Doncaster
Metropolitan Borough Council

To all Members of the

DONCASTER
HEALTH AND WELLBEING BOARD

AGENDA

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

VENUE Room 007a and b, Civic Office, Waterdale, Doncaster, DN1 3BU
DATE: Thursday, 3rd March, 2016
TIME: **9.30 am**

PLEASE NOTE VENUE FOR THIS MEETING

Items		Lead
1.	Welcome, introductions and apologies for absence.	(Chair)
2.	Chair's Announcements.	
3.	To consider the extent, if any, to which the public and press are to be excluded from the meeting.	(Chair)
4.	Public questions. **(A period not exceeding 15 minutes for questions from members of the public.)**	(Chair)
5.	Declarations of Interest, if any.	(Chair)
6.	Minutes of the Meeting of the Health and Wellbeing Board held on 7th January, 2016. (Attached).	(Chair)

Jo Miller
Chief Executive

Issued on: 24th February, 2016

Governance Officer for this meeting: Jonathan Goodrum
01302 736709

Delivery of Health and Wellbeing Strategy.

7.	Quarter 3 Performance Update and Focus on Mental Health. *(Paper attached/presentation).*	(Allan Wiltshire/ Andrea Butcher)
8.	Joint Strategic Needs Assessment Update. (Verbal update)	(Laurie Mott)

Board Assurance

9.	Doncaster Libraries and Culture supporting Wellbeing. *(Presentation).*	(Nick Stopforth)
10.	Health Protection Assurance Annual Report. *(Paper attached/presentation).*	(Victor Joseph)
11.	Learning Disabilities Review. *(Paper to follow).*	(Andrea Butcher)

Developments and Risk Areas

12.	Stronger Families Update. *(Paper attached/presentation).*	(Matt Cridge)

Board Development.

13.	Director of Public Health Annual Report 2015. *(Paper attached).*	(Dr Rupert Suckling)
14.	Report from the Health and Wellbeing Officer Group and Forward Plan. *(Paper attached).*	(Dr Rupert Suckling)

Date/time of next meeting: Thursday, 9th June 2016, at 9.30 am, Room 007a and b – Civic Office **(please note change of date)**

Members of the Health and Wellbeing Board

Chair – Cllr Pat Knight	Portfolio Holder for Public Health and Wellbeing
Vice-Chair – Chris Stainforth	Chief Officer, Doncaster Clinical Commissioning Group
Councillor Nuala Fennelly	Portfolio Holder for Children, Young People and Schools
Councillor Glyn Jones	Deputy Mayor and Portfolio holder for Adult Social Care and Equalities
Councillor Cynthia Ransome	Conservative Group Representative
Damian Allen	Director of Learning, Opportunities and Skills
Kim Curry	Director of Adults, Health and Wellbeing
Dr Rupert Suckling	Director of Public Health, Doncaster Metropolitan Borough Council
Karen Curran	Head of Co-Commissioning, NHS England (Yorkshire and Humber)
Colin Hilton	Chair of Doncaster Children's Services Trust
Susan Jordan	Chief Executive, St Leger Homes
Mike Pinkerton	Chief Executive of Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Steve Shore	Chair of Healthwatch Doncaster
Trevor Smith	Chief Executive, New Horizons
Dr Nick Tupper	Chair of Doncaster Clinical Commissioning Group
Chief Superintendent Richard Tweed	District Commander for Doncaster, South Yorkshire Police
Norma Wardman	Chief Executive Doncaster CVS
Kathryn Singh	Chief Executive of Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
Steve Helps	Head of Prevention and Protection South Yorkshire Fire and Rescue

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DONCASTER METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY, 7TH JANUARY, 2016

A MEETING of the HEALTH AND WELLBEING BOARD was held in the DRAWING ROOM - ST CATHERINES HOUSE, BALBY on THURSDAY, 7TH JANUARY, 2016 at 9.30 A.M.

PRESENT: Chair – Councillor Pat Knight, Portfolio Holder for Public Health and Wellbeing
Vice-Chair – Chris Stainforth, Chief Officer, Doncaster Clinical Commissioning Group (DCCG)

Councillor Nuala Fennelly	Portfolio Holder for Children, Young People and Schools
Councillor Glyn Jones	Portfolio Holder for Adult Social Care and Equalities
Councillor Cynthia Ransome	Doncaster Council Conservative Group Representative
Dr Rupert Suckling	Director of Public Health, Doncaster Metropolitan Borough Council (DMBC)
Damian Allen	Director of Learning, Opportunities and Skills
Karen Curran	Head of Co-Commissioning, NHS England (Yorkshire & Humber)
Paul Wilkin	Deputy CEO, Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), substituting for Kathryn Singh
Dr Nick Tupper	Chair of Doncaster Clinical Commissioning Group
Steve Shore	Chair of Healthwatch Doncaster
Jacqueline Wilson	Director of Transformation, Doncaster Children's Services Trust, substituting for Colin Hilton
Mike Pinkerton	Chief Executive, Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Susan Jordan	Chief Executive, St Leger Homes
Chief Superintendent Richard Tweed	District Commander for Doncaster, South Yorkshire Police
Norma Wardman	Chief Executive, Doncaster CVS
Steve Helps	Head of Prevention and Protection, South Yorkshire Fire and Rescue

Also in attendance:

Peter Dale, Director of Regeneration and Environment, DMBC
Elaine Thompson, Public Health Improvement Coordinator, DMBC
Louise Robson, Public Health Specialist, DMBC
Oliver Judges, Interim Project Director – Assets & Property Rationalisation, DMBC

37 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies were received from Colin Hilton (Jacqueline Wilson deputised) and Kathryn Singh (Paul Wilkin deputised).

The Chair welcomed Ian Margerison, Macmillan Involvement Co-ordinator who was observing today's meeting.

38 CHAIR'S ANNOUNCEMENTS

The Chair advised the Board that she had agreed to a request to defer agenda item no. 10 (Doncaster Libraries and Culture Supporting Wellbeing) to the Board's next meeting.

39 PUBLIC QUESTIONS

There were no questions from the public.

40 DECLARATIONS OF INTEREST, IF ANY

No declarations of interest were made.

41 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 5TH NOVEMBER 2015 (ATTACHED)

RESOLVED that, subject to the addition of Peter Dale's name to the list of those in attendance, the minutes of the meeting of the Health and Wellbeing Board held on 5th November 2015 be approved as a correct record and signed by the Chair.

42 OBESITY PERFORMANCE UPDATE

As requested at a previous meeting, the Board received a presentation on the Obesity priority area and was asked to consider proposals to move away from providing small-scale, local weight management services and initiatives towards a whole systems approach to obesity.

Elaine Thompson, Public Health Improvement Coordinator, outlined in detail the current position in Doncaster with regard to the prevalence of obesity amongst the Borough's population and the harmful effects that this had, the current services provided and the need to move towards a whole system approach (WSA) to tackling obesity in the future. It was noted that a WSA would allow for a longer term, more sustainable plan to be put in place and this would have a much wider focus on tackling obesity, rather than continuing to deliver small-scale initiatives that were showing little, if any, improvement. In particular, the Board noted the following points:-

- Currently the prevalence of people who were classified as being overweight or obese across Doncaster was considerably higher than the England average.

- In Doncaster, it was estimated that over 7000 children (aged 2-15) and 71,000 adults (16+) were classified as obese.

- The proportion of overweight and obese adults was estimated to rise to 74.4% last year, and the 2014/15 data from the National Child Measurement Programme (NCMP) showed that 34% of 10-11 year old children and 22% of 4-5 year olds in Doncaster were overweight and obese.

- Childhood obesity can be associated with emotional and behavioural problems from a very young age, weight related teasing and bullying and increases in school absenteeism.

- The harmful effects of obesity on communities included long term health conditions which placed increasing demands on social care services and resulted in lost productivity for employers.

- With regard to current services, despite what appeared to be a comprehensive pathway of service provision, there was very little change – in fact, the NCMP figures for 2014/15 suggested that children were becoming more obese during their school years. Although obesity was a Health and Wellbeing priority, current provision was piecemeal and involved the commissioning of small scale services. Given the reduction in the Public Health Grant, it was no longer possible to work in this small scale manner and there was a need to consider other wider reaching methods of tackling obesity across the lifespan but especially in children.

- A whole system approach was needed in order to address those factors influencing obesity that were outside an individual's control and which required society wide action to change. These included:

    - Creating an environment where it was easy for people to shop healthily, do physical activity, spend time doing positive things with families and friends, travel actively, cook affordable healthy meals and have good mental health and resilience;

    - Ensuring people had enough money and the right skills, knowledge and equipment to feed themselves and their families;

    These measures required input society-wide from a range of partners across statutory, voluntary, community and private sectors. In order to work towards this approach, Public Health were linking with the development of the Local Plan particularly in relation to improving health and wellbeing, transport and movement, and quality of place.

- With regard to how this Board could support this work going forward, it was suggested that a 'Health in all Policies' perspective was needed. The Board also had a key role in helping to achieve the aim of making the healthy choice the easy choice for people, via environmental change and action at population and individual levels. This would include working together to engage with local businesses in encouraging healthy workplace initiatives and the adoption of environments that would promote healthy weight and improved wellbeing. It was also hoped that a member of this Board would take on the role of 'Champion for Obesity' and be the driving force behind the WSA to this priority area.

The Board then discussed at length the points raised in the presentation. In response to a query regarding examples of best practice elsewhere, Dr Rupert Suckling explained that 4 areas had been selected to operate as whole system providers in a national pilot and it was hoped that Doncaster would be able to learn from that exercise, possibly by shadowing one of the participating areas.

Members recognised that individual responsibility had a significant part to play in changing people's attitudes and behaviours and that there were personal triggers that would make people take steps to curb obesity, as with other conditions/habits. The Board also acknowledged that more could be done by targeting specific sectors of the population, such as children in care, many of whom came from deprived areas. Schools also needed to be engaged in this work, as a lack of physical activity was a major factor which contributed to obesity, and it was felt that currently there was more of a focus on attainment targets than on health and wellbeing in schools. It was also suggested that the partner organisations represented on this Board could each do more to support this work by reviewing their own internal policies in order to help their staff live healthier lifestyles.

It was then

RESOLVED:

1) To approve, in principle, the development of a whole system approach to obesity, subject to any decisions affecting the future provision of specific local weight management services being discussed in detail between the relevant partners/service providers prior to being implemented; and

2) To pursue the possibility of shadowing one of the 4 local authority areas selected to operate as whole system providers in the national pilot scheme.

43 HEALTH AND WELLBEING STRATEGY UPDATE

The Board considered the final draft of the Doncaster Health and Wellbeing Strategy 2016-21, together with the Due Regard Statement 2015-21, for endorsement and subsequent referral to Full Council for adoption.

In presenting the Strategy, Louise Robson summarised the latest changes made to the document. During subsequent discussion, Members endorsed the Strategy for recommendation to Full Council, subject to making the following observations/comments:

- The Mission Statement on page 8 should be amended to read "Prevent disease, disability and harm, **and** sustain health and wellbeing through a world class health and care system." It was also suggested that the use of the words 'world class' should be reviewed.

- It was pointed out that the last bullet point on page 7 of the Strategy, which read "Ofsted recognised improvements in services for children in need of safeguarding, looked after children and care leavers, including 'Good' services for looked after children", was inaccurate as the 'Good' rating had been given for the adoption service.

- A view was expressed that the section on Children and Families on page 18 was still quite narrow in its focus, as it only referred to the Stronger Families programme and not to any other services.

After Members had discussed the issue of the alignment of the planning frameworks of the various partnership bodies and the need for a clearer understanding of the wider relationships between each of the thematics, it was

RESOLVED that, subject to the above comments and further minor drafting amendments, the final draft of the Doncaster Health and Wellbeing Strategy 2016-21, including the Due Regard Statement 2015-21, be approved for recommendation to Full Council for adoption.

44 BETTER CARE FUND UPDATE

The Board received a detailed update by Chris Stainforth on the latest position regarding the development of the Better Care Fund (BCF). In particular, the Board was briefed on the following key issues:

- The planning guidance from the NHS in respect of the Better Care Fund for 2016/2017;
- The services currently funded from the BCF;
- The performance targets that were being looked at nationally; and
- Changes to the governance arrangements to manage the individual workstreams.

During subsequent discussion on issues relating to the BCF, Board Members commented on/noted the following:-

- The proposed use of 'place based plans' was welcomed;

- There was a need to ensure that real transformation took place, rather than relying upon the BCF to prop up services;

- Currently the focus was on 3 main transformation areas:

    - Urgent Care system – this was being redesigned in line with the recommendations from Professor Keith Willett's Urgent and Emergency Care Review report;

    - Intermediate Care Service – ways of improving services received by dementia patients were being looked at; and

    - Primary Care Strategy/System – there was a need to identify alternative methods of delivering primary care services. Once this work was done, the findings would be brought to this Board at the appropriate time.

RESOLVED to note the update on the progress and future of the Better Care Fund.

45 DONCASTER LIBRARIES AND CULTURE SUPPORTING WELLBEING

This item was deferred until the next meeting.

46 JOINT WORKING WITH SOUTH YORKSHIRE FIRE AND RESCUE SERVICES

The Board considered a report which outlined a proposal to broaden the content of the Home Safety Checks conducted by the South Yorkshire Fire and Rescue Services (SYFRS) to include Health and Wellbeing messages and the introduction of preventative activities. The Board also viewed a video which illustrated the wide range of services provided by SYFRS.

In presenting the paper, Steve Helps explained that within Doncaster a steering group comprising representatives from Public Health, CCG commissioning, St Ledger Homes, Age UK and SYFRS was working towards the introduction of Fire and Rescue Service led Safe and Well Visits across the Borough. The introduction of Safe and Well Checks in Doncaster would enable closer working between key agencies who shared responsibility for supporting vulnerable older people across the Borough.

Taking into account the local priorities identified through the Joint Strategic Needs Assessment and the Health and Wellbeing Board, the Safe and Well Visit would focus on ageing safely, falls prevention, fire safety in the home and crime prevention, with established signposting pathways in place to enable additional support through the most appropriate partners.

It was noted that training of SYFRS staff would be through accredited courses provided by the Royal Society of Public Health with Safe and Well Visits being delivered from 1st April 2016.

During subsequent discussion, Members gave their full support for this initiative.

In response to a comment, Steve Helps confirmed that the Fire and Health conference to be held on the 16th Feb 2016 and hosted by SYFRS was aimed at identifying the current and future joint working between Fire and Health service partners. Invites to this event had been sent out to senior managers who worked across the various health and social care providers.

It was then

RESOLVED to note and support the proposed introduction by SYFRS of Safe and Well Visits within Doncaster.

47 ASSETS - THE HEALTH PARTNERS WORKING TOGETHER UNDER ONE PUBLIC ESTATE

The Board received a presentation by Oliver Judges outlining the One Public Estate and the Doncaster Health Partnerships Joint Assets Strategy, which essentially looked at ways of co-locating and working together to reduce costs on buildings whilst supporting improvement to services.

It was noted that the key focus was to reduce the cost of the Health and Public estate by reducing the number of buildings and supporting the protection of front line services. This also brought an opportunity to reorganise service locations making them more accessible and, working under a single system approach, to improve service levels, experience of the service and efficiencies.

Having outlined the aims and objectives of the One Public Estate, Oliver Judges explained how this work would be taken forward. It was reported that funding had been awarded to support the delivery of the Programme, and that a cross-public sector Operational Assets Board and One Public Sector Project Delivery Team had been established.

Discussion followed, during which Dr Rupert Suckling pointed out that it was important to remember that there were also other third sector partner assets and non-public estate properties situated across the Borough. In reply, Oliver Judges confirmed that work was ongoing in relation to mapping the distribution of various property assets in the Borough but he acknowledged that there was scope for collecting more data in respect of third sector assets.

After Members had agreed that it would be useful to receive the Doncaster Health Partnerships Joint Assets Strategy at a future meeting of this Board, it was

RESOLVED to:

1) note the potential of the One Public estate and agree to work together to deliver projects under this initiative;

2) note the development of a new Health Partnership Estates Strategy and request that this be submitted to a future meeting of the Board when completed.

48 REPORT FROM HWB OFFICER GROUP AND FORWARD PLAN

The Board considered a report which provided an update on the work of the Officer 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.

Dr Rupert Suckling summarised the salient points in the report, which included updates on:

- Use of the Pharmaceutical Needs Assessment;
- Public Health Grant Reductions 2016/17;
- Draft Recommendations from the Director of Public Health's Annual Report 2015;
- Anti-Poverty issues; and
- Forward Plan for the Board.

RESOLVED:

1) to note the update from the Officer Group; and

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

CHAIR:_____ DATE:_____

Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No. 7
Date: 03.03.2016

Subject: 2015-16 Q3 Performance Report

Presented by: Allan Wiltshire

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

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

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

Recommendations
The Board is asked to:- a) Note the performance against the key outcomes b) Receive and note the short presentation from the 'Mental Health' area of focus c) Agree what area of focus the Board would wish to have further information in Q4 2015-16

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Doncaster
Metropolitan Borough Council

Agenda Item No: 7
3rd March 2016

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

PERFORMANCE REPORT Q3 2015-16

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Cllr Pat Knight	All	NA

EXECUTIVE SUMMARY

1. A refreshed 'outcomes based accountability' (OBA) exercise was completed parallel to the refresh in the Health and Well-being strategy. The five outcome areas remain and specific indicators have been identified which will measure our progress towards these outcomes in 2015-16, shown below,

OUTCOME 1: ALL DONCASTER RESIDENTS TO HAVE THE OPPORTUNITY TO BE A HEALTHY WEIGHT

- % of Children that are classified as overweight or Obese (Aged 4/5)
- % of Children that are classified as overweight or Obese (Aged 10/11
- % of Adults Overweight or Obese
- % of adults achieving at least 150 minutes of physical activity per week.

OUTCOME 2: ALL PEOPLE IN DONCASTER WHO USE ALCOHOL DO SO WITHIN SAFE LIMITS

- Numbers of people being screened for alcohol use and, where
- Alcohol-related attendance at A&E (per 1000 pop) appropriate, receiving brief advice
- Alcohol-related violent crime per 1000 pop (2015/16 YTD Only)
- Alcohol related admissions to hospital

OUTCOME 3: FAMILIES WHO ARE IDENTIFIED AS MEETING THE ELIGIBILITY CRITERIA IN THE EXPANDED STRONGER FAMILIES PROGRAMME SEE SIGNIFICANT AND SUSTAINED IMPROVEMENT ACROSS ALL IDENTIFIED ISSUES.

- Number of Families Identified as part of the Phase 2 Stronger Families
- Number of families achieving positive outcomes through the Programme
- Number of Families Engaged in the Expanded Stronger Families Programme

OUTCOME 5: IMPROVE THE MENTAL HEALTH AND WELL-BEING OF THE PEOPLE OF DONCASTER ENSURES A FOCUS IS PUT ON PREVENTIVE SERVICES AND THE PROMOTION OF WELL-BEING FOR PEOPLE OF ALL AGE'S ACCESS TO EFFECTIVE SERVICES AND PROMOTES SUSTAINED RECOVERY.

- Proportion of adults in contact with secondary mental health services in paid employment
- Proportion of adults in contact with secondary mental health services living independently, with or without support
- Proportion of People Completing Treatment and Moving to Recovery
- % of patients with agreed care pathway & treatment plans

OUTCOME 4: PEOPLE IN DONCASTER WITH DEMENTIA AND THEIR CARERS WILL BE SUPPORTED TO LIVE WELL. DONCASTER PEOPLE UNDERSTAND HOW THEY CAN REDUCE THE RISKS ASSOCIATED WITH DEMENTIA AND ARE AWARE OF THE BENEFITS OF AN EARLY DIAGNOSIS

- Dementia Diagnosis Rate (%)
- Number of 4hr RDaSH Emergency responses for people with dementia
- Reduce the number of Hospital Admissions (DRI) for people with
- Length of stay of people with Dementia in an acute setting (average days)
- Hospital re-admissions within 30 days (DRI) for people with Dementia
- Number of patients having any delayed discharges encountered at RDaSH
- Attendances at A&E for people with dementia
- Number of people with dementia being admitted from care homes to DRI
- Number of Hospital deaths for patients with dementia
- Unplanned episodes of Respite for people with Dementia
- Proportion of referrals for Assistive Technology that are for people with Dementia
- Number of Safeguarding Referrals that are for people with a Primary Support Reason as Memory and Cognition
- Proportion of People with Dementia living at home

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

EXEMPT REPORT

3. NA

RECOMMENDATIONS

4. The Board is asked to:-
   a) Note the performance against the key priorities
   b) Receive and note the short presentation from the 'Mental Health' area of focus
   c) Agree what area of focus the Board would wish to have further information in Q4 2015-16

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

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

BACKGROUND

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

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

8. As agreed with the board in Q1 2015-16 a short presentation on one of the areas of focus will be provided at each quarterly performance update. In Q2 the board agreed to invite the lead officer for Mental Health to give a short update in Q3 2015-16. The Board will need to decide which area of focus should be invited for Q4 2015-16.

OPTIONS CONSIDERED

9. NA

REASONS FOR RECOMMENDED OPTION

10. NA

IMPACT ON THE COUNCIL'S KEY PRIORITIES

11.

Priority	**Implications**
We will support a strong economy where businesses can locate, grow and employ local people. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	
We will help people to live safe, healthy, active and independent lives. *Mayoral Priority:* Safeguarding our Communities *Mayoral Priority:* Bringing down the cost of living	Reduce Obesity. Reduce Alcohol Misuse Dementia

	Mental Health
We will make Doncaster a better place to live, with cleaner, more sustainable communities. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	
We will support all families to thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	Stronger Families Programme
We will deliver modern value for money services.	
We will provide strong leadership and governance, working in partnership.	

