Public Document Pack

Doncaster Council

Agenda

To all Members of the

HEALTH AND WELLBEING BOARD

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

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

Date: Thursday, 6th September, 2018

Time: 9.30 a.m.

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

Jo Miller
Chief Executive

Issued on: Wednesday 29th August 2018

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

Doncaster Metropolitan Borough Council
www.doncaster.gov.uk

6.	Minutes of the Meeting of the Health and Wellbeing Board held 14th June 2018 *(Attached – pages 1 – 10)*	5 mins (Chair)
	Delivery of Health and Wellbeing Strategy	
7.	Joint Strategic Needs Assessment Policy Statement and Work Plan 2018/19. *(Paper attached – pages 11 – 16)*	10 mins (Jon Gleek/ Laurie Mott)
8.	An Overview of the Impact Report of the Children and Young People's Plan. *(Presentation)*	25 mins (Rebecca Mason)
	Board Assurance	
9.	Better Care Fund Annual Report 2017/18. *(Paper attached – pages 17 – 30)*	15 mins (Dr Rupert Suckling)
	Developments and Risk Areas	
10.	Prevention. *(Presentation/Paper attached – pages 31 – 40)*	20 mins (Dr Rupert Suckling)
11.	Recovery City. *(Presentation/Cover sheet attached – pages 41 – 42)*	20 mins (Dr Rupert Suckling)
12.	Oral Health Needs Assessment. *(Presentation/Paper attached – pages 43 – 106)*	20 mins (Dr Rupert Suckling)
	Board Development	
13.	Report from Health and Wellbeing Board Steering Group and Forward Plan. *(Paper attached – pages 107 – 142)*	10 mins (Dr Rupert Suckling)

Date/time of next meeting:

Thursday, 15th November 2018 at 9.30 a.m. in Room 007a and b - Civic Office, Waterdale, Doncaster, DN1 3BU.

Members of the Health and Wellbeing Board

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

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

This page is intentionally left blank

DONCASTER METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY, 14TH JUNE, 2018

A MEETING of the HEALTH AND WELLBEING BOARD was held in Room 007A AND B - CIVIC OFFICE on THURSDAY, 14TH JUNE, 2018, at 9.30 am.

PRESENT:

Vice-Chair - Dr David Crichton, Chair of Doncaster Clinical Commissioning Group (CCG) (in the Chair)

Councillor Nuala Fennelly	Portfolio Holder Children, Young People and Schools
Councillor Cynthia Ransome	Conservative Group Representative
Dr Rupert Suckling	Director of Public Health, Doncaster Council
Paul Tanney	Chief Executive, St Leger Homes Doncaster
Andrew Goodall	Chief Operating Officer, Healthwatch
Joanne McDonough	Deputy Chief Operating Officer RDaSH
Karen Barnard	Director of People & Organisational Development DBTH
Debbie John-Lewis	Interim Assistant Director Communities, Doncaster Council
Laura Sherburn	Chief Executive, Primary Care Doncaster
Lucy Robertshaw	Assistant Director Darts, Doncaster Community Arts (Health and Social Care Forum representative)

Also in attendance

Allan Wiltshire	Head of Policy and Partnerships, Doncaster Council
Helen Conroy	Public Health Specialist
Emma Challens	Deputy Chief Operating Officer DBTH
Alexandra Norrish	Programme Director, Hospital Services Review
Duncan Robertshaw	Chief Executive Darts

1 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies were received from the Chair, Councillor Rachael Blake and Councillor Nigel Ball, Jackie Pederson, Kathryn Singh (Joanne McDonough deputised), Richard Parker (Karen Barnard deputised), Steve Shore (Andrew Goodall deputised), Steve Helps, Karen Curran, Damian Allen (Debbie John-Lewis deputised), Peter Dale, Paul Moffatt (Pauline Turner deputised).

The Vice-Chair welcomed Laura Sherburn and Lucy Robertshaw to their first meeting as new members of the Board.

