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Doncaster
Metropolitan Borough Council

To all Members of the

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
DATE: Thursday, 9th June, 2016
TIME: **9.30 am**

PLEASE NOTE VENUE FOR THIS MEETING

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

Jo Miller
Chief Executive

Issued on: 1st June, 2016

Governance Officer for this meeting: Amber Torrington
01302 737462

Delivery of Health and Wellbeing Strategy

8.	Quarter 4 Performance Update and Focus on Substance Misuse. *(Paper attached/Presentation)*	(Alan Wiltshire/ Helen Conroy)
9.	JSNA Update. *(Paper attached)*	(Dr Rupert Suckling)

Board Assurance

10.	Health and Social Care Transformation Update. *(Presentation)*	(Jackie Pederson/ Kim Curry/Dr Rupert Suckling)

Developments and Risk Areas

11.	Health inequalities - BME Health Needs Assessment Proposal. *(Paper attached)*	(Dr Rupert Suckling)

Board Development

12.	Report from from the Health and Wellbeing Steering Group and Forward Plan. *(Paper attached)*	(Dr Rupert Suckling)

Date/time of next meeting: Thursday, 1st September 2016, 9.30 am, Montagu Hospital, Mexborough

Members of the Health and Wellbeing Board

Chair – Cllr Pat Knight	Portfolio Holder for Public Health and Wellbeing
Kim Curry	Director of Adults, Health and Wellbeing
Dr David Crichton	Chair, Doncaster Clinical Commissioning Group
Jackie Pederson	Chief Officer, Doncaster Clinical Commissioning Group
Damian Allen	Director of Learning, Opportunities and Skills
Paul Moffat	Chief Executive Doncaster Children's Trust
Dr Rupert Suckling	Director of Public Health, Doncaster Metropolitan Borough Council
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
Karen Curran	Head of Co-Commissioning, NHS England (Yorkshire and Humber)
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
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
Peter Dale	Director of Regeneration and Environment

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DONCASTER METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY, 3RD MARCH, 2016

A MEETING of the HEALTH AND WELLBEING BOARD was held at the CIVIC OFFICE on THURSDAY, 3RD MARCH, 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 Glyn Jones	Portfolio Holder for Adult Social Care and Equalities
Dr Rupert Suckling	Director of Public Health, Doncaster Metropolitan Borough Council (DMBC)
Damian Allen	Director of Learning, Opportunities and Skills (DMBC)
Debbie Smith	Service Director of Adult Mental Health, Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), substituting for Kathryn Singh
Dr Nick Tupper	Chair of Doncaster Clinical Commissioning Group
Karen Johnson	Assistant Director Adults, Health and Wellbeing (DMBC), substituting for Kim Curry
Steve Shore	Chair of Healthwatch Doncaster
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:

Mark Douglas, Chief Operating Officer, Doncaster Children's Services Trust
Allan Wiltshire, Head of Performance and Data, DMBC
Nick Stopforth, Head of Libraries and Culture, DMBC
Victor Joseph, Consultant in Public Health, DMBC
Sarah Smith, Public Health Specialty Registrar, DMBC
Andrea Butcher, Head of Strategy and Delivery, Mental Health and Learning Disability, DCCG
Matt Cridge, Head of Stronger Families, DMBC

49 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies were received from Cllrs Nuala Fennelly and Cynthia Ransome, Kim Curry (Karen Johnson deputised), Kathryn Singh (Debbie Smith deputised), Karen Curran, Trevor Smith and Peter Dale.

The Chair also welcomed Mark Douglas who was representing the Doncaster Children's Services Trust at this meeting.

50 CHAIR'S ANNOUNCEMENTS

The Chair pointed out that this was Chris Stainforth's last meeting as a member and Vice-Chair of the Health and Wellbeing Board. On behalf of the Board, she thanked Chris for the significant contribution he had made to the work of the Board since its inception and wished him all the very best for the future. It was noted that Chris's departure also meant that there would be a need to appoint a new Vice-Chair of the Board at the next meeting.

The Chair reported that Colin Hilton, Chair of Doncaster Children's Services Trust, had tendered his resignation from the Board with immediate effect due to his time commitment in Doncaster being reduced. She advised, however, that it was intended that a full time member of the Trust's Executive would take on representing the Trust in this capacity in the future and that a nomination from the Trust would therefore be forthcoming in due course.

The Chair stated that she was sorry to announce that Cllr Tony Revill, Chair of the Council's Health and Adult Social Care Overview and Scrutiny Panel, had passed away on Tuesday 1 March. She stated that Cllr Revill would be sadly missed both as a Member and as a colleague.

51 PUBLIC QUESTIONS

Question from Mrs Sheila Barnes

Mrs Sheila Barnes asked the following question in relation to Mental Health Personal Budgets:

"Concerns about this matter have been discussed at the Mental Health Strategic Alliance Group over the past few months and relate to the seemingly lengthy delay in the assessment of applications and the difficulty in any specific access point and pathway for information. I agreed to bring this matter to the intention of the HWB Board as Mental Health had been specified as one of the strategic health priorities.

Personal Health Budgets originally had a slow start in Doncaster but is now much better. Mental Health Budgets were first piloted in Doncaster 5 years ago. The profile of mental health is also currently receiving more national attention.

- What is the reason for such delay and lack of clear pathway?
- Are there adequate resources in relation to funding and manpower?
- Where does the ultimate responsibility lie in addressing this issue?
- Is there an efficient level of cooperation between DMBC and RDaSH?"

Mrs Barnes added that of the 10 applications for personal budgets made 5 months ago, only 3 had been processed to her knowledge.

In response, Debbie Smith explained that she was not aware of any problems with the pathway for assessments but she stated that she would investigate the situation.

Chris Stainforth confirmed that there had been some issues around capacity for dealing with Personal Health Budgets, but he explained that the relevant team had now been restructured and steps were being taken to ensure that there would be sufficient capacity to meet demand in future.

Karen Johnson stated that she would also take this issue away as an action and urged any individuals who may have been waiting a long time for their applications to be processed to make contact with the Council and their cases would be looked at as a priority. She added that an update on this matter would be reported back to the Board's next meeting.

Question from Mr Tim Brown

Mr Tim Brown addressed the Board as follows:-

"Chair, as stated previously, I stand before you as a parent, a son, a brother and a law abiding black citizen. My immediate family, including brothers and sisters have given over 250 years of service to the NHS and associated public services.

It gives me no pleasure and in fact it is very intimidating having to repeatedly come along to such a high level meeting to basically ask for rights that are enshrined in the Health and Care Act, NHS constitution and the Equality Act Public Sector Equality Duty. As the HWB is aware, the NHS Constitution states:

The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve both physical and mental health. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

It is in this context Chair, that I am genuinely grateful to the Deputy Mayor and Equalities portfolio holder for acknowledging the significant harm to the Equalities Agenda in Doncaster.

Chair, if we accept at face value the veracity of Cllr Jones' comment it is legitimate to ask HWB members individually and collectively when did they know about the stated "significant harm to the equalities agenda" in Doncaster and what actions have been taken to safeguard the basic rights of protected groups, including black and minority ethnic citizens?

Chair , it is distressing to find no evidence of the significant harm to the equalities agenda being reflected by officers in the Health and Wellbeing strategy?

There is no mention of how such significant harm could have occurred and its impact on the health and wellbeing of citizens, who incidentally should be afforded protection under the Equality Act legislation.

And whilst I am grateful to Dr Suckling for previously acknowledging the lack of proportionate and meaningful BME engagement along with gaps in the BME data especially in the context of access, outcomes and experience, it is a sad indictment of where we are in Doncaster that I am informed by Dr Suckling that the BME Health Needs Assessment is over 10 years old.

As somebody who generously gave up their time along with other members of the BME community to assist Suras complete the BME HNA assessment, it is painful to know that no feedback was ever given and to my knowledge not one of the recommendations was ever implemented.

Why would such distinguished people around this table be so at ease with behaviours in Doncaster which are incompatible with best practice, EDS 2 Workforce Race equality scheme, Equality Act PSED.

Given that it is nationally recognised that BME People are more likely to:

- Get a long term disease (Diabetes, CHD, Stroke, mental illness)
- Earn less and be unemployed
- Die earlier

How much longer will black and minority ethnic citizens have to wait for their basic rights to be safeguarded and to be treated with a modicum of decency and respect?

In conclusion Chair and given today's article in the Free Press that Doncaster partnerships are out of touch with the true reality facing BME communities, does the Board have a date in mind when BME needs will a) be assessed and b) considered for action. Or are you waiting for the finance well to run dry, and then tell us it's tough?"

In reply, Dr Rupert Suckling confirmed that one of the recommendations in his Annual Report of the Director of Public Health, which had been endorsed at the Council meeting in January 2016, was to carry out a local Health Needs Assessment for BME Groups. He pointed out that the Annual Report of the DPH was an item later on today's agenda and so there would be an opportunity to discuss this matter further then. [At this point, the Chair asked that it be noted that Mr Brown left the meeting without hearing any subsequent discussion.]

52 DECLARATIONS OF INTEREST, IF ANY

No declarations of interest were made.

53 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 7TH JANUARY, 2016

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 7th January 2016 be approved as a correct record and signed by the Chair.

54 QUARTER 3 PERFORMANCE UPDATE AND FOCUS ON MENTAL HEALTH

The Board considered a report which provided the latest performance figures for the Quarter 3 period. The paper set out the current performance against the agreed priorities in the Health and Wellbeing Strategy.

It was reported that a refreshed 'outcomes based accountability' (OBA) exercise had been completed parallel to the refresh of the Health and Wellbeing Strategy. The five outcome areas remained and specific indicators had been identified which would measure progress towards these outcomes in 2015-16. Further information and narrative around the performance was provided in Appendix A to the report, with each

indicator being accompanied by a 'story behind the baseline' together with an action plan indicating 'what we will achieve in 2015-16' and 'what we will do next period'. It was noted that the OBA methodology moved away from targets for the whole population indicators and this was reflected in the report. Instead, the trend and direction of travel was the key success criteria.

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

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

In response to a query, Allan Wiltshire explained that it was very difficult to provide the Board with quarterly performance figures for these particular Indicators due to the way they were measured.

Members acknowledged that with the imminent de-commissioning of weight management services, there would be a need for closer working between school nurses and the National Child Measurement Programme and with Public Health colleagues.

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

In referring to Indicator b) – Alcohol related attendance at A&E (per 1000 population), Dr Rupert Suckling advised that this amounted to approximately 4000 people attending A&E in Doncaster every year. He stated that one option to alleviate the situation might be to trial a 'safe haven' initiative similar to schemes running in other areas such as Blackpool, which was designed to take the pressure off A&E and prevent avoidable hospital admissions by offering alternative support facilities for those in need. During subsequent discussion, the view was expressed that there was also a need to look at interventions to stop people reaching the stage of needing a safe haven in the first place, such as discouraging excessive alcohol consumption. Members also discussed the links between alcohol consumption and areas of high deprivation and poverty. With regard to health promotions, Susan Jordan reminded the Board that SLHD would be happy to feature any campaign material in its 'Houseproud' magazine for tenants.

Outcome 4: People in Doncaster with dementia and their carers will be supported to live well

During discussion on the suite of indicators relating to dementia, it was suggested that it would be helpful to know how the different indicators were interlinked and how they influenced each other. The Board also acknowledged that, in interpreting certain indicators, it was necessary to exclude other issues/factors in order to focus on dementia. In response to a comment, Dr Rupert Suckling suggested that an update on Intermediate Care could be added to the Board's Forward Plan for a future meeting.

Mike Pinkerton stated that he was pleased to report that the latest Hospital Standardised Mortality Ratio (HSMR) figure for Doncaster and Bassetlaw Hospitals was down to 98, compared to a figure of 117 three years ago. This was good news for all patients in Doncaster, including those with dementia. He passed on his thanks to colleagues in the CCG and at RDaSH for their support to the Trust in contributing to this improved result.

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

The Board received a presentation by Andrea Butcher on the Mental Health area of focus. Members were updated on progress in a number of key areas, including:

- Progress to date with the Doncaster Crisis Care Concordat Action Plan;
- Implementation of a recovery house service model;
- Development of Secondary Care Mental Health Services;
- 'Wellness for Life' event for service users and carers to be held on 21 March 2016;
- Key messages from the Five Year Forward View for Mental Health;
- Future Developments 2016/17;
- What will success look like?

Arising from a comment by Karen Johnson, it was suggested that the concept of a virtual recovery college could be discussed at the forthcoming Wellness for Life event.

RESOLVED:

1) To note the performance against the key priorities; and

2) To receive and note the presentation on the Mental Health area of focus.

55 JOINT STRATEGIC NEEDS ASSESSMENT UPDATE

RESOLVED that consideration of this item be deferred.

56 DONCASTER LIBRARIES AND CULTURE SUPPORTING WELLBEING

The Board received and noted a presentation by Nick Stopforth, Head of Libraries and Culture (DMBC) which outlined the important role played by the library service and wider cultural resources in providing wellbeing benefits for the residents of the Borough. These benefits included:-

- Mental stimulation gained from activities such as reading, which was recognised as one of the factors that could help defer the onset of dementia;
- Volunteering opportunities for individuals in facilities such as libraries could assist in terms of improving people's self-confidence and self-esteem;
- The Home Library Service visited approximately 4000 residents across the Borough, many of whom lived in social isolation;
- The wellbeing benefits of arts and culture were borne out by the following statistics:-
    - 76% of older people say arts and culture is important in making them feel happy
    - 60% say it is important in encouraging them to get out and about
    - 57% say arts and culture is important in helping them meet other people.

During subsequent discussion, the Chair cited an example of how volunteering at a community library had helped one young man cope with Bipolar Disorder.

The Board then discussed how a strategy for libraries and cultural services might incorporate and develop a focus on health and wellbeing for the public in Doncaster in future, and whether there were opportunities to create better joined up working with health providers in order to achieve this. Members recognised that arts and culture had a significant part to play in terms of making a positive impact on residents' health and

wellbeing. In particular, it was acknowledged that there was scope for making wider use of public/community art in public buildings, including hospitals, and in ensuring that maximum benefits were gained from the positive contribution that culture and arts could make in the provision of health care.

RESOLVED to note the important role played by the library service and wider cultural resources in providing wellbeing benefits for the residents of the Borough.

57 HEALTH PROTECTION ASSURANCE ANNUAL REPORT

The Board received a presentation by Victor Joseph and Sarah Smith on the Health Protection Assurance Annual Report for 2015/16, a copy of which was included in the agenda papers. Members noted that this was the first Health Protection Report to this Board since the responsibility of health protection moved to the local authority following the introduction of the Health and Social Care Act 2012.

It was reported that there had been sustained progress in ensuring that the health protection assurance system in Doncaster was robust, safe, effective, and met the new statutory duty placed on local government to protect the health of the people of Doncaster. This had been achieved through the meeting of the Health Protection Assurance Group that provided assurance on various elements of health protection.

During discussion on the various recommendations set out in the Report, Victor Joseph confirmed that a new national strategy on smoking was expected later this year, which would be reflected in the refreshed version of Doncaster's local Tobacco Strategy.

Dr Rupert Suckling explained that Health Protection was a wide ranging area of work which relied upon good working relationships with key agencies and partner organisations. He felt that the Annual Report was a useful summary of the vital work being carried out in this area and pointed out that the Report would also be submitted to the Council's Health and Adult Social Care Overview and Scrutiny Panel for information.

RESOLVED to:

1) Note the progress made against areas identified for development in 2015/16;

2) Note the update on the health protection assurance system in Doncaster; and

3) Support the recommendations made in the report.

58 LEARNING DISABILITIES REVIEW

Andrea Butcher presented a briefing paper for the Board's information which outlined proposed changes and developments to learning disability services.

It was noted that a challenge had been set to remove the need for permanent hospital care for patients with a Learning Disability and/or Autism by March 2019. In order to do this, there would be a need to build and develop community based services which were responsive to need and reduce the reliance on in-patient beds.

During discussion on the proposals, Chris Stainforth stated that it was acknowledged that services needed to be modernised and whilst this would be financially challenging, a shift towards community services was to be welcomed.

After Members had recognised the important role that would be played by families, carers and the third sector/voluntary resource in enabling people with a learning disability and/or autism to live in the community, it was

RESOLVED to:-

1) Receive the briefing paper as an introduction to the Building the Right Support principles which would now need to be delivered across the Transforming Care Partnership and locally;

2) Note the proposed direction of travel to deliver the principles and the work planned in Doncaster to deliver a whole system and service review of learning disability and autism services over the next 2 years;

3) Receive the finalised plan early in the new Financial Year and note the governance arrangements and receive timely progress reports.

59 STRONGER FAMILIES UPDATE

The Board received a presentation by Matt Cridge which provided an update on the Doncaster Stronger Families Programme. It was reported that the Doncaster Stronger Families Programme was a service transformation programme focussing on developing a whole family coordinated approach to family support. Families often displayed behaviours linked to physical or mental health difficulties or health issues resulting in social issues such as debt, poor school attendance or domestic violence.

The aim of Stronger Families was 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 were integral to the Stronger Families programme and the success in supporting families to improve their lives and build resilience for the future.

It was noted that an expanded programme had commenced in Doncaster in April 2015, with the aim of engaging and achieving outcomes with a total of 3090 families up to April 2020.

The Board welcomed the expanded programme and the focus on early intervention, but noted that there had been some difficulties in securing the engagement of Health service partners/agencies in the programme.

After Members had acknowledged the significant amount of work being put into this Programme and noted that there were some good case studies available which demonstrated the benefits of the Programme to families, it was

RESOLVED to note the progress of the Stronger Families Programme to date.

60 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2015

Dr Rupert Suckling presented the Director of Public Health's Annual Report for 2015 to the Board, which had been endorsed by Doncaster Council at its meeting held on 28th January 2016. It was noted that hard copies of the Annual Report would be circulated to all partners with an offer for Dr Suckling to attend their Board/Management Team meetings to talk through the contents.

In what was his first Annual Report, Dr Suckling advised that he had identified four key challenges that would need to be addressed in order to sustain progress. The challenges were:

- 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; and
- Reducing inequalities in health between and within Doncaster communities.

He stressed that none of these challenges could be addressed simply by one agency or individual acting alone. All needed cross agency support and leadership by and with local people. One example of this was the recommendation to carry out a local Health Needs Assessment for Black and Minority Ethnic (BME) Groups, which Dr Suckling explained would need a partnership approach, along with other initiatives and pieces of work identified in the Report.

The Report also contained a small number of case studies illustrating where teams were already supporting individuals to take control of their own and their friends and families' health.

During discussion, Damian Allen questioned whether an adequate profile was currently available for measuring the impact of poverty on people's health and other factors, such as the numbers of suicides linked to austerity. He felt it would be useful as a Board to be able to track austerity related impacts on the health of the Borough's residents.

RESOLVED to note and endorse the conclusions and recommendations as set out in the Director of Public Health's Annual Report.

61 REPORT FROM THE HEALTH AND WELLBEING 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:

- Childhood Obesity;
- Loneliness and social isolation;

- Health and Social Care Planning 2016/17 – 2020/21; 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. 8
Date: 09.06.2016

Subject: 2015-16 Q4 Performance Report

Presented by: Allan Wiltshire

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

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

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

Recommendations
The Board is asked to:- a) Note the performance against the key outcomes b) Receive and note the short presentation from the 'Alcohol' area of focus c) Agree what area of focus the Board would wish to have further information in Q1 2016-17 d) Agree that the report will contain drug performance information from Q1 2016017

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Doncaster
Metropolitan Borough Council

Agenda Item No: 8
Date: 09/06/16

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

PERFORMANCE REPORT Q4 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.
- Number of people participating at DCLT Leisure Centres per 1000 population (includes multiple visits)

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
- Number of people in specialist alcohol treatment
- Number of people in specialist alcohol treatment entering via the CJS
- Successful exits for people in specialist treatment
- Representations for people in specialist treatment

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 outcomes
   b) Receive and note the short presentation from the 'Alcohol' area of focus
   c) Agree what area of focus the Board would wish to have further information in Q1 2016-17
   d) Agree that the report will contain drug performance information from Q1 2016017

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.