RISKS AND ASSUMPTIONS

12. NA

LEGAL IMPLICATIONS

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

FINANCIAL IMPLICATIONS

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

EQUALITY IMPLICATIONS

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

CONSULTATION

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

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

BACKGROUND PAPERS

18. NA

REPORT AUTHOR & CONTRIBUTORS

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Dr. Rupert Suckling
Director of Public Health

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Doncaster Health & Well Being Board

Performance Report

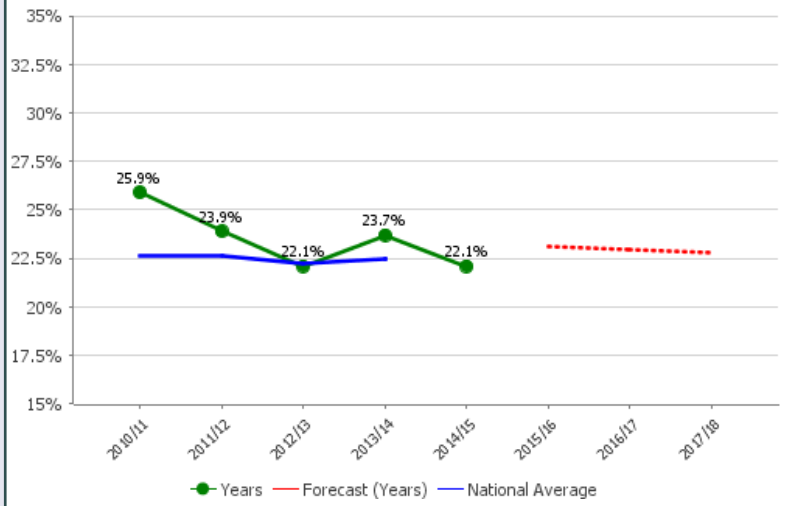
Q3 2015-16

Appendix A

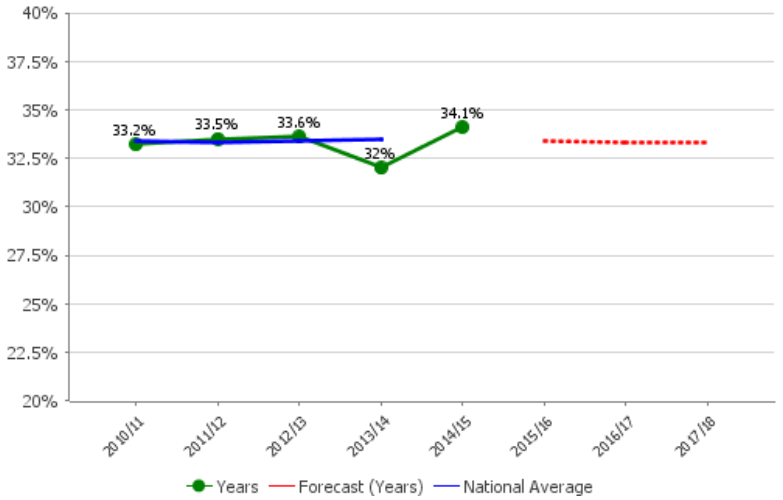
Values below 5 have been rounded to 0 or 5

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

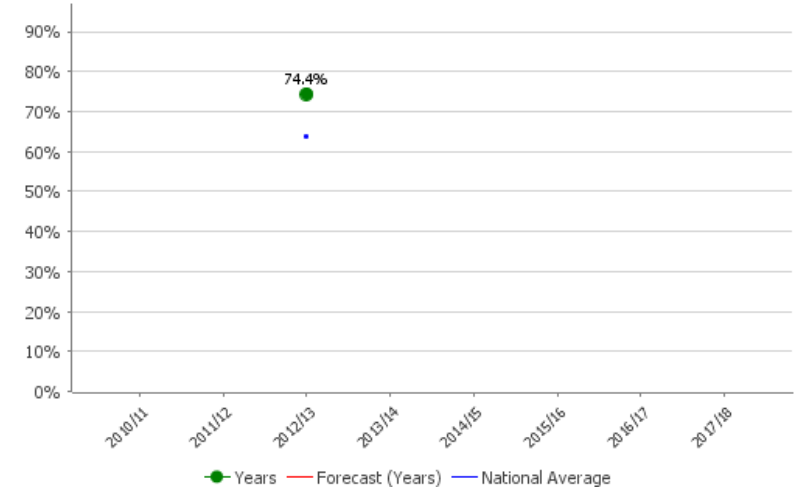
a) % of Children that are classified as overweight or Obese (Aged 4/5)



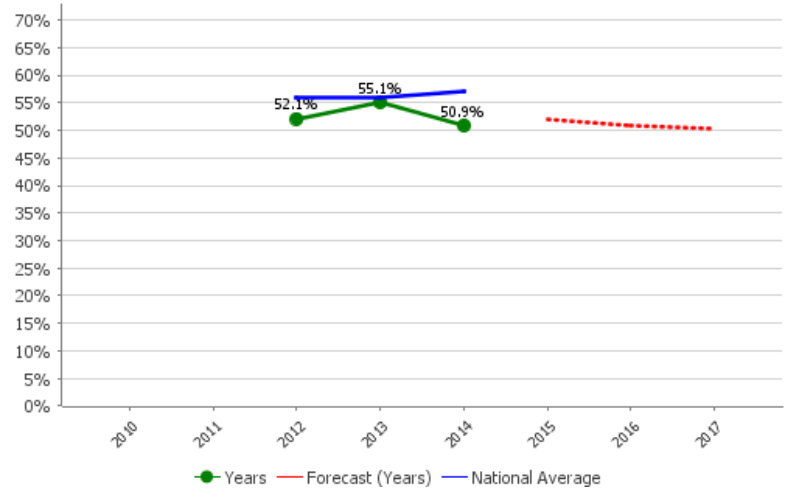
b) % of Children that are classified as overweight or Obese (Aged 10/11)



c) % of Adults Overweight or Obese



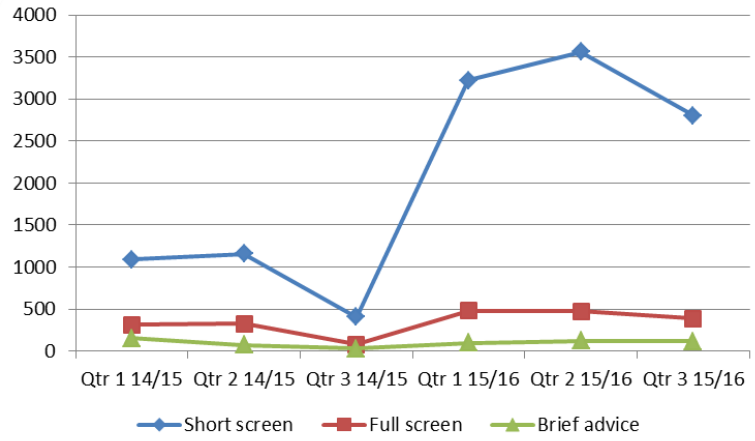
d) % of adults achieving at least 150 minutes of physical activity per week



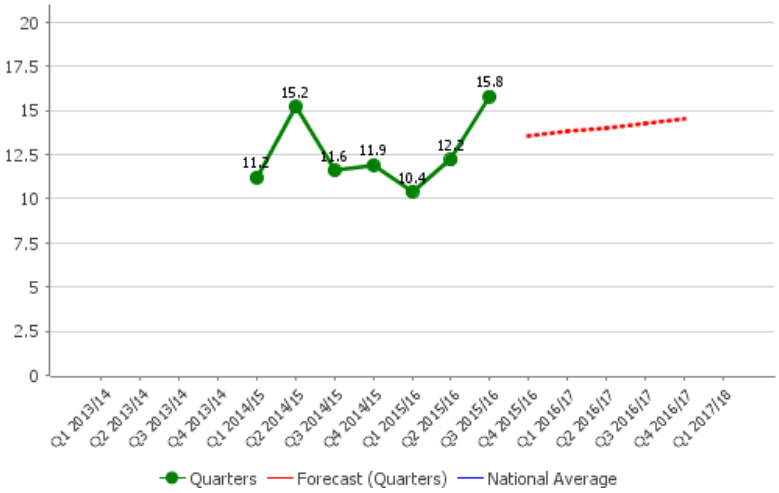
STORY BEHIND THE BASELINE	Our Reception and Year 6 overweight and obesity figures are similar to the Regional and National prevalence. Obesity figures for Year 6 (17.1%) were 2% lower than the Regional and National prevalence (19.1/19.2%). In previous years we have been in line with National trends; however this reduction may be a natural fluctuation rather than a sustained downward trend. Childhood obesity remains a high priority – by improving the National Child Measurement Programme (NCMP) systems and sharing data with partners we can better target prevention and management services in high priority schools and utilise more opportunities to proactively engage with families. An NCMP plan has been developed for school year 15/16 covering sharing of data, pro-active feedback, and engagement of primary care, pro-active engagement of schools and Governors and improvements to the referral pathways. Current weight management services for children have been seriously underperforming over the last 18months and, as a result of the CSR and cuts to the Public Health grant, the current service will cease from 31st March 2016. Other options are currently being explored in relation to taking a local whole systems approach to obesity, especially in children, and those children who are currently still within the current service will be offered support until they have completed the programme. In Doncaster, Public Health has re-commissioned a physical activity service for residents aged 50+ years to contribute to the prevalence in falls. This contract is initially for 3yrs starting on the 1st April 2016. The review of the system for physical activity and sport is ongoing.	
ACTION PLAN	**What we will achieve in 2015-16**	**What we will do next period**
	1. The development of a plan to address access to healthier food (to incorporate Doncaster food plan, food procurement, school meals, workplace health award environmental health plan). 2. Work with academic partners to explore the feasibility of a toolkit to improve the food environment in Doncaster communities 3. Active promotion of physical activity opportunities (promotion of discount cards). 4. Development and rollout of a Making Every Contact Count (MECC) training package. 5. Continued work with planning teams to ensure access to healthier food and physical activity opportunities are incorporated into the Local Development Plan.	1. Work with DBH Nutrition & Dietetics Dept. to implement tapered weight management services from 1/4/16 for both children and adults to support those already within the current services, which are under review to be stopped as a result of the CSR & PH budget cuts. 2. Work with DBH Nutrition & Dietetics Dept. to develop a service that will provide a weight management programme for those people who are waiting for bariatric surgery. 3. Complete series of workshops relating to the Child Obesity Prioritisation Tool pilot and develop a plan to take the findings forwards. 4. Investigate better partnership working with school nurses and NCMP programmes to be co-beneficial 5. Complete the Doncaster Food Plan – now known as Doncaster Healthy Eating Guidance – and disseminate website link to partners. 6. Support the Decent Helpings research project (currently awaiting ethics approval) 7. Complete development of MECC e-learning tool. 8. Review OBA template in relation to changes to service provision and prioritisation of work areas in relation to overall aims. 9. Maintain links with Whole Systems Approach project through Leeds Beckett to learn from work being carried out.

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

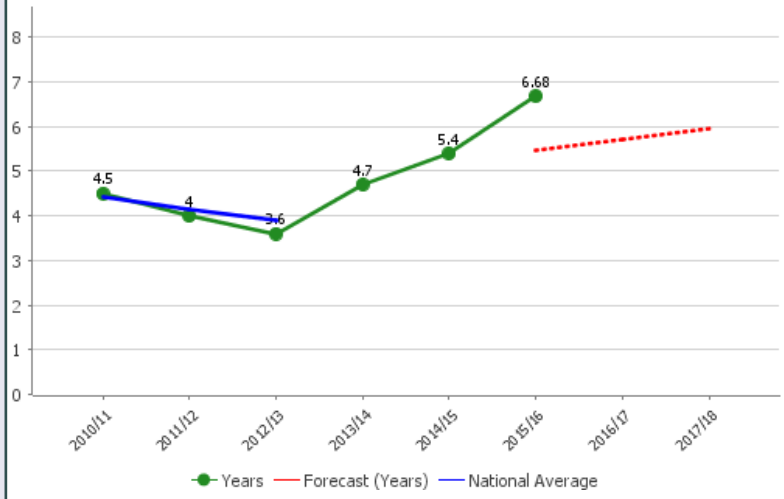
a)Numbers of people being screened for alcohol use and, where appropriate, receiving brief advice



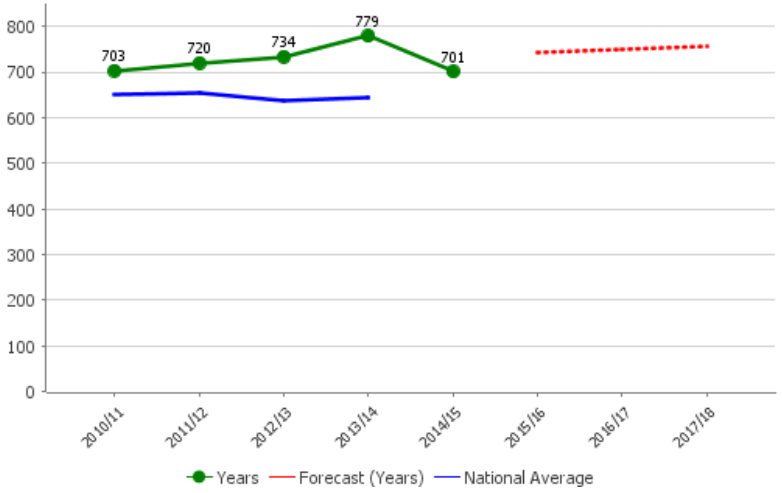
b) Alcohol-related attendance at A&E (per 1000 pop)



c) Alcohol-related violent crime per 1000 pop (2015/16 YTD Only)



d) Alcohol related admissions to hospital (14/15 data provisional)

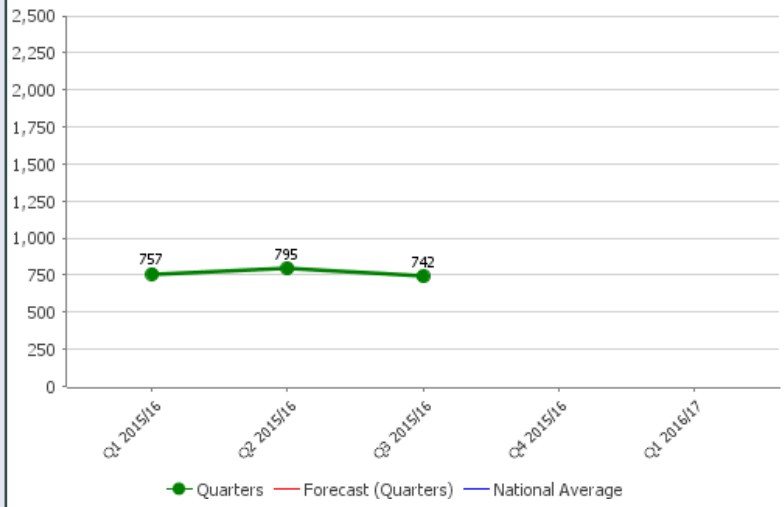


STORY BEHIND THE BASELINE	The short form of alcohol screening has approximately trebled from last year to this and the ratios then receiving a full screen and brief advice mirror the evidence base (i.e. 5:1 at each stage). This suggests screening and advice is being targeted at suitable patient groups. From Q1 16/17 this service will be subcontracted via RDASH as lead provider. Alcohol-related admissions increased up to 2013/14 and were consistently above England. The rate for 2014/15 appears to decrease sharply though this requires further investigation. These admissions are primarily linked to cancer, unintentional injuries and mental/behavioural disorders. Alcohol-related A&E attendances fluctuate over time but there are no significant trends. Attendance peaks sharply between 21-25 years but over half of attendances occur in people aged 26 to 60, cutting across age groups. Reviewing the presenting condition, it appears three quarters of attendances are linked to minor injuries and accidents rather than assaults. Alcohol-related crime has increased significantly from a low in 2012/13. The Joint Strategic Intelligence Assessment notes this increase citing increases in Town Centre violence and recorded domestic abuse, but also discrepancies in the recording process.	
ACTION PLAN	**What we will achieve in 2015-16**	**What we will do next period**
	1. Work with GP practices to expand and improve screening and interventions from this year to next. There is also scope to deliver screening and very brief interventions in non-primary care settings such as pharmacies, hospitals, criminal justice, housing providers and social care (the evidence base outside primary care is mixed so investment would be carefully considered). 2. Evaluate the Community Alcohol Partnership (CAP) in Askern, Campsall and Norton and expand the model to other areas if appropriate. The CAP was launched in November 2014 and is a partnership approach to address underage sales and antisocial behaviour. This is a collaboration between the community, schools, retailers, the Local Authority, Police and St Leger Homes. Utilising communities and addressing underage consumption will be key in the future. 3. Make greater use of campaigns to raise public awareness and influence attitudes to alcohol in the population. Fixed national dates include Alcohol Awareness Week and Dry January while local campaigns will likely include topics such as alcohol in pregnancy, alcohol and older people and the link between alcohol and house fires. Public Health will work on campaigns aimed specifically at businesses to help foster an ethos of responsible retailers, for instance working with Pub Watch organisations and delivering a 'Reduce the Strength' campaign to limit the availability of very strong alcohol. 4. Improve the referral pathway between hospitals and the treatment system and enhance the identification and support to people repeatedly attending A&E or admitted to wards. Alcohol Concern defines these as 'Blue Light' clients - people who become vulnerable and isolated so that emergency services are their only source of support. Similarly there are vulnerable people, including alcohol misusers, who revolve through the Criminal Justice System. The Criminal Justice Liaison and Diversion Scheme launched in April 2015 and Public Health will work with partners to embed substance misuse within the model.	1. Work with GP practices to expand and improve screening and interventions from this year to next. There is also scope to deliver screening and very brief interventions in non-primary care settings such as pharmacies, hospitals, criminal justice, housing providers and social care (the evidence base outside primary care is mixed so investment would be carefully considered). 2. Evaluate the Community Alcohol Partnership (CAP) in Askern, Campsall and Norton. The model was expanded to Conisbrough and Denaby in November 2015. CAP is a partnership approach to address underage sales and antisocial behaviour. This is a collaboration between the community, schools, retailers, the Local Authority, Police and St Leger Homes. Utilising communities and addressing underage consumption will be key in the future. 3. Make greater use of campaigns to raise public awareness and influence attitudes to alcohol in the population. Fixed national dates include Alcohol Awareness Week and Dry January while local campaigns will likely include topics such as alcohol and cancer, alcohol in pregnancy, alcohol and older people and the link between alcohol and house fires. Public Health will work on campaigns aimed specifically at businesses to help foster an ethos of responsible retailers, for instance working with Pub Watch organisations and delivering a 'Reduce the Strength' campaign to limit the availability of very strong alcohol. 4. Improve the referral pathway between hospitals and the treatment system and enhance the identification and support to people repeatedly attending A&E or admitted to wards. Alcohol Concern defines these as 'Blue Light' clients - people who become vulnerable and isolated so that emergency services are their only source of

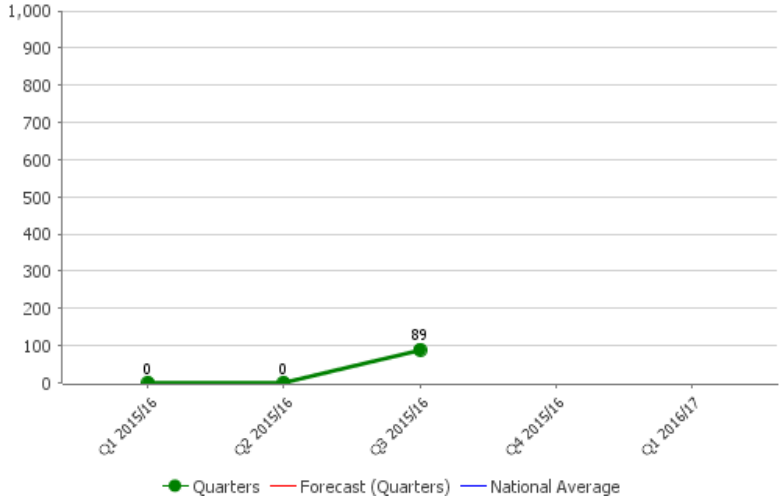
		support. Similarly there are vulnerable people, including alcohol misusers, who revolve through the Criminal Justice System. The Criminal Justice Liaison and Diversion Scheme launched in April 2015 and Public Health will work with partners to embed substance misuse within the model. 5. Increase public and professional awareness re alcohol and older people through partnership with services which work with older people such as AgeUK, DIAL and Rdash. A leaflet and poster campaign will be produced and distributed across Doncaster highlighting the increasing issue. The pathway between dementia services and alcohol services will be looked at and discussed at a Alcohol Related Brain Injury seminar at DRI on the 24th of May.