2 APPOINTMENT OF VICE-CHAIR

It was proposed by Dr Rupert Suckling and seconded by Paul Tanney that Dr David Crichton be appointed as Vice-Chair of the Board for the 2018/19 Municipal Year.

Upon being put to a vote, it was unanimously

RESOLVED that Dr David Crichton be appointed as Vice-Chair of the Doncaster Health and Wellbeing Board for the 2018/19 Municipal Year.

3 CHAIR'S ANNOUNCEMENTS

Whilst there were no specific Chair's announcements, the Chair requested that member presenting items to the Board be respectful of keeping to the time allocated on the agenda.

4 PUBLIC QUESTIONS

In addressing the Board, Mr Tim Brown thanked the Board for his opportunity to speak and made reference to previous discussion around a former DMBC officer fighting against alleged racism and if this was thought to be true it was incumbent upon the Board to address the impact of Health and Wellbeing outcomes for BME people and communities. He made reference with regard to his past involvement with the Community Forum and sought reasons as to why the Forum had been disbanded without due regard and consultation being undertaken.

Mr Brown spoke again of the FOI response sent to him which suggested that BME candidates across DMBC were still over 2 times less likely to be appointed after shortlisting than white candidates who were shortlisted. As a parent, he could not understand this position, and sought clarification as to why nobody had provided an explanation for this. Mr Brown highlighted to the Board that he had been informed that anybody applying for an apprenticeship with DMBC were required to have knowledge of DMBC operating systems. He stated that there were people within the BME community, including himself and family members, that had contributed to the NHS for many years and felt that there was a need for conversations to take place with BME communities. He requested that from the outcome of those discussions, 3-4 key actions be established which would be delivered over a 12 month period.

~~~~~~

In response, the Chair, Dr David Crichton stated that the Board would take his comments on board. He commented that the Board did take these issues seriously and a number of reports had been discussed at the Board covering some of the points raised. In his capacity as the Chair of CCG he stated that there was a high percentage of BME people within the medical profession. He assured Mr Brown that his comments had been acknowledged.

In reference to the comment made on apprenticeships, Councillor Nuala Fennelly, Cabinet member for Schools, Children and Young People stated that she was unaware that apprentices needed to have knowledge of operating systems within DMBC and asked Mr Brown to email her and she would investigate the issue and a response would be provided in due course.
~~~~~~

Paul Tanney, Chief Executive St Leger Homes reported that Doncaster Council and St Leger Homes followed the equalities framework the same as all other public bodies. He accepted that there were pockets of under representation and these were being addressed in order to promote fairness to all employees. He stated that he would speak to the Head of HR outside of the meeting.

Alexandra Norrish, Programme Director, Hospital Services stated that a lot of work had been carried out with specific seldom heard groups including the BME communities and from the analysis of the population effected by the Hospital Review, data could be broken down which included data on BME communities. The data could also be used to identify specific areas/communities which required specific further engagement. She commented that she would be happy to speak to Mr Brown outside of the meeting if he so wished.

Mr Brown was thanked for his attendance and his comments raised.

5 DECLARATIONS OF INTEREST, IF ANY

No declarations were reported at the meeting.

6 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 15TH MARCH 2018

RESOLVED that minutes of the HWB meeting held on 15 March 2018 were approved as a correct record and signed by the Chair subject to the following amendments:-

(1) In relation to public question by Mrs Valerie Wood, page 3, paragraph 5 should read as follows:-

'He confirmed that the CCG would ensure that the points set out in the Charter were considered in all of our services'; and

(2) In relation to Minute No 51, page 5, paragraph 5, 3rd bullet point should read as follows:-

- Steve Hackett invited the Officers to bring their presentation from today's meeting to a future meeting of the operational management team at RDASH.

