospital Services Review Update** Alexandra requested that members should forward any	

	comments directly to her regarding the Stage 1B report by Monday, 15th January 2018. A revised version based upon the comments received will be drawn up and circulated to members next week. The Chair added that he will liaise with Helen Stevens regarding the issues identified in comments from members at this meeting.	All Alexandra Norrish The Chair/Helen Stevens
11/18	**Draft workforce strategy for England** Mike Curtis and Kevan Taylor volunteered to draft a response via the Local Workforce Action Board and would bring the draft to a Collaborative Partnership Board for members to approve.	Mike Curtis and Kevan Taylor

South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

12 January 2018

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw ACS	ACS Lead/Chair, Sheffield Teaching Hospitals NHS FT, CEO	✓		
Adrian Berry	South West Yorkshire Partnership NHS FT	Deputy Chief Executive		✓	
Adrian England	Healthwatch Barnsley	Chair	✓		
Ainsley Macdonnell	Nottinghamshire County Council	Service Director	✓		Anthony May CEO
Alison Knowles	Locality Director North of England,	NHS England	✓		
Alan Davis	South West Yorkshire Partnership NHS FT	Director of Human Resources	✓		Adrian Berry
Alexandra Norrish	South Yorkshire and Bassetlaw ACS	Programme Director – Hospital Services Review	✓ (pt)		
Andrew Hilton	Sheffield GP Federation	GP		✓	
Anthony May	Nottinghamshire County Council	Chief Executive		✓	
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher	✓		
Catherine Burn	Voluntary Action Representative	Director		✓	
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer	✓		
Chris Holt	The Rotherham NHS FT	Deputy Chief Executive & Director of Strategy and Transformation	✓		Louise Barnett
Chris Welsh	South Yorkshire and Bassetlaw ACS	Independent Lead - Hospital Services Review	✓ (pt)		
Des Breen	Working Together Partnership Vanguard	Medical Director	✓		
Diana Terris	Barnsley Metropolitan Borough Council	Chief Executive		✓	
Greg Fell	Sheffield City Council	Director of Public Health	✓		John Mothersole CEO
Frances Cunning	Yorkshire & the Humber PHE Centre	Deputy Director – Health & Wellbeing	✓		

David Purdue	Doncaster & Bassetlaw Teaching Hospitals NHS FT	Deputy Chief Executive/COO	✓		Richard Parker
George Critchley	Sheffield Children's Hospital NHS Foundation Trust	Senior Communications Officer	✓		
Gilly Brenner	South Yorkshire and Bassetlaw ACS	Public Health Registrar	✓		
Helen Stevens	South Yorkshire and Bassetlaw ACS	Associate Director of Communications & Engagement	✓		
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer	✓		
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer	✓		
Jane Anthony	South Yorkshire and Bassetlaw ACS	Corporate Committee Administrator, Executive PA & Business Manager	✓		
Janette Watkins	Working Together Partnership Vanguard	Director	✓		
Janet Wheatley	Voluntary Action Rotherham	Chief Executive	✓		
Jeremy Cook	South Yorkshire and Bassetlaw ACS	Interim Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive		✓	
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Jo Miller	Doncaster Metropolitan Borough Council	Chief Executive		✓	
Julia Burrows	Barnsley Council	Director of Public Health	✓		
Julia Newton	NHS Sheffield CCG	Director of Finance		✓	
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive		✓	
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive	✓		
Lesley Smith	NHS Barnsley Clinical Commissioning Group	SYB ACS System Reform Lead, Chief Officer, NHS Barnsley CCG	✓		
Lisa Kell	South Yorkshire and Bassetlaw ACS	Director of Commissioning Reform		✓	
Lisa Wilkins	South Yorkshire and Bassetlaw ACS	Consultant in Public Health Medicine	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive		✓	
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer		✓	
Matthew Groom	NHS England Specialised Commissioning	Assistant Director		✓	
Matthew Sandford	Yorkshire Ambulance Service NHS Trust	Associate Director of Planning & Development		✓	Rod Barnes
Mike Curtis	Health Education England	Local Director	✓		
Neil Taylor	Bassetlaw District Council	Chief Executive	✓		
Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		✓	

Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Chief Operating Executive		✓	
Richard Henderson	East Midlands Ambulance Service NHS Trust	Chief Executive		✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS FT	Chief Executive		✓	
Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Acting Chief Executive	✓		
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		✓	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive		✓	
Roger Watson	East Midlands Ambulance Service NHS Trust	Consultant Paramedic Operations	✓		Richard Henderson
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health	✓		
Ruth Hawkins	Nottinghamshire Healthcare NHS FT	Chief Executive		✓	
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive		✓	
Simon Morritt	Chesterfield Royal Hospital	Chief Executive		✓	
Steve Shore	Healthwatch Doncaster	Chair		✓	
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		✓	
Victoria McGregor-Riley	NHS Bassetlaw CCG	Director of Primary Care		✓	
Will Cleary-Gray	South Yorkshire and Bassetlaw ACS	Sustainability & Transformation Director	✓		

Minute reference	Item	Action
1/18	**Welcome and introductions** The Chair welcomed members to the meeting.	
2/18	**Apologies for absence** The Chair noted the apologies for absence.	
3/18	**Minutes of the previous meeting held 8th December 2017** The minutes of the previous meeting were agreed as a true record.	
4/18	**Matters arising** Will Cleary-Gray added that a matrix will be produced and circulated following Collaborative Partnership Board meetings.	

	The matrix will guide members on the dissemination of papers post CPB meetings helping to ensure there is consistent communication of information across the ACS and that members of Governing Bodies and Boards are well informed. **Integrated Operational Report** Richard Jenkins informed members that he is working through this issue with support from Sheffield Teaching Hospitals. **Workstream Priorities:** **Estates** Chris Edwards informed members that the estates workstream is still awaiting the publication of the Estates National Guidance which has been deferred. **Finance** Jeremy Cook is working on the early stages of the analytical review and he will involve Richard Jenkins (and others) at the appropriate stage of the review.	
5/18	**National Update** **CEO ACS Report** The Chair gave his Chief Executive Officer report to the meeting. This monthly report provides members with an update on: • The work on the ACS CEO over the last month. • A number of key priorities not covered elsewhere on the agenda. In addition to his report the Chair added the following updates: The Chair informed members that the work of SYB ACS could be divided into the three following elements for the 2018-19 year: 1. Issues for the ACS. 2. Issues that are business as usual for partners. 3. Transformation issues. The Chair added that everyone should ensure they have exact clarity regarding the aforementioned three elements. The Chair highlighted that in the next twelve months the ACS will be: • establishing its management structure and its way of operating, • implementing the Hospital Service Review, • commissioning reform and establishing partnerships in 'place', • ensuring that its constitution rights and financial basis are	

	firmly established, • beginning to work on a small number of key transformational issues. The Chair added that central government is keen for SYB ACS to succeed. The Chair noted that it is important for the ACS to be ready and able to engage in anything in 2018-2019. The Chair informed members that SYB ACS has met with Greater Manchester ACS to share learning and establish strong relationships as both develop and mature. Lesley Smith updated members on the ACS Development Day that she attended on 13th December 2017 in London. The event brings together the eight ACSs in England. The members present on the day discussed the various elements of being an ACS e.g. they noted that guidance was required regarding the size of the footprint to be an ACS, the specialised commissioning functions required, regulations in the future and capacity to take on regulations and functions, terminology concerning accountable care and the confusion with the USA model, how models of ACSs are unfolding and what they could look like in the future. SYB ACS was in the spotlight on the day as the oversight framework of SYB ACS was presented at the event. She added that looking into the future it was likely that there will be 18 ACSs across the whole of England. Alison Knowles added that NHSE/I will need to draw out a nomenclature for the future to identify exactly what is required as a system and what is required as a partnership. The Chair noted that SYB ACS would await the nomenclature from NHSE/I. **SYB ACS Workshop** The Chair informed members that the ACS workshop is planned for 2nd February 2018 at the New York Stadium in Rotherham. The invitations to this workshop will be revisited as it has been decided to have two workshops, the first workshop would be a small group of Chief Executives and Accountable Officers followed by a second workshop, invitations to the second workshop will be extended to a wider group of stakeholders. **2018/2019** The Chair informed members that NHSE/I has asked for thoughts from the ACSs moving from a conceptual model into an integrated ACS and how this would affect the governance of the ACS. The Chair gave a short presentation entitled ‘Integrated ACS vision system and place’, and information contained therein identified:	