9. An additional OBA exercise has taken place for drugs (appendix b), which tracks the harmful impact of drug misuse on individuals, families and communities. This along with alcohol will provide information for a combined area (alcohol & drugs) of focus for substance misuse for 2016-17. Additional measures proposed to be included are;

   - Increase the proportion of all in treatment, who successfully complete treatment and do not re-present within 6 months
   - Reduce drug related offending (reoffending of DRR clients)
   - Increase the number of clients in treatment who live with children
   - Increase Numbers in Treatment
   - Drug related crime (TBC)

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

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Director of Public Health

Doncaster Health & Well Being Board

Performance Report

Q4 2016-17

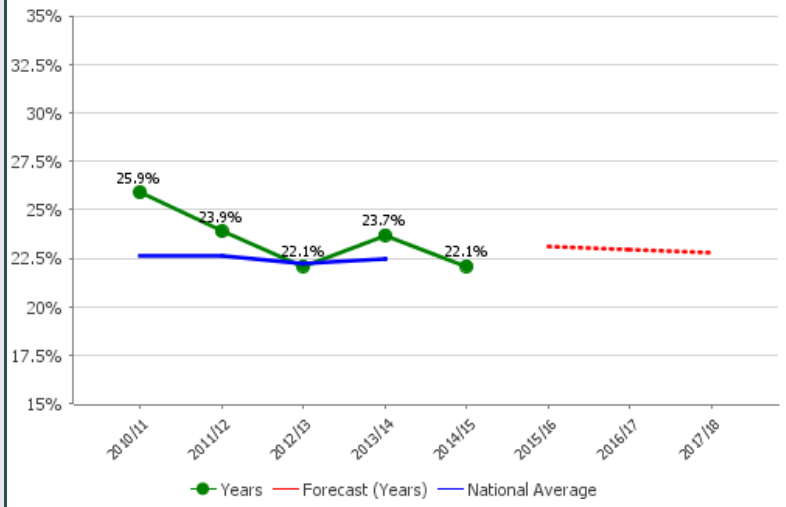
Appendix A

Values below 5 have been rounded to 0 or 5

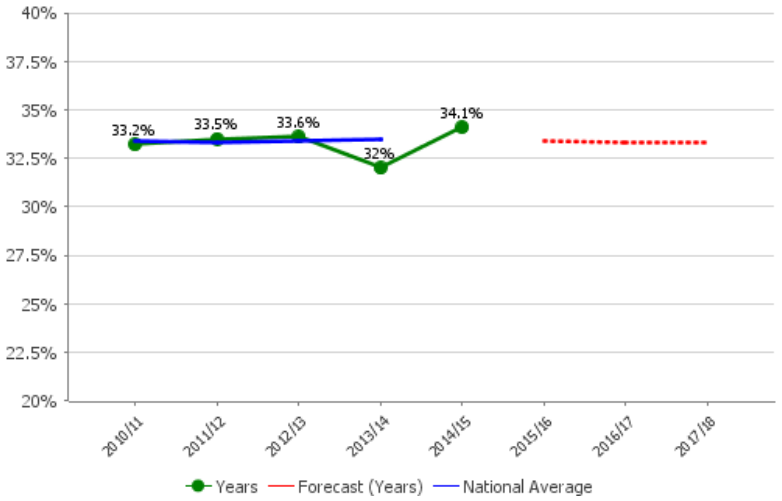
OUTCOME	All Doncaster residents to have the opportunity to be a healthy weight

INDICATORS

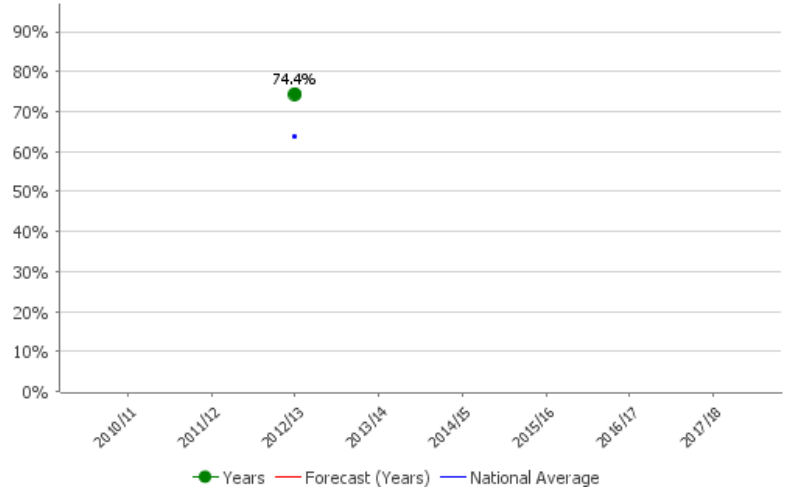
a) % of Children that are classified as overweight or Obese (Aged 4/5)



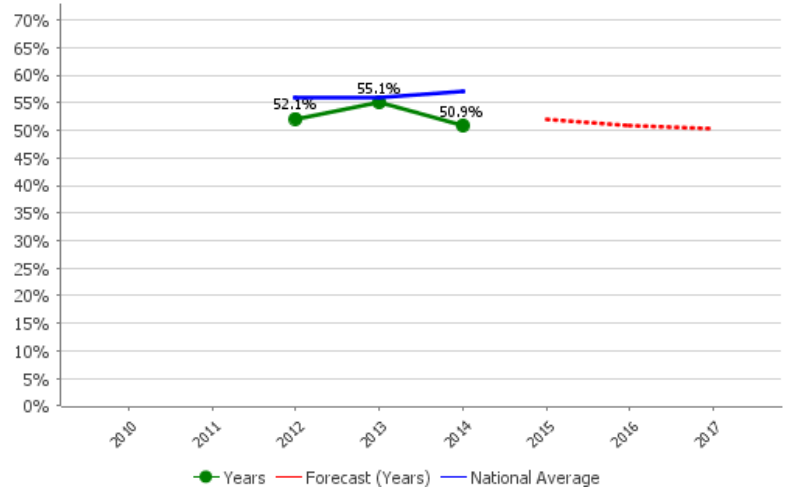
b) % of Children that are classified as overweight or Obese (Aged 10/11)



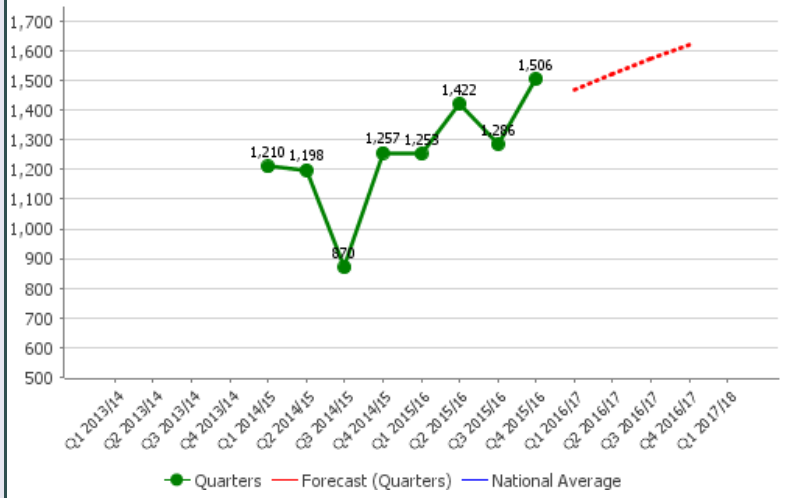
c) % of Adults Overweight or Obese



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



e) Number of people participating at DCLT Leisure Centres per 1000 population (includes multiple visits)



STORY BEHIND THE BASELINE

The Reception and Year 6 overweight and obesity figures will be available nationally (and locally) by September 2016. The data will be collected at the end of the school year. In the meantime over the summer months, public health will be undertaking a descriptive epidemiology of childhood obesity in the city using data from the National Child Measurement Programme (NCMP). There are 124 primary schools in Doncaster and 9 years of NCMP data which identifies the weight status of all children in reception (age 4-5) and year 6 (age 10-11) for the years 2006/7 to 2014/15. Data is coded to schools. There are measurements for 50,307 children in that time period, of which 24,155 pertain to year 6 children and 26,152 to reception children. Initially the data, by school, will be sorted according to IMD deprivation score. Schools will then be grouped into deciles based on deprivation. This data will be analysed to identify what pattern of obesity is emerging locally to highlight obesity rates (growth or reduction) over time. Uptake of school meals and physical activity in schools will also be analysed to identify whether there is any correlation between these variables and local childhood obesity rates.

This work will help to identify priority local areas of focus and also whether local school policy can be further informed to help address childhood obesity. The report will be available mid-September and will be fed back in the Q3 Performance report. A series of 3 childhood obesity workshops have been held in Q4 which included a self –assessment exercise with key stakeholders, a mapping of activity across a wide range of partners and a prioritisation exercise to identify future priorities around childhood obesity. The tool used was a prioritisation tool from the Shared Intelligence Unit. The findings of these workshops will inform the future childhood obesity work plan using a whole family and whole system approach. A Childhood Obesity Alliance will be set up in Q2 to start work on these priorities. The national childhood obesity strategy is due to be released over the summer period which will support and inform these developments. The Shared Intelligence work was piloting a national tool ahead of the dissemination of the national Childhood obesity strategy.

There is ongoing work to find a number of proxy indicators around the obesity data and a proposal will be brought back in a future performance report. Active kids data and participation at local leisure facilities is already collated and available.

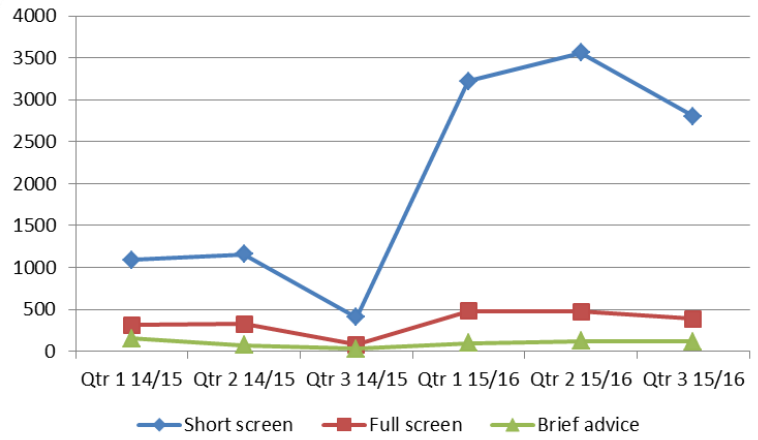
Public Health have contributed to the planning policies that will be within the revised Local Plan. This aims to provide a whole system approach to planning a healthy weight environment. In particular it has been proposed to limit the concentration of hot food takeaways and restrict opening hours and proximity near schools, improved infrastructure for cycling and protect green space. Health Impact assessments will also be requested for certain types/size of developments to help build on any opportunities to create a place where healthy choices are easy choices.

	The Tier 2 Weight Management service was ceased in March 2016 (Q4) and was subject to a Corporate decision process. At the same time the Tier 3 Weight Management service was reviewed and a contract variation has been issued and a revised exit plan and pathway agreed between the commissioner and the provider. The Tier 3 children's pathway weight management service will be tapered by 30th September 2016 and the Tier3 Adults weight management service will operate as a pre-bariatric surgery pathway until 31st March 2017. Contract meetings are about to re-commence in Q1. Communications have been circulated to key stakeholders and a signposting package is in development including links to the Health checks programme.	
ACTION PLAN	**What we will achieve in 2015-16**	**What we will do next period**
	1. Public Health are working in collaboration to address healthy food options – the food plan is completed and undergoing final checks before dissemination by Q2; the work around proximity of takeaways and healthy food choices is underway and results will be provided when available. Two research studies are being undertaken around food takeaways and food banks and will be completed by Q2. 2. Physical activity proxy measures through discount promotions are being explored. 3. The One You Campaign has been launched and a walking campaign is to be launched in September 2016. 4. The MECC e learning package has been developed and is undergoing final review and a communications s plan will be developed by Q2. 5. Ongoing work around the development of health policies into the local plan by Q2. 6. The Decent Helpings research in Edlington will help to inform future developments about what works in an area. 7. The outcomes of the 3 childhood obesity workshops will inform the priorities for the next year and will enable the development of a Childhood obesity Alliance using a whole systems approach.	1. Tier 3 weight management service – we will continue to monitor this service and work with DBH Nutrition and Dietetics service to ensure a safe tapering of the Tier 3 children's weight management service and a smooth transition for the Adults service into the revised pre-bariatric surgery pathway through regular contract meetings and activity monitoring. We will look at signposting information pathways for GPs and stakeholders in the community and increasing awareness of other services available. 2. We will establish a Childhood Obesity Alliance and develop a multi -faceted work plan by Q2 which encompasses a whole system approach and builds on the foundations identified in the 3 childhood obesity workshops held in Q4. A Champion for childhood obesity will be sought. We will be seeking partners from key organisations to support the alliance.. 3. We will complete the analysis of previous NCMP data identifying hotspot areas with trends towards highest overweight and obesity rates in the last few years. The use of school plans to identify current priorities will also be used as well the uptake of school meals and physical activity in local communities. The 2015/16 NCMP data will be analysed when available in Q2 and will inform future priorities. 4. The Doncaster food plan will be completed and a communications plan will be developed. 5. The Decent Helpings research in one Doncaster locality (Edlington) will be looked at to identify if there are any common denominators around behaviour in one locality and links to lower obesity levels. This will also be looked at across other areas (exploration through the Leeds Beckett pilots) and other countries to find out what works elsewhere. Lessons from the Well Denaby project could also be applied in terms of an assets based approach. A whole family approach has been recommended for this work by the stakeholders. 6. The MECC e learning package will be completed and a communications plan developed. 7. The obesity OBA will be reviewed in light of recent staff changes and developments to ensure it maintains its focus and direction of travel. Meeting to take place with regional schools meals lead (Let's Get Cooking) to discuss school meals and possible developments in Q1. 8. The Workplace Weight Watchers pilot in Public Health will be evaluated and success stories will be promoted. Feedback to date has been very positive and weight loss has already been identified. 9. The Healthy schools programme model is being reviewed and an event will be held in Q1 to explore a new Healthy schools model which will include criteria around healthy eating and physical

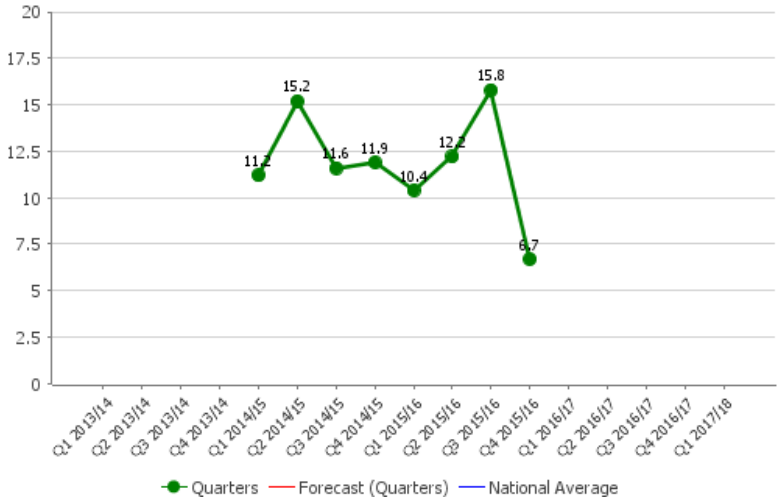
		activity monitoring. Links to the School sports premium are also being explored. 10. There will be further exploration around other proxy indicators to measure physical activity and healthy eating behaviours over the next 6 months. 11. Public Health are supporting 2 university students with research around household food insecurity in Doncaster – interviews and focus groups will be conducted at local food banks and children's centres to further determine experiences of families in Doncaster and another research project will explore food consumption behaviour and patterns around food takeaways particularly in areas of deprivation. The results of these research projects will be available by Q3.

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

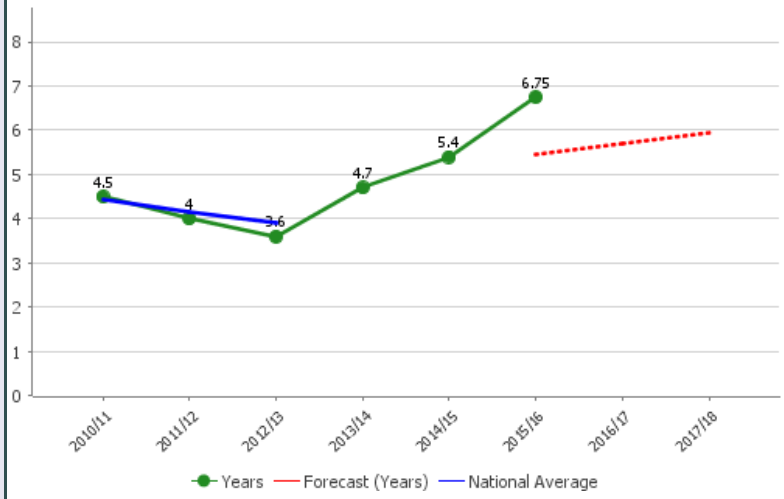
a)Numbers of people being screened for alcohol use and, where appropriate, receiving brief advice



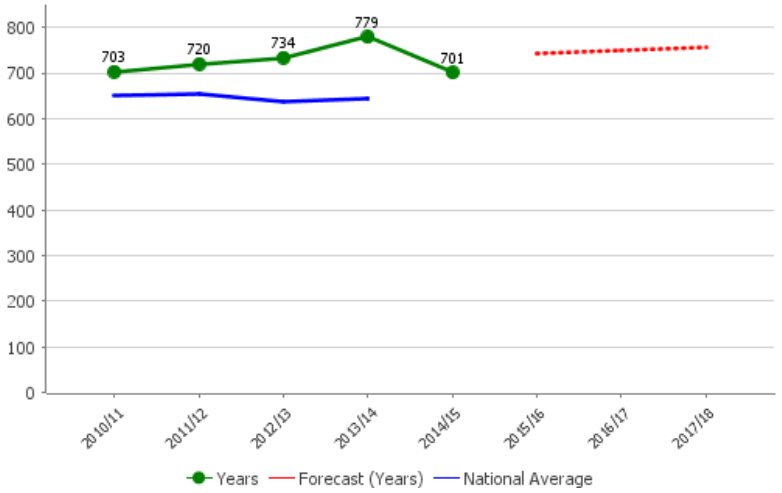
b) Alcohol-related attendance at A&E (per 1000 pop)



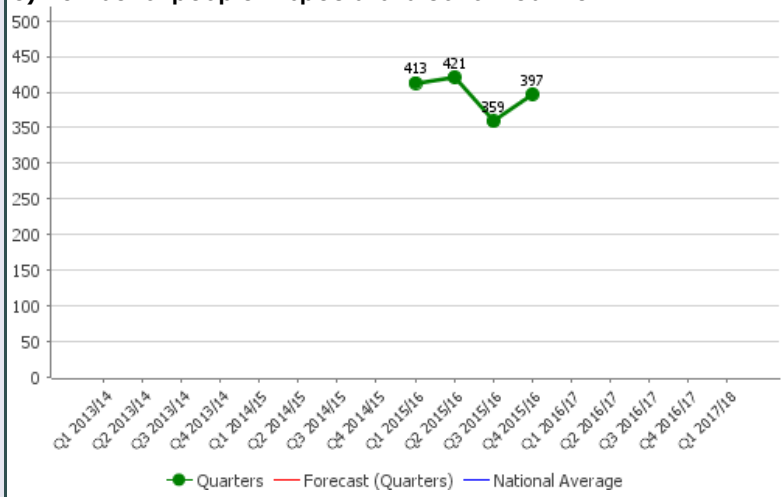
c) Alcohol-related violent crime per 1000 pop (2015/16 YTD Only)