7 HEALTHWATCH DONCASTER REPORT - 'WHY PEOPLE MISS THEIR HOSPITAL APPOINTMENTS IN DONCASTER AND BASSETLAW'

The Board considered a report and received a presentation by Andrew Goodhall, Chief Operating Officer, Healthwatch Doncaster and Emma Challens, Deputy Chief Operating Officer Doncaster & Bassetlaw Teaching Hospital (DBTH) which presented the findings from the 3 month engagement project carried out by Healthwatch Doncaster in partnership with DBTH and Doncaster Clinical Commissioning Group (DCCG), looking at why people miss their hospital appointments.

It was reported that over 50,000 hospital appointments were missed every year at DBTH NHS Trust which equated to 4,166 per month and over 140 per day. Not only did this impact on the productivity of the Hospital and inevitably caused administrative

burden on both secondary and primary care in chasing up those who do not attend their appointment, but more importantly patients may not access the diagnosis and subsequent treatment required.

It was noted that the cost to the NHS of missed appointments could be measured in a number of ways but best estimates were that this number of missed appointments each year could equate to income/expenditure of around £6m per annum.

During subsequent discussion, Members made a number of comments/observations including the following:-

- Councillor Cynthia Ransome thanked officers for the presentation. However expressed some concern with regard to the cost of doing this work when the information could have been provided through existing resources in each department.

- Feedback was welcomed. However, officers felt that the time and effort put into the project would reap rewards in the long term and it was important to recognise that engagement and talking to people was of the upmost importance to ensure the success of the project and to provide an improved service.

- Councillor Nuala Fennelly raised the issue of appointments for children and parents having to take children out of school to attend. It was clear that further engagement needed to take place with schools.

- Dr Rupert Suckling stated that great work had been carried out with regard to this. However raised the question of how radical officers wanted to be for example non-traditional appointment times. It was stated weekend appointments/later clinics had been tested. However it had had little effect on attendance but this would continue to be tested.

- A comment was raised with regard to carers, and whether the carer felt confident in requesting a time for an appointment which they are entitled to do and some people may not know that they have a choice.

- With regard to the data received, it was asked whether this had been analysed to assess whether there were any geographical reasons for missing appointments and whether asset bases in localities within the community could be used to ensure people can attend their appointments.

It was suggested that an update report on the implementation of the recommendations be received by the Board in 12 months.

RESOLVED that:-

(1) the report be noted;

(2) the implementation of the recommendations be supported; and

(3) an update on the implementation of the recommendations be received in 12 months.

8 SOUTH YORKSHIRE & BASSETLAW SHADOW INTEGRATED CARE SYSTEM - HOSPITAL SERVICES REVIEW

The Board received a presentation from Alexandra Norrish on the South Yorkshire and Bassetlaw Shadow Integrated Care System – Hospital Services Review.

It was reported that clinical services contributed 20% towards health and wellbeing. The review looked at the delivery of 5 clinical services:-

- Urgent and emergency care;
- Maternity;
- Care of the acutely ill child;
- Stroke; and
- Gastroenterology

Following the presentation, members of the Board were afforded the opportunity to make comments with regard to its content which were as follows:-

- In relation to emergency care, the Vice-Chair, Dr David Crichton reported that there had been an increase in workforce and the service had trained more A&E consultants.

- The Board welcomed the timelines within the presentation and felt these were very useful. It was also recognised that it was pleasing to see that staff were involved throughout the whole process and it was important that this should continue.

- Alexandra welcomed comments made by the Board and stated she would value any further thoughts on the refresh.

- In conclusion the Vice-Chair, Dr David Crichton wished to emphasise that whilst the Board acknowledged the report, the Independent Review make the recommendations to the Clinical Commissioning Groups as commissioners of these services. He also stated that he felt that Doncaster was in a strong position, however, there was always scope to improve patient outcomes. He reassured the Board that patients will continue to receive good care.

  RESOLVED that the report and presentation be noted.

9 HEALTH AND WELLBEING BOARD OUTCOMES FRAMEWORK 2018-2021: JUNE 2018 UPDATE

The Board received an update on the outcomes framework for the Health and Wellbeing Board which allowed the Board to drive delivery and be sighted on the key outcomes and indicators identified as important for the Board and links into the outcomes identified as part of the plan for the borough – Doncaster Growing Together (DGT).