OUTCOME	Families who are identified as meeting the eligibility criteria in the expanded Stronger families programme see significant and sustained improvement across all identified issues.
INDICATORS	

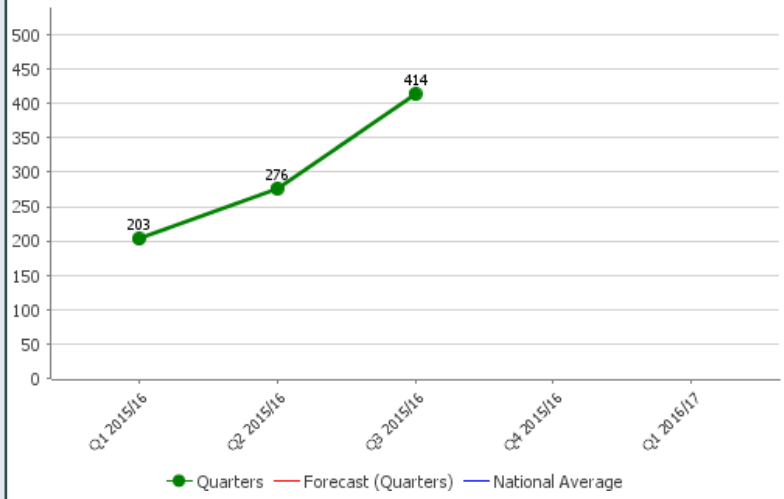
a) Number of Families Identified as part of the Phase 2 Stronger Families Programme



b) Number of families achieving positive outcomes through the Stronger Families Programme

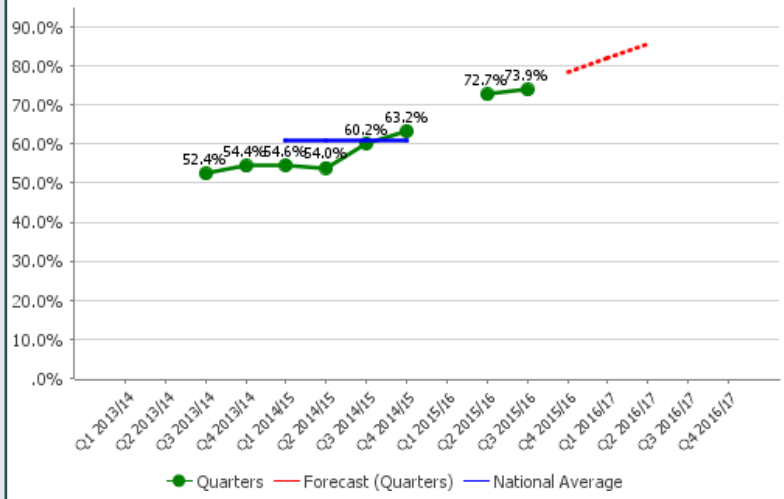
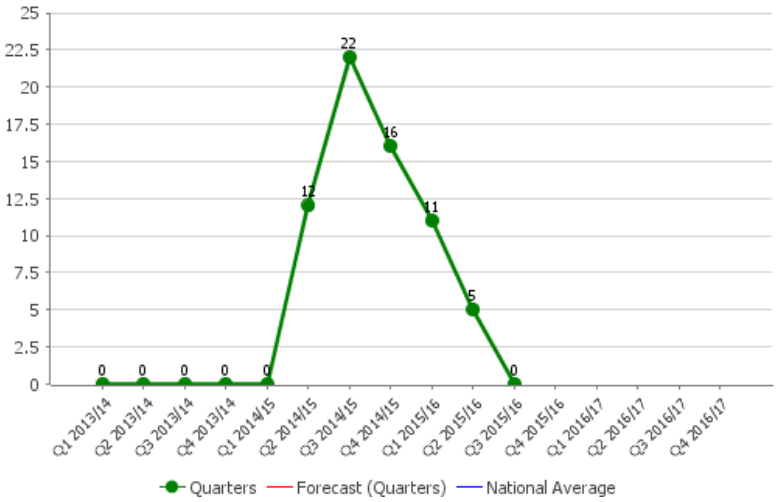
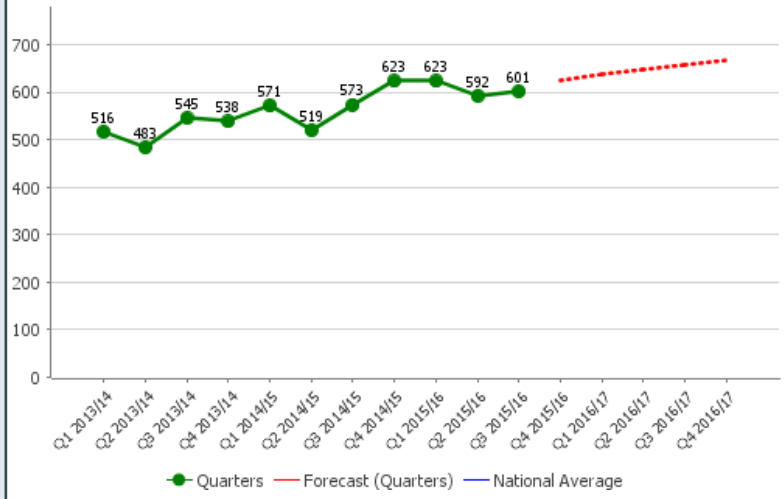
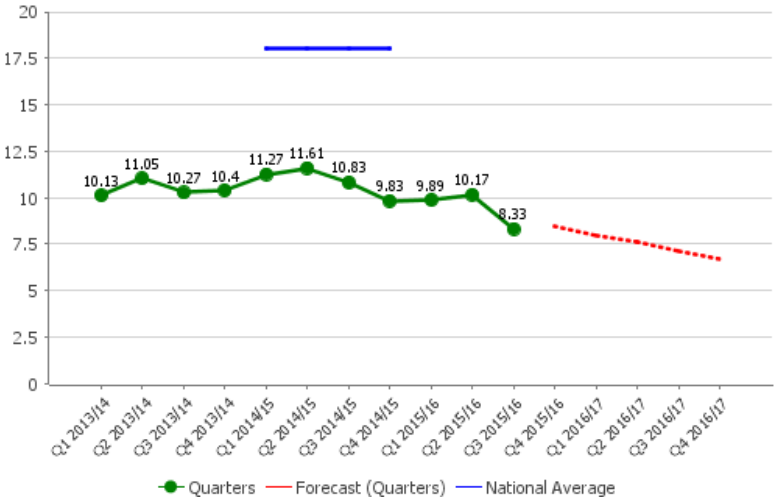


c) **Number of Families Engaged in the Expanded Stronger Families Programme**

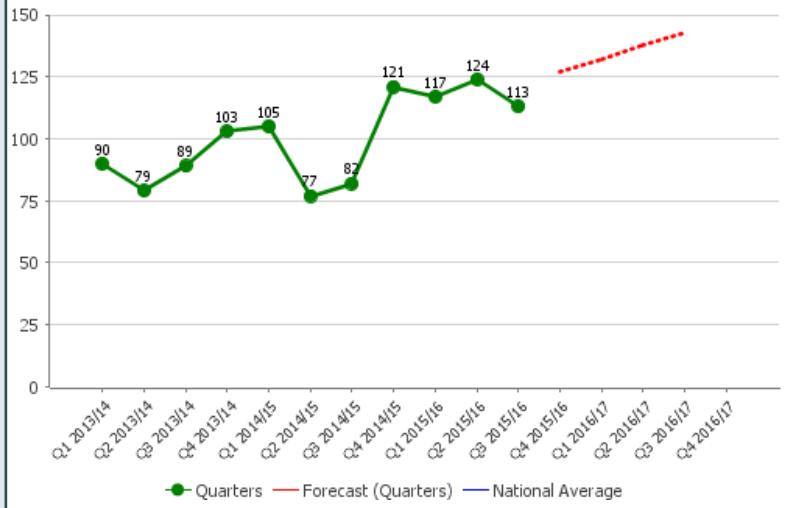


STORY BEHIND THE BASELINE	The Expanded Stronger Families Programme continues to develop at a good pace and Doncaster continues to show that it is able to deliver. Identification processes are working well and we are increasing the number of families identified as eligible by other professionals, however there is still much more work to do. During Q3 the Chancellor of the Exchequer announced the continuation of the Expanded Troubled Families Programme in his spending review speech late last year. Although we do not as yet know the details of our agreement, the budgets and numbers remain unchanged nationally. We expect to hear in February the details of our funding for the next four years. The delay is in part due to a redistribution of the funds through a renewed methodology. Our current total of identified and validated families is 742 at this point. The difference between figures for Q2 and Q3 is due families moving out of the Doncaster area or family group changes resulting in no longer eligible. Our planned additional identification is now scheduled to take place during Quarter 4, however we are on track to meet the targets for Year 1 of the expanded programme. The targeted number of families for year 1 of the expanded programme has been agreed to be increased from 491 to 550 following agreement with the Chief Executive and DCLG. Therefore the target has been re-profiled. The number of families engaged with is on target, taking into account this increase. The target is to claim for 20 families in our first claim due in January 2016 (roughly in line with first claims from early adopter areas). We are on target for this number; validated numbers will be reported in Quarter 4. Activity has been ongoing throughout Quarter 3 to gather progress information that also informs our claims. While Claims may only be made for sustained and significant progress against all outcomes, or, continuous employment, progress against individual outcomes has been made. The provisional progress is: Outcome 1 (Crime & ASB): 35 Outcome 2 (Children Attending School): 5 Outcome 3 (Children Needing Help): 13 Outcome 4 (Worklessness & Financial Exclusion): 20 Outcome 5 (Domestic Violence): 11 Outcome 6 (Health): 5

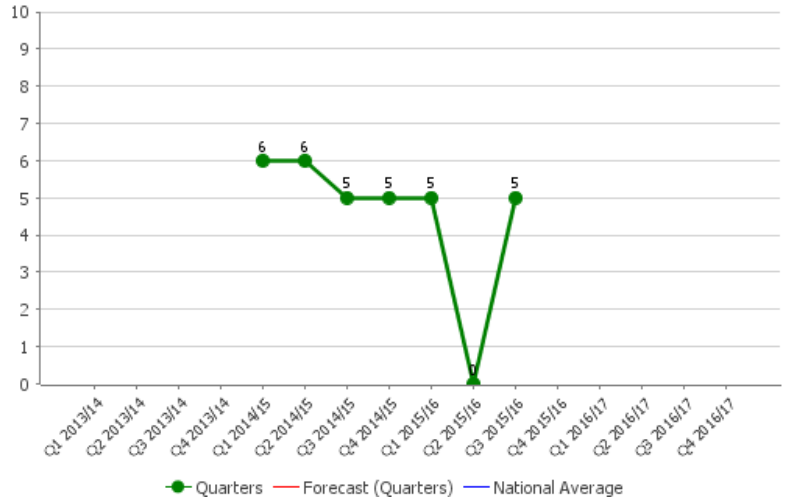
	What we will achieve in 2015-16	**What we will do next period**
ACTION PLAN	1. To identify as many families who meet the criteria as we can 2. Implement the case management system to allow for easier case management , tracking and progress reporting 3. Commission services needed by families following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

OUTCOME	**People in Doncaster with dementia and their carers will be supported to live well. Doncaster people understand how they can reduce the risks associated with dementia and are aware of the benefits of an early diagnosis**
INDICATORS	**a) Dementia Diagnosis Rate (%)**  **b) Number of 4hr RDaSH Emergency responses for people with dementia**  **c) Reduce the number of Hospital Admissions (DRI) for people with dementia**  **d) Length of stay of people with Dementia in an acute setting (average days)** 

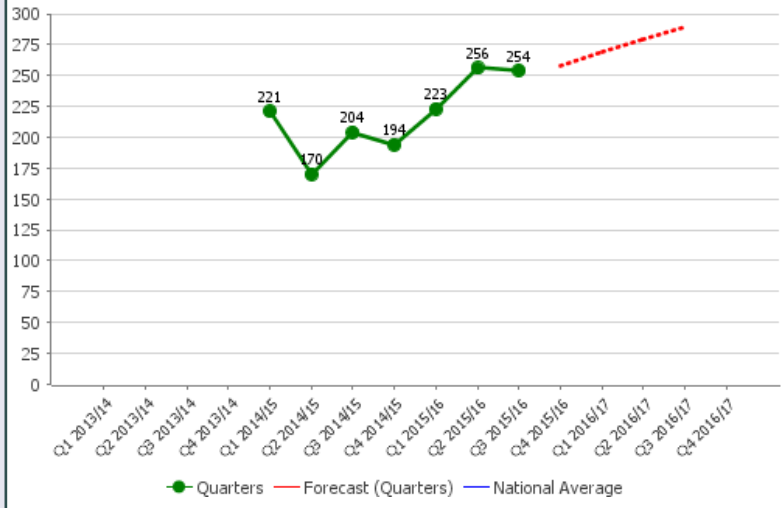
e) Hospital re-admissions within 30 days (DRI) for people with Dementia



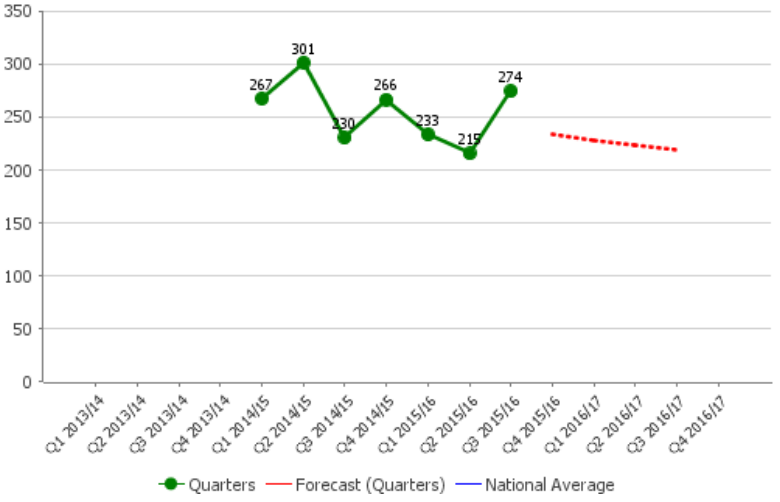
f) Number of patients having any delayed discharges encountered at RDaSH



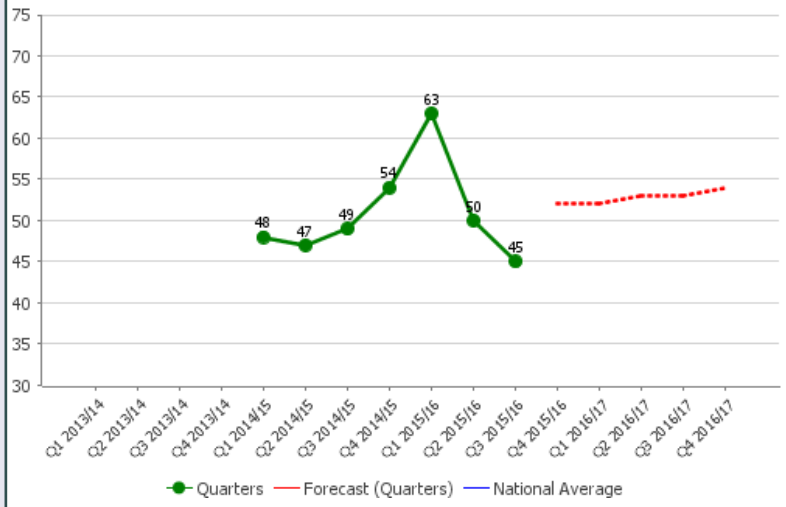
g) Attendances at A&E for people with dementia



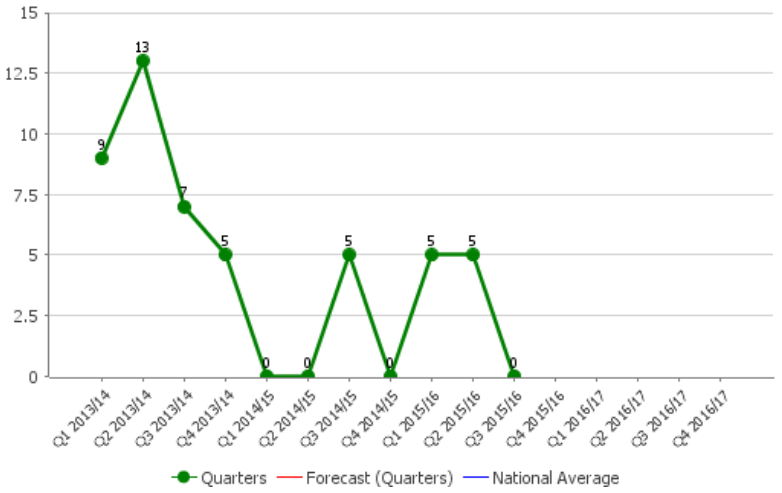
h) Number of people with dementia being admitted from care homes to DRI



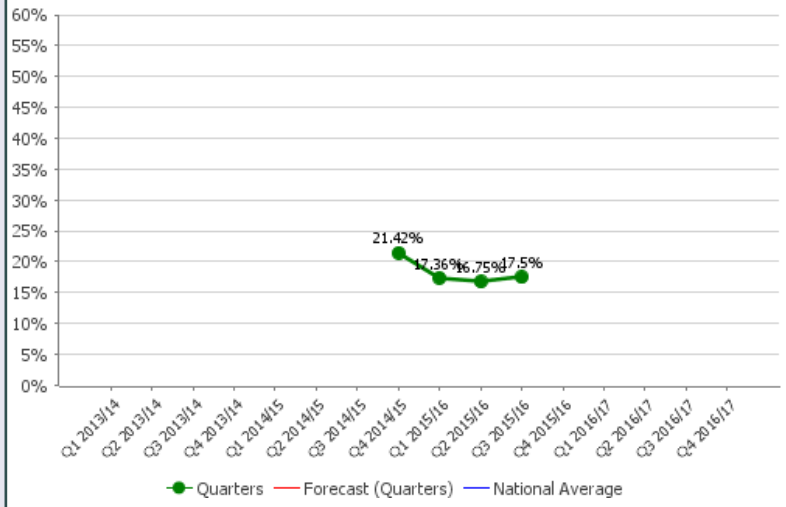
i) Number of Hospital deaths for patients with dementia



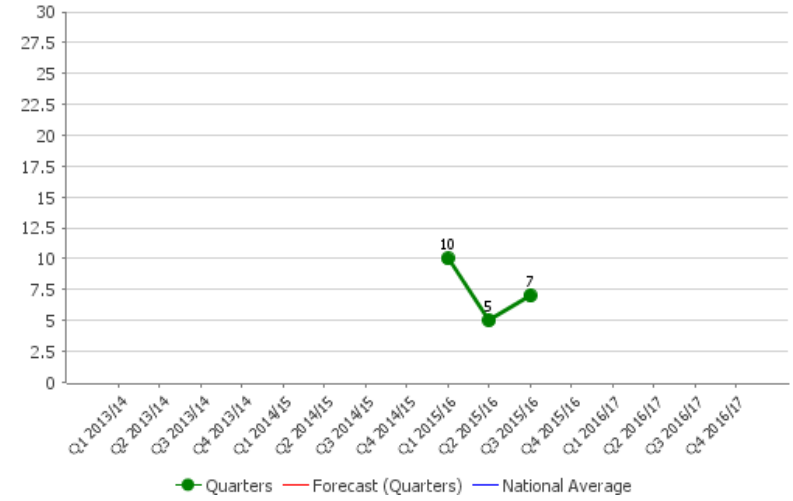
j) Unplanned episodes of Respite for people with Dementia



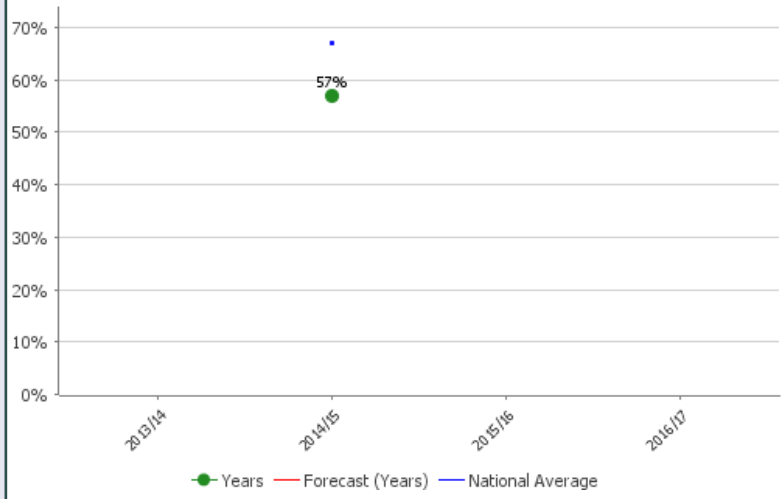
k) Proportion of referrals for Assistive Technology that are for people with Dementia (Q3 Provisional)



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



M) Proportion of People with dementia living at home



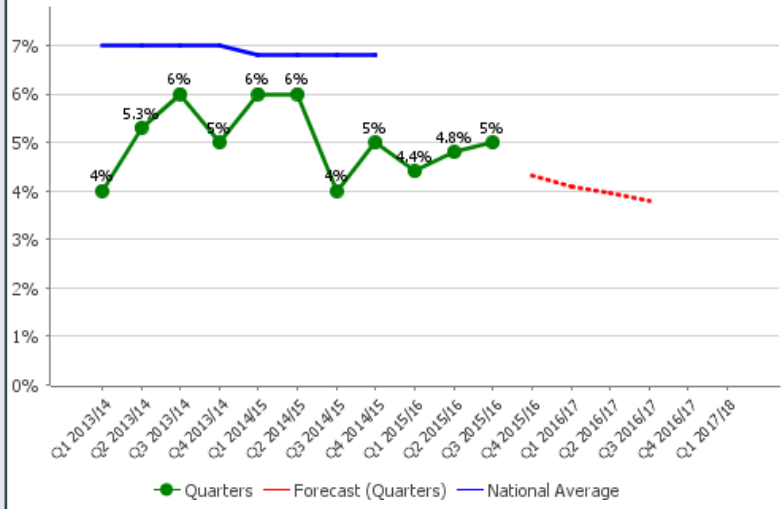
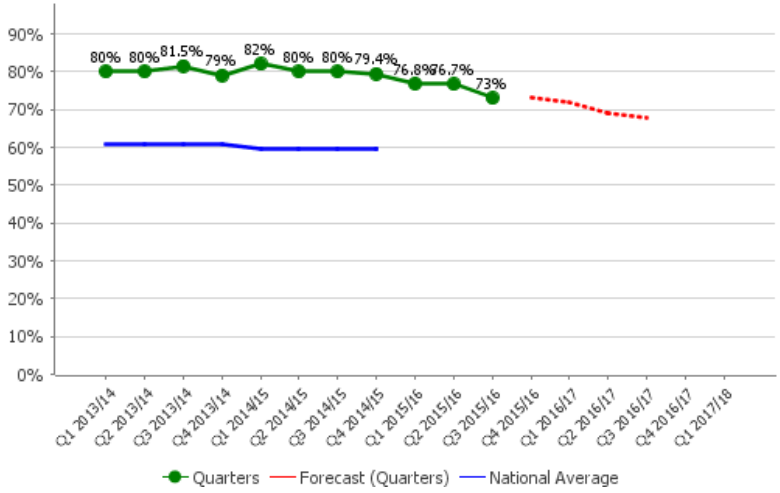
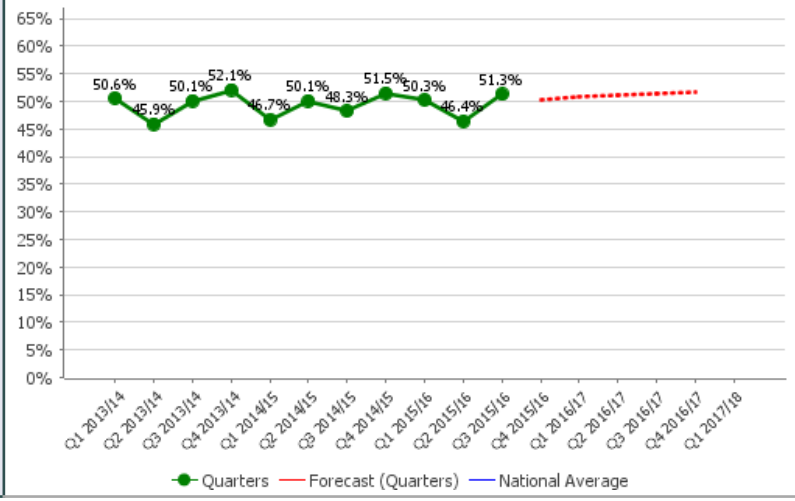
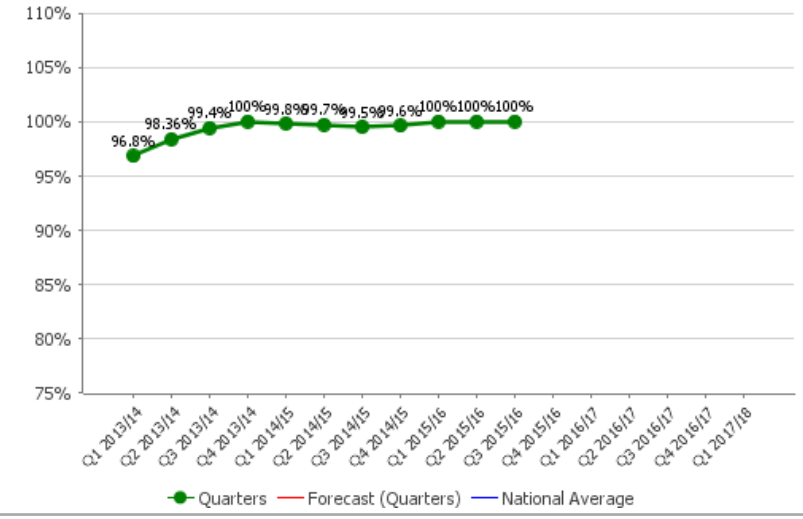
STORY BEHIND THE BASELINE

The measures capture the strategic direction of improving diagnosis rates, reducing inequalities and supporting people to live well with dementia by preventing crisis and helping people to be in control of their lives. The key significant highlight is that Doncaster's dementia diagnosis rate is now well over the national ambition of 67%. Having a diagnostic rate of 73.9% leaves an unknown gap of around 900-950. By being able to identify people with dementia results in 2 key outcomes; firstly it enables people with dementia and their carers to access the right services and support and secondly assists commissioners to identify more accurately activity in the health and social care system so improvements can be made. This maybe a contributory factor for the increase in acute activity (referrals and A&E) in Q3, but again this is a measure to note and monitor. Supporting carers is also a key ambition and measures show we are having some success.