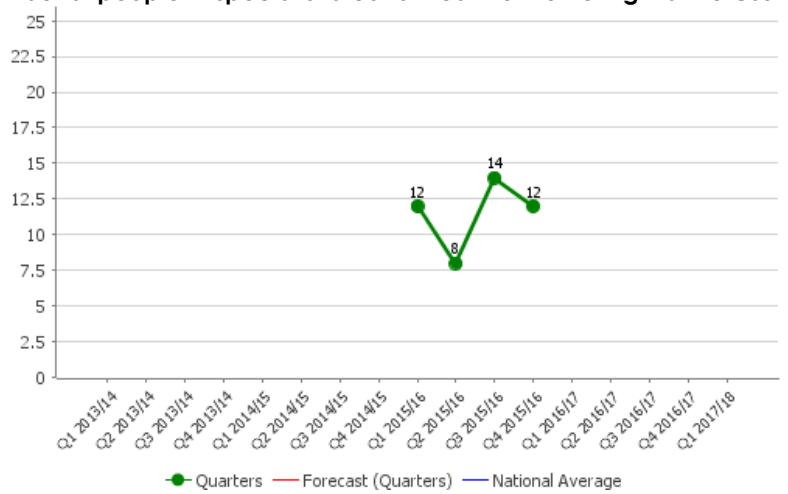
d) Alcohol related admissions to hospital (14/15 data provisional)



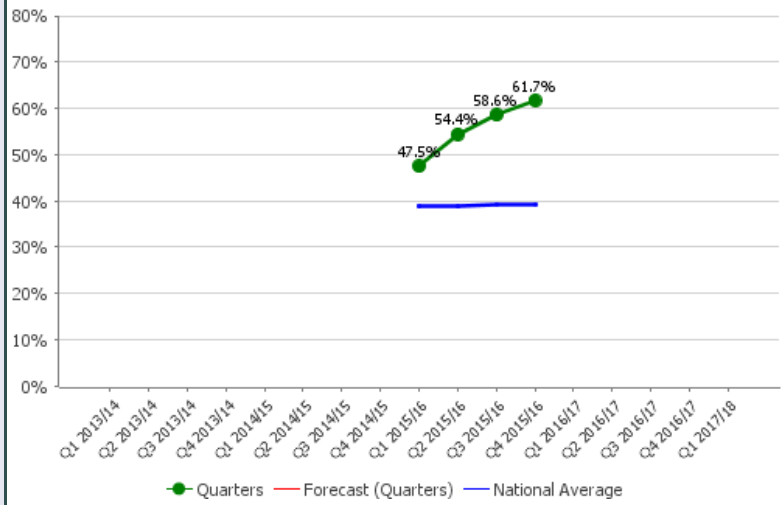
e) Number of people in specialist alcohol treatment



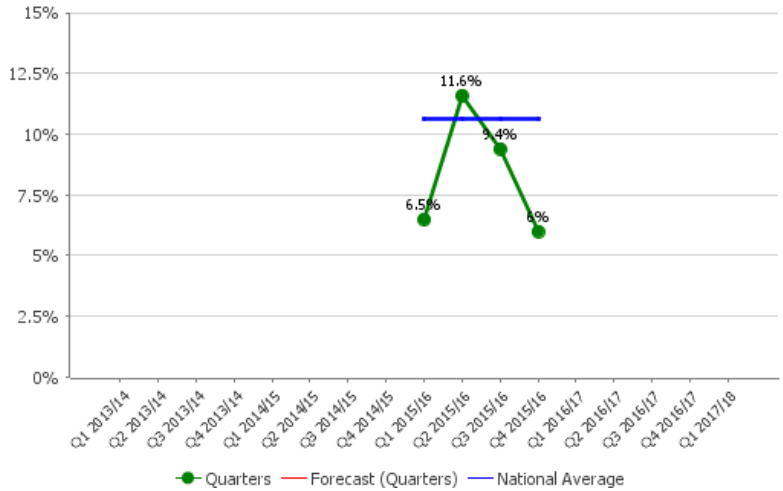
f) Number of people in specialist alcohol treatment entering via the CJS



g) Successful exits for people in specialist treatment



h) Representations for people in specialist treatment



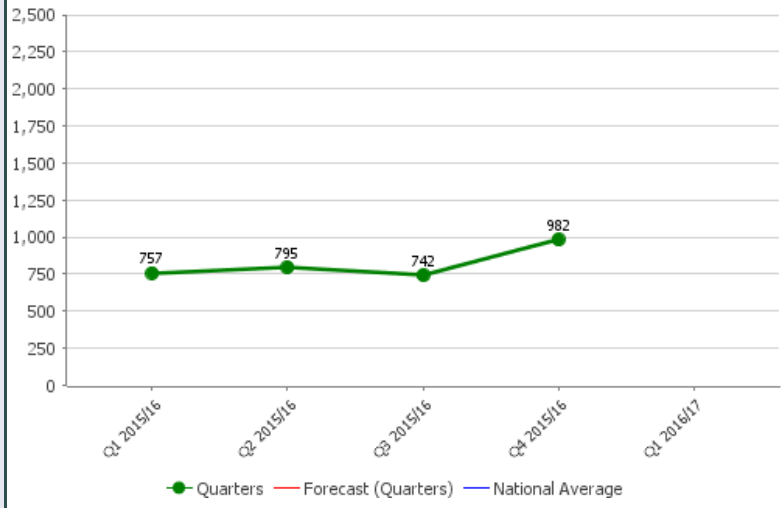
STORY BEHIND THE BASELINE

The number of people being screened for alcohol abuse has not been updated from Q3 due to processing of invoices. 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.

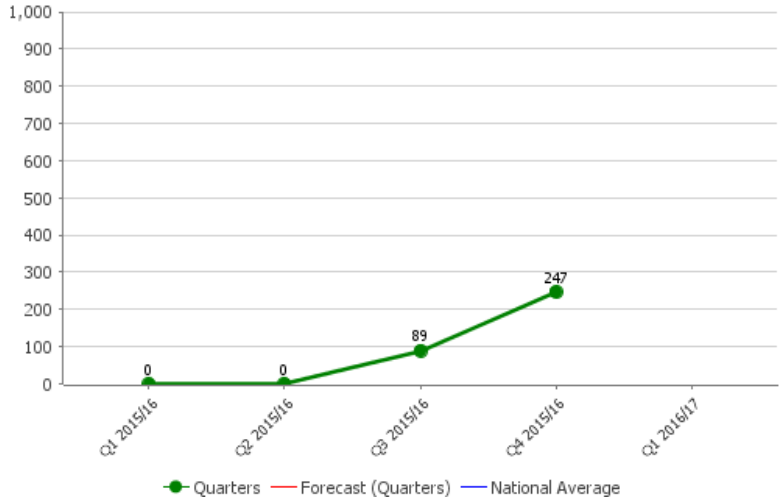
	There is a significant difference in data reported for alcohol related A&E attendances due to change in data source, Q4 data received from the CCG instead of directly from DRI, this is being investigated. Attendances fluctuate over time but there are no significant trends. Attendance peaks sharply between 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. The numbers in specialist treatment have remained relatively stable over the year. There are estimated to be over 5,000 dependent drinkers in Doncaster therefore the aim is to increase the number of people accessing services. However numbers entering via the criminal justice system are low and the aim is to increase the numbers entering via this pathway (as a benchmark the Probation Service historically targeted 80 service users per year). This decrease may be a result of changes in the CJS, reducing the number of Alcohol Treatment Requirements (ATRs) issued by Magistrates (e.g. less use of alcohol conditional cautions, the reorganisation of probation into the National Probation Service and Community Rehabilitation Companies). Successful exits stood at 61.7% in March 2016, which is above the local target (36%) and above the national rate for England (39%). The aim is to maintain this performance through the mobilisation of the new service. Re-presentations (people who exit successfully but return to services within 6 months) stood at 6% in March 2016, which is above the national figure of 10.6%. Re-presentations were declining prior to the gap in data linked to the national system. The aim is to maintain this performance through mobilisation of the new system. When interpreting the data, it is important to bear in mind that some people may relapse and do not represent to the service.	
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. 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. Monthly monitoring of exits and representations. 2. Mobilising the new recovery system around the lead provider (RDASH) from 1April 2016 3. Continuing to monitor and screening and brief interventions through GP practices contracted via RDASH from 1April 4. Delivering public awareness campaigns and planning for the year.

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	

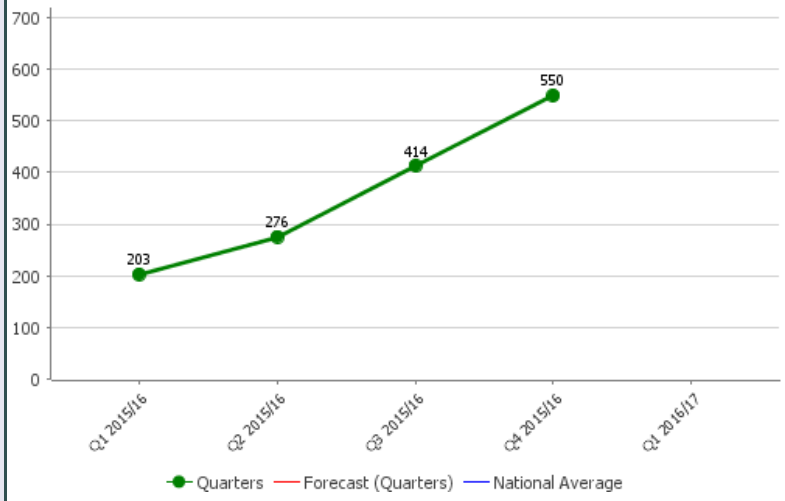
a) Number of Families Identified as part of the Phase 2 Stronger Families Programme



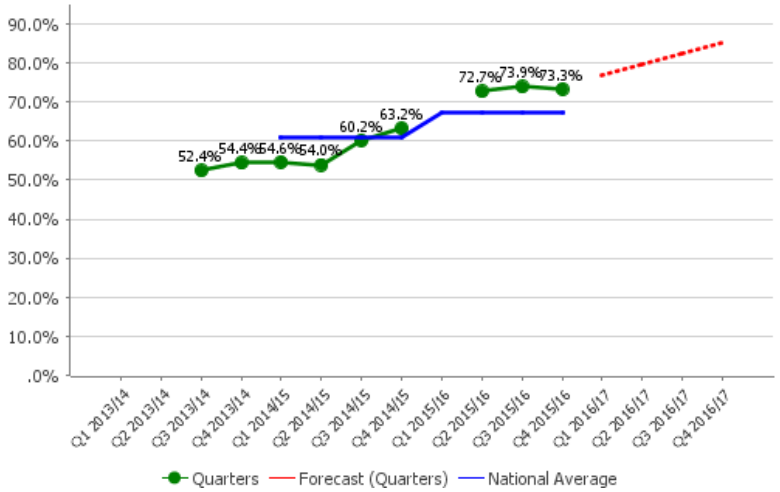
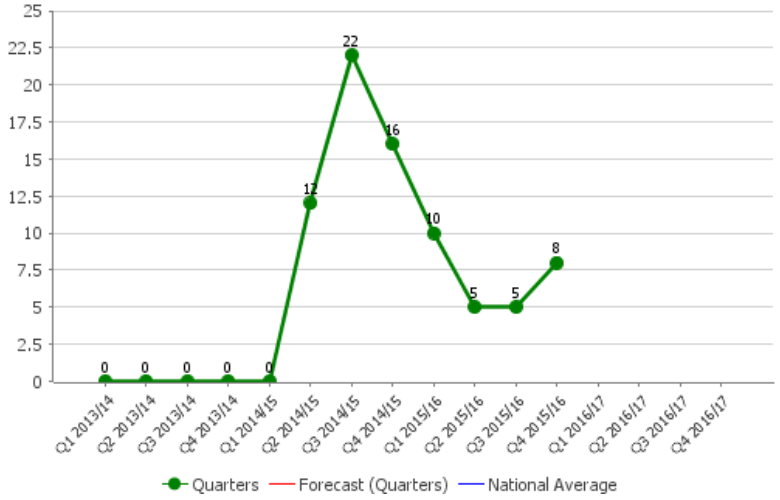
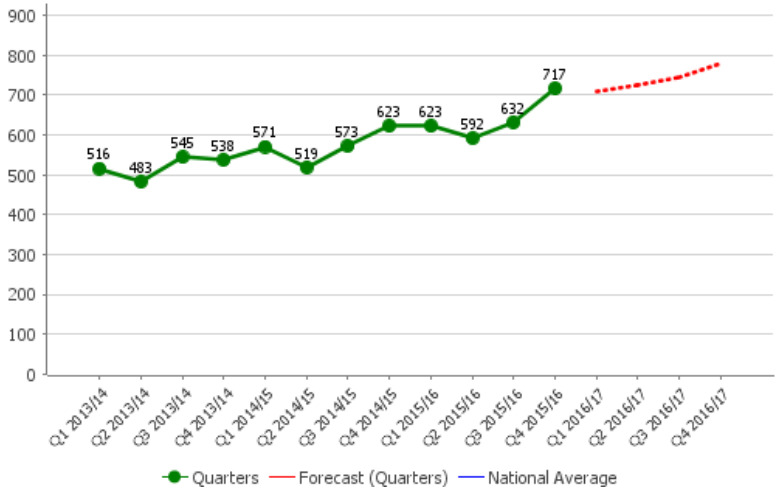
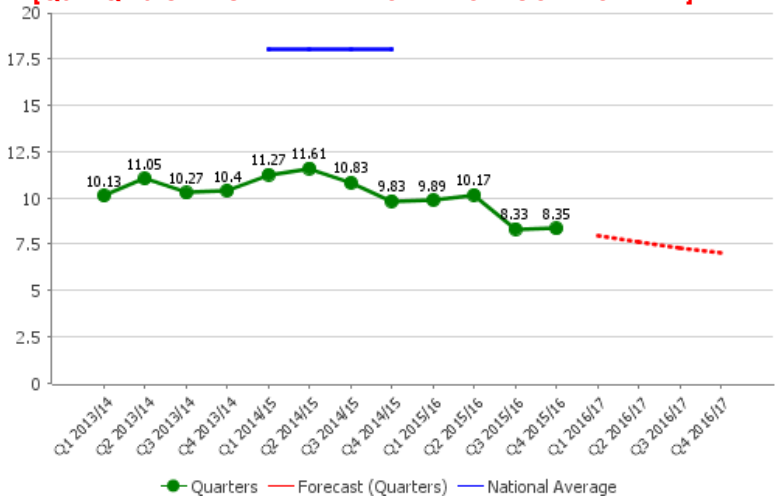
b) Number of families achieving positive outcomes through the Stronger Families Programme



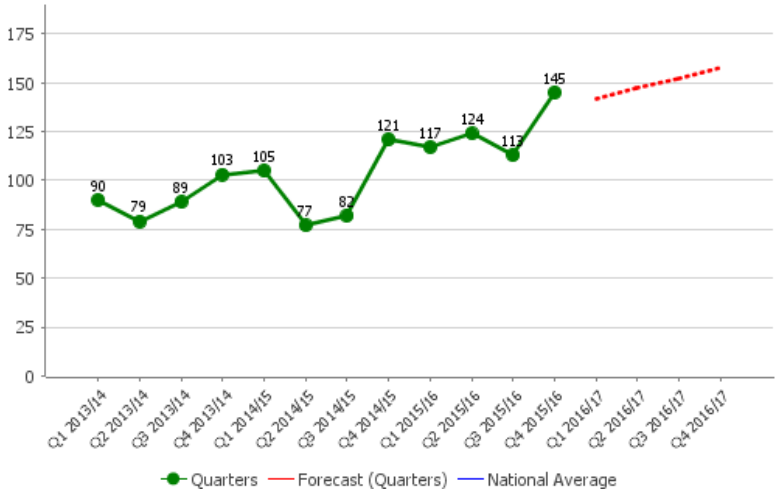
c) Number of Families Engaged in the Expanded Stronger Families Programme



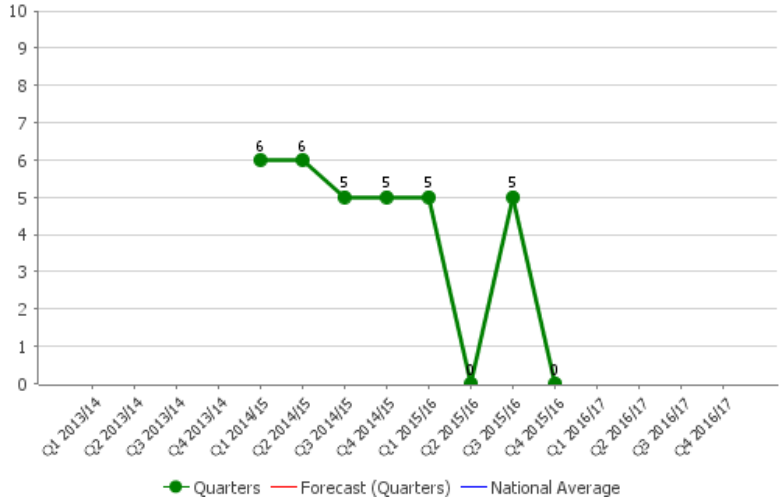
STORY BEHIND THE BASELINE	The Expanded Stronger Families Programme continues to develop at a good pace and Doncaster continues to show that it is able to deliver. Identification processes are working well and we are increasing the number of families identified as eligible by other professionals, however there is still much more work to do. Our current total of identified and validated families is 982 at this point which is on track to meet the expectations for Year 1 of the expanded programme. The targeted number of families engaged in the expanded programme for year 1 has been agreed to be increased from 491 to 550 following approval with the Chief Executive and DCLG. In Q4 550 families were actively engaged with the programme as planned. The next claim is in September 2016 and results will be reported in Quarter 2 2016/17. While Claims may only be made for sustained and significant progress against all assessed outcomes, or, continuous employment; progress against individual outcomes has been made by many families. The latest progress on positive outcomes is: Outcome 1 (Crime & ASB): 69 Outcome 2 (Children Attending School): 26 Outcome 3 (Children Needing Help): 58 Outcome 4 (Worklessness & Financial Exclusion): 68 Outcome 5 (Domestic Violence): 16 Outcome 6 (Health): 10	
ACTION PLAN	**What we will achieve in 2015-16**	**What we will do next period**
	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. Prepare for September 2016 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 [Q4 SIGNIFICANT DEVIATION ABOVE CONTROL LIMIT]**  **d) Length of stay of people with Dementia in an acute setting (average days) [Q3 + Q4 SIGNIFICANT DEVIATION BELOW CONTROL LIMIT]** 

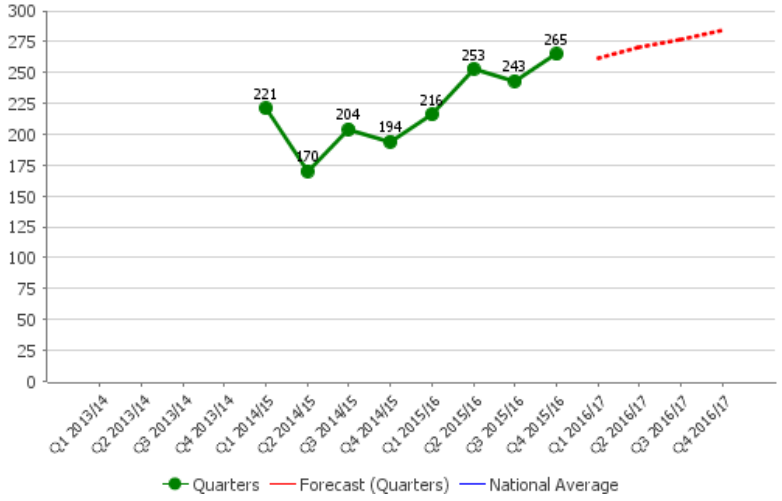
e) Hospital re-admissions within 30 days (DRI) for people with Dementia
[Q4 SIGNIFICANT DEVIATION ABOVE CONTROL LIMIT]