The report detailed the feedback taken from the March meeting which enhanced the framework specifically:-

- Adding in clear directional arrows on the Outcome Framework Summary page to a give a sense of journey and progress and the introduction of a new key to help clarity; and

- The report also focusses in on a cell within the outcomes framework to support the boards role to identify 'hotspots' and consider a response.

Members of the Board were also presented with Appendix A which provided a specific report on one of the cells; Prevention: Living Well.

Following the update, the Board made the following comments:-

- Whilst in other areas gaps seem to be closing, in relation to smoking prevalence there was still some way to go to close the gap. The Vice-Chair, Dr Crichton stated that Hospitals had been approached to undertake an agreement to sign up to the smoking cessation service. It was further acknowledged that hospitals are smoke free within the inpatients and within the detox unit work had been carried out nationally in introduce the use of disposable e-cigarettes. However there was a balance of safety required when dealing with violent patients. The Board were also advised that there were challenges and encouragement is given to patients to attend the detox unit. However, some patients refused as they were unable to smoke in the unit.

- In relation to how the Board could help, it was stated that commitment was required for partner organisations to re-committing to the Tobacco Declaration which would help to reduce smoking prevalence in Doncaster.

- With regard to Outcome Indicator 2 on page 77 of the report, it was reported to the Board that the Department of Health had written to Doncaster Council on the issue of parental partnership on alcohol abuse and the need to support children and parents who suffer from alcohol abuse. It was suggested that it could be useful to liaise with Probation Services and the CPS regarding Court Orders as it could be considered as domestic abuse.

- Dr Rupert Suckling made a general comment in relation to what he thought would be the biggest challenge in having the resources to provide support. It was stated that 1 in 6 residents were supported by Health and Social Care services so maximising the opportunity to make every contact count could have a large population impact.

- A question was raised with regard to the Workplace Charter and who had signed up to it. It was reported that this was a national charter and predominantly associated with large organisations with a dozen organisations working on it. Work was underway to develop a South Yorkshire Charter with better usability for small and medium sized enterprises.

- Councillor Nuala Fennelly wished to highlight that schools were now signed up to the 'Daily Mile' initiative which had proved very successful within the Boroughs Junior Schools.

- Board Members were also pleased to see the introduction of colour within Appendix B of the report which showed a much clearer picture.

- In conclusion, it was suggested that in relation to Outcome Indicator 3, it would be beneficial to look across the range of outcome measures to identify where there were links and if there was a particular prevalence in certain geographical locations.

RESOLVED that the performance information contained within the Health and Wellbeing Board Outcomes Framework particularly the Prevention/Living well data be noted.

10 DONCASTER DRUG AND ALCOHOL STRATEGIC OVERVIEW AND ACTION PLAN 2018-2021

The Board received a presentation from Helen Conroy, Public Health Specialist on substance misuse in Doncaster which accompanied the Drug and Alcohol Strategic Overview and Action Plan at pages 115-134 of the agenda.

It was reported that the misuse of drugs and alcohol has had a huge impact on individuals, children, families and communities in Doncaster. These included:-

- Damaging the health and wellbeing of individuals.
- Damaging the quality of life, life chances and safety of children and families of those who are misusing substances.
- Crime and antisocial behaviour.
- Economic cost to Doncaster from lost productivity and cost of health, social care and the criminal justice system.

The Overview which was outlined within pages 116-117 of the agenda provided the Board with more detailed statistics in relation to alcohol consumption and drugs use in Doncaster.

Following the presentation, Members of the Board were afforded the opportunity to make comments which included:-

- Councillor Nuala Fennelly reported that in her capacity as Portfolio Holder for Schools, Children and Young People she had been visiting schools across the borough and seeking information regarding children who are carers. She commented that there were many hidden carers that the Council was unaware of and highlighted that the supportive system in place for young carers appeared to be ineffective and not working as quick as she would like. She stated that she had asked the Heads of the schools to supply her with information on what effect it had on children's education when they were acting as a carer for a family member. She commented that once she had all the information a report would be produced and suggested that a report be submitted to a future meeting of the Board.