ACTION PLAN

What we will achieve in 2015-16	What we will do next period
For 2015/16 the action plan will address the 5 Key Areas of Focus as presented in Dementia Strategy for Doncaster, Getting There, launched in March 2015. These are: • Raising Awareness and reducing stigma – Information, Advice and Signposting, • Assessment and Treatment, • Peri and Post Diagnostic Support, • Care Homes • End of Life. This will ensure we build on the success of 2014/15 but also address identified gaps and areas for improvement. This year the people of Doncaster will be able 1. to access reliable and consistent dementia information and support in a timely manner;	1. The "Doncaster Admiral Service" went live February 1st 2016 and will commence accepting referrals from February 29th. This will be a 14 month pilot, where partners working together, will ensure everyone with a diagnosis of dementia, living in Doncaster will have adequate support with a point of contact following diagnosis and discharge from acute services. The expectation here will be that the service has a significant impact on preventing acute activity and improving quality of life. This pilot will be independently evaluated. Formal launch of the service will be 16th March invites will be forwarded.

	2. there will be reduced variance in assessment and treatment pathways ensuring every referral receives an equal, timely and effective response; 3. there will be an integrated and co-ordinated support pathway/service for people with dementia and their carers/families before and after diagnosis; more people will live at home with dementia and be in control of their life/care, delaying the need for possible residential care ; 4. when people with dementia need residential care they receive high quality care locally 5. people with dementia will die with dignity and in a place of choice through planned empowerment.	

OUTCOME	Improve the mental health and well-being of the people of Doncaster ensures a focus is put on preventive services and the promotion of well-being for people of all age's access to effective services and promote sustained recovery.
INDICATORS	a)Proportion of adults in contact with secondary mental health services in paid employment 
	b) Proportion of adults in contact with secondary mental health services living independently, with or without support 
	c) Proportion of People Completing Treatment and Moving to Recovery 
	d) % of patients with agreed care pathway & treatment plans 

STORY BEHIND THE BASELINE	There is a slight downward trend for both the proportion of adults in secondary mental health accessing paid employment and also the proportion living independently, with or without support. The Paid employment measure is below the national and regional averages and has been so for some time. The proportion of people completing treatment and moving to recovery has increased this quarter. Each CCG nationally has received a sum of £11,000 which will be used to support CCGs in an IAPT waiting list initiative to achieve fully validated waiting lists and good operational processes in all IAPT services. CCGs have also been invited to apply for further funding of £6 million nationally, due to significant regional variations in services as evidenced by the waiting list clearance times. NHS Doncaster has submitted a bid along with proposals for improvements.	
ACTION PLAN	**What we will achieve in 2015-16**	**What we will do next period**
	1. Continue to implement the recommendations of the Mental Health Review and by doing so, support the delivery of the National Mental Health Agenda: Continue the development and implementation of the Mental Health Development Programme and pathway redesigns – 3 year development programme (currently in year one) a. Crisis and acute care pathway b. Secondary Care & Community Teams i. Personality Disorder ii. Perinatal Mental Health iii. Eating Disorders iv. Attention Deficit Hyperactivity Disorder 2. Collaborate with Public Health to ensure that the Joint Strategic Needs Assessment has a strong focus on mental health and physical wellbeing 3. Implement the local Crisis Care Concordat Action Plan with regular progress reports to the Health & Wellbeing Board	1. Present the Summary Progress Report on the Doncaster Crisis Care Concordat Action Plan to the Health & Wellbeing Board 2. Redesign of the Eating Disorders pathway which will be combined with the new children's planning guidance for improving access for young adults to rapidly access Eating Disorder services locally 3. Redesign of the Attention Deficit Disorder pathway for young people in transition to adult secondary care services and support general practice to manage people in the community who have ADHD 4. The National Guidance for improved Access to Early Intervention in Psychosis has been published and Doncaster CCG will be working with RDASH to improve access response to 2 weeks from referral. 5. Support the development of a Psychiatric Liaison Service between RDASH and DBHFT.

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Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No. 9
3rd March 2016

Subject: DONCASTER LIBRARIES AND CULTURE SUPPORTING WELLBEING

Presented by: NICK STOPFORTH

Purpose of bringing this report to the Board	
Decision	
Recommendation to Full Council	
Endorsement	
Information	Regarding a future library strategy which integrates with Health and Wellbeing priorities within the Council and for its partners

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

How will this contribute to improving health and wellbeing in Doncaster?
The library service, and wider cultural resources, play an important role within the borough to provide free, accessible information, interventions and experiences which help improve people's lives. This presentation will document activities and engagement which has taken to place, and asks for consideration as to how libraries and cultural services can perform a wider function within the borough, in a more strategic way in future, to demonstrate a place within broader strategic objectives, demonstrating vfm, excellence in resources and experiences, and strong partnership working.

Recommendations
The Board is asked to:- make recommendations as to how a strategy for libraries and cultural services may incorporate and develop a focus on health and wellbeing for the public in Doncaster in future.

Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board
Agenda Item No. 10

3rd March 2016

Subject: Health Protection Assurance Annual Report for 2015/16

Presented by: Victor Joseph (Consultant in Public Health) and Sarah Smith (Public Health Specialty Registrar)

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

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

How will this contribute to improving health and wellbeing in Doncaster?
Health protection is one of the three public health pillars: it contributes to protecting the health of the people of Doncaster from threats resulting from communicable diseases and environmental hazards such as chemicals and radiation.

Recommendations
The Board is asked to:- 1. Note and comment on the Report. 2. Support recommendations for HWBB outlined in the Health Protection Report

Agenda Item 10
3rd March 2016

To the Chair and Members of the
HEALTH AND WELLBEING BOARD

HEALTH PROTECTION ASSURANCE ANNUAL REPORT FOR 2015/16

EXECUTIVE SUMMARY

1. This is the first Health Protection report to the Doncaster Health and Wellbeing Board since the responsibility of Health Protection moved to the local authority following the introduction of the Health and Social Care Act (2012).

2. This report has been developed taking into account best practice and guidance on health protection, including evidence from:
   a. The Centre for Public Scrutiny
   b. The Department of Health statement on assurance;
   c. The Developing Excellence in Local Public Health, with a focus on the health protection component (a tool developed by Public Health Directors in Yorkshire and the Humber);
   d. The Health Protection reports to Doncaster Health Protection Assurance Group.

3. As part of the Health and Social Care Act (2012), the organisations that were established are now coming into their third year of existence. They include Clinical Commissioning Groups, NHS England, and Public Health England. The roles of these organisations and that of Public Health in the Local Authorities are becoming clearer. However, there are areas that require on-going clarifications between and among the agencies

4. There has been sustained progress in ensuring that the health protection assurance system in Doncaster is robust, safe, effective, and meets the new statutory duty placed on local government to protect the health of the people of Doncaster. This has been achieved through the meeting of the Health Protection Assurance Group that provides assurance on various elements of health protection.

5. An annual Health Protection report has been presented since 2013/14 to the Health and Adult Social Care Overview & Scrutiny Panel. Prior to the Scrutiny Panel meeting in the first year (2013/2014), a series of 10 health protection scrutiny questions were agreed with the Chair and Vice Chair of the panel. Two more questions have since been added; one on performance of health protection against the Public Health Outcomes Framework and the second on smoking. This makes a total of 12 questions, updates on these 12 questions are provided in this report.

6. This report is structured as follows:

a. Background
b. Updates on the 12 areas of health protection including:
    i. Current progress for Doncaster
    ii. Update on actions set for 2015/16
    iii. Recommendations for future health protection work – identified through progress on previous actions and through the Health Protection Assurance Group.

EXEMPT INFORMATION

7. None

RECOMMENDATIONS

8. The Health and Wellbeing Board is asked to:

- **Note** and comment on the progress made against areas identified for development in 2015/16; and note update on assurance of health protection system in Doncaster
- **Support** the recommendations made in the report.

a. BACKGROUND

9. Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation.

The Responsibilities for Local Authorities in relation to Public Health

10. The new responsibilities of the Local Authorities for Public Health functions (including health protection) since 1 April 2013 are underpinned by legislation under the Health and Social Care Act 2012. There are also associated Regulations - Regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, made under section 6C of the National Health Service Act 2006. This is in addition to the existing health protection functions and statutory powers delegated to Local Authorities under the Public Health (Control of Disease) Act (1984), the Health and Social Care Act (2008), the Health and Safety at Work Act (1974) and the Food Safety Act (1990).

11. The Secretary of State (SoS) for Health has the overarching duty to protect the health of the population. This duty is generally discharged by the SoS to Public Health England (PHE).

12. According to the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, the Local Authority Director of Public Health (DPH) has responsibility for strategic leadership of health protection in a unitary/upper tier authority. This should be exercised by:

- Chairing a local Health Protection Committee (accountable to the Health and Wellbeing Board);

- Preparing a multi-agency health protection agreement and forward plan.

The DPH, on behalf of their Local Authority, should be absolutely assured that the arrangements to protect the health of their local communities are robust and are implemented appropriately.

What is meant by health protection?

13. The scope of health protection is broad. The scale of work undertaken by local government to prevent and manage threats to health will be driven by the health risks in the Local Authority area. The key areas of health protection are:

- Emergency preparedness, resilience and response (EPRR)
- Communicable diseases management, including Tuberculosis (TB) and Hepatitis
- Management of other health protection Incidents e.g.
  - Environmental hazards
  - Chemical, biological, radiological, nuclear (CBRN) and terrorist incidents
- Infection prevention and control (IPC) in health and social care, including healthcare acquired infections (HCAI), communicable disease and infection prevention and control standards in community settings;
- Screening
- Immunisation including routine and targeted programmes
- Contraception and Sexual Health
- Surveillance, Alerting and Tracking
- Port Health (e.g. airport health)

There are areas of health improvement that overlap with health protection. They include the following:

- Suicide prevention
- Drugs and substance misuse (in relation to infection with blood-borne viruses)
- Smoking (protection of the public from harm of tobacco).

Who else is responsible for health protection?

14. In addition to the Local Authority, there are a number of agencies which exercise health protection functions in relation to the borough either as a commissioner or provider. The key agencies include:

- Public Health England: Communicable disease control, Infection prevention and control, environmental, chemical, biological, radiological, nuclear, terrorist hazards/incidents; health improvement, and healthcare Public Health.
- Doncaster Clinical Commissioning Group: Infection prevention and control (in hospitals), immunisation, communicable disease control, screening.

- NHS England Local Area Team: Screening and Immunisation Programmes.
- Health care providers; General practice, pharmacies, Doncaster and Bassetlaw NHS Foundation Trust, Rotherham Doncaster and South Humberside NHS Foundation Trust.

15. The 6C Regulations require each Local Authority to;

"….provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority's area, with a view to promoting the preparation of appropriate local health protection arrangements, or the participation in such arrangements by that person or body".

Monitoring and Assurance

16. At a national level, within the new Public Health Outcomes Framework (PHOF), there is a health protection domain. Within that domain there is a placeholder indicator; *'Comprehensive, agreed inter-agency plans for responding to Public Health incidents.'* Public Health England measures progress by Local Authorities against this indicator. Doncaster has fully met this requirement (100%) for the year 2015/16 (compared with 92.3% for Yorkshire and the Humber Region, and 95.2% for England).

17. At a sub-regional there is a Local Health Resilience Partnership, chaired by a representative of the Directors of Public Health in South Yorkshire, and a Screening and Immunisation Advisory Board chaired by NHS England.

18. At a local level the Health Protection Assurance Group reports to the local Health and Wellbeing Board. Health Protection reports are also submitted to the Public Health Governance group (within the Public Health Team in DMBC) on a regular basis. The Health Protection Assurance Group meets quarterly and is chaired by a Consultant in Public Health.

19. Overview and scrutiny of the new health protection functions in DMBC is provided by the Health & Adults Social Care Overview and Scrutiny Panel on an annual basis.

b. SCRUTINISING DMBC's HEALTH PROTECTION FUNCTIONS

Q1. Does the Local Authority have a clear understanding of the pathways and providers involved in the delivery of health protection in Doncaster?

20. Pathways: There are a number of pathways involved in the delivery of health protection in Doncaster. They include the following:
    a) Routine activities, which encompass:
        1. Routine delivery and surveillance of vaccination and screening programmes.
        2. Infection Prevention and Control (IPC). Monitoring of HCAI cases, and IPC activity in hospitals commissioned by Doncaster CCG.
        3. Community IPC. Provided by RDaSH, commissioned by DMBC.

4. Disease surveillance by Public Health England e.g. Meningitis, Mumps etc.
5. Community TB service. Provided by RDASH, commissioned by Doncaster CCG.
6. Drugs and substance misuse service. Delivered by RDaSH, commissioned by DMBC.
7. Sexual Health Service provided by primary care and secondary care providers, commissioned by DMBC

b) Outbreaks and emergencies: activity undertaken in response to health protection incidents (may involve multi-agencies).

1. Outbreak reporting e.g. norovirus, measles etc.;
2. Escalation systems – see question 7 for more detail;
3. Targeted Vaccination programmes e.g. MMR catch up.

c) Future planning: Activity undertaken to plan for potential future health protection incidents.

1. Emergency plans e.g. Pandemic Influenza, Cold Weather, Heat Wave etc., Public Health contribution to DMBC Corporate Emergency plan;
2. Business continuity.

Question 1.
PROGRESS ON 2015/16 ACTIONS
None identified
RECOMMENDATIONS
• Further work could be undertaken to raise the profile of Health Protection and how this integrates with other functions across the local authority.

Q2. What are the local governance structures and responsibilities for Health Protection in the Borough?

Providers

21. Table 1 provides an overview of the agencies involved in Health Protection in Doncaster and what their responsibilities are.

Table 1 Providers involved in the health protection system in Doncaster during 2015/16 and their key roles.

Agency	Roles and responsibilities	Lead Officer
Doncaster Metropolitan Borough Council	Overall assurance of the Health Protection System, Emergency Planning, Resilience and Response. Environmental Health	Dr Rupert Suckling, Director of Public Health Peter Dale, Director of Regeneration and Environment
	Commissioning of community infection prevention and control	Dr Rupert Suckling, Director of Public Health; Victor Joseph, Consultant in Public Health
Public Health England	Communicable disease control and monitoring, expert advice on environmental, chemical, biological and radiation hazards, HCAI monitoring.	June Chambers, Senior Health Protection Specialist/Lead Nurse, South Yorkshire Team, Public Health England
NHS England Local Area Team	Commissioning routine vaccination, immunisation and screening programmes, commissioning primary care, responsibility for some closed communities, e.g. prisons Emergency planning	Fiona Jorden, Consultant in Public Health
Doncaster CCG	A duty to make available to LAs, CCG services or facilities so far as is reasonably necessary to enable LAs to discharge their functions relating to social services, education and Public Health HCAI monitoring and control, commissioning secondary care services, infection control commissioning (hospital)	Wendy Feirn, Senior Nurse / Clinical Commissioner – Quality & Patient Safety
Primary Care Providers	Reporting notifiable diseases, administering vaccination and screening programmes	GPs
Secondary Care Providers	Managing HCAI's, responding to emergencies, communicable disease notification and control	DBHFT – Director of Infection Prevention and Control; RDASH; YAS – Head of Safety.
Voluntary Sector Organisations	Infection Prevention Control where applicable	Lead Manager/staff

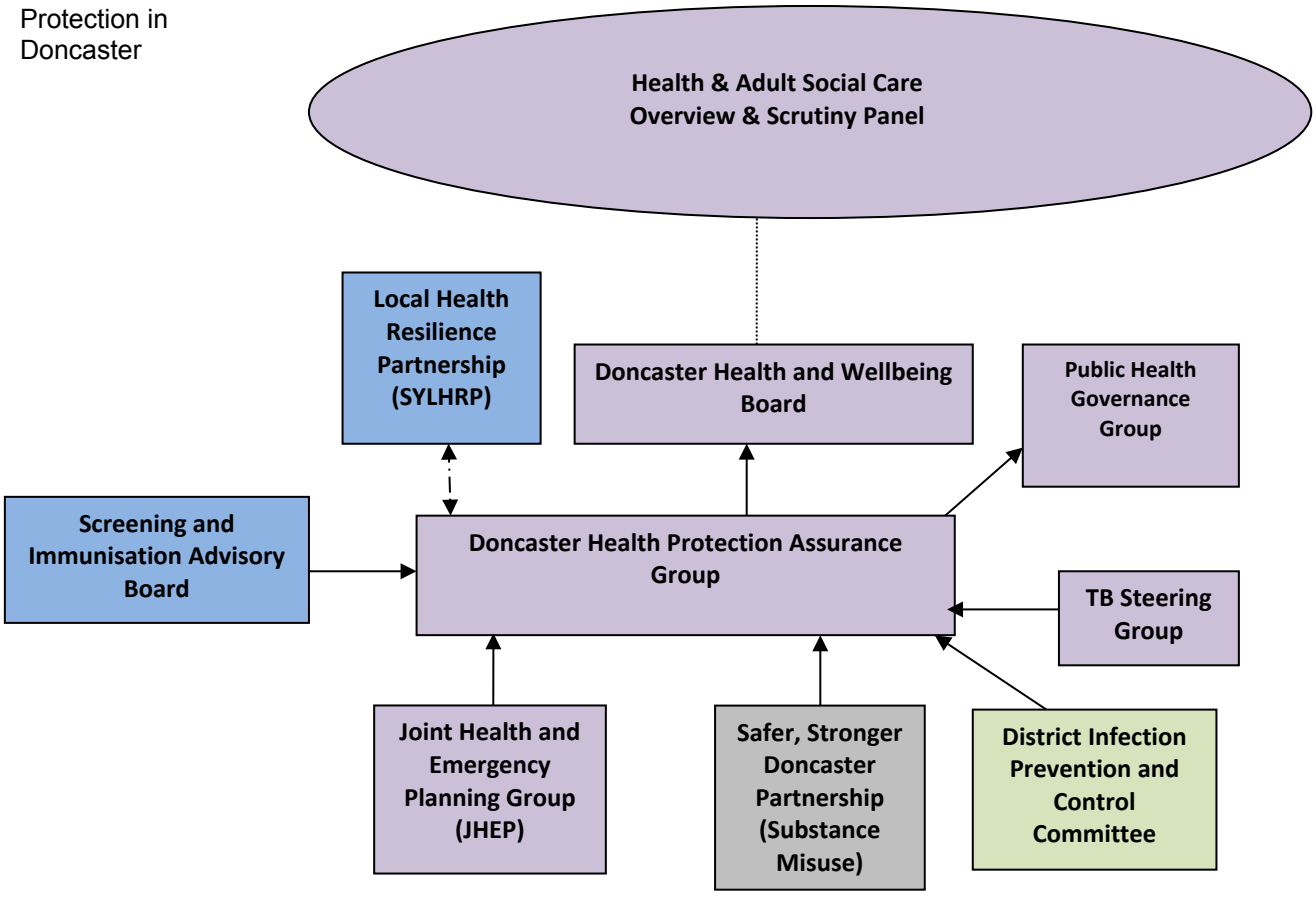
Governance Structures

22. The Doncaster Health Protection Assurance Group (HPAG) is the key group that is responsible for receiving assurance from a range of local and sub-regional committees involved in health protection. The HPAG provides

assurance to the Doncaster Health and Wellbeing Board and the DMBC Public Health Governance group.

Figure 1 below sets out the governance structures for health protection in Doncaster.

Figure 1: Governance Structures for Health Protection in Doncaster



= Convened by NHS England Local Area Team

= Convened by DMBC → = Provides assurance to…

= Convened by Doncaster CCG ←··→ = Provides information to…

= Convened by South Yorkshire Police

All of the above groups are multi-agency. A full list of the membership for the HPAG is included in Appendix 1 of this paper (Terms of Reference).

23. In terms of monitoring arrangements for health protection, a report is produced regularly (quarterly) to the Public Health Governance Group using an agreed standard template on health protection assurance during each quarter. There is also an agreed system of exception reporting to the Health and Wellbeing

Board in the event that a health protection incident should occur between statement periods.

Question 2.	
PROGRESS ON 2015/16 ACTIONS	
Health Protection to be included as a standing item on Health & Wellbeing Board meetings. This will demonstrate the strategic importance of health protection agenda.	An annual report on health protection will be presented to Health protection will be on Health and Wellbeing Board on 4th March 2016, and annually thereafter. A survey of practice in a number of local authorities in the region showed that majority of Health and Wellbeing Boards receive health protection report once a year.
RECOMMENDATIONS	
• Review the roles and responsibilities for organisations involved in the District Infection Prevention and Control Committee	

Q3. Are clear, up to date SLA's/MOU's in place between the Local Authority and all partner agencies involved in the local health protection system?

24. Existing agreements or MOU between DMBC and partner agencies have been maintained. These include:

- An MOU between DMBC and Doncaster CCG;
- A 'Local Ways of Working Agreement' between DMBC, PHE and NHS England;
- The Local Health Resilience Partnership (LHRP) has signed agreements in place with each NHS organisation across South Yorkshire.

25. As part of the changes in health protection on-call arrangements, PHE now runs its own health protection on-call system; Public Health Consultants employed by Local Authorities no longer take part in this on-call system. Instead, each Local Authority has its own on-call arrangements.

26. 'Ways of Working Agreement' between PHE and Local Authorities at a national level has not been agreed due to re-organisation and re-structuring within PHE. It is expected that this is still on going.

27. The mechanisms for the review of Memorandum of Understandings (MOUs) / agreements are carried out through existing mechanisms e.g. partnership meetings and business processes.

Question 3.
PROGRESS ON 2015/16 ACTIONS
• None identified
RECOMMENDATIONS
• None identified

Q4. How well does DMBC understand the potential and existing risks to health in the borough, and how do we ensure that partners also know and understand?

28. We have maintained a health protection assurance framework to update on health protection risks in Doncaster over the year.

29. In addition, there is a system for receiving timely surveillance and alert information from PHE, both at national and sub-regional levels by Public Health officers in the Council. For example, through the South Yorkshire PHE Team, a regular daily situational report is provided to the Local Authority and this information is also cascaded to partner organisations in Doncaster for information and action where appropriate. They include information on outbreaks of infectious diseases in Doncaster.

30. Through the quarterly Health Protection Assurance Group, a report is received on individual elements of health protection from the lead officer for the area e.g. sexual health, vaccination, screening, infection prevention and control, etc. The report covers key risks in the subject area, and what is being done to address them. A forward plan containing all elements of health protection is in place, and all the elements are discussed in the course of the year.