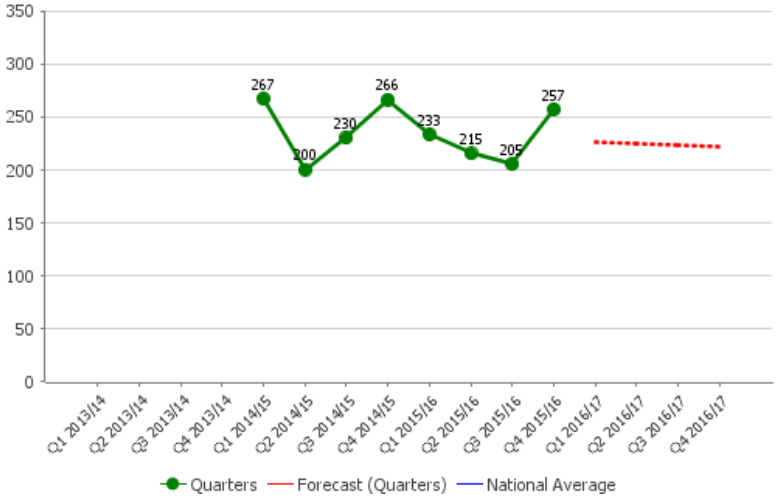
f) Number of patients having any delayed discharges encountered at RDaSH



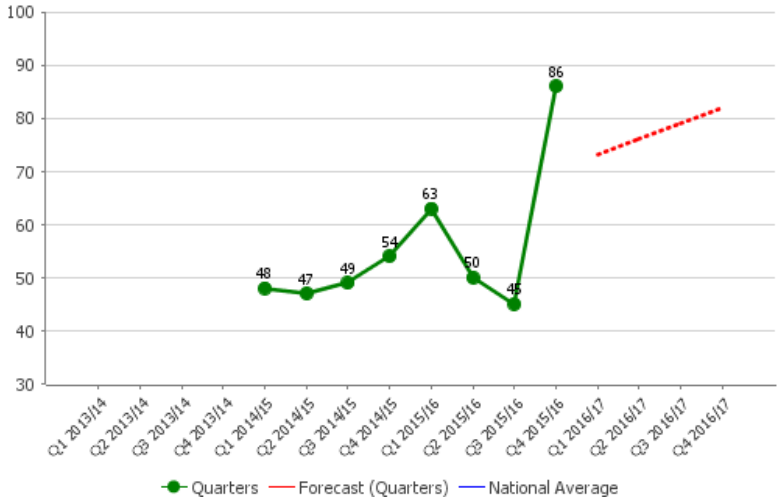
g) Attendances at A&E for people with dementia



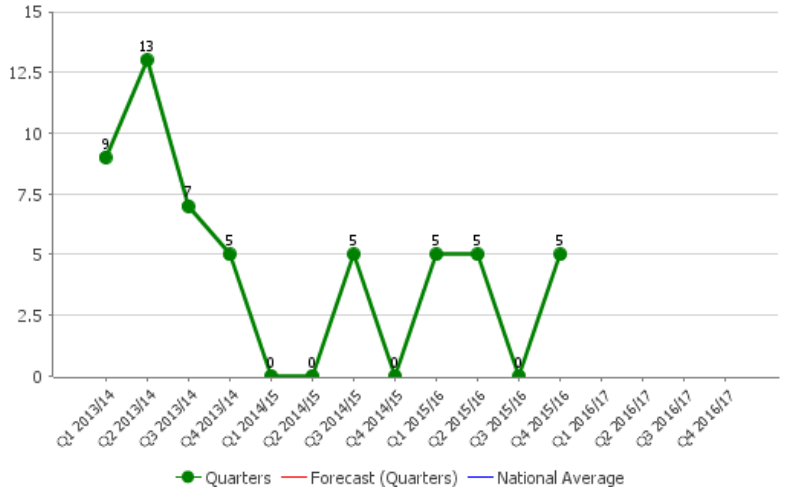
h) Number of people with dementia being admitted from care homes to DRI



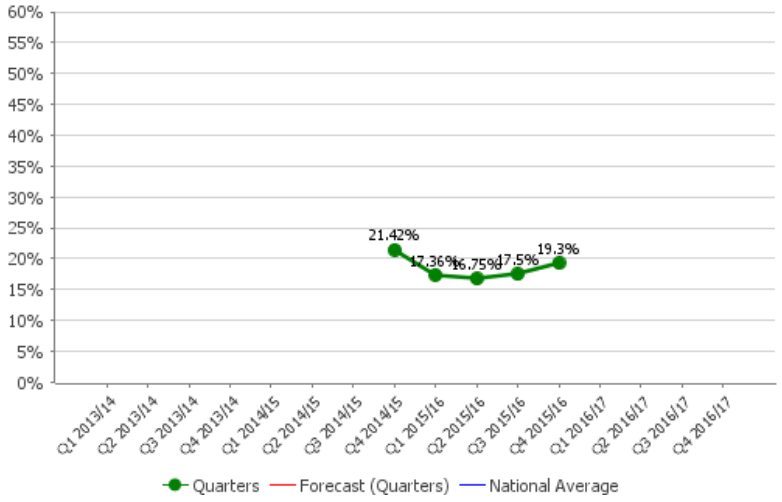
i) Number of Hospital deaths for patients with dementia
[Q4 SIGNIFICANT DEVIATION ABOVE CONTROL LIMIT]



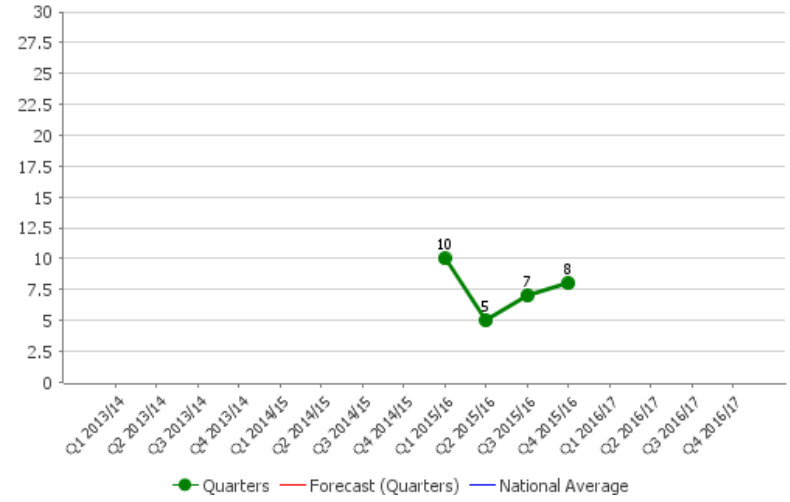
j) Unplanned episodes of Respite for people with Dementia



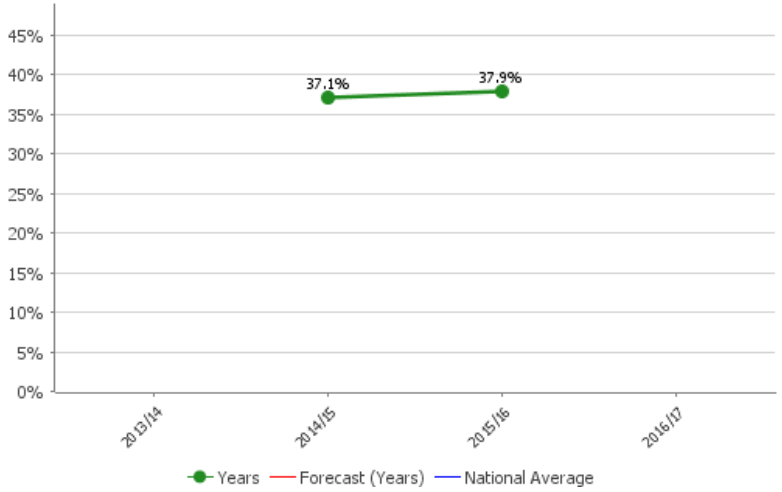
k) Proportion of referrals for Assistive Technology that are for people with Dementia



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



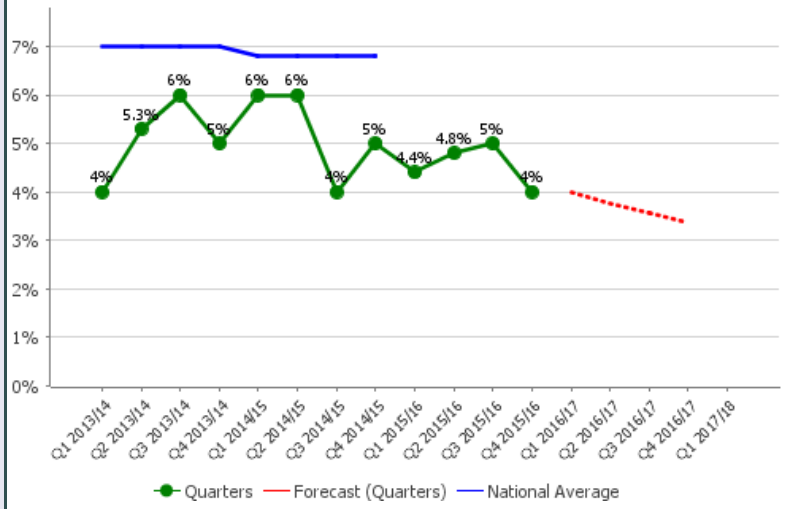
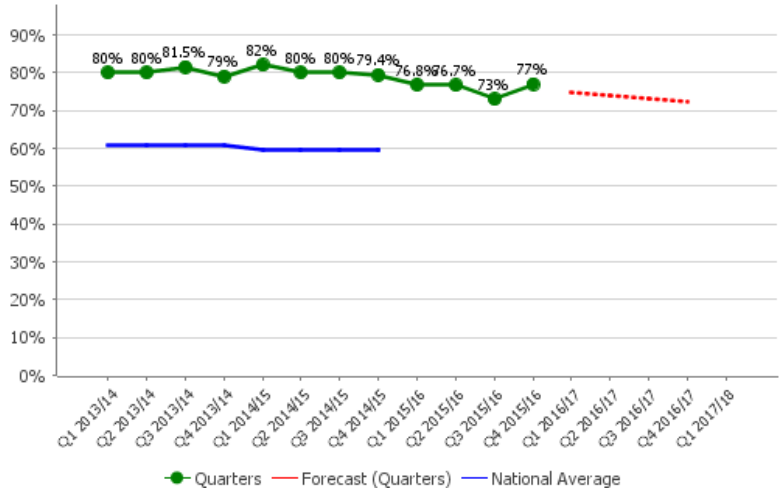
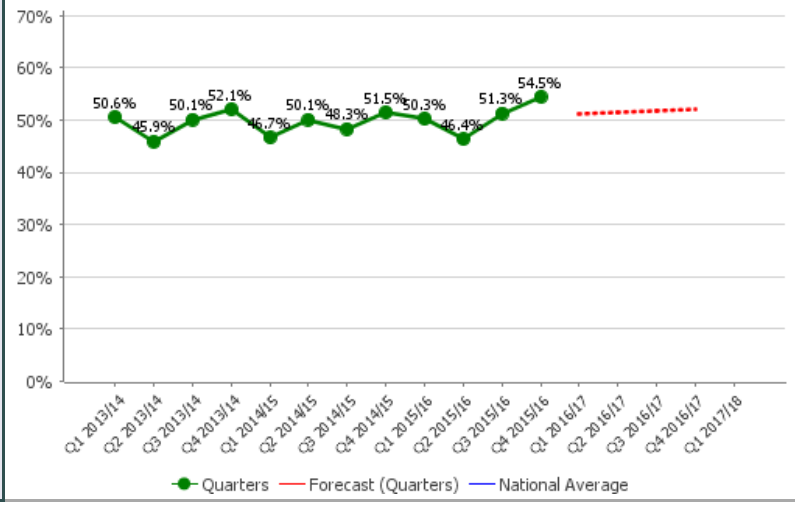
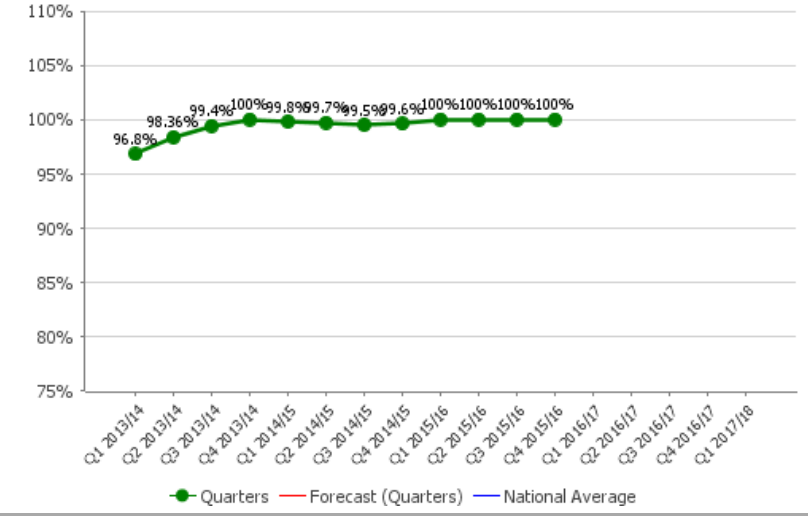
M) Proportion of People who access social care services and have a PSR of Memory Support & cognition living at home



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 73.3% 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 Q4, 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.

	What we will achieve in 2015-16	**What we will do next period**
ACTION PLAN	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	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

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

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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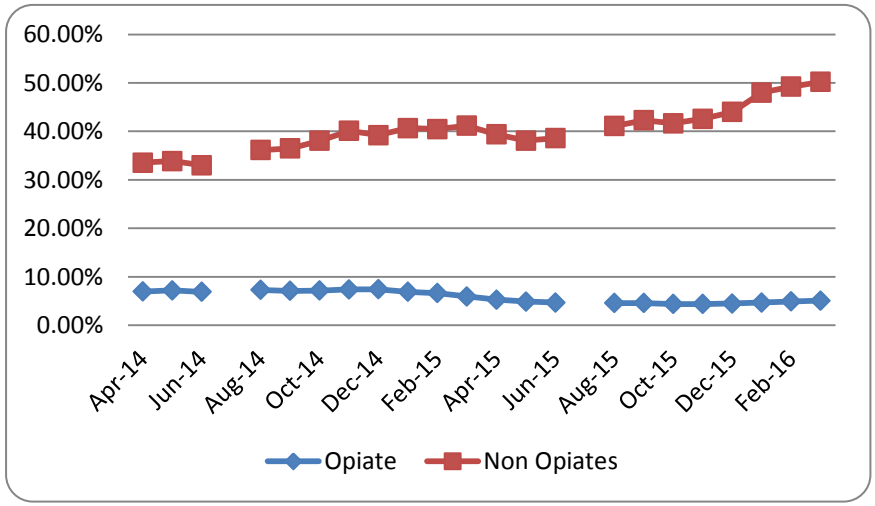
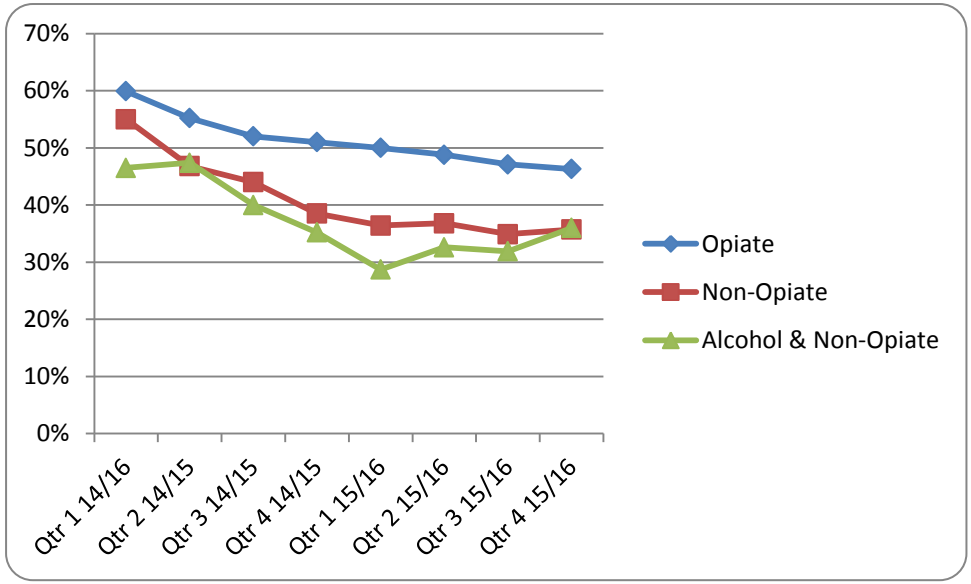
Drug O.B.A Q4 2015/16 - Reduce the harmful impact of drug misuse on individuals, families and communities.

1. Indicators

1. Increase the proportion of all in treatment, who successfully complete treatment and do not re-present within 6 months	**2. Reduce drug related offending (reoffending of DRR clients)**
 *N.B. (No national data for comparison)NB final data is shown on graph for March 2016*	*Data/information to be developed. This data development issue requires further debate to agree the measure, as CRC and police sourced data is potentially available.*

Drug O.B.A Q4 2015/16 - Reduce the harmful impact of drug misuse on individuals, families and communities.

3. Increase the number of clients in treatment who live with children



Story behind the Baseline

Indicator 1: Performance is slowly improving for the non-opiate group, but opiate users have not improved performance. Some of the reasons why this is, may be due to lack of recovery capital and complex needs of this client group such as aging opiate users who are somewhat 'stuck' in the treatment system. An action plan with number of opiate user discharges needed at a keyworker level has been developed and agreed with the provider.

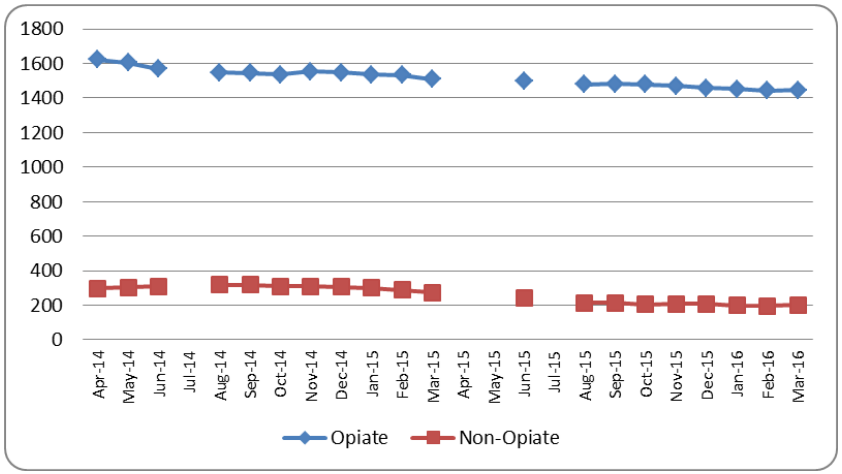
This indicator is linked to 2.5% of the annual contract value (top quartile performance to be achieved)

Indicator 2: awaiting data

Indicator 3: It could be argued that a decrease in number of clients in treatment is preferable. However, due to the protective nature of treatment and support, an increase in number of clients in treatment is still a positive outcome for the families affected.

Drug O.B.A Q4 2015/16 - Reduce the harmful impact of drug misuse on individuals, families and communities.