- Dr Rupert Suckling stated that from a Health perspective, the system and the ways of working were operating well particularly surrounding the excellent work of the complex lives team. He stated that there was a need to develop a more family approach.

- It was reported that there was a need to spend money more effectively and whether it would be beneficial to have a worker within Aspire to work with

children and provide the early help that was much needed. It was commented that we only seem to be dealing with the symptoms rather than the causes.

- In conclusion, the Board identified that there needed to be more focus on dealing with Drug and Alcohol Abuse in a family approach rather than individually as it affected all members within the family and not just the child or adult.

RESOLVED to endorse a 3 year strategic drug and alcohol local plan for Doncaster.

11 UPDATE ON LONELINESS AND SOCIAL ISOLATION

The Board received an update report around the loneliness and social isolation agenda in Doncaster. It was reported that loneliness had been high on Doncaster's agenda since the Adult and Social Care Overview and Scrutiny review in 2015. The Board noted that there had been a number of developments since, including the commitment for Doncaster to be the least lonely borough in the county by 2021. It was noted that this reflected the increasing importance of the issue across all ages and social isolation and loneliness was now recognised to be as detrimental to health as tobacco.

The report also provided an update following the recent Health and Wellbeing Board workshop on loneliness and outlined the next steps for an alliance of interested organisations to take some elements of the work forward.

Members were advised that the voluntary community sector had a strong will to work together to form an alliance and work with organisations. It was noted that there had been a session planned to hold a 'show and tell' workshop in June 2018. It was envisaged that the session would present information of what the organisations are doing and what the geographical spread was and identify demographics and where there were any gaps. It was noted that it would be a similar initiative to 'Expect Youth' Model and whilst it was in the early stages there had been positive feedback. The Board were advised that it was envisaged that organisations would sign up to the Charter attached at Appendix 3 of the report by the end of September, 2018.

Dr Rupert Suckling stated that if any organisations wanted to sign up this could be facilitated by the Steering Group. It was suggested that Parish Councils may want to be involved. It was highlighted that through the 'Your Life Doncaster Portal' there was a lot of information identifying what Parish Councils offer. However, it was acknowledged that there was a need to ensure that Parish Councils in rural parts of the Borough needed to be consulted.

RESOLVED to:-

(1) note and endorse the progress outlined in the report and support the vision to eradicate loneliness in Doncaster by 2021; and

(2) delegate establishing a programmatic approach to loneliness to the Health and Wellbeing Board Steering Group.

12 ARTS ON PRESCRIPTION IN DONCASTER - OUTCOMES FROM FEBRUARY 2018 HWB WORKSHOP

The Board received a report updating members following the workshop held in February, 2018 on the Arts on Prescription in Doncaster and outlined some key next steps.

Members were presented with a little background to the subject stating that the Arts can play a crucial role in improving health and wellbeing of Doncaster people. It was noted that the recently published UK All Party Parliamentary Group (APPG) report 'Creative Health' clearly evidenced how the arts can play a central role in healthy communities. It was reported that it represents a national call to action for both the health and cultural sectors to apply this understanding to benefit the local populations.

The Board were advised that the vision for Doncaster was that community hubs, among them cultural venues, would be home to participatory creative activities for people of all ages and means, with health professionals referring patients into them as part of a Borough wide 'Arts on Prescription' service. It was noted that Doncaster residents taking part in creative activity would be healthier, happier and more resilient, and the positive effects would reach into the surrounding community.

The Action plan within the agenda set out the vision and outlined some case studies, together with the outcomes from the HWB workshop held in February 2018.

Following the update, the Board made the following comments:-

- Clarification was sought as to what and how the project would look like. It was envisaged that there could be a series of sessions for example, singing groups, dance for dementia which had evidenced improvement in mental health. It was stated that there could be any number of different groups which would link to improvements on isolation and loneliness.