31. As part of the process of managing potential risks, there is an on-going process of EPRR in relation to health protection. The following plans were reviewed and updated in 2015/16:
    - Pandemic Influenza;
    - Heat Wave;
    - Cold weather;
    - Multi-agency outbreak plan
    - The Management of Sexually Transmitted Infection (STI) Outbreaks and Incidents in Doncaster

32. There are areas still for further development, which include:

    - Mass Treatment plan: these are on-going pieces of work with health partners across Doncaster being undertaken through the Joint Health and Emergency Planning Group (JHEPG).

33. A South Yorkshire Health Protection local Memorandum of Understanding for roles and responsibilities in health protection incidents and emergencies was has agreed through the LHRP and is in place.

Question 4.	
PROGRESS ON 2015/16 ACTIONS	
Develop the Mass Treatment plan for Doncaster	Work is in progress to develop this. A multi-agency plan has been drafted through JHEPG.
Develop a multi-agency outbreak plan.	This has been developed and signed off.
RECOMMENDATIONS	
• Continue work on the Mass Treatment plan for Doncaster	

Q5. What system is in place to provide assurance to the DPH, on behalf of the Local Authority, that arrangements to protect the health of the people of Doncaster are robust and being implemented appropriately?

34. The Health Protection Assurance Group (HPAG) continues to meet at quarterly intervals and it receives assurance that health protection duties are discharged effectively in the borough from various groups, as described in Figure 1. The terms of reference of HPAG can be found in Appendix 1. The HPAG regularly receives information and reports on a range of health protection areas. The Chair of the HPAG provides a regular report to Public Health Governance Group meetings on health protection matters in the borough. The Public Health Governance Group is chaired by the DPH.

35. The Health Protection Assurance Framework continues to provide a comprehensive tool to manage risks across all areas of health protection. This document is owned by the HPAG and regularly reviewed. There is an active programme of risk management in place.

36. The DMBC Scrutiny Committee also has a key role in assuring the health protection system by taking an overview and scrutinising the systems and procedures in place to ensure that they are, and will remain, fit for purpose. This is the third year the DMBC Scrutiny panel will receive an annual report on health protection functions in the borough.

37. A national TB control strategy for England was published in January 2015. This emphasises the need for local work in order to realise the Governments long-term ambition of eliminating TB as a Public Health problem by 2050. New NICE guidance on the management of TB was published in January 2016. Therefore, an updated TB strategy for Doncaster is needed to incorporate national strategy and guidance.

38. During the course of the year, a self-assessment exercise has been undertaken, using a regional tool (Delivering Excellence in Local Public Health).

The health protection section was completed for Doncaster, and an action plan developed to guide improvement to protect the health of the people of Doncaster.

Question 5.	
PROGRESS ON 2015/16 ACTIONS	
In view of membership changes to the Health Protection assurance group. The membership of the group should be reviewed to ensure the appropriate level of staff is represented on the group.	Membership of the Health Protection Assurance Group has been reviewed by Public Health Governance Group.
Continual review of the function of the Health Protection Assurance Group should be carried out.	The Public Health Governance Group reviewed the function of the Health Protection Assurance Group and it was felt it should continue as it is.
Review local TB strategy (plan) and services in light of national TB strategy for England.	The local TB strategy is currently being reviewed, along with service specifications, in consultation with relevant partners. This is expected to be completed by March 2016.
RECOMMENDATIONS	
Complete and get sign-off of Doncaster TB strategy and service specifications in view of new national TB strategy and NICE guidance	

Q6. Is DMBC assured that the system can respond appropriately in the event of an outbreak/incident?

Emergency Plans

39. There are a range of multi-agency contingency plans in place, along with strategic agreements allowing agencies and organisations to work together. Plans are tested through exercises and actual incidents, and multi-agency groups are in place which allows learning from each other. Multi-agency plans held by South Yorkshire Local Health Resilience Partnership (SY LHRP) are in place, or in development, for across the South Yorkshire region, and assurance is also sought through this group for across South Yorkshire.

40. Internal to the Council, PH input has been made into the DMBC Corporate Emergency Plan as part of its annual review, ensuring the ability of DMBC specifically to respond. Joint plans have been developed between PH and DMBC Resilience and Emergency Planning for events such as Pandemic Flu,

and these compliment multi agency plans developed by the LHRP, and the Local Resilience Forum (LRF), as appropriate.

41. Assurance on plans and the ability to respond in Doncaster is sought through the JHEP group which has representatives from across the local health community. The overall aim of this group is to provide the main local strategic focus for health sector emergency planning and resilience to ensure a co-ordinated approach in EPRR locally.

Testing the System

42. The system remains vigilant in ensuring that plans in place are regularly tested and lessons learnt from them. Lessons identified from exercises are shared at multi-agency meetings by those who attended, for members across the system to be aware of any issues/areas that need addressing and further attention. On-call systems, both internal to DMBC and wider are regularly tested during real incidents and exercises.

Learning from Experience

43. The system continues to learn from real events in order to improve response to future events.

Infection Prevention and Control

44. IPC specifications are embedded in contracts of all relevant LA commissioned services and an IPC standard paragraph is embedded in all relevant local authority contracts.

Question 6.	
PROGRESS ON 2015/16 ACTIONS	
Continue to review emergency plans as appropriate according to national and local guidance and ensure further testing of plans.	A review of emergency plans has been undertaken and tested. DMBC participated in a tactical level table top pandemic flu exercise (Exercise Alberio) held on a South Yorkshire level. Recommendations from this exercise have been incorporated into relevant plans.
Ensure there is an on-going approach to learning from experience and that issues identified from real events are acted upon.	Lessons learned from experience of incidents have been built into actions for future improvement.

RECOMMENDATIONS
•Continue to review contingency plans as appropriate according to national and local guidance, and ensure further testing response arrangements. •Ensure that there is an on-going approach to learning from experience and that issues identified from real events are acted upon.

Q7. What accountability structures would be used by the DPH to escalate health protection concerns as necessary, and can current arrangements ensure a timely response?

45. As described in Figure 1, there are established governance arrangements for managing and escalating health protection concerns in Doncaster. If a health protection incident could not be managed within Doncaster the DPH could escalate concerns to other key groups and agencies including the LHRP and PHE. The HPAG can also escalate concerns through the Public Health Governance Group, which in turn can ensure that risks are placed onto the DMBC corporate risk register as necessary. These arrangements remain active and are working well. They are embedded in the relevant governance structures such as Public Health Governance Group and HPAG.

Question 7.
PROGRESS ON 2015/16 ACTIONS
• None identified
RECOMMENDATIONS
• None identified

Q8. What arrangements are in place to manage cross-border incidents and outbreaks?

46. There are plans in place and under review/development that take into account cross border incidents and outbreaks that are held by the SYLHRP e.g. pandemic influenza. PHE is the key link to support management of cross border outbreaks and incidents. They will notify DMBC and other local authorities as necessary, and would establish cross-border incident/outbreak meetings as required.

47. In addition, arrangement for the management of TB cases in secondary care, in both Doncaster and Bassetlaw is being delivered by the same trust. Through the local TB Steering Group, we have included members from Bassetlaw to ensure the pathway of care is standardised between the two areas. This arrangement is captured in the terms of reference of Doncaster's TB Steering Group.

Question 8.
PROGRESS ON 2015/16 ACTIONS
• None identified
RECOMMENDATIONS
• None identified

Q9. How are we developing new joint working arrangements between Public Health / the wider health protection system and environmental health within DMBC?

48. Environmental health is part of the Health Protection Assurance framework. There has been extensive work on the framework with collaboration and contribution from staff from across the DMBC directorates, in particular Regeneration and Environment. Risks will be reviewed on a regular basis. There has been more integration between PH Health Protection functions and environmental health which will continue to develop. Joint plans have been developed with each directorate to allow for joint working where appropriate and where beneficial. This also applies to environmental health issues.

49. Since the move of Public Health into DMBC, EPRR plans have been harmonised and are being jointly updated and produced together with the Resilience and Emergency Planning team. Examples of these include the Heat Wave Plan, Pandemic Flu Contingency Plan, and Cold Weather Plan. These have been prioritised based on the perceived risk from the SY risk register, and timed to new national guidance being issued. This is particularly relevant to the new structure of the health system. Joint work priorities/plans have been developed between Public Health and the Resilience and Emergency Planning team to highlight what needs to be developed next e.g. Mass Vaccination.

50. Public Health has worked with the air quality team to develop a process for issuing joint warnings about fluctuations in air quality that could have an impact on health, specifically respiratory health. This includes factsheets and information being shared with health partners and schools, amongst others. Information and advice will also be shared with the public through the use of social media. Public Health and the air quality team meet on a regular basis to review progress and identify further opportunities for joint working.

51. The HPAG has representatives from across health protection system including DMBC Environmental Health/Environmental Protection, Public Health England, DBHFT, Doncaster CCG and DMBC Public Health. This allows for regular updates from all areas responsible for health protection and enables joint working where appropriate through developing stronger working relationships. The purpose of the HPAG is to ensure co-ordinated action across all sectors to protect the health of the people of Doncaster from health threats, including major emergencies.

Question 9	
PROGRESS ON 2015/16 ACTIONS	
Continue to strengthen and develop existing joint working between Public Health and Environmental Health as a whole.	There is continued joint work between Public Health and Environmental health on a range of health protection areas, including air quality, control of infectious diseases, tobacco control, and EPRR. We envisage this collaborative work will continue into the future.
RECOMMENDATIONS	
•Continue to strengthen and develop existing joint working between Public Health and Environmental Health as a whole.	

Q10. What formal agreements are in place between PHE and DMBC to determine the specialist health protection support, advice and services PHE will provide to DMBC?

52. The following agreements remain in force between DMBC and partner agencies. These include:

- An MOU between DMBC and Doncaster CCG;
- A South Yorkshire Health Protection Local Memorandum of Understanding for roles and responsibilities in health protection; the Local Health Resilience Partnership (LHRP) has signed agreements in place with each NHS organisation across South Yorkshire.

53. However, PHE now runs its own health protection on-call system, without the input of Local Authority Public Health Consultants.

54. It is uncertain whether or not there will be national guidance on “Ways of Working”, however, local arrangements are in place.

Question 10.
PROGRESS ON 2015/16 ACTIONS
• None identified
RECOMMENDATIONS
• None identified

Q11. How is Doncaster performing in relation to health protection matters?

55. Doncaster generally performs well in relation to Health Protection. Doncaster is meeting national targets in 13 out of 15 indicators and performing significantly better than the England average in a further two indicators. Details of the performance against the health protection indicators of the Public Health outcome framework (PHOF) are shown in Table 2 below.

Table 2: Public Health Outcomes Framework Immunisation Indicators
[1] (Based on Published PHOF by Public Health England, 10th February 2016)

Indicator	Period	Doncaster value	England value	Target
Population vaccination coverage – Hepatitis B (1 year old) - %	2014/15	100*	N/a	N/A
Population vaccination coverage – Hepatitis B (2 years old) - %	2014/15	0*	N/a	N/A
Population vaccination coverage – DTAP/ IPV / HiB (1 year old) - %	2014/15	94.6*	94.2	*90%*
Population vaccination coverage – DTAP/ IPV / HiB (2 years old) - %	2014/15	96.7*	93.2	90%
Population vaccination coverage – MenC (Group C Meningooccal vaccine) %	2012/13	95.0*	93.9	90%
Population vaccination coverage – PCV (pneumoccal conjugate vaccine) %	2014/15	94.2*	93.9	*90%*
Population vaccination coverage – Hib / MenC booster (2 years old) %	2014/15	93.4.	92.1	*90%*
Population vaccination coverage – Hib / MenC booster (5 years old) %	2014/15	95.1	92.4	*90%*
Population vaccination coverage – PCV booster %	2014/15	93.7	92.2	*90%*
Population vaccination coverage – MMR for one dose (2 years old) %	2014/15	93.0	92.3	*90%*
Population vaccination coverage – MMR for one dose (5 years old) %	2014/15	94.5	94.4	*90%*
Population vaccination coverage – MMR for two doss (5 years old) %	2014/15	89.0	88.6	*90%*
Population vaccination coverage – HPV (Previous years) %	2013/14	90.0	86.7	*> previous years England average*
Population vaccination coverage – PPV (Pneumococcal Polysaccharide Vaccine) %	2014/15	71.4	69.8	*70%*
Population vaccination coverage – Flu	2014/15	73.4	72.7	*75%*

1. Source: http://www.phoutcomes.info/public-health-outcomes-framework#page/1/gid/1000043/pat/6/par/E12000003/ati/102/are/E08000017/iid/30101/age/230/sex/4

(aged 65+) %				
Population vaccination coverage – Flu (at risk individuals)	2014/15	51.4	50.3	*Better than England average*

56. The two indicators where Doncaster is not meeting the national target for immunisation are:

•Population vaccination coverage – MMR for two doses (5 years old):
Doncaster achieved 89.0% against a national target of 90% (WHO target). This is based on 2014/15 data in the Public Health Outcomes Framework. The 89.0% coverage rate for 2014/15 is however an increase on the coverage rate of 88.2% that Doncaster achieved in 2013/14.

•Population vaccination coverage – Flu (aged 65+)
Doncaster achieved 73.4% against a national target of 75% (WHO target). This is based on 2014/15 data in the Public Health Outcomes Framework. The 73.4% coverage rate for 2014/15 is however an increase on the coverage rate of 73.0% that Doncaster achieved in 2013/14; it is also the PHOF target.

Table 3: Public Health Outcomes Framework Screening Indicators
(Based on Published PHOF by Public Health England, 10th February 2016)

Indicator	Period	Doncaster value	England value	Target
Cancer screening coverage – breast cancer - %	2015	76.2	75.4	Significantly better than England average
Cancer screening coverage – cervical cancer - %	2015	75.6	73.5	Significantly better than England average
Cancer screening coverage – bowel cancer - %	2015	61.3	57.1	Significantly better than England average
New born bloodspot screening coverage - %	2014/15	94.8*	95.8	Significantly worse than England average
New born hearing screening coverage - %	2013/14	98.7	98.5	Not statistically different from the England average
Access to non-cancer screening programmes – diabetic retinopathy %	2012/13	88.6	79.1	Significantly better than England average
Abdominal aortic aneurysm Screening - %	2014/15	99.9	97.4	Significantly better than England average

*New born bloodspot screening achievements in Doncaster for 2015/16 quarter 2: 95.0% (PHOF acceptable level). Issues identified by NHS England related to timely receipt of specimen in to laboratory. NHS England is reviewing this.

57. Doncaster has performed well compared to the England average in measures for cancer screening, diabetic retinopathy and AAA screening. Performance on new born screening indicators could be improved.

Table 4: Public Health Outcomes Framework Smoking Indicators

(Based on Published PHOF by Public Health England, 10th February 2016)

Indicator	Period	Doncaster value	England value	Target
Smoking status at time of delivery - %	2014/15	20.5	11.4	Significantly worse than England average
Smoking prevalence at age 15 - current smokers (WAY survey) - %	2014/15	8.9	8.2	Not statistically different from the England average
Smoking prevalence at age 15 - regular smokers (WAY survey) - %	2014/15	6.8	5.5	Not statistically different from the England average
Smoking prevalence at age 15 - occasional smokers (WAY survey) - %	2014/15	2.1	2.7	Not statistically different from the England average
Smoking prevalence - %	2014	22.7	18.0	Significantly worse than England average
Smoking prevalence – routine and manual	2014	29.6	28.0	Not statistically different from the England average

58. Doncaster is significantly worse than the national average figure for women smoking at the time of delivery. This figure is a decrease from previous years, 22.1% in 2013/14 and 22.5% in 2012/13.

Overall smoking prevalence in Doncaster is significantly higher than the national average. The number of smokers in Doncaster decreased from 26.5% in 2010 to 21.4% in 2013. This number did increase to 22.7% in 2014.

Table 5: Public Health Outcomes Framework Other Health Protection Indicators

(Based on Published PHOF by Public Health England, 10th February 2016)

Indicator	Period	Doncaster value	England value	Target
Fraction of mortality attributable to particulate air pollution (PM2.5)	2013	5.7	5.3	*N/A*
Chlamydia detection rate (15-24 year olds) (per 100,000)	2014	2809	2012	*>2300*
People presenting with HIV at a late stage of infection - %	2012 -14	48	42.2	*25 – 50% average*
*Treatment completion for TB - %	2013	Not enough data	*N/A*	
Incidence of TB (rate per 100,000)	2012-14	7.7	13.5	*Better than England average*
NHS organisations with a board approved sustainable development management plan - %	2013-14	66.6	41.1	*N/A*
Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	2014/15	100	95.2	*N/A*

Note: TB treatment completion in Doncaster for 2015/16 was 89% (national target >85%)

59. Doncaster is meeting the national target for detection of Chlamydia and is average for the proportion of people presenting with HIV at a late stage of infection.

60. Doncaster's incidence of TB is significantly below the England average. An initiative aimed at reaching hard-to-reach groups, including black and minority ethnic (BME) groups. The initiative related to early identification of TB using the Health Bus that targeted asylum seekers and migrants in Doncaster town centre. The initiatives had been effective in identifying latent TB cases among those screened. It also enabled extension of the initiatives to other services like sexual health.

61. Doncaster is performing well in relation to the corporate management of Health Protection.

Question 11.	
PROGRESS ON 2015/16 ACTIONS	
Working with NHS England to improve areas of red performance: • Treatment completion for TB • Population vaccination coverage: ➢ MMR for two doses (5 years old) ➢ Flu (those aged >65years) Flu (at risk individuals)	Regular assurance meeting with NHS England and through Health Protection Assurance Group were held during the year to review performance of health protection related to screening and immunisations (MMR and Flu vaccination). Reviewed outcomes for TB treatment completion (Quarter 2 of 2015/16 showed that treatment completion was 89%, above the national target of 85%>
To review KPIs for Health Protection as outlined in the Public Health Outcomes Framework to determine Doncaster's national position.	Performance of health protection was reviewed quarterly through Health Protection Assurance Group, and Public Health Governance Group. Additional performance metrics have been considered in this report to account for the wider remit of Health Protection.
RECOMMENDATIONS	
•Work with NHS England to improve areas of performance where Doncaster is not meeting national targets. •Review performance indicators to determine the measure are relevant to Health Protection.	

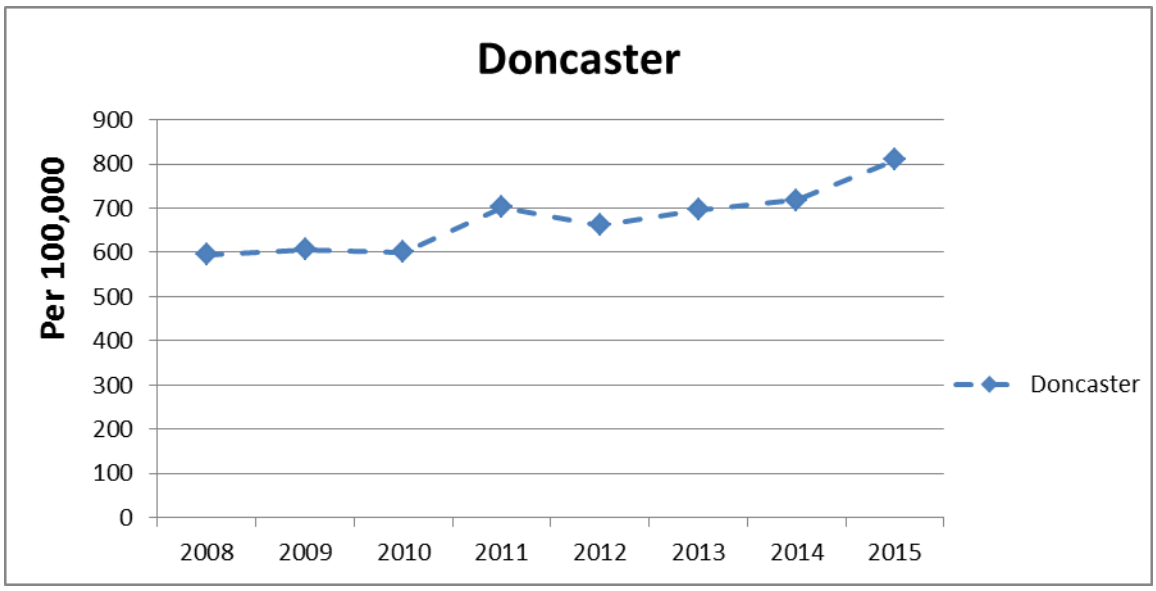
Q12. How effective are the interventions on smoking in Doncaster to protect the health of the local population?

62. Smoking is a major Public Health problem in Doncaster. Currently, 22.7% of adults aged 18 years and over smoke in Doncaster, compared with 20.1% in Yorkshire and Humber and 18% England. This equates to around 54,000 adults who smoke.

The rate of people dying from smoke related conditions in Doncaster (389.8 per 100,000) is worse than that seen in the country (288.7 per 100,000 for England). This equates to more than 1,900 deaths between the years 2011-2013 in Doncaster. Equally, Doncaster is one of the worse areas compared to England's rates in relation to hospital admissions that can be attributed to smoking (Doncaster: 1819 versus 1420 per 100,000 for England). There are

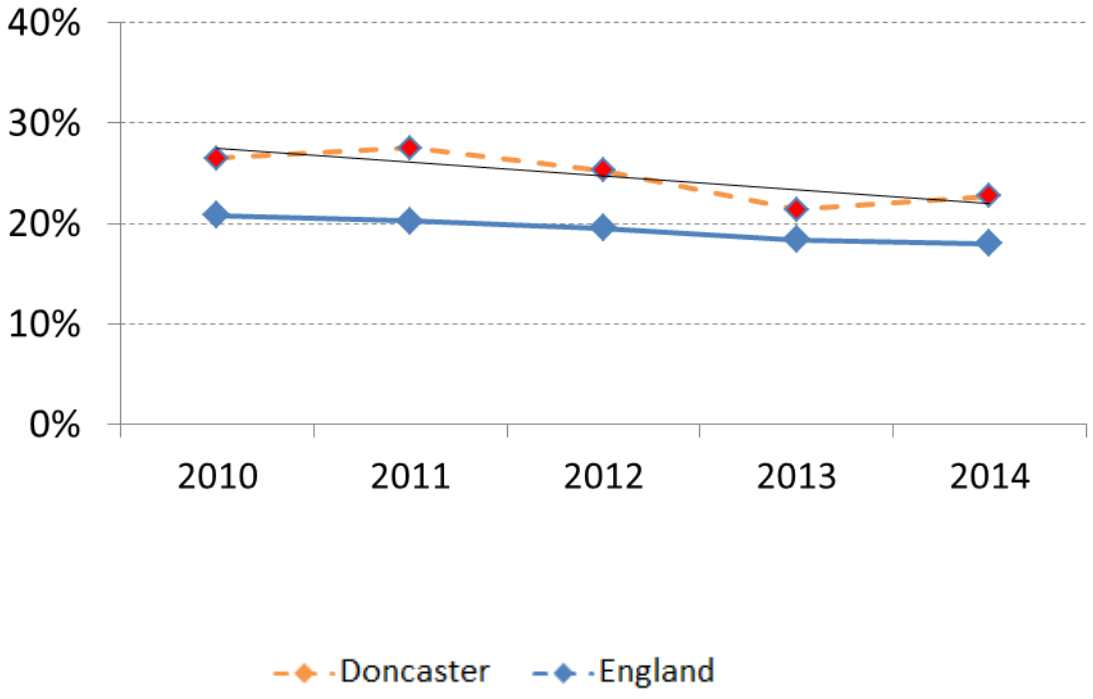
172,000 people aged 35 years and over admitted to hospital in Doncaster from smoking related causes each year and the trend is increasing (Figure).