	• Integrated SYB ACS – Vision System • Integrated SYB ACS – Place vision • Emerging ACS priorities and functions • Focus areas for the SYB system working together in phase 1 – 2018/19 • Maturing ACS governance identifying the current governance arrangements for the ACS and ACPs in 2017-18 and giving draft options for 2018/19 for phase 1. Will Cleary-Gray added that the Audit Chairs and Governance Group met in December 2018 and started preparatory discussions around future governance of the ACS and we will share our current thinking with NHSE/I. The Chair said that there are a number of items that need to be worked through regarding the future governance of SYB ACS and this subject will be discussed and developed at the workshop on 2nd February 2018. The Collaborative Partnership Board noted the update.	
6/18	**Public Health Dashboard** The Chair invited Greg Fell and Lisa Wilkins to present the public health dashboard information to the meeting. Greg Fell informed members that the public health dashboard is currently work in progress. The dashboard has been developed with Lisa Wilkins and it sets out the key SYB ACS actions that will give the largest impact in terms of public health. The dashboard is a first draft and more information will be added to give a more fuller picture regarding public health before the workshop on 2nd February 2018. Lisa Wilkins gave her presentation to the meeting. She highlighted that the dashboard has three sections: 1. Population /deprivation and overarching health outcomes. 2. System wide public health priorities – focus on collective action. 3. Place based wider determinants and health improvement – local priorities. Lisa informed members that the next steps will be to: 1. Confirm work and health and social prescribing indicators. 2. Find out Public Health England publishing timetable and agree reporting frequency / timing. 3. Incorporate into overall ACS dashboard and format accordingly. 4. Identify analytical capacity to populate.	

	The Chair thanked Greg Fell and Lisa Wilkins for the excellent work they had produced and indicated that SYB ACS should seek to create a simple public health dashboard. Discussion ensued regarding the interventions that SYB ACS could progress in 2018/19 that would produce a positive public health impact. Members agreed that smoking cessation would be the primary intervention to progress. A query was raised regarding the reduction of health inequalities and where it would emerge in this dashboard from the data. Greg Fell responded saying that health inequalities should not solely be linked to the healthy lives box, health inequalities must be linked to all workstreams. Lisa Wilkins agreed to liaise with Chris Edwards outside this meeting to discuss the evaluation work vis-à-vis the health and social prescribing indicators (step 1 of the next steps identified above). The Chair will meet with Helen Stevens to discuss the formulation of a successful intervention that SYB ACS could implement and promote in our shadow phase, this subject will be discussed at a future meeting. The Chair and Lisa Wilkins will discuss the level of clarity required in the development the public health dashboard. The Chair thanked Lisa Wilkins and Greg Fell for their attendance at this meeting.	Lisa Wilkins The Chair/ Helen Stevens The Chair/ Lisa Wilkins
7/18	**Workstream Priorities –** **Prevention** Greg Fell presented the prevention workstream top 3 priorities for the Collaborative Partnership Boards approval as: • Embedding the treatment of tobacco dependence in secondary care. • Systematic quality improvement in the identification and management of clinical risk factors for cardiovascular disease. • Expansion of social prescribing. Greg advised members that each of the workstream top 3 priorities will be developed and delivered through the plans in 'place'. He added that the priorities are areas of work that are currently being actively taken forward at an ACS programme level. Greg stated that SYB ACS must focus its energies where the need is greatest regarding the 3 top priorities.	

Greg highlighted that there has been a large number of contacts in primary care in previous years regarding tobacco dependence and prevention strategies. However, secondary care has not had the same history or the same level of contacts but it is recognised that secondary care does have a huge role to play in tobacco dependence and prevention strategies.

The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented.

Cancer

Lesley Smith presented the Cancer workstreams top 3 priorities for the Collaborative Partnership Boards approval as:

- Early diagnosis – taking specific action to improve early diagnosis.
- Quality of life – improving quality of life and patient experience for patients following cancer diagnosis and treatment.
- CWT/63 day – delivering the 62 day referral to treatment target and working towards faster diagnosis standard.

The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented.

Primary Care

Karen Curran presented the Primary Care workstream top 3 priorities for the Collaborative Partnership Boards approval as:

- Increased investment in primary care in order to deliver service transformation – national commitment to increase investment into primary care by at least £2.4bn by 2020/2021.
- Wider workforce – national targets to increase, retain and return clinical workforce and introduce new workforce models.
- Local care networks – National: Local Care Networks to be established covering populations of c.30000-50000.