- It was reported that social prescribing had worked extremely well and it was asked whether this initiative would naturally sit under that and whether this programme would part of the voluntary sector offer. It was advised that the Arts organisations bid for lottery funding outside of Doncaster funders and whilst there is a response to some of the needs it is challenging from an arts perspective.

- A comment was raised with regard to the link between RDaSH who already had links with Doncaster Community Arts (darts). Although service users attend darts there was no regular financial transfer from RDasH to darts.

- It was acknowledged by the Board that with regard to the New Sector Leadership Body that had been established in Leeds, it was a good time for the borough to pool resources.

RESOLVED that the Board agree the recommendations set out within the Action Plan at pages 181-182 of the agenda.

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

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

In particular, the report included updates for the Board on:-

- The Motor Neurone Disease Charter;
- The minutes of the SY&B SICS Collaborative Partnership Board meetings held in February, 2018; and
- Forward Plan for the Board

RESOLVED that:-

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

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

Prior to the closure of the meeting, Dr David Crichton wished to share with the Board that the Digital Care Record was now live.

CHAIR:_____ DATE:_____

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 6 September 2018

Subject: Doncaster JSNA Policy Statement

Presented by: Jon Gleek & Laurie Mott

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

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

How will this contribute to improving health and wellbeing in Doncaster?
This Policy statement outlines a new approach to understanding the health, wellbeing and social care needs of the Doncaster population.

Recommendations
The Board is asked to agree this new approach to assessing need in Doncaster.

Doncaster Joint Strategic Needs Assessment

(JSNA) Policy Statement

Background

The Health and Social Care Act 2012 introduced duties and powers for the Health and Wellbeing Board (HWB) in relation to the Joint Strategic Needs Assessment (JSNA), with the Council and its Partners having a shared responsibility in ensuring that all duties relating to the JSNA process and its identified priorities are discharged.

The JSNA provides the best evidence base for understanding the current and future health and well-being needs of the local population. It is used to inform the Health & Wellbeing Strategy, supports ongoing significant transformation programmes across health and social care, and contributes to the development and direction of services and overall strategic commissioning decisions.

Previous reports have been lengthy and static PDF documents. In an era of collaboration across health and social care there is a need for new ways of working, which has seen the growth of analytical work across the sectors. Furthermore, the introduction of new technology enables new approaches to be considered and implemented.

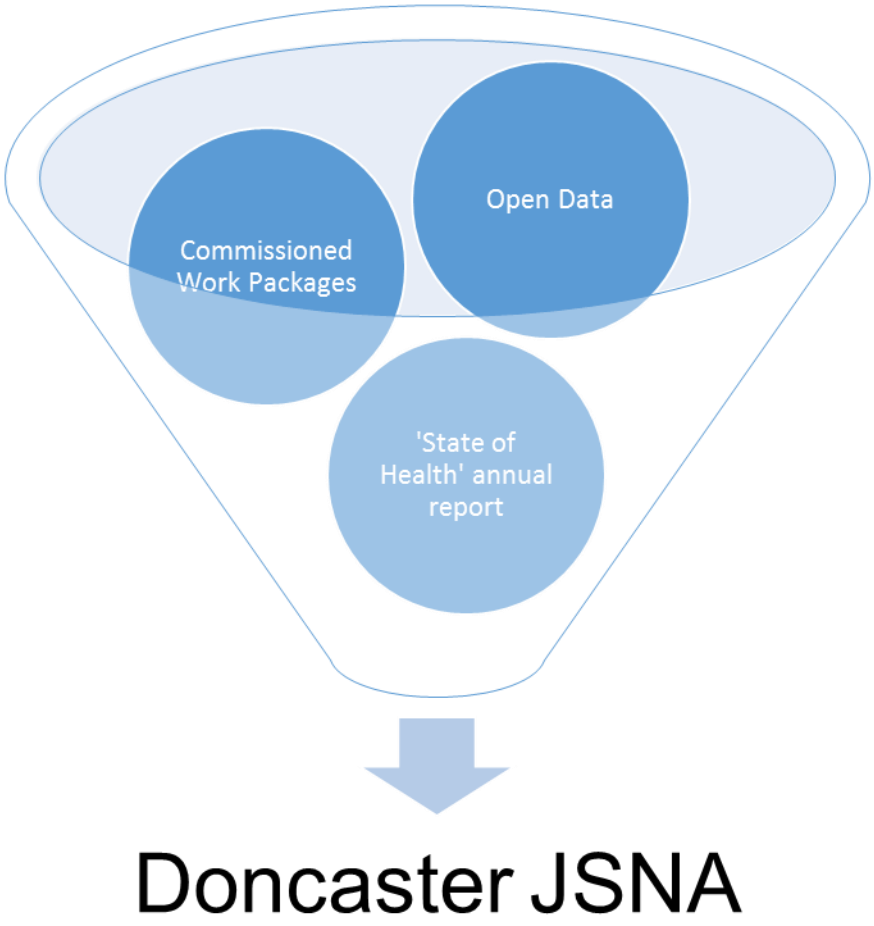
The JSNA aims to describe the Doncaster population and what impacts upon their health and quality of life, across the life course, providing an overview of a wide range of factors, from the economy and unemployment through to disability and diseases that are prevalent.