Figure: Emergency hospital admissions for Respiratory infections among adults in Doncaster



63. There is some indication that the prevalence rate of smoking among adults aged 18 years and over is falling, and it currently stands at 22.7%, based on 2014 data (down from 26.3% in 2011), see Figure below.

Figure: Smoking prevalence among adults aged 18 years and over - % of current smokers in the Household Survey for England: 2010-2014. (Source: PHE, Local Tobacco Control Profiles.)



64. Responding to this challenge, the Council has reviewed the approach to commissioning services to address smoking and has currently got a range of service contracts in place. Stopping smoking services are commissioned for the whole population and to targeted groups including pregnant women.

65. Doncaster Council has commissioned social marketing campaigns, which targeted illicit tobacco and smoking in pregnant women. Health campaigns have been carried out based on intelligence gathered on these groups. In addition to this a regional TV campaign was launched on 1 February for a month, focusing on raising public awareness of 16 cancers linked to smoking.

66. Doncaster Council signed a Tobacco Declaration in March 2015. This is a public statement of commitment that we are working to reduce the prevalence of smoking in Doncaster.

Illicit tobacco remains one of the major areas of public health interventions in reducing the prevalence of smoking in Doncaster. Since April 2015, there had been 85,000 cigarettes and 45kg of hand rolling tobacco seized by the Trading Standards Team at Doncaster Council.

67. The Doncaster Tobacco Control Alliance has facilitated partnership working between DMBC, RDASH, DBHFT and Doncaster CCG to encourage compliance with smoke-free premises. There is on-going work to ensure the respective premises are smoke-free.

68. Doncaster has undertaken a self-assessment on tobacco control and an action plan developed. A refresh of the Doncaster Tobacco Strategy has been drafted, awaiting national strategy due later in 2016. Once the national strategy on tobacco is out, our local strategy will be finalised incorporating the output of the tobacco control self-assessment.

Question 12.	
PROGRESS ON 2015/16 ACTIONS	
Support the Council in effort to sign Tobacco Declaration.	Doncaster Council has signed Tobacco Declaration in March 2015. This commits the organisation to take action to reduce the prevalence of smoking.
Monitor the performance of existing contracts related to smoking interventions	Regular performance monitoring of contracts on smoking had been held during the course of the year.
Explore other innovative actions that could be done to tackle smoking	There have been social marketing campaigns aimed at reducing cigarette smoking among young people and pregnant women. Also there have been actions to support the Council's premises to be smoke-free.

RECOMMENDATIONS
• Continue work on Breathe2025. A regional initiative with a vision of seeing the next generation of children born and raised in a place free from tobacco, where smoking is unusual. It is calling for people and organisations to sign up. http://www.breathe2025.org.uk/. • Finalise local Tobacco Strategy following the release of the National Strategy later in 2016. • Demonstrate the impact specific interventions have had on reducing smoking prevalence in Doncaster. • Embedding Making Every Contact Count (MECC) or very brief advise into routine practice among Health and Wellbeing partner organisations in Doncaster.

OPTIONS CONSIDERED

69. There are no specific options to consider within this report as it provides an opportunity for the Panel to receive and hold to account the progress and work undertaken as part of the Council's responsibilities for Health Protection.

IMPACT ON THE COUNCIL'S KEY PRIORITIES

	Priority	Implications
	We will support a strong economy where businesses can locate, grow and employ local people. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	Health is a resource for life, and economic productivity. Healthy people contribute to the economy, and health protection functions aims to protect the health of the population, including those who are current and potential workforce.
	We will help people to live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	Health protection impacts on how we keep our population safe from certain diseases, which are preventable by vaccination (e.g. MMR) and conditions that could be identified early by screening so that appropriate treatment can be given. Health protection is also about protecting the health of our people from risks and hazards related to major emergencies and incidents.

	We will make Doncaster a better place to live, with cleaner, more sustainable communities. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	
	We will support all families to thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	Health Protection contributes to healthy families and their ability to thrive and realise their full potentials.
	We will deliver modern value for money services.	The health protection work is delivered within Public Health financial grant.
	We will provide strong leadership and governance, working in partnership.	The Health Protection Assurance Group provides the leaders to ensure appropriate plans are in place to protect the health of the people of Doncaster. It has appropriate governance to ensure the delivery of health protection functions.

RISKS AND ASSUMPTIONS

70. The Health Protection Assurance system in Doncaster is a risk management system. The areas for development identified in this report will further strengthen Doncaster Council's ability to manage these risks. Risks are reviewed by Health Protection Assurance Group, and reported to Public Health Governance Group on quarter basis. A report by Internal Audit identified substantial assurance related to maximizing public health outcomes within the limited resources available. The current risk assessment of health protection score is 10 (likelihood = 2; impact = 5) from original risk score of 15 (likelihood = 3; impact = 5). One of the main current risks that the Health Protection Assurance Group has identified and is working to put measures in place to mitigate relates community infection prevention and control; and tuberculosis (TB) in light of national emphasis on future eradication of the infection as a public health threat. Other risks related to low coverage of vaccination, especially Flu vaccination update among the local population.

71. These plans are based on the assumption that key agencies will continue to work together going forward.

LEGAL IMPLICATIONS

72. Supporting the recommendations in this report will enable DMBC to continue to discharge its statutory duty to protect the health of the public effectively.

FINANCIAL IMPLICATIONS

73. Managing risk effectively will reduce potential financial implications of health protection incidents to DMBC.

CONSULTATION

74. There is a mechanism in place for on-going consultation with stakeholders through HPAG and the various subgroups that report to it.

This report has significant implications in terms of the following:

Public Health	✓	Crime & Disorder	
Human Resources		Human Rights & Equalities	✓
Buildings, Land and Occupiers		**Environment & Sustainability**	✓
ICT		Capital Programme	

BACKGROUND PAPERS

75. - Health Protection Assurance Framework
- Ways of working document between DMBC & PHE
- MOU between CCG and DMBC
- Terms of Reference of Health Protection Assurance Group
- Public Health Governance Terms of Reference
- Delivering Excellence in Local Public Health (Public Health Self-assessment tool for sector led improvement produced by DsPH Network for Yorkshire and the Humber).

REPORT AUTHOR & CONTRIBUTORS

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Dr Rupert Suckling
Director of Public Health, DMBC

Doncaster
Metropolitan Borough Council

Doncaster Health Protection Assurance Group

Terms of Reference

Reporting to:	Doncaster Health and Wellbeing Board
Health Protection Group authorised by:	Doncaster Health and Wellbeing Board
Responsible Directorate:	Public Health Directorate, Doncaster Metropolitan Borough Council (DMBC)
Approval date of TOR:	8 October 2013
Reviewed date:	16 April 2014
Reviewed date:	17 April 2015
Next review date:	April 2016

Document history (author)

Draft Version 1.1 (VJ):	22 July 2013
1.2 (JW comments incorporated)	29 July 2013
1.3 PH DMT input	5 August 2013
1.4 Statement added on Local Health Resilience Partnership and outbreak responsibilities re: school nurses, etc. (Section 5.1)	23 September 2013
1.5 Final draft agreed by HP Assurance Group	8 October 2013
2.1 Amended frequency of meeting to be quarterly (VJ)	16 April 2014
PHE representation: South Yorkshire Health Protection Team, Public Health England (VJ).	17 April 2015

1. Purpose:

1.1. The purpose of the Health Protection Group is to ensure co-ordinated action across all sectors to protect the health of the people of Doncaster from health threats, including major emergencies.

1.2. It supports the Director of Public Health (DPH) to carry out statutory responsibility to protect the health of the community through effective leadership and coordination, ensuring appropriate capacity and capability to detect, prevent and respond to threats to public health and safety.

1.3. The Health Protection Group will provide strategic direction and assurance on matters relating to health protection policy, risks and incidents.

1.4. All agencies will work collaboratively to exchange information and share knowledge and where appropriate pool resources for the purpose of protecting Public Health.

2. Functions:

2.1. To ensure that public health (PH) threats requiring local intervention are identified, analysed and prioritised for action to protect public health.

2.2. To ensure that health threats are prevented through implementation of relevant national strategies and regulations to protect public's health.

2.3. To ensure plans exist to coordinate responses to public health emergencies and threats.

2.4. To ensure appropriate governance for all health protection activities.

2.5. To ensure appropriate policies and plans associated with health protection activities are in place.

2.6. To establish local health protection assurance system and support organisations to deliver against the health protection outcomes (part of public health outcomes framework).

2.7. To receive annual reports that demonstrate compliance with, and progress against, health protection outcomes.

2.8. To ensure plans are in place for prompt and effective cascade of major health protection alerts (including Chief Medical Officer cascade, Medicines and Healthcare products Regulatory Agency (MHRA) alerts, Met Office alerts, and other major alerts) to appropriate audiences and to confirm that systems are in place for responding to such alerts.

2.9. To scrutinise incidents (including outbreaks), considering the responses of providers and commissioners so giving an overview to the Health Protection Group.

2.10. To provide health protection (including emergency preparedness,

resilience and response (EPRR)) assurance and statements on regular (quarterly) basis to Doncaster Health and Wellbeing Board and any other relevant local bodies via the Director of Public Health.

3. Accountability

3.1. The Health Protection Group will report to Doncaster Health and Wellbeing Board (HWBB).

3.2. The DPH is accountable to the Chief Executive of DMBC on discharging health protection duties of the local authority.

4. Scope

The scope of the Health Protection Group is to minimise hazards to human health, and to ensure that any threats are promptly dealt with. Geographically, the scope covers the population of Doncaster. (Links will be established with professionals in Bassetlaw and other areas as appropriate). Thematically, the scope covers the following health protection areas in the Health Protection Assurance Framework for Doncaster:

4.1. Vaccination & immunisations

4.2. Infection prevention and control (IPC) related to healthcare associated infections

4.3. Drugs and substance misuse

4.4. Alcohol

4.5. Injury prevention (including suicide prevention)

4.6. National screening programmes.

4.7. Sexual health

4.8. Communicable disease control including TB, blood-borne viruses, gastro-intestinal (GI) infections, seasonal and pandemic influenza

4.9. Emergency preparedness, resilience and response (EPRR)

4.10. Healthy environments for living, working and recreation

4.11. Public health advice regarding the planning for and control of pollution

4.12. Climate change

4.13. Sustainable environment

4.14. Regulation and enforcement

5. Strategic Linkages: to receive minutes and update from relevant committees / groups

5.1. Local Health Resilience Partnership (LHRP): There will be linkage with emergency preparedness, resilience and response (EPRR) for which there is an established process for assurance through LHRP chaired by a Director of Public Health; and the Joint Health Emergency Partnership Group (JHEPG). The LHRP and the JHEPG shall provide statement of assurance and minutes of their meetings to the Health Protection Assurance Group. Among other things, the LHRP shall provide assurance that the following services are in place to respond to any major outbreak if it occurs: school nursing services, community nursing services, out-of-hours services, walk-in centres, and medicine management services.

5.2. Safer Doncaster Partnership (SDP): for substance misuse

5.3. Doncaster Data Observatory: for intelligence related to health protection

5.4. Public Health England: for surveillance data and outbreak control

5.5. District Infection and Control meeting (Doncaster CCG)

5.6. Quality and Patient Safety meetings (Doncaster CCG)

5.7. District Vaccination and Immunisation Committee

5.8. NHS England: Screening and Immunisation Advisory Board for South Yorkshire and Bassetlaw

5.9. Any other groups whose work remits are linked to the health protection assurance framework.

6. Membership of Health Protection Group:

6.1. Consultant in Public Health (Chair), DMBC

6.2. Director of Public Health (Deputy Chair), DMBC

6.3. Assistant Director of Public Health (Lead for EPRR), DMBC

6.4. Senior Nurse / Clinical Commissioner – Quality & Patient Safety, Doncaster CCG

6.5. Screening and Immunisation Lead, NHS England

6.6. Chair of Doncaster Vaccination and Immunisation Committee, NHS England

6.7. South Yorkshire Health Protection Team, Public Health England

6.8. Director of Infection Prevention and Control, DBHFT

6.9.	Director of Infection Prevention and Control (or equivalent), RDASH
6.10.	Representative from Environmental Health, DMBC
6.11.	Representative from Adult Social Care, DMBC
6.12.	Public Health Practitioner (Health Protection and Emergency Planning), DMBC

7. Co-option of members

7.1.	Other Leads of health protection elements maybe co-opted as and when appropriate.

8. Declarations of Interest

8.1.	If any member had an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussion. The Chair will have the power to request that member to withdraw until the Health Protection Group has given due consideration to the matter.
8.2.	All declarations of interest will be minuted.

9. Deputising

9.1.	All members must make every effort to attend. If members are unable to attend they must send formal apologies, otherwise they will be recorded as 'did not attend'. Deputies should attend only when necessary.

10. Quorum

10.1.	Chair or Deputy; and at least 3 other members from different agencies.

11. Frequency of meetings:

11.1.	Quarterly as from April 2014.

12. Agenda deadlines:

12.1.	Items to be received two weeks prior to meeting
12.2.	Agenda to be circulated within two weeks of meeting.

13. Minutes:

13.1.	Minutes will be circulated within two weeks of the meeting.
13.2.	Minutes will be circulated to all members of the Health Protection Group.

14. Urgent matters	
14.1.	Any urgent matters arising between meetings will be dealt with by Chair's action after agreement from three other members of the group.

15. Administration:	
15.1.	Public Health Support Officer, Directorate of Public Health, DMBC

16. Attendance:	
16.1.	Members (or their nominated deputies) are required to attend a minimum of 4 out of 6 meetings annually.

GLOSSARY

CCG – Clinical Commissioning Group

Communicable Disease - A disease that can be spread from one person to another, by direct or indirect means.

DBHFT – Doncaster and Bassetlaw NHS Foundation Trust

DPH – Director of Public Health

EPRR – Emergency Preparedness, Resilience and Response

Healthwatch – The independent consumer champion organisation for health and social care

HCAI – Healthcare Acquired Infections are acquired as a result of healthcare interventions. They include infections such as MRSA and C.Difficile.

HPAG – Health Protection Assurance Group

HWBB – Health and Wellbeing Board

IPC – Infection Prevention and Control

JHEP – Joint Health and Emergency Planning Group

LHRP – Local Health Resilience Partnership

NHSE – NHS England

Notifiable Disease - Any disease that is required by law to be reported to government authorities.

PH – Public Health
PHE – Public Health England

PHOF – Public Health Outcomes Framework

RDaSH – Rotherham, Doncaster and South Humberside NHS Foundation Trust

SoS – Secretary of State (for Health in this paper)

STI – Sexually Transmitted Infections

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Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No. 12
3rd March 2016

Subject: Stronger Families Update

Presented by: Matt Cridge

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)	Yes
	Mental Health	Yes
	Dementia	Yes
	Obesity	Yes
	Children and Families	Yes
Joint Strategic Needs Assessment		No
Finance		No
Legal		No
Equalities		No
Other Implications (please list)		No

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

Doncaster Stronger Families Programme is a service transformation programme focussing on developing a whole family coordinated approach to family support. Families often display behaviours linked to physical or mental health difficulties or health issues result in social issues such as debt, poor school attendance or domestic violence.

The aim of Stronger Families is to improve support for whole families and improve coordination between services and organisations in order to avoid duplication and reduce costs while improving outcomes in the longer term. Health and wellbeing partners are integral to the Stronger Families programme and the success in supporting families to improve their lives and build resilience for the future.

Recommendations
The Board is asked to:- Note the progress of the Stronger Families programme to date.

Building Stronger Families
Quarterly Performance Report
Quarter 3 2015-16

Headlines

The Expanded Stronger Families Programme continues to develop at a good pace and Doncaster continues to show that it is able to deliver. Identification processes are working well and we are increasing the number of families identified as eligible by other professionals, however there is still much more work to do.

During Q3 the Chancellor of the Exchequer announced the continuation of the Expanded Troubled Families Programme in his spending review speech late last year. Although we do not as yet know the details of our agreement, the budgets and numbers remain unchanged nationally. We expect to hear in February the details of our funding for the next four years. The delay is in part due to a redistribution of the funds through a renewed methodology.

No. of families identified as being eligible **808**	No. of families who we are working with **426**
No. of families claimed for sustained and significant improvement **3**	No. of families claimed for continuous employment **7**

The funding allocations are to be based on data from the current indices of multiple deprivation (IMD), updated demographics data and the income deprivation affecting children index (IDAC). This means some areas will see a rise in their allocations and some will see a fall. We do not envisage any changes in Doncaster as our positions on these indices has changed little. We have been told that there will not be any future reviews during the lifetime of the Programme.

So this is excellent news as we can begin to plan properly for a full four year period. Following this speech the Director of the Troubled Families Unit in the Department for Communities and Local Government (DCLG) asked areas if they would like to apply to increase the number of families they engage with in the first year (2015 /16) of the programme. We considered this carefully as we must demonstrate we are engaging with families following the principles as outlined below produced by DCLG recently, these are:

1. A lead worker is allocated to the family recognised as such by the family and other professionals
2. A whole family assessment has taken place
3. A whole family action plan is in place
4. The objectives in the action plan align to the priorities in the Outcomes Plan

We are confident that given the numbers we are able to engage with a further 59 families before the end of March this year so taking our year 1 cohort to 550 (from 491). This sends out a clear message to DCLG that Doncaster has a grip on the programme and is delivering. Our application has recently been accepted and signed off by The Director of the TF unit and Jo Miller CEO of Doncaster Council.

We have just completed our January claim. This is the first claim we are eligible to undertake due to the timescales involved in demonstrating sustained improvement (min 6 months from last incident). We expected this to be low numbers given the experiences of the early adopter areas (Wave 1 and 2 areas) and 'core cities' (the top major cities across the country) who have been through the claim process in September last year. The range of claim numbers across the region is varied but Doncaster appears to be in the mid-range of the areas. The following figures were given by the respective areas as un audited numbers:

Jan 2016 claim figures (Before audit validation):

North Lincs – 3 (Wave 2)
Barnsley - 5 (Wave 2)
York - 12 (Wave 2) * Not submitting claim though due to audit charges.
Rotherham - 15 (Wave 3)
Lincolnshire - 20 (Wave 2)
Hull - 20 (Wave 2)
Doncaster - 22 (Wave 3)
Bradford - 30 (Wave 1)
N.E. Lincs - 30 (Wave 2)
East Riding - 60 (Wave 2)
Kirklees - 60 (Wave 2)
Sheffield - 80 (Wave 1)
N. Yorkshire - 150 (Wave 1)

There are now only two claim criteria we can go for, these are: Sustained and significant improvement across ALL assessed issues or continuous employment. Following the audit process our numbers went from 21 potentials down to 10 validated. This is not unusual in the first few claim processes as we iron out issues and clarify criteria and understanding across partners. The 'dropout' rate will decrease significantly as time goes on as it did in Phase 1. We are unable to determine the final figures from other areas as they also need to be audited.

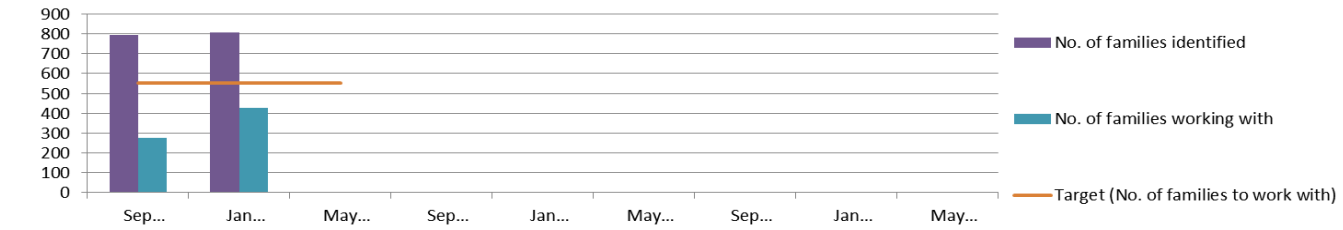
Doncaster was one of only 7 'Wave 3' (April 2015) areas to be included in the first Cost Savings Calculator report by DCLG last year. This report used data we sent to them on a sample of our families. The amount and quality of the data we sent enabled Doncaster to be included in the report. This report gives indications of the potential savings the programme is making with families and where the savings are being generated. This is the first of these reports but they will be a regular feature of the Expanded Programme fed by our returns to Government through the National Impact Study (NIS) and Family Progress Data (FPD) processes.

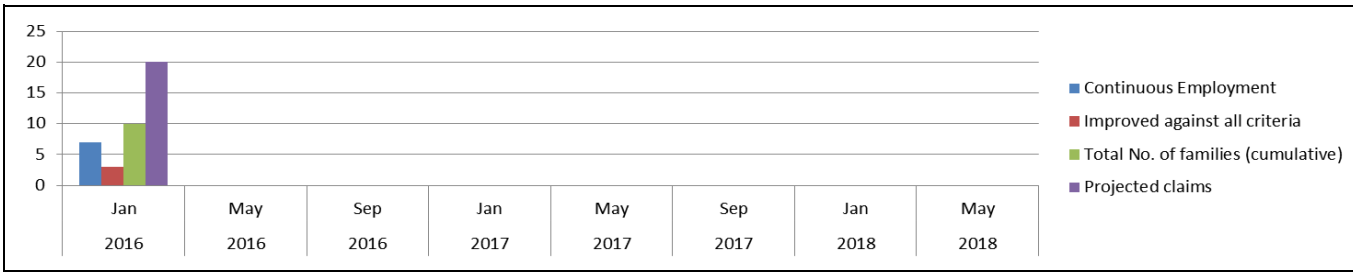
Due to the complex nature of the claim process in this programme we intend to report more on the ongoing progress of families across the range of issues identified through the whole family assessment. These will feature in the quarterly reports. It is important to show progress as this can indicate a variety of things including trends, interventions and issues.

Current processes mean family tracking and monitoring is done manually through the Neighbourhood Area Teams and central performance officers (now Strategy and Performance Unit). This has been satisfactory for Phase 1 and this initial claim for this Phase; however the numbers involved in the programme now make this far too unwieldy and rife with potential for errors. Our ability to undertake future claims relies heavily on our implementation of the case management system which to date has been fraught with difficulties. A technical issue with the system has delayed our implementation for nearly 6 months and is critical to the ability to deliver the programme. An option to proceed but with limited functionality has been agreed with the steering Group so we can progress but with limited reporting abilities. A new implementation plan has been developed an is to be implemented immediately.