2. Performance measures – how much are we doing

Measure 1: Increase Numbers in Treatment	**Measure 2: (Need a measure on drug related crime)**
	

Story behind the baseline:

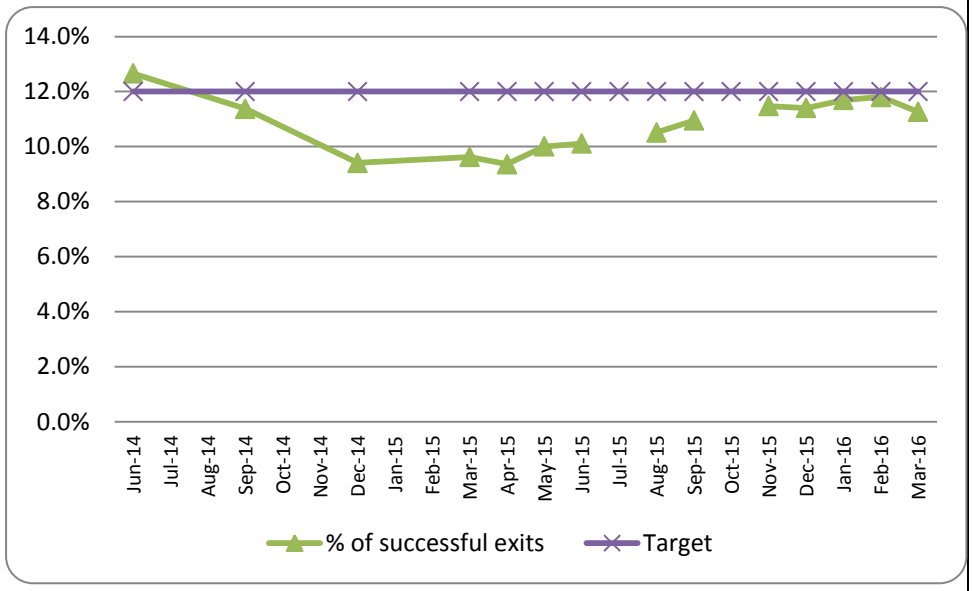
Measure 1: Aiming to increase the proportion of non-opiate users into the treatment system relative to the number of opiate users over the 4 year period of the whole system contract. There is national evidence that numbers of younger (i.e. under 25 years) opiate users is falling, and new drug trends are emerging (New Psychoactive Substance, club drugs, Image and Performance Enhancing Drugs, Over The Counter medication). There is an ageing population of opiate users in the treatment system who have complex health needs that need to be met.

Measure 2: To raise with SSDP Exec, CRC and Police how this measure can be reported, further discussion needed as the measures are not straightforward.

Drug O.B.A Q4 2015/16 - Reduce the harmful impact of drug misuse on individuals, families and communities.

3. Performance measures – how well are we doing it?

Measure 3: Successful completions of treatment



Measure 4: Re-presentations to treatment

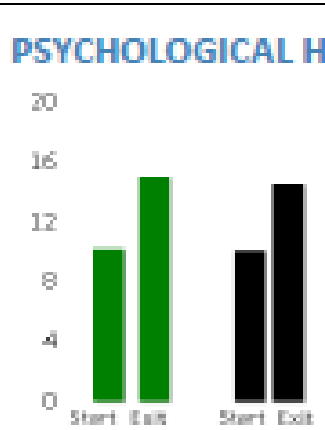
Story behind the baseline:

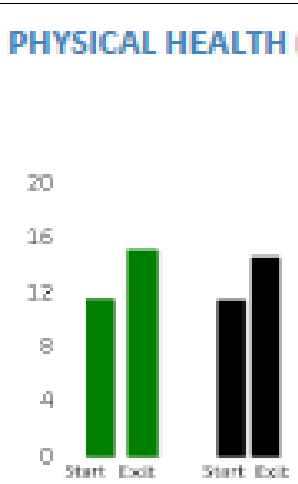
Measure 3: Over the past year, performance dipped to below 10%. However, performance improved to within 0.5% of target at year end.

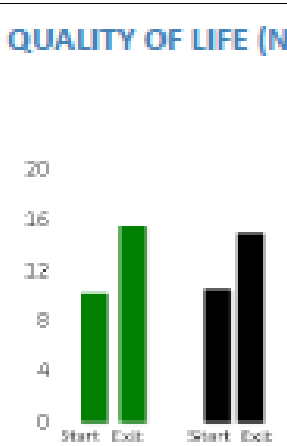
Measure 4: Representations continue to perform better than target. This means that for at least 6 months people are not coming back into treatment.

Drug O.B.A Q4 2015/16 - Reduce the harmful impact of drug misuse on individuals, families and communities.

4. Performance measures – is anyone better off







Key: Green = Local data Black= National data

Story behind the baseline:
Local performance mirrors National performance which shows the protective nature of treatment on an individual's wellbeing. Clients are reporting improvements to their health, measuring from Start to the end of their treatment.

What are we doing over the next quarter:

- Mobilisation of new whole system model delivered by Aspire from 1st April 2016. Monthly operational group meetings are taking place in order to monitor the developing service.
- A Hidden Harm Strategy is being developed for Doncaster jointly owned by key strategic partners with an action plan due to be delivered in 2016/17.
- A targeted IPED awareness/prevention/education campaign is being devised targeting gyms across Doncaster
- A new specialist needle/syringe exchange provision has opened across the Aspire service, including at community hub

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Doncaster
Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No. 9
Date: 9 June, 2016

Subject: Adult social care JSNA

Presented by: Rupert Suckling (on behalf of Laurie Mott)

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

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

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

The attached report outlines some of the potential challenges facing adult social care over the next 15 years. The report shows that Doncaster has an ageing population but also has a population that has lower 'disability free life expectancy'. Doncaster men and women are living longer with disability than many similar areas and with greater disability will come greater demand on social care services. The report then presents the potential increases in demand for social care that could result from an increasingly ageing population.

The trajectories described in this report should be regarded as predicting demand if no changes were made in the commissioning and delivery of social care services.

Recommendations
The Board is asked to:- Consider the potential impacts of an aging population on adult social care.

Adult Social Care – Joint Strategic Needs Assessment

Doncaster 2015

Doncaster Data Observatory

May 2016

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Contents

Summary

The following report outlines some of the key challenges that face adult social care in Doncaster. Doncaster has an aging population and, compared to similar areas, has poor health outcomes. This is particularly true when measured as disability free life expectancy. This implies that Doncaster could face a future with an ageing population which is also living with above average levels of disability.

Disability or infirmities are not the only reasons that people need support from adult social care. But it does represent a significant challenge for those services. The report then highlights the increasing levels of demand that Doncaster's social services could face if nothing changes.

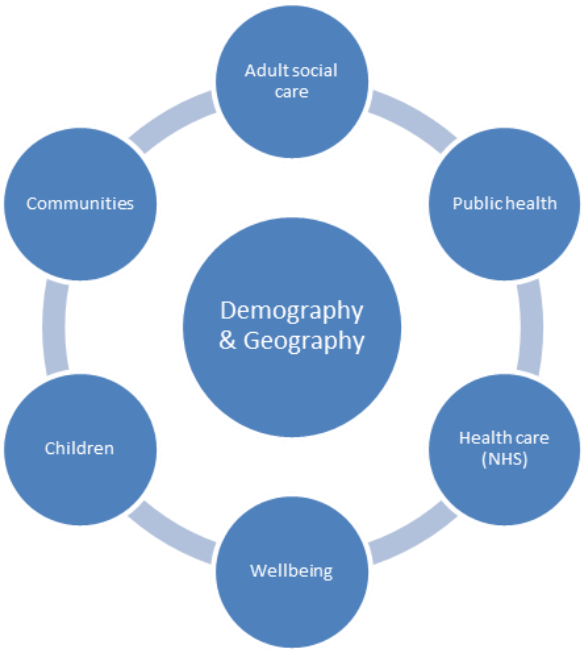
The report includes two appendices to the main report. The first outlines the potential advantages of an ageing population and the second looks at the social care and ethnicity.

It is important to note that Doncaster adult social care services are already embarked on an extensive programme of transformation to address many of the issues that are presented in this report.

Introduction

Joint Strategic Needs Assessment (JSNA) is an analysis of the current and future health and wellbeing needs in Doncaster. This report is intended to inform and improve strategic commissioning, support the health and wellbeing strategy, and help Doncaster's Health and Wellbeing Board address health inequalities[1]. This is the latest in a series of JSNAs that the Doncaster Data Observatory has produced, copies of which can be found on the Team Doncaster partnership website[2] .

This JSNA report reflects the structure outlined below. This graphic has seven domains: Public Health, Healthcare, Wellbeing, Children, Communities, and Adult social care. Underlying all of these is a comprehensive description of the demography and geography of the borough. This report describes some of the strategic challenges facing adult social care[3].

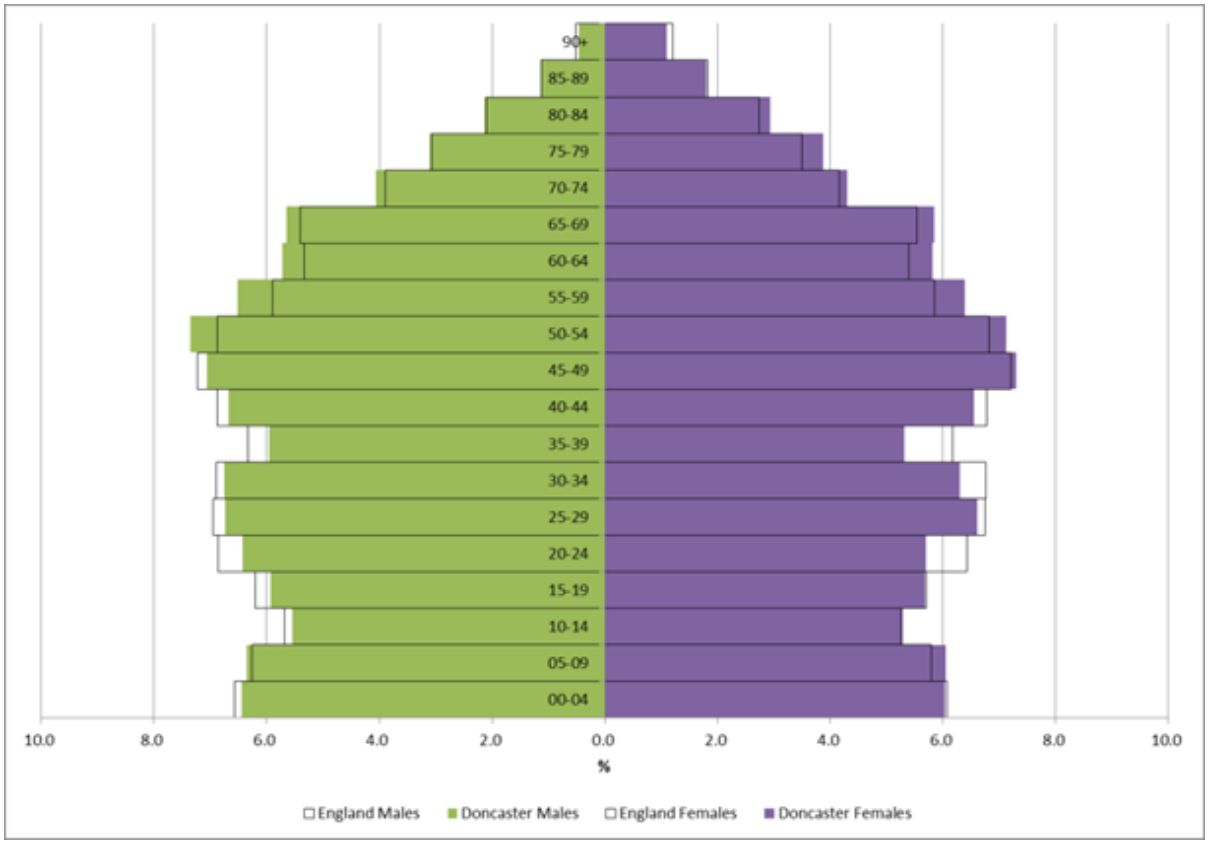


[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215261/dh_131733.pdf
[2] http://www.teamdoncaster.org.uk/Doncaster_Data_Observatory/joint_strategic_needs_assessment.asp
[3] A description of the commissioning process that lead to this themed approach can be found in the previous JSNA report.
http://www.teamdoncaster.org.uk/Images/Doncaster%20JSNA%202014_tcm33-110466.pdf

Doncaster's population

The resident population of Doncaster was, in 2014, estimated to be 304,185, 150,582 men and 153,603 women. The Doncaster population is on average a little older than the national average. The average age in Doncaster is 40.8 years and in England it is around 40.2 years. The population pyramid (Figure 1) shows that the age profile of the Doncaster population is broadly similar to the national population. Doncaster has slightly fewer people ages 20 to 49 years and slightly more aged 50 to 74 years.

Figure 1: Population of Doncaster and England by 5 year age bands, 2014



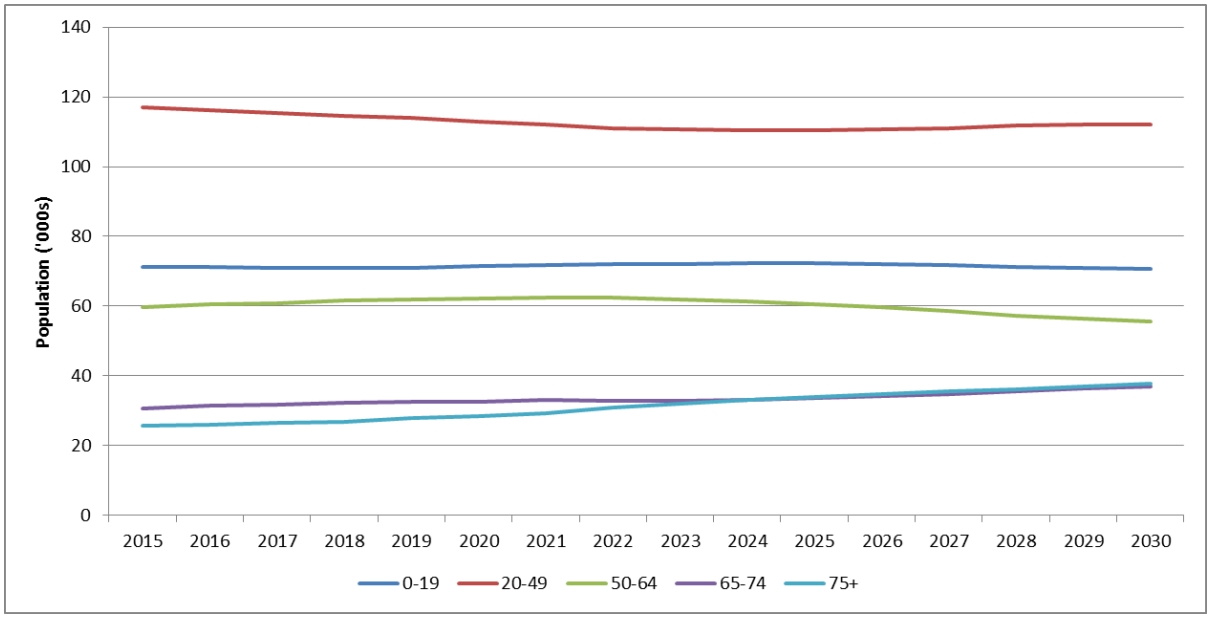
Source: Office of National Statistics (ONS)

Population Projections

The population of Doncaster in 2015 was around 304,200; by 2020 it is expected to be around 307,700 and by 2030 close to 313,000. Doncaster will add about 600 people each year to its resident population over the next 15 years. However these increases are not equally distributed across the age groups. The numbers of 0-19 year olds will actually fall over the next 15 years. The same is true for both the young working age population (20-49 years) and the older working age population (50-64 years). The numbers of people aged 65+ will increase. In 2015 around 18% of the population was over 64 years. By 2030 around 24% will be in this age group. This means almost 1 in 4 of the

population aged 65 years or older. The 65+ population will increase, on average by around 1,200 each year between 2015 and 2030. Doncaster, in common with most areas of the country, has an aging population[4].

Figure 2: Population change by age group in Doncaster, 2015-30



Source: Office for National Statistics (ONS)

Older people living in households

At the time of the 2011 census there were 297,200 people living in households in Doncaster[5], of these 16,179 (5.4%) were aged over 65+ were living alone[6]. In all there were 38,994 (13.1%) people in Doncaster living in households in which all were aged over 64 years old, this means that more than 1 in 10 of the population in Doncaster are households exclusively aged 65+.

Figure 3: Households composition in Doncaster, 2011

Household Type	Number	%
All Household residents	297,200	
One person households: Aged 65 and over	16,179	5.4
One family: All aged 65 and over	21,966	7.4
Other household types: All aged 65 and over	849	0.3

Source: Census 2011 (ONS)

[4] http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Ageing

[5] This figure excludes people living in communal establishments. Communal establishments include: care homes, prisons, university halls, boarding schools, and military establishments.

[6] A person living alone according to the 2011 census is: someone who lives alone and does not share cooking facilities and does not share a living room or sitting room or dining area.

As Doncaster has an ageing population the numbers of elderly people living alone is predicted to increase. The latest estimates show that there could be 20,500 people now living alone in 2015, by 2030 this could be 27,700[7]. This group will be predominantly women (see Figure 4)[8].

Figure 4: People aged 65+ predicted to live alone in Doncaster, 2015-30

	2015	2020	2025	2030
Males aged 65-74	2,960	3,160	3,260	3,620
Males aged 75+	3,570	4,148	5,032	5,678
Females aged 65-74	4,770	5,100	5,190	5,670
Females aged 75+	9,272	9,943	11,651	12,810
Total population aged 65-74	7,730	8,260	8,450	9,290
Total population aged 75+	12,842	14,091	16,683	18,488

Source: POPPI (Projecting Older People Population Information System)

Ethnicity in Doncaster

The most accurate data available about ethnicity in Doncaster is from the 2011 census. At the time of the census 95.3% of the population considered themselves to be 'White'. The largest Black and Minority Ethnic (BME) are from the Asian community accounting for 2.5% of the population. These figures show that Doncaster has a smaller BME community compared to England & Wales.

Figure 5: Ethnicity in England & Wales and Doncaster, 2011

	England and Wales		Doncaster	
	No.	%	No.	%
All Usual Residents	56,075,912	100.0	302,402	100.0
White	48,209,395	86.0	288,066	95.3
Mixed/Multiple Ethnic Groups	1,224,400	2.2	3,321	1.1
Asian/Asian British	4,213,531	7.5	7,614	2.5
Black/African/Caribbean/Black British	1,864,890	3.3	2,337	0.8
Other Ethnic Group	563,696	1.0	1,064	0.4

Source: 2011 Census (ONS)

Changes in the constituent ethnic communities in Doncaster are more difficult to gage, this because how ethnicity was measured changed between the 2001 and 2011 censuses. However using the numbers of people who considered themselves to be 'White British' in 2001 and 2011 it is clear that Doncaster has become considerably more ethnically diverse over these 10 years. In 2001 96.5% considered themselves to be in this category by 2011 this figure had fallen to 91.8%.