Whilst considering 'need' this should be balanced within the context of assets. Doncaster should utilise an "Asset" based approach for the JSNA, which provides a new way of challenging health inequalities, with a focus on place/neighbourhood and provides an opportunity to build upon strengths that already exist locally.

Developing a new approach

Rather than being 'a document' our new JSNA approach will have three strands of information:

- Open data including demographics and routine health and care statistics, which will accessible and interactive and will be utilised to measure progress and strengthen transparency and accountability
- Commissioned work packages of investigations, deep dives and reviews which will be published and accessible
- A "State of Health" report, which will be produced annually as an evaluation of what has been learnt from the other two strands and what questions this therefore prompts.



Presented in line with the Adult Social Care Framework (ASCOF), this JSNA will be a continuing model, providing lines of enquiry which can be prioritised over subsequent years and as demographics and other information becomes available. Within this will be an array of analytics and data sources, informing the continuous process of strategic assessment and planning.

It should be noted that work will always be required around incorporating the voice of the local people and Partners and so consultation and community voice will need to be sought in order to inform the JSNA further. This will also ensure that the JSNA has given due regard and evidenced how it meets obligations under Equality, Diversity and Inclusion.

The JSNA continues to be co-produced; a collaboration between the NHS, local authority and Team Doncaster Partners. The JSNA (and JSNA products) should be co-authored and co-produced and the approach above allows flexibility of authorship, however primarily the responsibility for 'holding the pen' resides between Public Health and the Council's Strategy and Performance Unit.