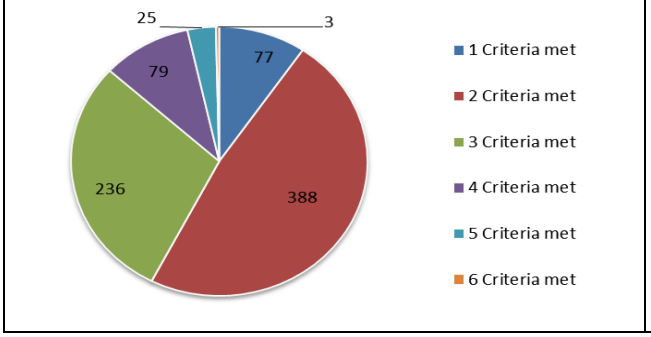
Doncaster is progressing well but we have a great deal to do. The nature of the programme means we have much less direct control over processes and information, relying much more on wider services and partners to contribute their bit. There is still a great deal of work to do to embed this work and change the culture of working to a whole family model with a lead practitioner approach.

Eligibility and Payment by results performance

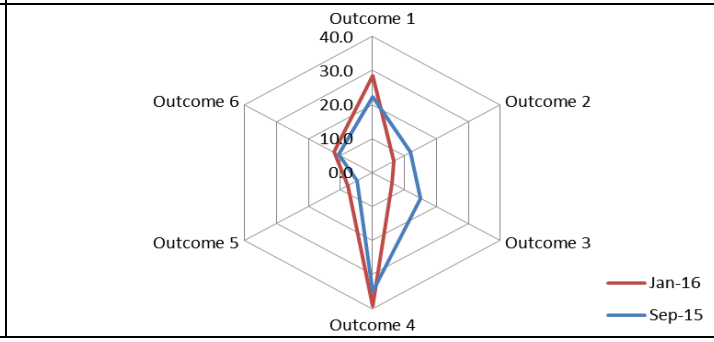




Families identified as being eligible



Family problems as at the start of engagement - Expanded programme family problem

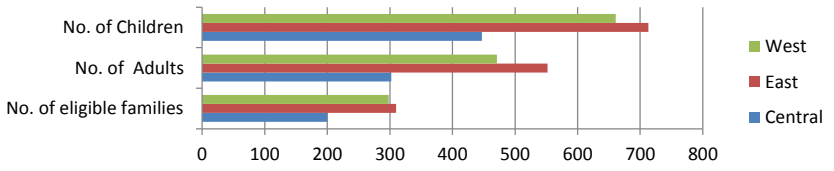


Family identified by	Grand Total
Early Help Team	6
EWO	2
GP	1
Intensive Family Support Team	0
SCO	23
Social Care	5
School	1
Triage / MDT	119
Other	23
Data matching process	512
Unknown (Data Quality)	116
Grand Total	808

Family problems as at the start of engagement - Expanded programme family problem	% Met Jan 2016
1 - Parents or children involved in crime or anti-social behaviour	28.40%
2 - Children who have not been attending school regularly	6.5%
3 - Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan	6.1%
4 - Adults out of work or at risk of financial exclusion or young people at risk of worklessness.	39.3%
5 - Families affected by domestic violence and abuse	7.7%
6 - Parents or children with a range of health problems	11.9%

Demographics

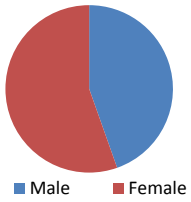
	No. of eligible families	No. of Adults	No. of Children
Central	200	302	447
East	310	552	713
West	298	471	661
Total	808	1325	1821



Central		East		West	
53% % of children (male)	47% % of children (female)	53% of children (male)	47% of children (female)	51% of children (male)	49% of children (female)
Average number of children = 2		Average number of children = 2		Average number of children = 2	
Average age of children = 10 years old		Average age of children = 9 years old		Average age of children = 9 years old	

Stronger families data (Across all areas)

Gender (All ages)



Average number of children

2.2

Average age of children

9

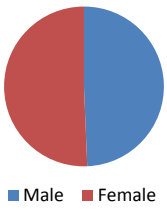
Number of lone parent households

175

(21.7% of Stronger families identified)

Census 2011 (Doncaster)

Gender (whole population)



Average number of children

1.7

Average age of children

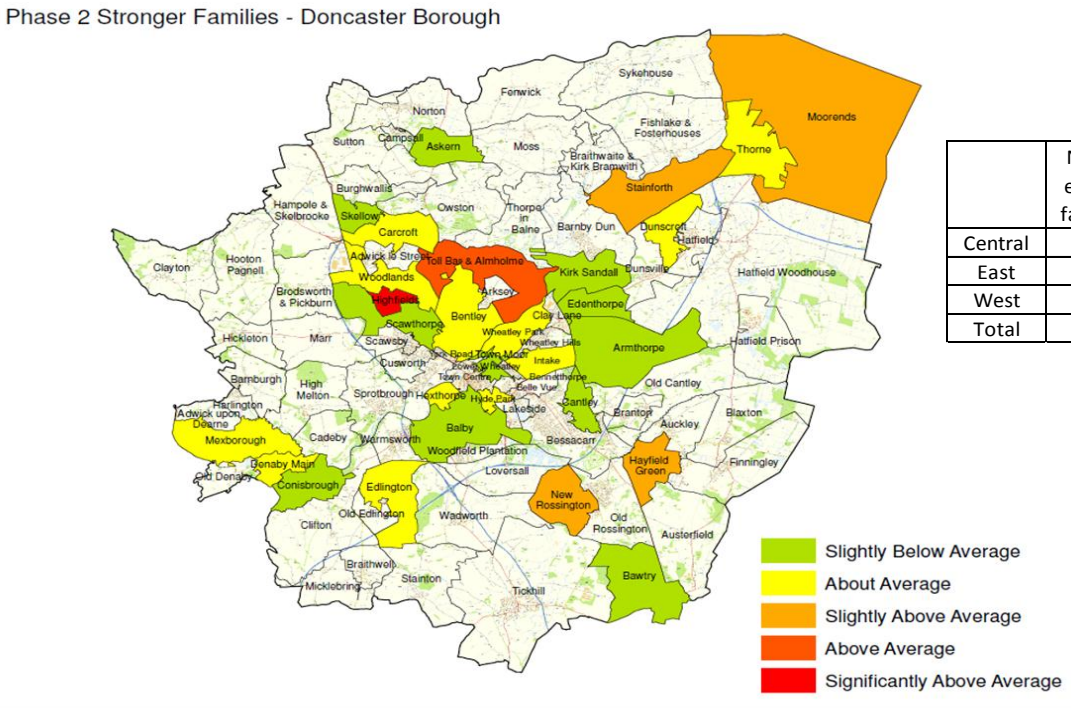
9

Number of lone parent households

9,434

(10.6% of all family households in Doncaster)

Distribution of Stronger Families in Doncaster



	No. of eligible families
Central	200
East	310
West	298
Total	808

Map calculation - number of families per community divided by number of households in each community (from Census 2011) times 1000 population

Please note areas that have 5 or less families in have been removed from the map above to ensure no one can be identified

Doncaster's Stronger Families Programme
Latest progress (January 2016)

We are working with **426** families

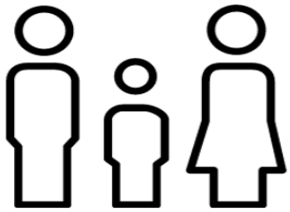
Progress has been made with families that we have been working with since 1st April 2015. Our first PbR claim was made in January 2016 for families who acheived improvement against all their criteria (excluding any families who met any education criteria as we have not had 3 full terms) or an adult in the family who came off benefits and were in employment for at least 3 or 6 months depending on the benefit type. The following graphics illustrate where families have made progress against the 6 headline outcomes.

57 Families have improved against Outcome 1 - parents and children involved in crime or anti-social behaviour

10 Families have improved against Outcome 2 - Children who have not been attending school regularly

29 Families have improved against Outcome 3 - Children who need help

21 Families have improved against Outcome 4 - Adults out of work or at risk of financial exclusion and young people at risk of worklessness



29 Families have improved against Outcome 5 - Families affected by domestic violence and abuse

6 Families have improved against Outcome 6 - Parents and children with a range of health problems

25 individuals who were in receipt of an out of work benefit (JSA, IS, ESA etc.) have secured a job but have not yet hit the required timescale for payment by results to be claimed.

Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No. 13
3rd March 2016

Subject: Director of Public Health Annual Report 2015

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		Yes
Finance		No
Legal		No
Equalities		Yes
Other Implications (please list)		No

How will this contribute to improving health and wellbeing in Doncaster?
The Director of Public Health Annual Report is an independent report on the health of Doncaster. Doncaster Council has agreed to its publication and the recommendations impact directly on the health of Doncaster people.

Recommendations
The Board is asked to:- NOTE the conclusions and recommendations, AGREE action against the recommendations

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Director of Public Health Annual Report 2015

Doncaster MBC

Contents

Foreword

I am delighted to present my first Annual Report as Director of Public Health for Doncaster Metropolitan Borough Council.

As this is my first Annual Report I have deliberately taken the opportunity to stand back and reflect on the key challenges for health in Doncaster. I have identified four key challenges that will need to be addressed in order to sustain progress. The challenges are:

- Improving children's health and wellbeing
- Making the link between education, work and health
- Addressing low Disability Free Life Expectancy and high levels of preventable health conditions
- Reducing inequalities in health between and within Doncaster communities

None of these challenges can be addressed simply by one agency or individual acting alone. All need cross agency support and leadership by and with local people. These challenges are not new and there is already work underway to address them. However, this is an opportunity to ask ourselves whether we are implementing the plans and strategies fast enough and/or whether our strategies and plans are ambitious enough to make the improvements we want for our children, families and communities.

I have also highlighted a small number of case studies where teams are already supporting individuals to take control of their own and their friends and families health. The people, ideas and energy to improve health in Doncaster are already here, but often they are untapped or uncoordinated. Together, and only together, we can make a difference.

In compiling this report I am grateful for the help of a number of colleagues. In particular I would like to thank Claire Hewitt, Laurie Mott, Dagmara Blaszczyk, Caroline Temperton, Ian Carpenter, Lynn Hall and Dan Debenham. I am also grateful for inheriting a dedicated and professional public health team and hope to build on the strong foundations left by my predecessor Dr Tony Baxter.

If you have any questions or comments about any aspect of the report please send them to me at PublicHealthEnquiries@doncaster.gov.uk

Dr Rupert Suckling
@rupertsuckling

Director of Public Health

Doncaster Metropolitan Borough Council

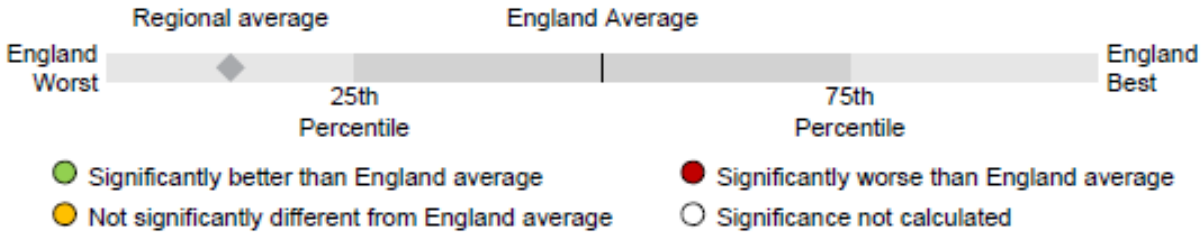
The Picture of Health in Doncaster

Health in Doncaster is improving, Life Expectancy is at an all time high. However, Life Expectancy is not improving as fast as the rest of the country leading to inequalities in health between Doncaster and the rest of the country.

Even though Life Expectancy is improving Healthy Life Expectancy is lagging behind and this is mirrored by a higher rate of people reporting low life satisfaction than the national average. Healthy Life Expectancy is a measure of how long people live in reasonable health.

Health outcome indicators

	Period	Local value	Regional value	England value	England worst	Range	England best
Healthy life expectancy at birth - Male (Years)	2011 - 13	58.3	61.1	63.3	53.6		71.4
Healthy life expectancy at birth - Female (Years)	2011 - 13	57.9	61.8	63.9	55.5		71.3
Life expectancy at birth - Male (Years)	2011 - 13	77.5	78.5	79.4	74.3		82.6
Life expectancy at birth - Female (Years)	2011 - 13	81.7	82.2	83.1	80.0		86.2
Inequality in life expectancy at birth - Male (Years)	2011 - 13	9.8		-	17.3		2.4
Inequality in life expectancy at birth - Female (Years)	2011 - 13	7.0		-	11.4		0.6
People reporting low life satisfaction (%)	2014/15	7.6	5.7	4.8	8.7		2.8



There are 4 major challenges locally

- Improving children's health and wellbeing
- Making the link between education, work and health
- Addressing low Disability Free Life Expectancy and high levels of preventable health conditions
- Reducing inequalities in health between and within Doncaster communities

What makes us Healthy?

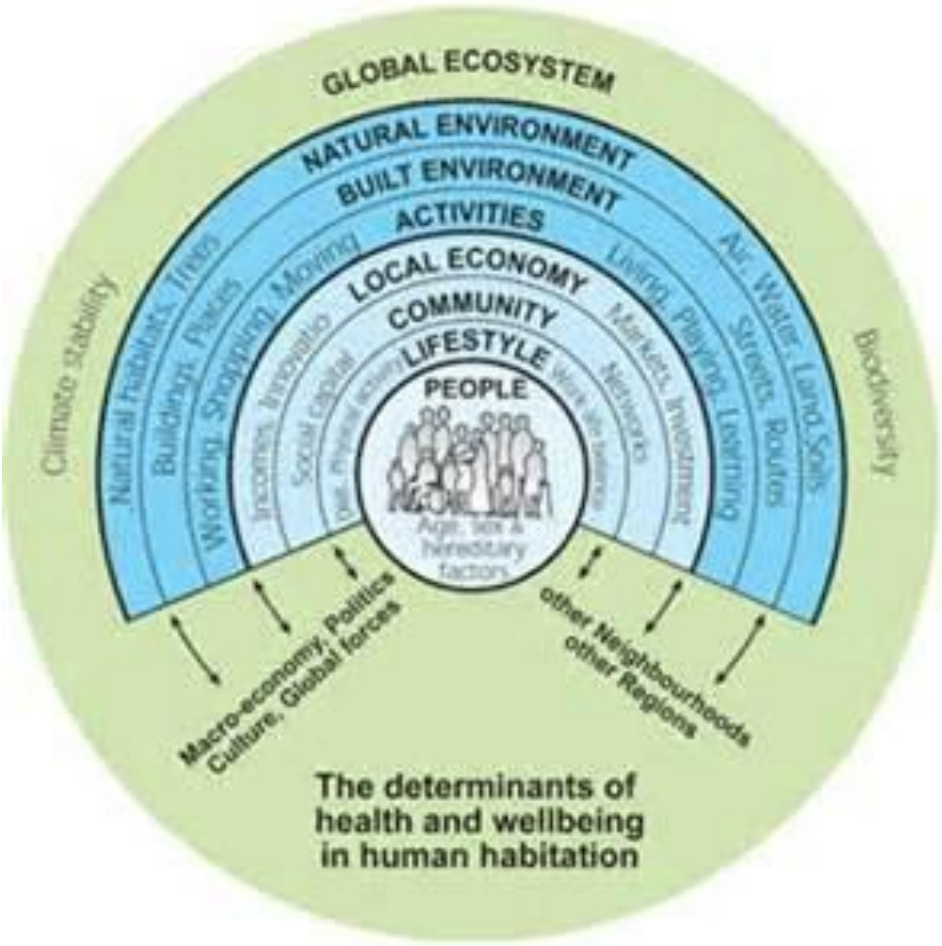
The evidence for what makes us healthy, keeps us healthy or makes us unhealthy is growing every year. In 1991 Göran Dahlgren and Margaret Whitehead produced a framework that allows us to group these impacts on health.[1]

The framework (below) demonstrates that although age, sex and genetic make-up undoubtedly influence people's health there are other factors that can also promote or damage someone's health. These include:

• Individual lifestyle factors such as smoking habits, diet and physical activity

• Relationships with friends, relatives and mutual support within a community

• Wider influences on health include living and working conditions, food supplies, access to essential goods and services, and the overall economic, cultural and environmental conditions that people live in



[1] Dahlgren, G and Whitehead, M. (1991). Policies and strategies to promote social equity in health, Institute of Futures Studies, Stockholm.

However, not all these factors have an equal impact on our health. The University of Wisconsin Population Health Institute together with the Robert Wood Johnson Foundation have reviewed the evidence for how these factors interact to produce rankings for US states.[2]

The relative contribution of the factors to health is:

30% Health Behaviours

- 10% Tobacco
- 10% Diet & exercise
- 5% Alcohol & drug use
- 5% Sexual activity

20% Clinical care

- 10% Access to care
- 10% Quality of care

40% Social and Economic Factors

- 10% Education
- 10% Employment
- 10% Income
- 5% Family and social support
- 5% Community safety

10% Physical Environment

- 5% Environmental quality
- 5% Housing & Transport

In addition, these factors whether health promoting or health damaging add together as people age. So having good family support, a good education and living in high quality housing when you are young can protect you from health damaging behaviours as you age, whilst growing up with a poorer education and in poor quality housing can make you more vulnerable to ill health as you get older. The case studies in this report show how social and economic factors particularly social support are being addressed locally.

Take Home Messages

Health is influenced by a number of factors. Social and economic factors are the largest contributor (40%) followed by health behaviours (30%).

The impacts, health promoting or health damaging can accumulate over time

Action to improve health needs to address more than just access to high quality health services

[2] http://www.countyhealthrankings.org/our-approach (last accessed 30/12/2015)

Case Study 1: Social Prescribing – Social Support

In July 2015 a Doncaster man became the 500th referral to Doncaster's social prescribing service. Run in partnership between Doncaster CVS and South Yorkshire Housing and funded jointly by the council and NHS Doncaster Clinical Commissioning Group, social prescribing is the perfect tonic for linking people up to activities in the community that they might benefit from. Social prescribing is open to everyone in Doncaster with issues such as isolation, loneliness, bereavement, housing, debt and much more. All referrals must be made through your GP.

Many people suffer health problems because of issues that impact on their lives, such as managing their money and paying their bills, or finding suitable accommodation to live in. Some people also need help to look after their emotional wellbeing, or support to find a job or to do volunteering activities. The way that the service works is that a 'prescription' is given in the form of an introduction to various, related, activities going on throughout the borough. This presents clients with new experiences, support and friends, which can help them improve their general physical and mental wellbeing.

What people say about the service.

'I would recommend the service to anyone. At my age you can lose touch with what's happening in your local area. My GP referred me to the service and working with my advisor, Debbie I've been put in touch with a new bunch of people to socialize with, as well having some improvements made to my house which has made getting up and about easier for me and my wife."

These improvements included converting their bathroom into a wet room to make showering easier and installing adaptive equipment to make getting in and out of bed less challenging.

"If you think you can benefit from the service, prompt your doctor. Have a word with him. It's better if you can stay independent and active, especially at my age. It's easy to get morbid when you're sat in at home all the time, but, as I've been shown, there's always things you can do – so get out there!"

Mandy Willis, Social Prescribing Manager at Doncaster CVS, said: "This is a great service and provides the link for GPs and their patients to the voluntary and community sector in Doncaster. Our advisors visit people in their own homes and support clients to explore community groups and activities in the borough and help them to access these services. It may be a referral for aids and adaptations, for a benefits check or a group to make friends and new connections.

Dr Nick Tupper, chair of the CCG, said: "Social prescription is another way that we can reduce the strain on busy GPs by offering an alternative which empowers people to tackle their health problems which can't be solved through pills, tablets and other medical interventions. It's important that we commission services that help people to stay independent and support them to make changes to their life that can improve their general wellbeing."

Health Differences between Doncaster and England

As described earlier, although health in Doncaster is improving it is not improving as fast as in other parts of the country.

Health is complex and in order to improve health we need to address the combination of factors described by Dahlgren and Whitehead in a coordinated way. One effective set of actions would be to:

Give every child the best start in life

Enable all children, young people and adults to maximise their capabilities and have control over their lives

Create fair employment and good work for all

Ensure a healthy standard of living for all

Create and develop healthy and sustainable places and communities

The Institute of Health Equity publishes indicators on an annual basis that provide data for each of the 150 'upper tier' Local Authorities in England on the above set of actions.[3] Collectively we need to ask ourselves what more we could do to support children get a good start in life and support children to succeed at school. We also need to tackle the issue of worklessness as a key health issue. The local performance against these indicators is shown in the tables below.

Giving every child the best start in life

	Period	Local value	Regional value	England value	England worst	Range	England best
Good level of development at age 5 (%)	2013/14	53.1	58.7	60.4	41.2		75.3
Good level of development at age 5 with free school meal status (%)	2013/14	39.6	42.4	44.8	31.7		68.1

Enabling all children, young people and adults to maximise their capabilities and have control over their lives

	Period	Local value	Regional value	England value	England worst	Range	England best
GCSE achieved 5A*-C including English and Maths (%)	2013/14	49.4	53.9	56.8	35.4		74.4
GCSE achieved 5A*-C including English & Maths with free school meal status (%)	2013/14	29.4	28.4	33.7	16.0		62.6
19-24 year olds not in education, employment or training (%)	2014		17.5	15.9			

[3] Institute of Health Equity (2015). Marmot Indicators http://www.instituteofhealthequity.org/projects/marmot-indicators-2015 (last accessed 30/12/2015)

Create fair employment and good work for all

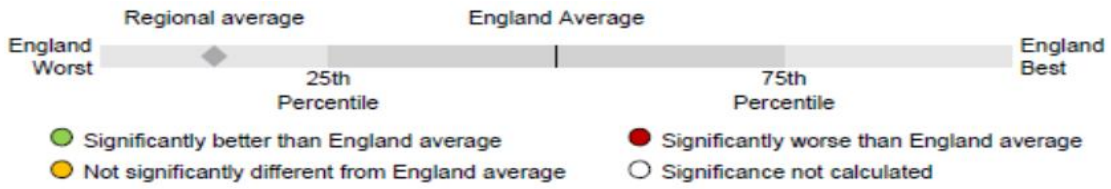
	Period	Local value	Regional value	England value	England worst	Range	England best
Unemployment % (ONS model-based method)	2014	8.6	7.4	6.2	12.5		2.9
Long term claimants of Jobseeker's Allowance (rate per 1,000 population)	2014	11.4	10.8	7.1	23.5		1.3
Work-related illness (rate per 100,000 population)	2013/14		4860	4000			

Ensure a healthy standard of living for all

	Period	Local value	Regional value	England value	England worst	Range	England best
Households not reaching Minimum Income Standard (%)	2012/13		27.1	24.4			
Fuel poverty for high fuel cost households (%)	2013	9.8	10.6	10.4	18.9		5.6

Create and develop healthy and sustainable places and communities

	Period	Local value	Regional value	England value	England worst	Range	England best
Utilisation of outdoor space for exercise/health reasons (%)	Mar 2013 - Feb 2014	15.7	18.3	17.1	0.3		30.8



Take Home Messages

Addressing children's health and wellbeing is a major contributor to health differences between Doncaster and England

Work and worklessness is a key health issue

Most of these health issues cannot be addressed by one organisation working alone

Case Study 2: Peer Mentoring – connecting health to work

Peer mentoring success in Doncaster

Two Doncaster men who have been helped by our Doncaster Drug and Alcohol Services are proving that new beginnings really are possible.