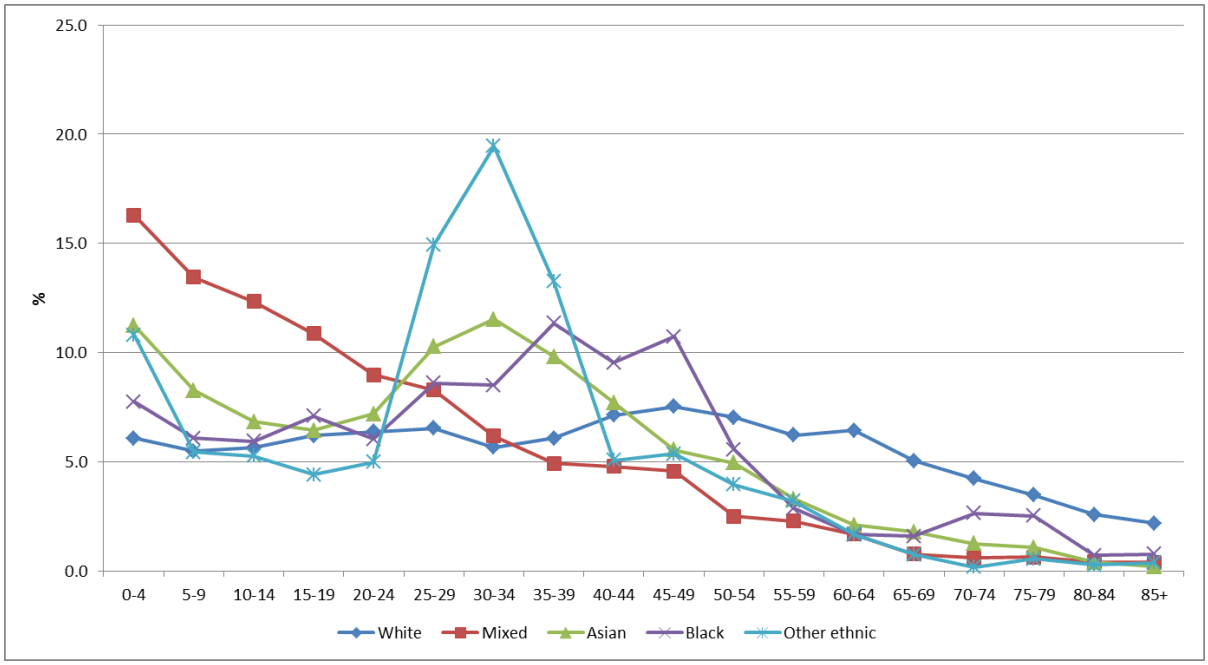
The BME population is, on the whole younger, than the white population. In the white population around 17.5% are aged 65 or more, while in the Asian population less than 5% are. It is important to note that BME populations will start to age more rapidly after 2021 and will therefore begin to find

[7] http://www.poppi.org.uk/

[8] The figures are calculated using the General Household Survey 2007. The General Household Survey is a continuous survey which has been running since 1971, and is based each year on a sample of the general population resident in private households in Great Britain.

they face some of the same health and wellbeing challenges as white community[9] .Black and Minority Ethnic communities' access to adult social care in Doncaster is explored further at the end of this report (Appendix 1).

Figure 6: Ethnic communities by age group in Doncaster, 2011



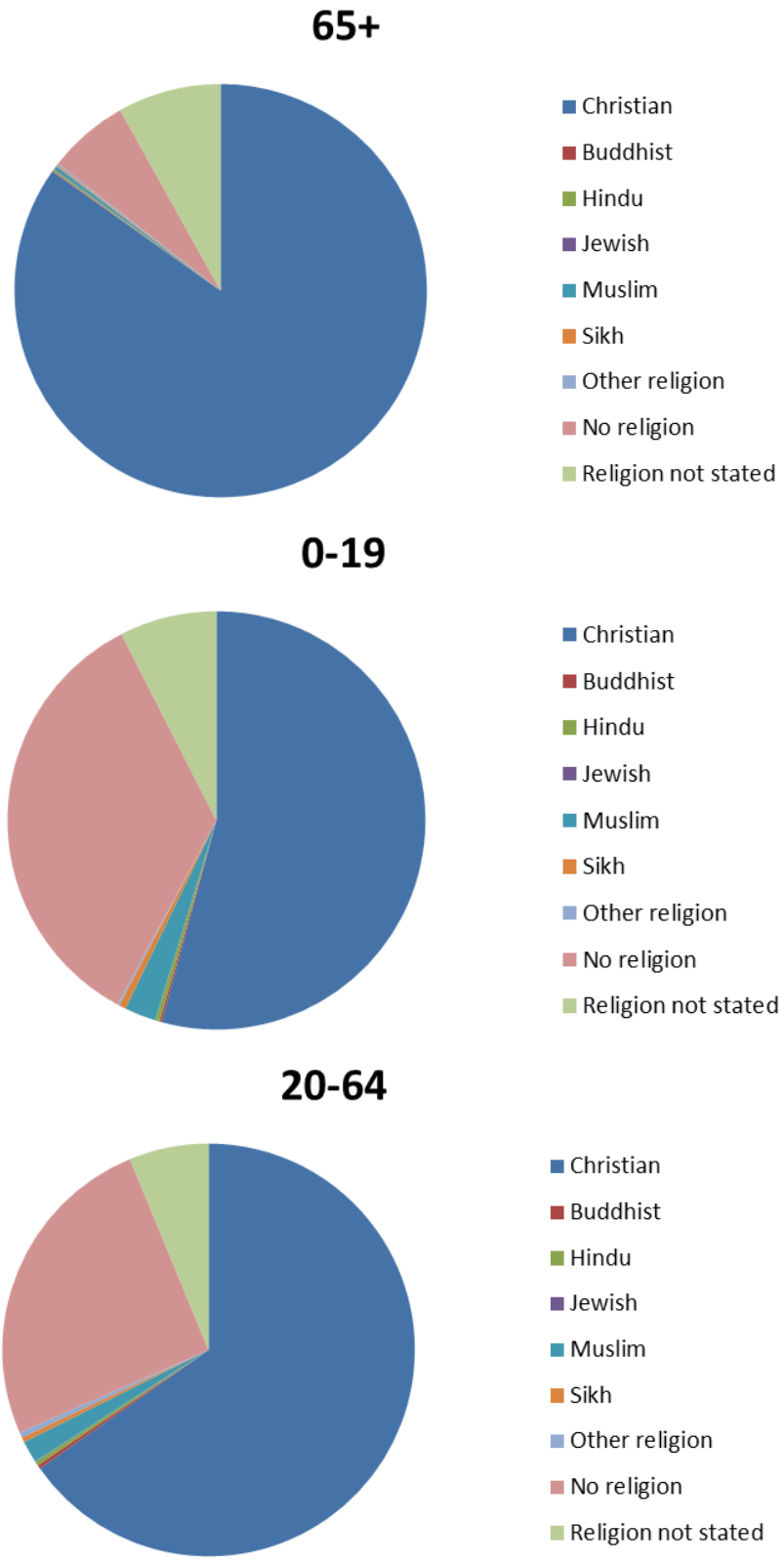
Source: Census 2011 (ONS)

Religion

The 2011 census asked a question about religion. The question is not compulsory and people can choose not to answer. People predominantly reported that they were Christian (66%) or had no religious affiliations (24%). This pictures changes with age, older people are more likely to report that they have a religion and are more likely to be Christian, younger groups are much less likely to have a stated religion. Religion can have some influence on the health of communities. Evidence from Scotland has found that Hindus often report better subjective health compared to other religions and Muslims, Hindus and Buddhists as well as some Christian denominations are least likely to report excessive drinking. The consumption of 5-a-day fruit and vegetables is greatest in Buddhists and Muslims[10].

[9] http://www.cpa.org.uk/BMEprojections/BMEprojections.html
[10] http://www.gov.scot/Topics/People/Equality/Equalities/DataGrid/Religion/RelHealth

Figure 7: Proportion of the Doncaster population by religion and age, 2011



Source: 2011 Census (ONS)

Life Expectancy in Doncaster

Over the last 30 years life expectancy has been improving nationally[11]. In Doncaster life expectancy (at birth) has been rising since at least the beginning of the 1990s. Male life expectancy has improved from 72.8 years (1991-93) to 77.5 years (2012-14). Among women in the same period it has improved from 78.1 years to 81.6 years.

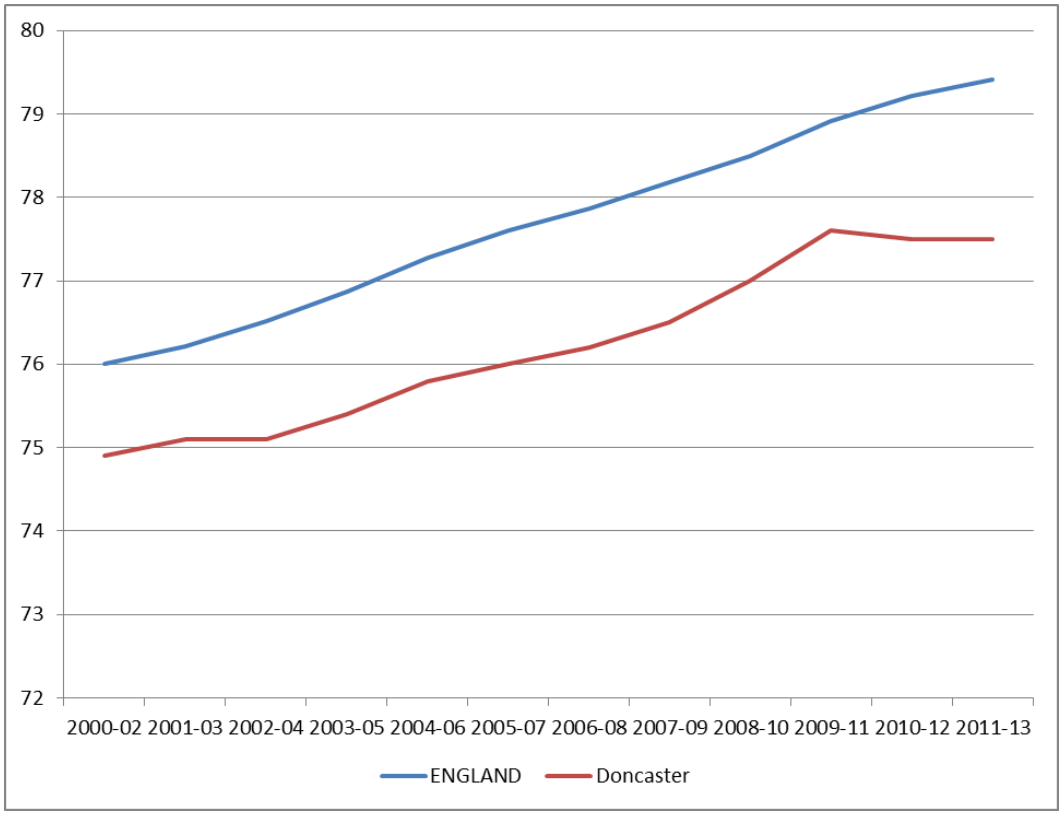
In the past life expectancy improved as infant mortality rates and deaths among younger people began to fall. However, the improvements in life expectancy that have happened in Doncaster (and nationally) are largely the result of improving mortality rates in older people. Life expectancy has been rising among older people. Life expectancy at age 65 among both men and women increased at more or less the same rate as life expectancy at birth.

These increases in life expectancy are making a significant contribution to the ageing population outlined in the previous section. People in Doncaster are living longer.

It should be noted that the improvements in life expectancy in Doncaster have slowed recently. This may be the result of natural changes over time but should be closely monitored in the future.

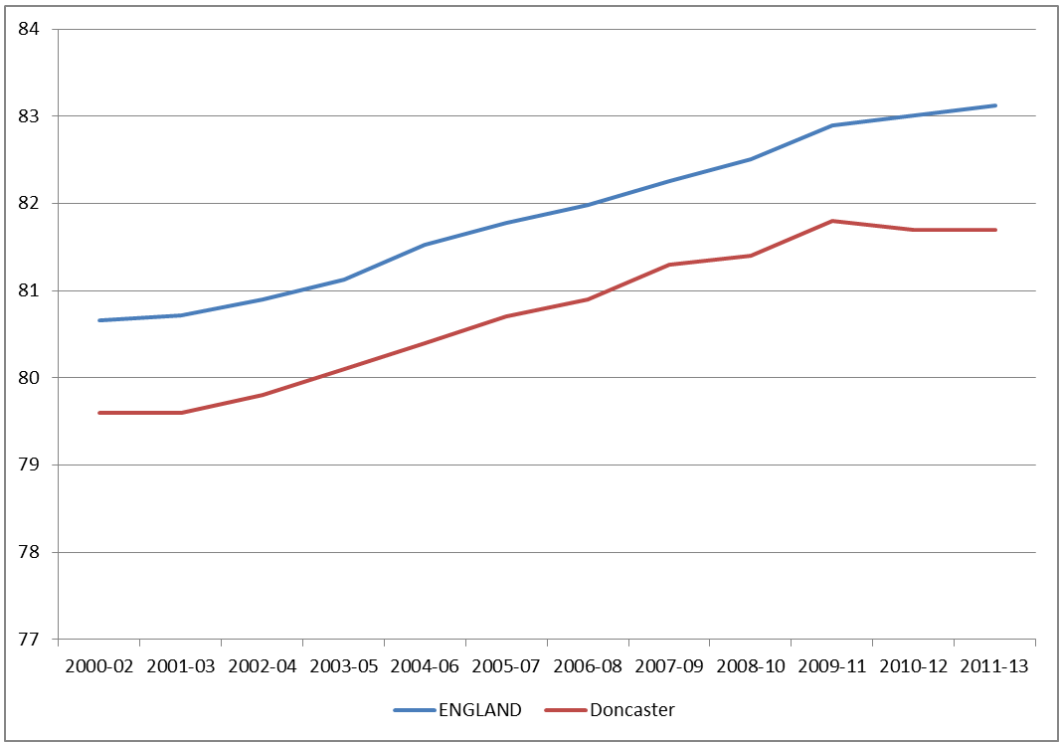
[11] Recent Trends in Life Expectancy at Older Ages, February 2015, Public Health England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403477/Recent_trends_in_life_expectancy_at_older_ages.pdf

Figure 8: Male Life expectancy at birth in Doncaster and England



Source: Health and Social Care Information Centre, Office for National Statistics

Figure 9: Female Life expectancy at birth in Doncaster and England



Source: Health and Social Care Information Centre, Office for National Statistics

Disability free life expectancy

Life expectancy measures mortality but does not capture how people live with poor health or disability. It is a poor measure of wellbeing and morbidity[12]. The Office for National Statistics (ONS) has produced data to address this deficit. The Office for National Statistics routinely publishes two types of health expectancies. The first is Healthy Life Expectancy (HLE), which estimates lifetime spent in 'Very good' or 'Good' health based upon how individuals perceive their general health. The second is Disability-Free Life Expectancy (DFLE), which estimates average lifetime free from a limiting persistent illness or disability. This is based upon a self-rated assessment of how health limits an individual's ability to carry out day-to-day activities[13].

The DFLE is based on a survey question used as part of the Annual Population Survey (APS)[14]. The results of these surveys have been aggregated over three years to provide sufficiently large local samples in each local authority.

The Question used to assess disability is:

Do you have any health problems or disabilities that you expect will last for more than a year? Yes/No

If 'Yes' the respondent is then asked the following question:

Do these health problems or disabilities, when taken singly or together, substantially limit your ability to carry out normal day-to-day activities? If you are receiving medication or treatment, please consider what the situation would be without the medication or treatment.
Yes/No

A person is considered to have a disability or limiting persistent illness if they answer yes to both questions in the box above. These questions are subjective and will relate closely to how the person perceives their health, and these perceptions are influenced by age, gender and social economic position. Nevertheless self-assessment of general health or disability have been found to be good at predicting the need and demand for health care as well as demand and usage of secondary care and nursing homes.

In Doncaster men have DFLE of 60.1 years and women 61.8 years (2009-13). This means that men on average live 22.4% of their lives with a disability and women, because they tend to live longer live

[12] James Nazroo, April 2015, Addressing inequalities in healthy life expectancy, Government Office for Science. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/455811/gs-15-20-future-ageing-inequalities-healthy-life-expectancy-er15.pdf

[13] http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/disabilityfreelifeexpectancybyuppertierlocalauthorityengland/2014-07-24

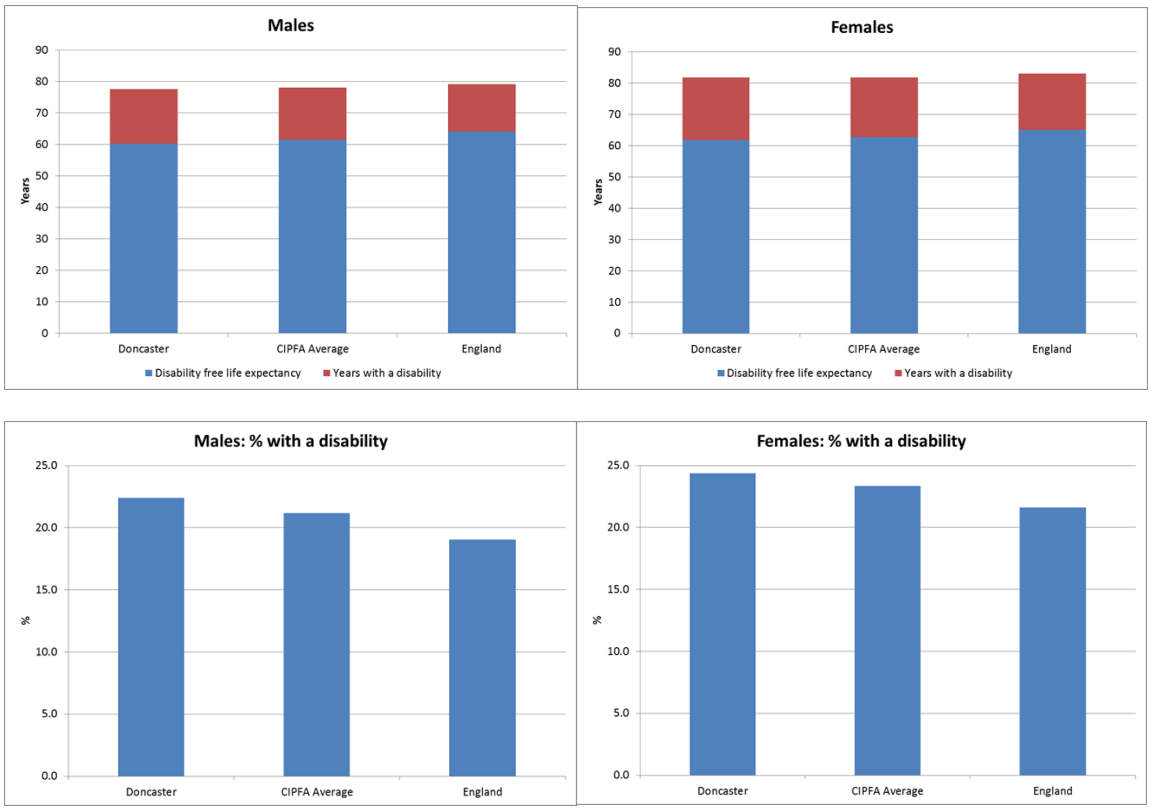
[14] https://www.nomisweb.co.uk/articles/873.aspx

around 24.4% of their lives with a disability. In England DFLE is 64 years in men and 65 years in women, a difference of almost 4 years in men and more than 3 years in women.

A further analysis of these data revealed, not only do Doncaster residents have a lower DFLE than the national average, the DFLE is lower than the average for similar areas. The Charted Institute of Public Finance and Accountancy (CIPFA) have identified groups of local authorities with similar characteristics[15]. When this group is compared to Doncaster it shows that DFLE is greater for both men and women. This implies that levels of disability and hence potential demand of social care is higher in Doncaster and may be even higher than in peer local authorities.

Figure 10 illustrates these findings. The average DFLE for Doncaster men is 60 years but the CIPFA average is almost 62 years. In women DFLE is around 62 years and for the CIPFA group nearly 63 years.

Figure 10: Disability free life expectancy



[15] Stockton-on-Tees, Darlington, Warrington, North Lincolnshire, Telford and Wrekin, Durham, Bury, Wigan, St Helens, Barnsley, Doncaster, Rotherham, Dudley, Calderdale, Kirklees, Wakefield.