Karen Curran added that a meeting is taking place next week with members from the five Clinical Commissioning Groups to determine if we want to submit one application on a SYB/ACS footprint for the international recruitment and the recruitment of overseas doctors to address some of the workforce issues we have. There are 36 overarching organisations, 5 Clinical Commissioning Groups and one ACS and by aggregating tasks and performing tasks once it will not mean detracting from place but it will mean that added value to the ACS as a whole will be

	achieved. The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented. The Chair thanked the presenters for the information regarding their workstreams top 3 priorities.	
8/18	**Communications and Engagement** Helen Stevens updated members on the communications and engagement of SYB ACS. Helen said that the Hospital Services Review had held a very successful event in December 2017. The communications and engagement team will continue to give their ongoing support the Hospital Services Review. Helen added her team will carry on supporting the SYB ACS workstreams. The communications and engagement team will also continue to carefully work through the detail required to produce an updated communications plan for 2018. The Chair requested Helen to produce a draft communication and engagement plan to share with members regarding the launch of the shadow ACS in April. The Chair thanked Helen Stevens for her update.	Helen Stevens
9/18	**Finance Update** Jeremy Cook, Interim Director of Finance SYB ACS, presented his finance report to the meeting. The report informs members on a number of items e.g. Directors of Finance meetings and other general updates, capital, winter funding, and financial reporting. The Collaborative Partnership Board noted the contents of the report and in particular the timetable to develop the ACS prioritised capital plan. A query was made regarding tranche one of winter monies vis-à-vis the control totals and Jeremy Cook agreed to gain clarification from the national team and report this information back to members. Lesley Smith raised the point that at 2.2 of the finance report the focus and understanding on the benefits of the emergency department development at Doncaster would not only be to Doncaster but would be to the whole of South Yorkshire. The Chair thanked Jeremy Cook for his report and for presenting the information.	Jeremy Cook

10/18	**Hospital Services Review Update** The Chair welcomed Chris Welsh and Alexandra Norrish to the meeting. Chris Welsh had three key messages to convey at this meeting: 1. The Hospital Services Review Team are not working to a predetermined plan, they are following information received from clinicians, the public and data. 2. The HSR is reviewing the medium to long term sustainability of services and will not be resolving current and new pressures on services. 3. The HSR will not be modelling services at a business case level as this is not possible within the time and resources available to the HSR team and also the legalities involved before having to go out to public consultation. Alexandra Norrish updated the group on progress on the Hospital Services Review (a copy of her presentation will be circulated to members). The report summarises the key problems identified for each of the 5 services, and highlights the main themes for solutions emerging. Alexandra requested that members should forward any comments directly to her regarding the Stage 1B report by Monday, 15th January 2018. A revised version based upon the comments received will be drawn up and circulated to members next week. Members made the following comments regarding the Stage 1B report: • Hospitals fit into a much broader system and this aspect did not come across in the draft report HSR. • Consideration should be given to the language used when referring to GP thresholds regarding tasks. • Funds should stay in the NHS and therefore the NHS options available should be identified in the report. Members noted that work should be initiated now to inform the Joint Oversight and Scrutiny Committee and Health and Well Being Boards regarding possible consultation of the final report. The Chair added that he will liaise with Helen Stevens regarding the issues identified in comments from members at this meeting. The Chair thanked Alexandra Norrish and Chris Welsh for their presentation and attendance at this meeting.	All Alexandra Norrish The Chair/Helen Stevens
11/18	**Draft workforce strategy for England** Mike Curtis introduced the workforce strategy for England. Launched by Health Education England (HEE), Facing the Facts, Shaping the Future, A health care workforce strategy for England	

	to 2027, this sets out the proposed strategy to ensure patients have access to the health and care staff they need to provide a high-quality service. Mike Curtis encouraged individual organisations to submit their own response to the draft strategy. However, he added that it would be appropriate for South Yorkshire and Bassetlaw Accountable Care System to forward their organisations response to the draft strategy. Mike Curtis and Kevan Taylor volunteered to draft a response via the Local Workforce Action Board and would bring the draft to a Collaborative Partnership Board for members to approve. The Collaborative Partnership Board duly noted the report and looked forward to receiving the draft response to the strategy at their next meeting.	Mike Curtis and Kevan Taylor
12/18	**To consider any other business** There was no other business brought before the meeting.	
13/18	**Date and Time of Next Meeting** The next meeting will take place on 9th February 2018 at 9.30am to 11.30am in the Boardroom, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU.	

This page is intentionally left blank