Daniel Bowden and Joe Sheerin are starting new careers as support workers after successfully graduating from a peer mentoring scheme, which sees people with direct experience of substance misuse, volunteering their time to help others on their own recovery journeys.

Stainforth dad of two Daniel (31) referred himself to the service when he felt his evening and weekend drinking was getting out of hand. He underwent a period of counselling and therapy at Rosslyn House on Thorne Road, and has now successfully given up alcohol.

Daniel said: "I felt like I was drinking too much and just didn't want the rest of my life to be like that.

"The therapy I received helped me by dealing with the issues and triggers that drove me to drink in the first place."

He added: "Since giving up drinking, I'm much happier and I'm now a better partner and dad.

"We have more money to enjoy family days out at weekends – and get to go further afield because we go in the car now, whereas before I'd have left it at home so I could have a drink."

After completing his therapy, Daniel used his annual leave from work and evenings to volunteer in Doncaster Drug and Alcohol Service's peer mentoring programme. He has recently been successful in finding new employment and will shortly take up a new job as a support worker with The Alcohol and Drug Service (ADS).

Joe, (45) from Wheatley, has just taken up his new post as support worker at New Beginnings Drug and Alcohol Rehabilitation Centre in Balby, helping people on the same recovery journey he himself successfully completed after 20 years of addiction.

He said: "Thanks to the brilliant support I received from New Beginnings, not only have I beaten my addiction, but I'm now in meaningful employment for the first time in around 10 years.

"When I saw the positive results of my own recovery, I decided to become a peer mentor to give something back to the service, because in my experience it really helps to meet someone who has 'been there' themselves, and who is proof there really is a way out."

Volunteer and Mentor Coordinator Lydia Rice said: "By sharing their own experiences, peer mentors deliver vital support to people beginning their recovery journeys.

"They offer empathy and encouragement, and play a valuable role in motivating others.

"All peer mentors are qualified through training certified to Level 2 in Peer Mentoring and Substance Misuse Awareness delivered by Certa, which gives them a good step on the pathway to employment."

Service Manager Stuart Green said: "Over 70 people applied for these posts, so competition was very high.

"Both Daniel and Joe went through a rigorous interview process and proved themselves worthy of the posts in a high pressure situation in front of the panel"

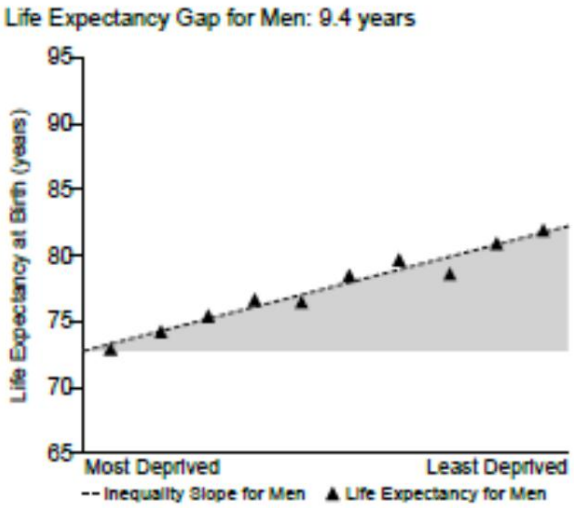
Lydia Rice added: "We are really proud of Daniel and Joe and know they will continue to be fantastic role models to Doncaster people in recovery."

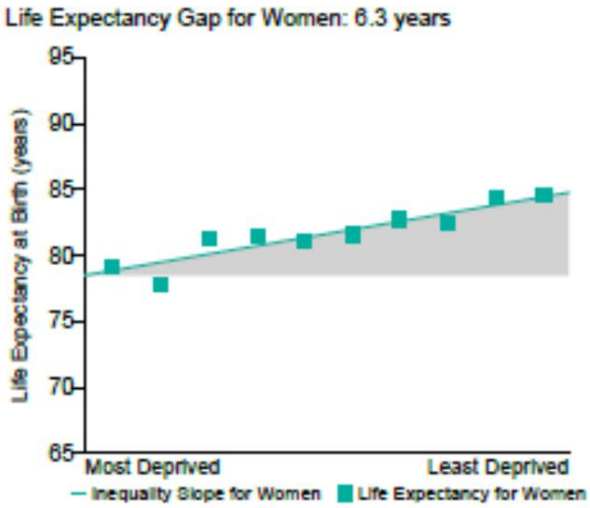
RDaSH Volunteer and Mentor Coordinator Lydia Rice (centre) with Joe Sheerin (left) and Daniel Bowden (right).

Health Differences within Doncaster

Doncaster's geography is an asset and a challenge. The Romans recognised the importance of Doncaster as a major logistics hub as a crossing point on the Don between York and Lincoln and today, Doncaster continues to thrive as a logistics hub, well connected by road, rail and the recent airport. Doncaster is the largest geographical metropolitan borough in the country and this brings its own challenges with key population centres in the town itself, Mexborough, Thorne and Bawtry together with numerous outlying villages and settlements.

Health varies across the Doncaster communities. Life expectancy (at birth) is over 9 years higher in the least deprived parts of the borough for men and over 6 years for women compared to the most deprived parts.[4]





One way the geography of Doncaster is divided is into the 21 electoral wards (map below). However not all the wards are the same they have different stories, assets and health.

Profiles for all these communities are available and each profile contains useful information which paints a picture about what a ward is like, including its population, educational attainment, crime levels and health issues. Three electoral wards have been compared in the table below, the ward and their consistent communities are:

Bessacarr: Bessacarr and Cantley

Conisbrough: Conisbrough, Denaby Main, Old Denaby and Clifton

Hatfield: Dunscroft, Hatfield, Dunsville, Hatfield Prison and Hatfield Woodhouse

[4] Doncaster Health Profile (2015). Public Health England
http://www.apho.org.uk/resource/browse.aspx?RID=50313 (last accessed 31/12/2015)

☐ Two member ☐ Three member

Index of Wards

1. Adwick-le-Street and Carcroft
2. Armthorpe
3. Balby South
4. Bentley
5. Bessacarr
6. Conisbrough
7. Edenthorpe and Kirk Sandall
8. Edlington and Warmsworth
9. Finningley
10. Hatfield
11. Hexthorpe and Balby North
12. Mexborough
13. Norton and Askern
14. Roman Ridge
15. Rossington and Bawtry
16. Sprotbrough
17. Stainforth and Barnby Dun
18. Thorne and Moorends
19. Tickhill and Wadworth
20. Town
21. Wheatley Hills and Intake

	Bessacarr	Conisbrough	Hatfield	Doncaster
Deprivation ranking (out of 21 wards)	16/21 (more affluent)	4/21 (more deprived)	14/21	
Population	13,760 Generally older than Doncaster as a whole	16,509 Similar age profile to Doncaster, less ethnically diverse	17,687 Similar age profile to Doncaster	303,622
Life expectancy men	81 yrs at birth 19.2 yrs at age 65	76.5 yrs at birth 16.8 yrs at age 65	80.2 yrs at birth 18.4 yrs at age 65	77.9 yrs at birth 17.8 yrs at age 65
Life expectancy women	85.1 yrs at birth 22.5 yrs at age 65	80.7 yrs at birth 20.0 yrs at age 65	81.8 yrs at birth 19.9 yrs at age 65	81.8 yrs at birth 20.4 yrs at age 65
Self reported good and very good health	79.4%	72.7%	66.8%	76.4%
Mortality rates all causes under 75 per 100,000	285.6	489.4	341.3	408
Low birth weight (%)	6.1	10.2	7.0	9.2
Children in poverty (%)	13.1	26.9	20.4	23.2
Excess winter deaths (ratio of winter to non-winter deaths)	25.4	13.2	30.2	17.4
Living within 1km of a takeaway	94.9%	98.0%	78.1%	89.3%
Population per asset*	281	226	353	

*assets include dentist, GP practice, pharmacy, school, children centres, support groups and community centres.

Take Home Messages

Life expectancy and mortality are related to deprivation and vary across the three wards

Early life indicators cluster together, so if one indicator is poor it is likely that all children's indicators will be poor

Levels of self reported health may indicate people living with disabilities

Excess winter deaths may be related to the condition of housing stock as well as the health of the population

Case study 3: Breast Feeding Mums – family support

Support for mums breastfeeding their baby

A team of mums are undergoing training so they can help other mothers who are breastfeeding their babies.

They will also be able to help mums-to-be who just want to know more about breastfeeding.

A group of 15 mums are undergoing the training and once it's completed will be on hand to help new mothers who would like a little extra advice and support. Called Breastfeeding Peer Supporters, the mums can be vital in helping a new mother get breastfeeding off to a good start and continue to breastfeed for as long as they want to.

Jayne Mundy, a Health Promotion Nursery Nurse at Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH), said: "We always encourage breastfeeding due to the many benefits for both the baby and mum.

"Our volunteer mums offer fantastic help and support to other mums across Doncaster. They help new mums who are breast feeding, and because they have all breastfed their own babies, they can pass on really good ideas and tips," added Jayne. "They offer an excellent service and the new mums we are training will be a vital asset to Doncaster."

If you are a mum and would like to get involved with breastfeeding support please call Jayne on 01302 640065. The Doncaster mums undergoing the training are pictured with RDaSH staff.

Health Differences between Different Population Groups in Doncaster

The 2011 census provides the most up-to-date picture of the differences in health and the factors improving or damaging health between different protected groups in Doncaster. This report focuses on 2 areas, ethnicity and disability.

Health and Ethnicity

The census 2011 still provides the best overall picture of the make up of Doncaster's population, although there are known problems and underestimates of some parts of the population e.g. Gypsy or Irish Traveller groups.

The overall picture shows 91.8% of Doncaster's population is White British, the White Irish population is the next largest group (3.4%), followed by Asian (2.5%), mixed (1.1%), Black (0.8%) and other (0.4%).

Ethnic Group Census 2011	**Population**
White: English/Welsh/Scottish/Northern Irish/British	277,740
White: Irish	10,326
White: Gypsy or Irish Traveller	587
White: Other White	8,556
Mixed	3,321
Asian	7,614
Black	2,337
Other	1,064
All categories: Ethnic group	302,402

Overall Asian and Black groups had higher self reported health (95.8% and 95.4%) than White British groups (91.3%), although both Asian and Black groups are less active than the general population.

White British groups show twice the level of alcohol dependency than other groups, however both White and Black groups show the same level of drug dependence. The Asian group has the lowest levels of alcohol and drug dependency.

National data shows that the Black population suffer from at least double the amount of Post Traumatic Stress Disorder than other populations and as much as 10 times the levels of severe mental illness (including psychosis). Other health conditions are more common in some ethnic groups, so heart disease is more common in the Asian population, stroke and hypertension more common in the Black population and both Asian and Black populations have high levels of infant mortality.

The census also shows that the level of educational qualification varies across the ethnic groups with White Irish, Asian and Black groups having higher numbers of people with level 4 (degree level) qualifications than the general population. Asian and Black groups are also more likely to be students and as a result of being younger populations are more likely to be unemployed and less likely to be retired than the general population.

Disability

Disability is an increasing issue in Doncaster. Although people are living longer, many people are only living longer with a disability. Men in Doncaster can expect to live to 77 years, but their Disability Free Life Expectancy is 57.8 years, for women life expectancy is 81.4 years with a Disability Free Life Expectancy of 58.7 years. On average then, people in Doncaster live 25% of their lives with a disability.

In the 2011 census 33,644 people reported being limited a lot by their disability over 10% of the Doncaster population, a similar number are limited a little by their disability. People with a disability that limits their day-to-day activities also have lower educational achievements, are less likely to be in work and more likely to live in rented accommodation. More women have a disability that limits their day-to-day activities than men 53% against 47%.

Take Home Messages

Most data on ethnicity and health is based on national surveys

Ethnicity impacts on both how people perceive their own health and the health that they experience. Different approaches to improve health may be needed in different ethnic groups

In Doncaster people may live 25% of their lives with a disability and over 10% of the population has a disability that limits them a lot

Case Study 4: Healthy Living for Black and Minority Ethnic (BME) Women in Doncaster – social suport

BME communities currently make up nearly 10% of the population of Doncaster. Through the commissioning of the Healthy Living for BME Women in Doncaster service Public Health provides an opportunity to engage with women from ethnic minority communities in Doncaster with the view to improving the health and well-being of themselves and their families. Working with BME women in this way is important because both they and their families experience inequalities in their health compared to the general population. Research tells us this is likely to be due to several reasons, for example:

- Some ethnicities are predisposed to certain conditions, for instance African Caribbean women are 60% to 70% more likely to suffer from strokes than the general UK population. Type 2 diabetes is 6 times as common amongst Pakistani women and there is also a lower risk age of 25 compared with 40 for the general UK population.[5]
- We also know that BME women in particular "may also be excluded from services that seem 'alien' and intimidating due to unfamiliarity, cultural/religious incompatibility, lack of language services and information gap in service provision." [6]

So how does this service help? It offers access to information, advice and guidance in a safe environment. The service looks at the circumstances of each woman and supports her accordingly. For example: the women are able to learn English through the English for Speakers of other Languages (ESOL) programme; they learn how to register with a GP and dentist; and, understand how important it is to participate in screening and immunisation programmes.

Over the year 2014/2015 the service engaged with 303 BME women; 61 women achieved an ESOL qualification and 12 gained accreditation in Volunteering. The service facilitated 37 health promotion workshops including diet and nutrition and cancer awareness. The service works hard to dispel myths about health so the women understand why they are invited for screening and immunisations and know the importance of attending. The service also teaches the women how to integrate into a different way of life; knowing how and why we do things, such as recycling and how to use our transport systems.

How does this impact on the women? This service doesn't just focus on accessing health services but teaches the women about a variety of factors that affects their health and wellbeing. This helps to build social cohesion.

Because of this service many women report they feel less isolated, are able to speak better English and therefore communicate better in the wider community. Some have gone onto employment or accessed further training and education.

[5] Leung, G., & Stanner, S. (2011). Diets of minority ethnic groups in the UK: influence on chronic disease risk and implications for prevention. Nutrition Bulletin, 36(2), 161–198.

[6] Chitembo, A., & Tsikira, L. (2012). Breaking the Cycles of Abuse: Understanding the Complexities of Domestic Violence & Abuse in BME Communities & Finding Pathways to Reduce It! West Sussex.

Conclusions and Recommendations

Improving health in Doncaster will require concerted action to address the four main challenges identified at the start of the report.

- Improving children's health and wellbeing
- Making the link between education, work and health
- Addressing low Disability Free Life Expectancy and high levels of preventable health conditions
- Reducing inequalities in health between and within Doncaster communities

As health is influenced by a wide range of factors the following recommendations are addressed to Team Doncaster and anyone interested in improving the health of Doncaster people.

Overarching Recommendations

- Adopt a 'Health in All Policies' approach
- Make a strategic shift to prevention
- Empower people and communities to take control of their own health and if services are required involve people in co-designing the services
- Improve data capture, sharing and reporting so that services can become more seamless and based on insight to address inequalities in access and outcomes
- Carry out a local Health Needs Assessment for Black and Minority Ethnic (BME) Groups
- Move beyond integration to population health systems and budgets

Recommendations for Children, Young People and Families

- Implement and evaluate the Early Help strategy
- Focus on vulnerable mothers from pregnancy until the child is 2 ½ (the first 1000 days)
- Build on the national Future in Mind developments to address bullying and improve the mental health of school aged children
- Support schools to develop a Curriculum for Life
- Support schools to increase physical activity in the curriculum

Recommendations for Employment and Health

- Use the Social Value Act to maximise equitable employment opportunities when commissioning
- Recommission the 'work programme' as part of the Sheffield City Region deal to help those furthest from the labour market find work
- Work to keep those with health issues in employment longer, improving health literacy and self management
- Continue to help residents keep their homes warm through collective switching schemes, improving energy efficiency of properties and ensure access to welfare advice

- Use community assets to join up health, social care, education, skills and employment around the family building on the Stronger Families and Well North approaches

Recommendations to Prevent Disability

- Include preventative approaches in all patient pathways and clinical services
- Launch 'Get Doncaster Moving' campaign to increase physical activity
- Continue to reduce the negative impact of takeaways and fast food on health and air pollution by considering health in spatial planning approaches
- Develop local approaches with South Yorkshire Fire and Rescue to promote fire safety and address falls including enhanced home safety checks

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Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No. 14
3rd March 2016

Subject: Report of the Officer Group and Forward plan

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)	No
	Mental Health	Yes
	Dementia	Yes
	Obesity	Yes
	Children and Families	Yes
Joint Strategic Needs Assessment		Yes
Finance		No
Legal		No
Equalities		Yes
Other Implications (please list)		No

How will this contribute to improving health and wellbeing in Doncaster?
This report provides an update on the Board workshops and the planning guidance for 2016/17 to 2020/21 for the health and care system.

Recommendations
The Board is asked to:- NOTE the report, DISCUSS and AGREE the forward plan.

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Doncaster
Metropolitan Borough Council

Agenda Item No: 14
3rd March 2016

To the Chair and Members of the
HEALTH AND WELLBEING BOARD

REPORT FROM THE HEALTH AND WELLBEING BOARD OFFICER 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 Officer Group to deliver the Board's work programme and also provides a draft forward plan for future Board meetings.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

2. The work programme of the Health and Wellbeing Board has a significant impact on the health and wellbeing of the Doncaster population through the Joint Health and Wellbeing Strategy, the Joint Strategic Needs Assessment, system management and any decisions that are made as a result of Board meetings.

EXEMPT REPORT

3. N/A

RECOMMENDATIONS

4. That the Board RECEIVES the update from the Officer Group, and CONSIDERS and AGREES the proposed forward plan at Appendix A.

PROGRESS

5. At the first full Board meeting on 6th June 2013, Board members agreed that there would be a Health and Wellbeing Officer group to provide regular support and a limited support infrastructure to the Board.

   The Officer group has had one meeting since the last Board in January 2016 and can report the following:

- **Childhood Obesity**

As a result of the last Board discussion on obesity Doncaster as a health community has agreed to pilot a new childhood obesity prioritisation tool. The tool has been developed by Public Health England and is being tested in 4 local areas. The tool consists of three steps, an initial assessment of leadership, a stocktake of current activity and a facilitated prioritisation session. To date the self-assessment of leadership and the stocktake have taken part. The prioritisation workshop is to follow.

- **Loneliness and social isolation**

A facilitated workshop run by the campaign to end loneliness was held on 25th February 2016. A full report will be circulated in due course.

- **Health and Social care planning 2016/17 – 2020/21**

The planning guidance for the health and social care system to take us to 2020/21 has been released. The guidance asks every health and care system to create their own ambitious local blueprint for accelerating the Five Year Forward View. These plans will be called Sustainability and Transformation Plans (STPs) and will be place based, multi-year plans built around the needs of local populations. The local STP will be based on a South Yorkshire and Bassetlaw footprint with a local Doncaster plan embedded within it.

The plans will need to be summited in the summer but before Easter we will need to agree three things for our STP:

- The governance arrangements
- The scale of the local challenges
- Key priorities to address the health and wellbeing gap, the quality gap and the financial gap.

The detailed guidance on the Better Care Fund is still awaited. A fuller report will be brought to the May meeting.

- **Forward Plan for the Board.**

This is attached at Appendix A.

IMPACT ON THE COUNCIL'S KEY PRIORITIES

6.

	Priority	**Implications**
	We will support a strong economy where businesses can locate, grow and employ local people. • *Mayoral Priority: Creating Jobs*	The dimensions of Wellbeing in the Strategy should support this priority.

	and Housing • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	
	We will help people to 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
	We will make Doncaster a better place to live, with cleaner, more sustainable communities. • *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
	We will support all families to thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	The Health and Wellbeing Board will contribute to this priority
	We will deliver modern value for money services.	The Health and Wellbeing Board will contribute to this priority
	We will provide strong leadership and governance, working in partnership.	The Health and Wellbeing Board will contribute to this priority

RISKS AND ASSUMPTIONS

7. None.

LEGAL IMPLICATIONS

8. None.

FINANCIAL IMPLICATIONS

9. None

EQUALITY IMPLICATIONS

10. The work plan of the Health and Wellbeing Board needs to demonstrate due regard to all individuals and groups in Doncaster through its work plan, the Joint Health and Wellbeing Strategy and Areas of focus as well as the Joint Strategic Needs Assessment. The officer group will ensure that all equality issues are considered as part of the work plan and will support the Area of Focus Leads to fulfil these objectives.

CONSULTATION

11. None

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APPENDIX A

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2016

	Board Core Business		**Partner Organisation and Partnership Issues**	**Officer Group Work plan**
	Meeting/Workshop	**Venue**		
3rd March 2016	• Q3 Performance Report (MH update) – Allan Wiltshire/Andrea Butcher • JSNA Update – Laurie Mott • Health and Social care Transformation update - Chris Stainforth TBC • Officer Group Report - Rupert Suckling • Health Protection Update – Victor Joseph • Stronger Families update – Matt Cridge • Doncaster Libraries and Culture Supporting Wellbeing – Nick Stopforth	Civic Office	• Plans and reports from ○ CCG ○ NHSE ○ DMBC ○ Healthwatch ○ 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	• 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 April 2016	Workshop TBC (Children's Health and wellbeing)	TBC		
9th June 2016 (Please note change of date)	• Q4 Performance Report • Health and Social care Transformation Update • Officer Group Report • Veterans Update	Civic Office		

APPENDIX A

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2016

14th July 2016	Workshop TBC (Mental Health and social emotional wellbeing)	TBC	• Regeneration	
1st September 2016	• Q1 Performance Report • Health and Social care Transformation Update • Officer Group Report • Annual Safeguarding reports (Adults and Children's)	Montagu Hospital		
13th October 2016	Workshop TBC (Fuel poverty)	TBC		
3rd November 2016	• Q2 Performance Report • Adults and Social Care Local Account • Health and Social Care Transformation Update • Officer Group Report	Civic Office		
1st December 2016	Workshop TBC (Time out/Review forward Plan)	TBC		

***Supported Living and Wellbeing workshop** to be rescheduled in 2017