Impact on Social care

To try to measure the potential impact of an aging population on adult social care in Doncaster a simple model was created to estimate how estimated levels of need would change over the next 15 years. In 2014 Doncaster council developed eligibility criteria to assess potential clients, this included a set of new needs based assessments:

- Carry Out Personal Care (dressing /undressing, personal grooming, personal hygiene, toileting/continence care),
- Preparing And Having Food And Drink (food Safety, food shopping, nutritional needs, food and drink preparation),
- Household Activity and Management (correspondence, laundry, cleaning the home, money management),
- Carry Out Tasks Of Being A Parent (family breakdown, parenting tasks),
- Relationships With Family And Friends (maintain/improve/establish relationships with family/friends),
- Being Part Of The Community (socially isolated, getting out and about, volunteering, employment, learning opportunities, meaningful activities, limited cultural opportunities),
- Keeping Safe (medication administration/prompting, service user poses a risk to themselves or others, accommodation, mobility),
- Behaviour Needs (anger, powerlessness, lack of confidence, victim of hate crime, fear, low self-esteem),
- Communication And Sensory Needs (specialist visual support, specialist hearing support, limited or no English language),
- Mental Well-Being/Psychological (bereavement and loss, reliance on prescribed medication, unhealthy relationships, stress, anxiety/depression/panic attacks),
- Carer Support (carer in ill health, carer is unable to cope, carer needs a break from caring role, carer unable to continue in caring role without support, carer choice to discontinue in caring role).

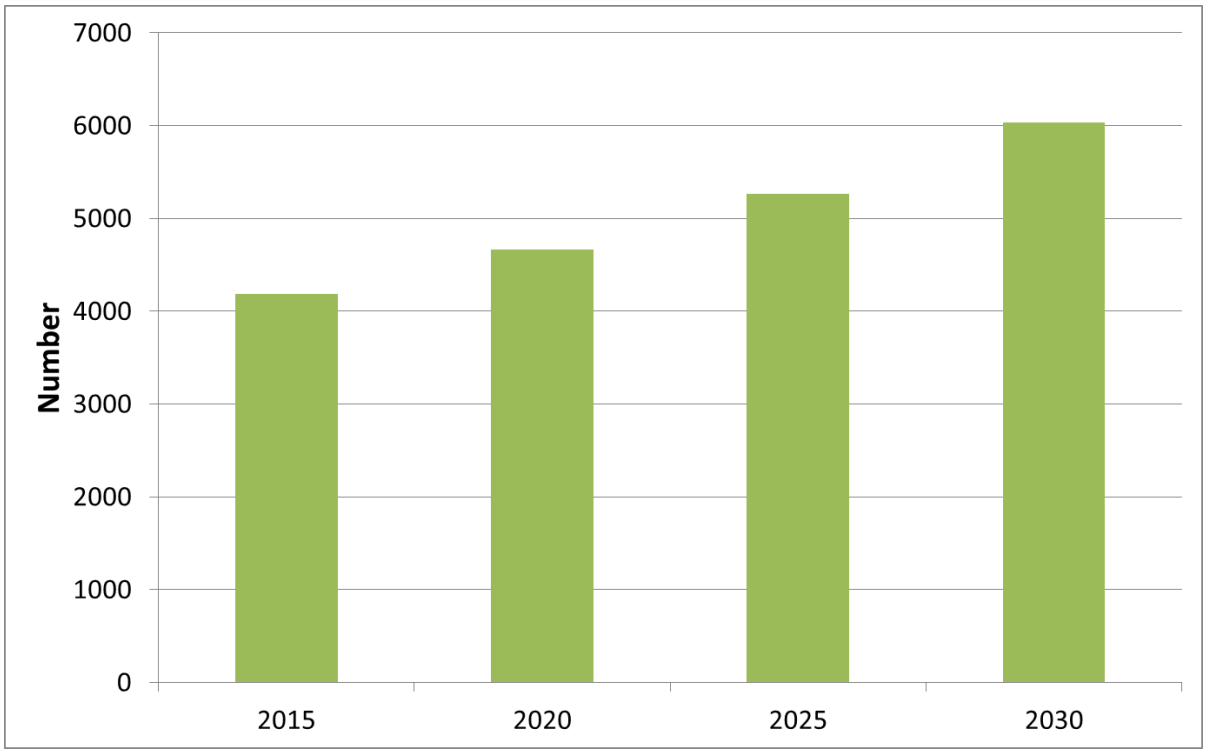
Not all clients, at the time of the analysis, had been assessed using the new needs domains. So the modelled needs were based on the 715 clients who had had their needs assessed against these new criteria. The model then adjusted this sample to reflect the current client population in Doncaster.

It is important to remember that the projections presented in this report are modelled and assume that there will be no changes in the commissioning and delivery of services in the future. Doncaster is already undertaking and developing an extensive programme of modernisation and improvement. However these figures will give both a sense of the scale of the challenge facing adult social care and a benchmark against which to measure the success of the modernisation and improvement programmes.

Personal care

Personal care includes help with dress toileting and personal grooming. This is a vital component in maintaining people's self-esteem, dignity and self-respect[16]. The modelling undertaken to support this report found that in 2015 there were just over 4,000 people needing personal care. By 2025 this could have grown to more than 5,000 and by 2030 it could be almost 6,000.

Figure 11: People with a need for help with personal care (modelled projections)



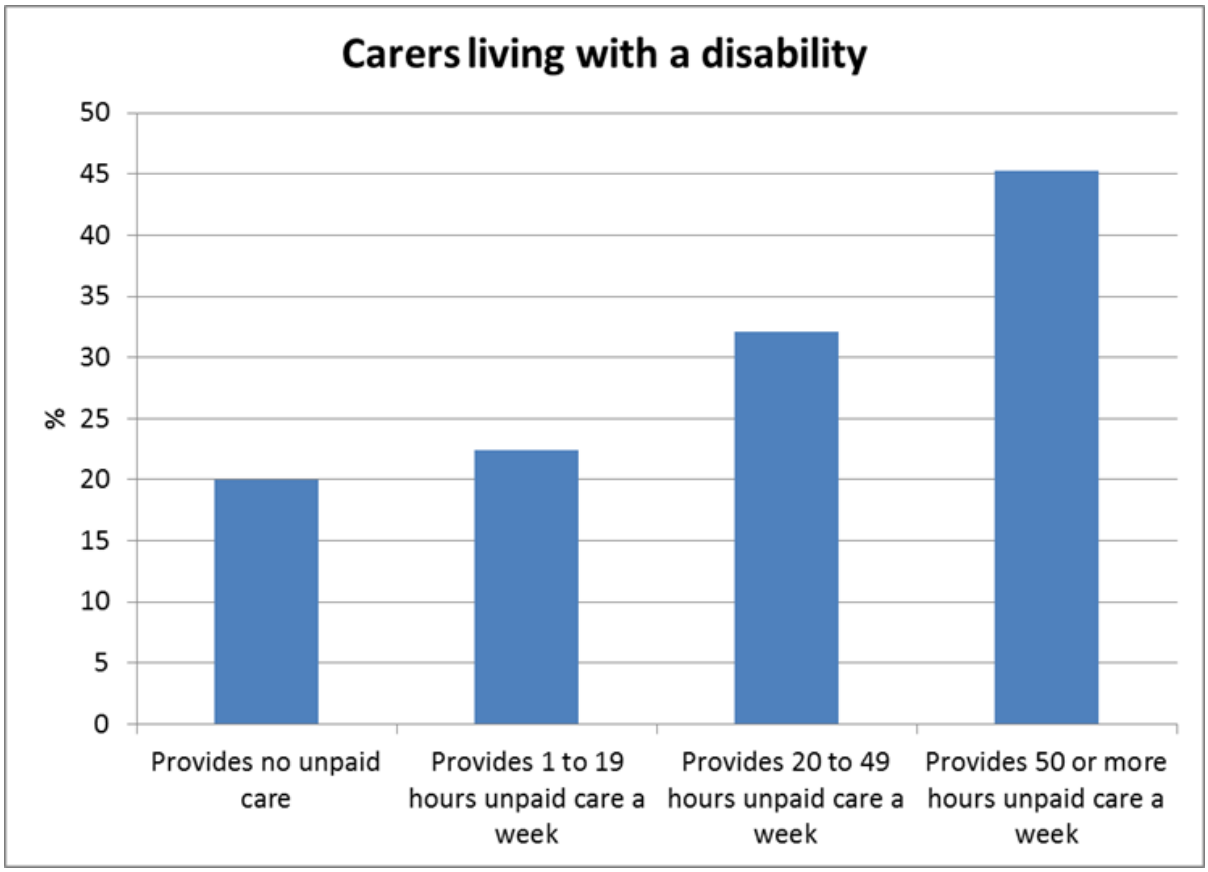
Source: Doncaster Council

[16] http://www.scie.org.uk/publications/guides/guide15/factors/personalhygiene/

Carers

A carer is someone who provides help to someone in their day to day life. The 2014 Care Act has given local authorities a legal duty to provide an assessment and made these assessments more widely available[17]. The council will then provide support to carers deemed eligible for support. Carers can themselves also be facing significant challenges regarding their own health. The census has shown that the more care a person provides, the great likelihood they will report that they are living with a disability themselves. Amongst people who provide no unpaid care only around 20% reported that they were living with a disability. Amongst people who provide 50 or more hours this rate increases to 45%, more than double. It should be noted that this is largely because older people are more likely to to be informal carers and are also more likely to report that they are living with a disability.

Figure 12: Carers providing unpaid care living with a disability in Doncaster

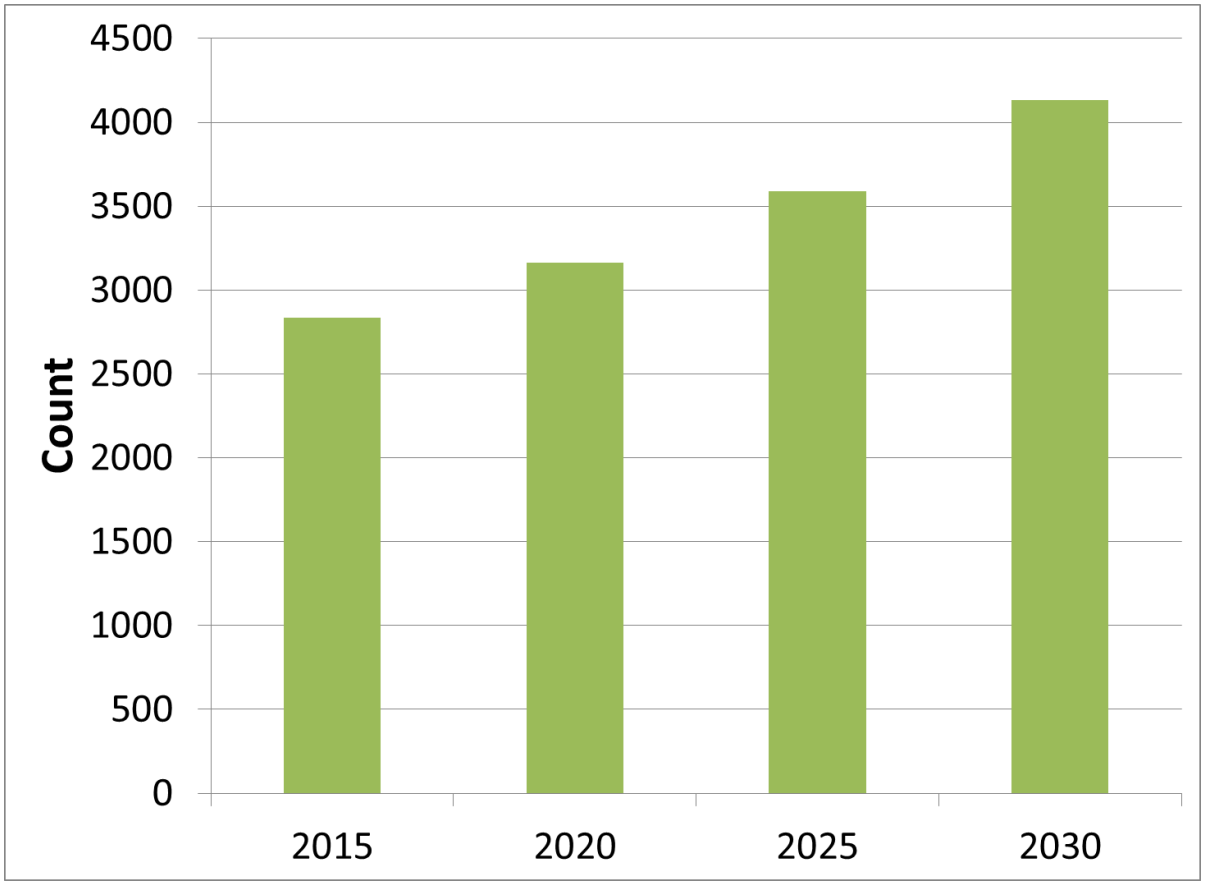


Source: Office of National Statistics

[17] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm

The figure below illustrates the increase demand that could result just as a result of Doncaster's aging population. In 2015 there were around 2,800 people requiring carer support, by 2025 this could be 3,500 and by 2025 more than 4,000.

Figure 13: Carers need social care support in Doncaster (modelled projections)



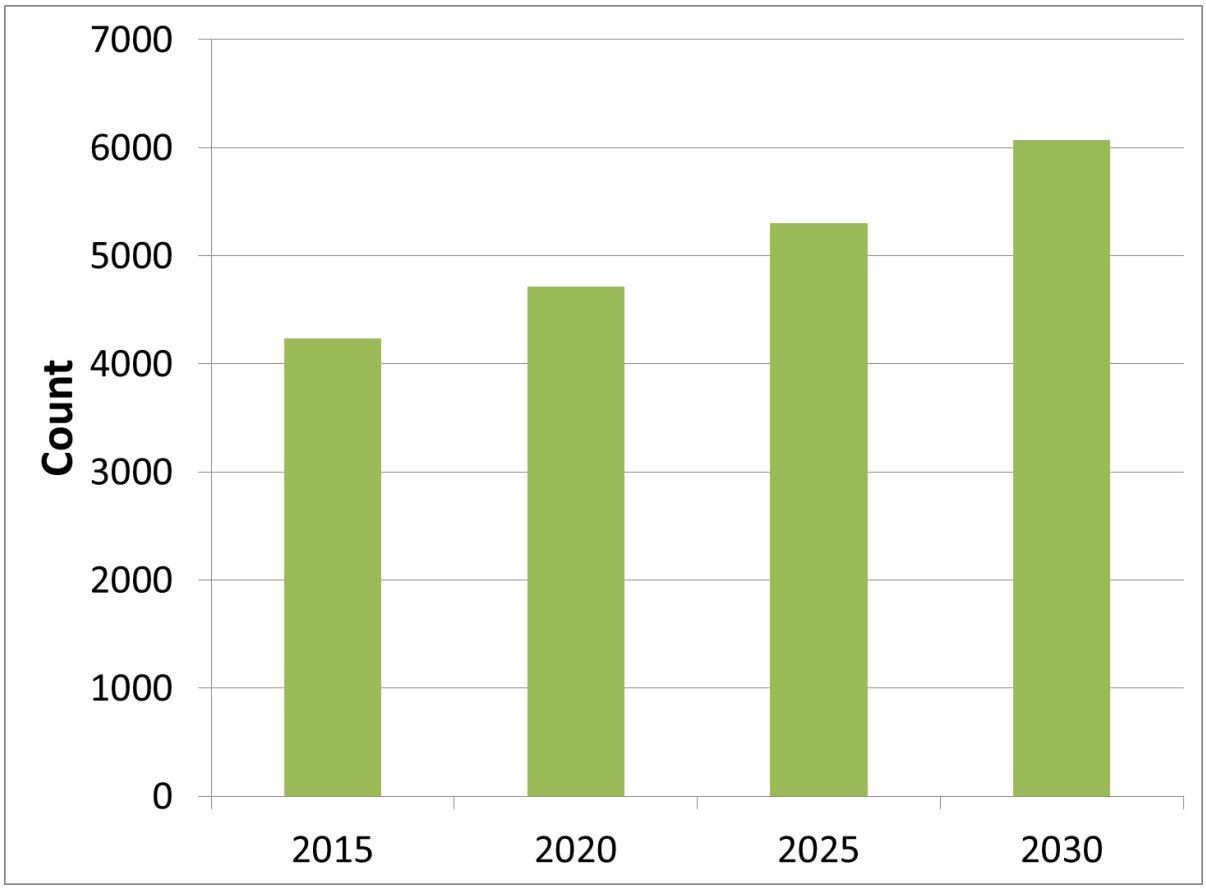
Source: Doncaster Council

Being part of the community

Social isolation and loneliness are related but slightly different things. It is defined as a subjective negative feeling that can encompass emotional loneliness – the absence of a significant other (for example, a partner or close friend), and social loneliness – the absence of a social network (for example, a wider group of friends, neighbours). In contrast, social isolation tends to be defined as an objective state referring to the number of social contacts or interactions[18].

Older people are at increased risk of experiencing social isolation, they are also more likely to face ill-health and caring responsibilities, these are also risk factor that can predict loneliness and social isolation[19].

Figure 14: People needing help to be part of their community (modelled projections)



Source: Doncaster Council

The chart above illustrates the increases in the numbers of people who require support to live more fully in their communities, from more than 4,000 in 2015 to over 6,000 in 2025.

[18] Loneliness and Social Isolation Among Older People in North Yorkshire, Sylvia Bernard, April 2013, University of York
http://www.york.ac.uk/inst/spru/research/pdf/lonely.pdf
[19] Reducing social isolation across the lifecourse, UCL Institute of Health Inequality, September 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

It is important to remember that all of these increases in demand for social care are modelled and assume that there will be no changes to the way that social care will be delivered over the next 15 years. They are merely intended to be illustrative of the kinds of challenges that Doncaster could face as its population gets older during this period

Safeguarding

The council has a duty to keep people safe from abuse and neglect. Prevalence data from a study by the Department of Health found that 2.5% of people aged 66 and older reported that they had experienced mistreatment involving a relationship of trust (friend, neighbour, or partner). This research only included people in households and so excludes nursing homes and other institutions[20].

An individual is at greater risk of abuse if:

- they are isolated and don't have much contact with friends, family or neighbours
- they have memory problems or have difficulty communicating
- they become dependent on someone as a carer
- they don't get on with their main carer
- their carer is addicted to drugs or alcohol
- their carer relies on them for a home, or financial and emotional support[21]

As Doncaster's population ages it will probably become more demanding of social care services and is those services find themselves increasingly stretched. There is a danger that a more isolated and a more ill population could find itself with more cases of neglect or abuse as carers are increasingly put under pressure.

Conclusions

Doncaster faces some significant challenges as its population ages. One clear part of this challenge will be increasing demands places on social care services.

[20] UK study of abuse and neglect of older people: prevalence survey, O'Keeffe et al, June 2007, Department of Health.
http://www.natcen.ac.uk/media/308684/p2512-uk-elder-abuse-final-for-circulation.pdf
[21] http://www.nhs.uk/conditions/social-care-and-support-guide/pages/vulnerable-people-abuse-safeguarding.aspx

Appendices

Ethnicity and social care

People from Black and Minority Ethnic (BME) communities tend to have poorer health than their white counterparts. People from BME communities tend to report age-related health problems earlier in life and consequently health inequalities are often greater amongst older people[22]. The reasons for these differences are largely due to the challenging social and economic circumstances that many people from these communities find themselves in. These conditions in combination the impact of discrimination and racism lead to poorer health outcomes[23].

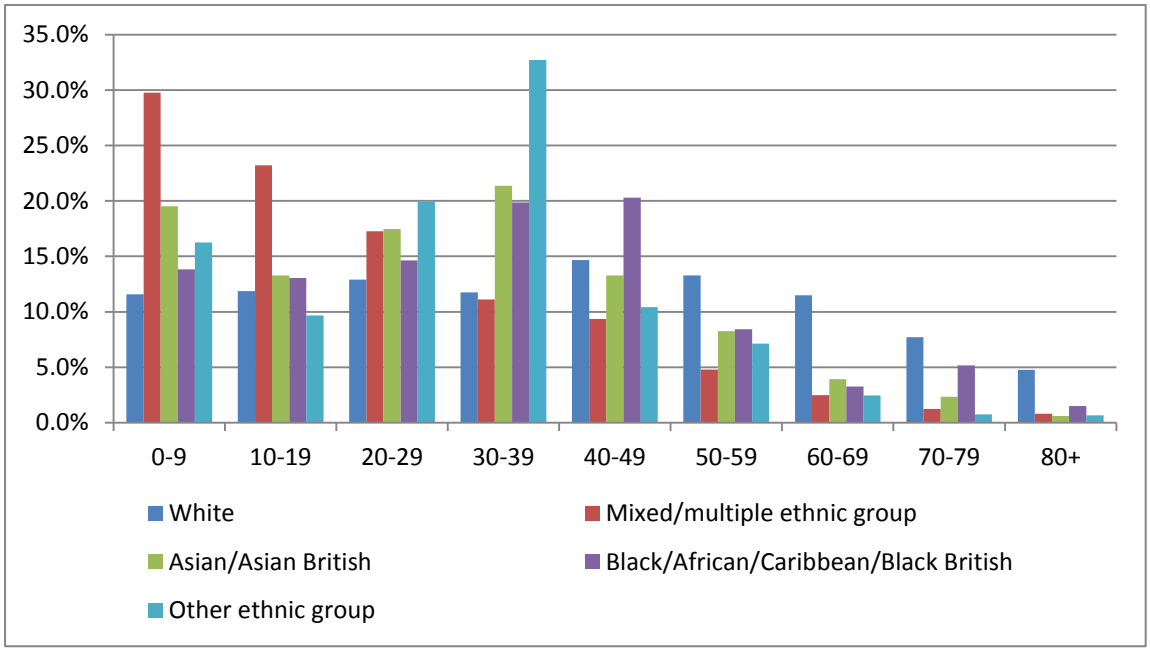
The health experiences of people from BME communities are not uniform. Some people from BME communities find that the health of first generation migrants is often better than those born in the UK[24]. Research from the Joseph Roundtree Foundation has found that people from the Chinese and Black African communities tend to report better health and people from the Bangladeshi and Pakistani communities much poorer health. The community with the worst health is the Gypsy and traveller community[25]. People of South Asian back ground have increased risk of developing coronary heart disease and stroke, people from African Caribbean background tend to have higher blood pressure and higher prevalence of type 2 diabetes[26].

As people from BME communities generally suffer from poorer health and these heath inequalities become more marked as the MBE community ages, it is to be expected that these communities might be making greater demands in the social care system. However older people from BME communities tend to be less aware of services available to them and can face the additional barriers of language and culture[27].The use of adult social care and the experience of BME communities of these services is an under-researched area[28].

In Doncaster the BME community is around 4.7% of the resident population[29]. It is a younger population than the white community. Figure 15 illustrates that at the time of the census over 50% of the BME community were aged under 30 years and less than 4% were aged 70 or over. In the white community just over 37% are under 30 and around 12% are 70 or older.

[22] Jo Moriarty, July 2008, Better Health Briefing 9: The health and social care experiences of Black and minority ethnic older people, Race Equality Foundation & Department for Communities and Local Government. http://www.better-health.org.uk/sites/default/files/briefings/downloads/health-brief9.pdf
[23] Postnote: ethnicity and health, January 2007, Parliamentary Office of Science and Technology. http://www.parliament.uk/documents/post/postpn276.pdf
[24] Ibid.
[25] Which ethnic groups have the poorest health? Ethnic health inequalities 1991 to 2011, October 2013, Joseph Rowntree Foundation & University of Manchester. http://www.ethnicity.ac.uk/medialibrary/briefingsupdated/which-ethnic-groups-have-the-poorest-health.pdf
[26] https://www.bhf.org.uk/heart-health/preventing-heart-disease/your-ethnicity-and-heart-disease
[27] http://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2012/reports/moriarty2012update9.pdf
[28] Tom Vickers, Gary Craig & Karl Atkin, 2012, Research with black and minority ethnic people using social care services, School for Social Care Research & National Institute for Health Research. https://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/SSCR_Methods_Review_11_web.pdf
[29] BME: Mixed/multiple ethnicity, Asian/Asian British, Black/African/Caribbean/Black British, Other ethnic groups. A broader definition of BME communities which includes: Irish, Gypsy traveller and other white groups would increase this to 8.2%.

Figure 15: Ethnicity by age group, 2011

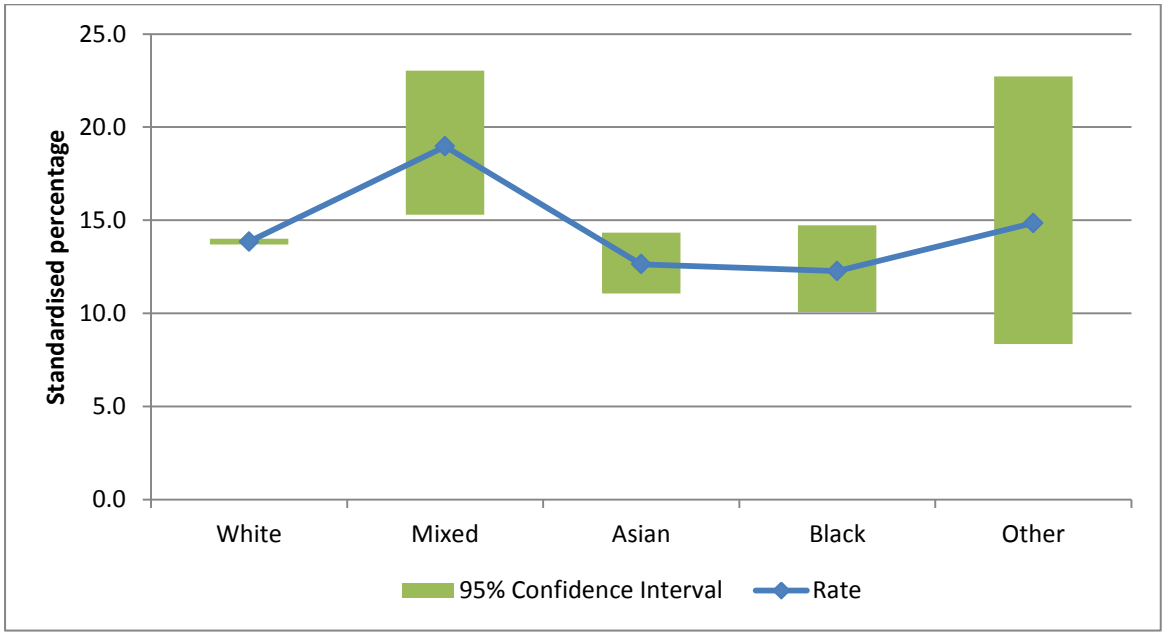


Source: 2011 census

Because of these disparities in the age structures of different ethnic populations it is important to age-standardise reported ill-health and service uptake rates. This will enable fair comparisons to be made between groups.

Figure 16 shows that long-term disability is significantly higher in people from mixed ethnic groups. The other groups show no statistical difference compared to the Doncaster average.

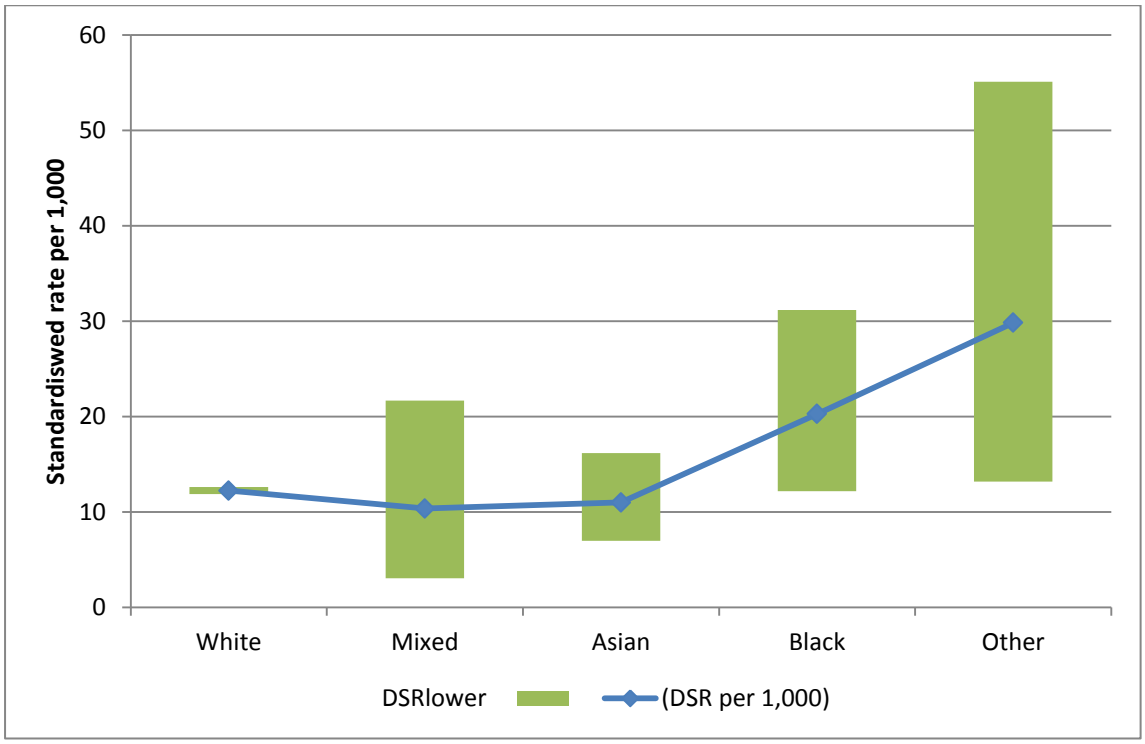
Figure 16: Limiting long term illness or disability by ethnic group, 2011



Source: 2011 Census

Access to Adult social care was measured using the same age standardisation methodology (Figure 17). This shows that on the whole no one ethnic community has better or poorer access to adult social care. It is worth noting that the community with the lowest client rate is those from mixed ethnic back grounds but this is also the group with the highest levels of reported disability.

Figure 17: Social care clients by ethnicity



Source: Doncaster council

The following caveat should be noted. These data only reflect the current clients identified on Doncaster Council's care system. It does not provide insight in to the quality of the experiences of these clients. There is some evidence here that clients from different BME groups are able to access an equitable service, however this does mean that the services they receive are culturally appropriate and not base on cultural assumptions and generalisations[30].

[30] https://www.jrf.org.uk/report/experiencing-ethnicity-discrimination-and-service-provision

The advantages of an ageing population

Much of this report has focused on the challenges that an ageing population presents in Doncaster. Conventional wisdom asserts that with an ageing population will come significant challenges to the health and social care system. The annual costs of health and social care are greater for older people, hospital admissions are raising more rapidly in older people in any other age group. Older people will increasingly be living alone with an attendant increase in the demand for care[31].

However it is important to remember that an ageing population is not necessarily a sicker population many people are living longer and remaining healthier much later in life. The 'Wanless report' noted that a significant proportion of the costs for an individual occur in the last year of life[32]. This cost does not appear to rise with age and there is even some evidence that with increasing age, end of life costs actually fall[33].

The latest data from the Office of National statistics has found that people aged 65-79 report the highest average levels of personal wellbeing. People in their 90s were reporting their levels of happiness to be greater, on average, than people in their middle years. Older people's wellbeing did fall after 75, if they felt their activities were not 'worthwhile'[34].

Older people are a large and growing resource for the voluntary sector. These volunteers will not only improve their own health by volunteering but will be bringing the advantages of their previous experience to their wider communities[35]. Evidence indicates that 'grand-parenting' instils benefits in young children[36]. Older people are also increasingly remaining engaged in paid employment, nationally the proportion of people remaining in work over 65 has been increasing since at least 2001[37]. Older people are, on the whole, more law abiding and so use fewer resources maintaining community safety[38].

In conclusion while an aging population could represent a significant challenge to the future of adult social care delivery there is evidence when considered across all aspects of older people's lives people over 65 are in fact net giver to society rather than net receivers.

[31] http://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population
[32] http://webarchive.nationalarchives.gov.uk/20130129110402/http://www.hm-treasury.gov.uk/consult_wanless04_final.htm
[33] http://www.tai.org.au/documents/downloads/DP63.pdf
[34] http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015-09-23
[35] https://www.ucl.ac.uk/news/news-articles/1204/24042012-Ageing-population-could-boost-economy
[36] http://www.scotlandfutureforum.org/assets/library/files/application/1213786643.doc.
[37] http://www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population
[38] http://www.scotlandfutureforum.org/assets/library/files/application/1213786643.doc.

Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No. 11
Date: 9th June, 2016

Subject: Proposal to Update Black and Minority Ethnic Health Needs Assessment

Presented by: Dr R Suckling

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

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

How will this contribute to improving health and wellbeing in Doncaster?
A better understanding of local needs should help both the commissioning and provision of a range of health and care services. This is also an opportunity to strengthen links with Doncaster BME communities.

Recommendations
The Board is asked to:- DISCUSS, AMEND and AGREE the worknplan to revise the BME health needs assessment.

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Black and Minority Ethnic (BME) Health Needs Assessment

Briefing for Doncaster Health and Wellbeing Board

Introduction

The purpose of this briefing is to propose an outline for an updated Black and Minority Ethnic (BME) health needs assessment.

Background

The last specific BME health needs assessment in Doncaster was 2004. Since then, the health needs of BME communities have been identified through Joint Strategic Needs Assessments and latterly have been included in individual organisational approaches to equalities. In 2015 Doncaster established a Fairness and Inclusion forum with an independent chair. Although the health needs of BME communities are recognised in individual and organisational strategies including the Health and Wellbeing strategy, many of the needs are extrapolated from national data. The make-up of BME communities in Doncaster are changing and the 2015 Director of Public Health Annual Report recommended that the BME health needs assessment was updated in order to ensure the local understanding of needs was as full as possible.

Health Needs Assessments are a way of establishing the gap (if any) between the expressed needs of particular groups and both access to and outcomes from the current range of available services, public, private or voluntary. In addition through discussion with the communities themselves a range of possible options for improvements may be generated with implications for both commissioners and providers of services.

Proposal

The Health and Wellbeing Board should ensure an updated BME health needs assessment is undertaken. This should be led by the steering group and should consist of:

1. Establish baseline demographic details using the most recent national census data, NHS data and other local census data e.g. school census data. (June 2016 to July 2016)
2. Review the literature and evidence base for effective engagement approaches, common BME health needs and possible solutions. (June 2016 to July 2016)
3. Conduct a range of focus groups with identified local BME groups using the Team Doncaster partnership 'map' of groups and other local data. (August 2016 to October 2016)
4. Assess any differences in access to and outcomes from local health and care services. (September 2016 to October 2016)
5. Final report and recommendations back to the Health and Wellbeing Board. (December 2016)

Recommendation

The Health and Wellbeing Board is asked to discuss the proposal, make any amendments and support the production of an updated BME health needs assessment.

R Suckling 30/05/2016

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Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item No. 12
Date: 9 June, 2016

Subject: Report of the Steering 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	No
	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, outlines future work on health and employment and provides an update on work with South Yorkshire Fire and Rescue on the revised Safe and Well check.

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: 12
Date: 9th June, 2016

To the Chair and Members of the
HEALTH AND WELLBEING BOARD

REPORT FROM THE HEALTH AND WELLBEING BOARD STEERING GROUP AND FORWARD PLAN

EXECUTIVE SUMMARY

1. The purpose of this report is to provide an update to the members of the Health and Wellbeing Board on the work of the Steering Group to deliver the Board's work programme and also provides a draft forward plan for future Board meetings.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

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

EXEMPT REPORT

3. N/A

RECOMMENDATIONS

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

PROGRESS

5. At the first full Board meeting on 6th June 2013, Board members agreed that there would be a Health and Wellbeing Officer group to provide regular support and a limited support infrastructure to the Board. In March 2016 this support was changed to a steering group.

   The Steering group has had two meetings since the last Board in March 2016 and can report the following:

- **Childhood Obesity**

Three workshops have been held over the spring to pilot a new national childhood obesity prioritisation tool. The tool was developed by Public Health England and was tested in 4 local areas. The tool consisted of three steps, an initial assessment of leadership, a stocktake of current activity and a facilitated prioritisation session. The outputs of this work should feed into the new Obesity Alliance. Board members are asked to nominate representatives for the Obesity Alliance.

- **Loneliness and social isolation**

The report from the workshop has been circulated. It is proposed that an action plan is developed and monitored by the Health and Wellbeing Board steering group.

- **Sheffield City Region Health and Employment**

The link between good employment and good health is well established. Locally delivered integrated services are at the heart of strategies to drive up both the effectiveness and cost-efficiency of employment support for 'harder-to-help' claimants i.e. those people with more complex barriers to work including health related conditions.

As part of the Sheffield City Region devolution deal work is beginning to develop a pilot for health related supported ahead of a recommissioning of the entire 'Work Programme'. A local integration and delivery board will be required reporting to the Health and Wellbeing Board and Team Doncaster. Board members should identify potential reporting structures and members.

- **Self and Well Visits (Joint work with South Yorkshire Fire and Rescue)**

In Jan 2016, the Board approved for South Yorkshire Fire and Rescue to work with health partners and Age UK Doncaster to undertake a project to introduce Safe and Well visits within Doncaster.

A multi-agency steering group has been established to implement Safe and Well Visits. One key element of a Safe and Well Visit is the ability to refer vulnerable people to other agencies for further support, referral pathways have been agreed for falls and crime prevention and are contained within a publication which supports Safe and Well Visits.

The Royal Society of Public Health have provided training to South Yorkshire Fire Rescue (SYFR) staff, in addition SYFR have become a registered centre for the delivery of the Royal Society of Public Health training packages enabling the training of Firefighters across Doncaster during May, June and July.

Work is taking place to ensure Safe and Well Visits are targeted at the most vulnerable within our communities, SYFR are currently identifying properties to target using data sets such as NHS Exeter data and broader partnership data.

A communications sub group tasked with providing and managing a communications strategy has been established and work is ongoing.

To support the evaluation of the Safe and Well pilot a group has been established and is managing the evaluation strategy, this will capture the learning and value form Safe and Well Visits. The evaluation will consider all aspects of the Safe and Well Pilot and will gain significant data during a 6 month period from September 2016 until March 2017. The evaluation is being supported by a registrar from Public Health who is currently leading on the evaluation of the national Safe and Well Pilots which are being supported by NHS England and the Chief Fire Officers Association.

- **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 and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	The dimensions of Wellbeing in the Strategy should support this priority.
	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*	The Health and Wellbeing Board will contribute to this priority

	• *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*	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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Dr Rupert Suckling
Director Public Health

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**		

14th July 2016	Workshop
	(Mental Health and social emotional wellbeing)
		Venue TBC	• 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
			• Regeneration
				• Areas of focus – schedule of reports and workshop plans
				• Integration of health and social care (BCF)) workshop plan
				• Other subgroups – schedule of reports
				• Communications strategy
				• Liaison with key local partnerships
				• Liaison with other Health and Wellbeing Boards (regional officers group)
				• Learning from Knowledge Hub

1st September 2016	• Q1 Performance Report • Health and Social care Transformation Update • HWBB Steering Group Report	Montagu Hospital		
13th October 2016	Workshop TBC Health Inequalities TBC	Venue TBC		
3rd November 2016	• Q2 Performance Report • Adults and Social Care Local Account • Health and Social Care Transformation Update • HWBB Steering Group Report • Annual Safeguarding reports TBC • Local Plan – TBC (Adults and Children's) • Health watch update TBC • Stronger Families update TBC	Civic Office		

1st December 2016	Workshop TBC (Time out/Review forward Plan)	TBC		

***Supported Living and Wellbeing workshop/Fuel Poverty workshop and Learning Disabilities plan update** to be rescheduled in 2017

2017 Health and Wellbeing Board meetings

12 January 2017 (Venue: St Catherine's House, Balby)

9 March 2017 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

8 June 2017 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster – TBC)

7 September 2017 (Venue: Montagu Hospital, Mexborough - TBC)

2 November 2017 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster – TBC)