J Gleek

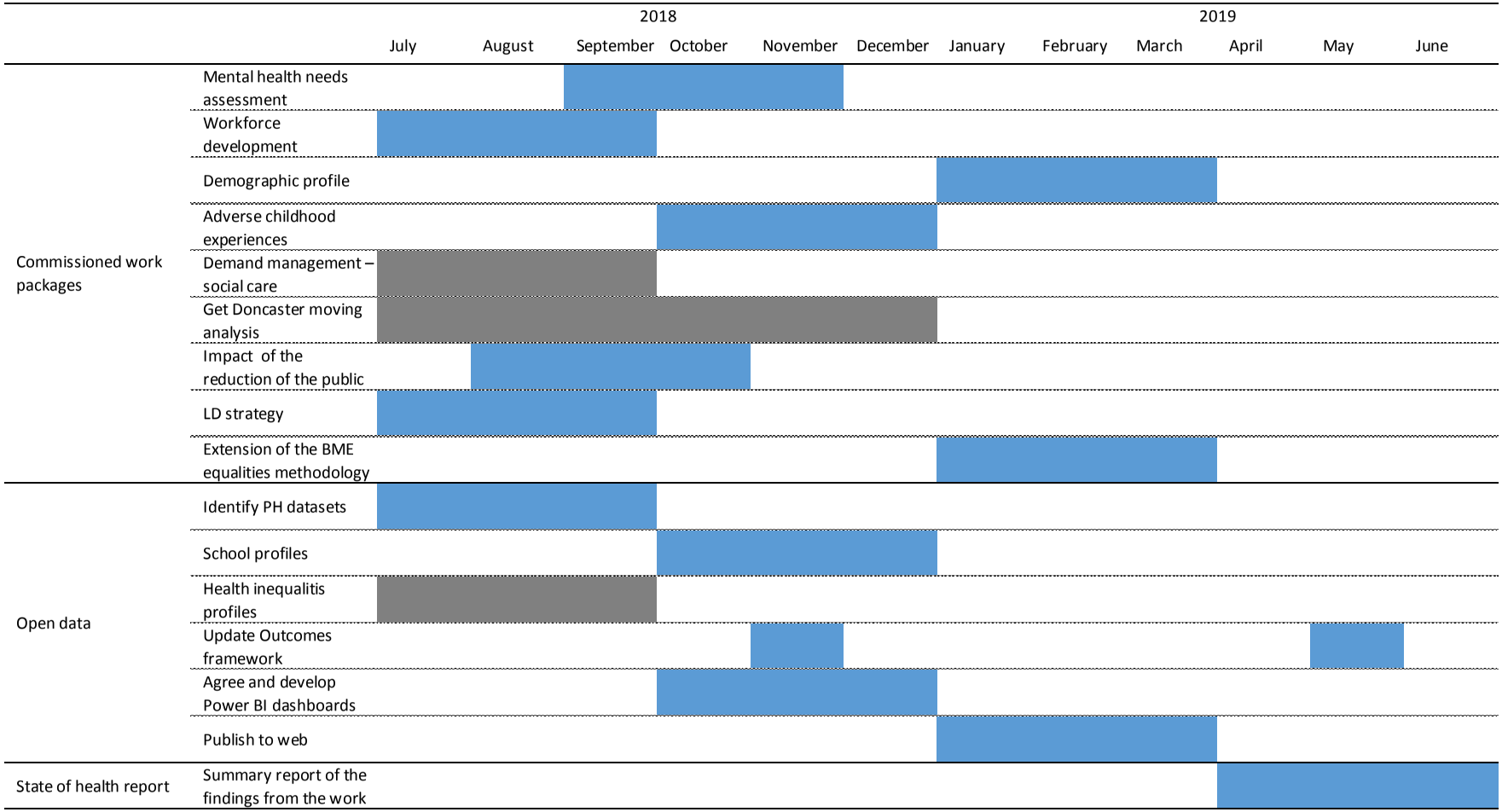
J Briggs

R Suckling

03/05/2018

Appendix 1

JSNA workplan 2018/19



This page is intentionally left blank

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 06/09/2018

Subject: Better Care Fund (BCF): Annual Report for 2017/18

Presented by: Dr Rupert Suckling, Director of Public Health

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

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

How will this contribute to improving health and wellbeing in Doncaster?
This report updates on the 2017/18 year end position of the Better Care Fund (BCF). The BCF itself contributes to preventing unnecessary hospital admissions, reducing delayed transfers of care and enabling people to stay at home for longer.

Recommendations
1) The Board is asked to note the following: a) The final BCF out-turn position for 2017-18; b) Progress against the BCF national conditions and performance indicators; and wider integration of health and social care.

This page is intentionally left blank

Doncaster Council

Agenda Item No: 9

Report

Date: 6 September 2018

To the Chair and Members of the Health and Wellbeing Board

BETTER CARE FUND: ANNUAL REPORT FOR 2017/18

EXECUTIVE SUMMARY

1) This report updates on the 2017/18 year end position of the Better Care Fund (BCF).

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

3) There are a number of national BCF conditions that the partnership must meet and four key BCF national indicators must be monitored and reported against. Each quarter the partnership submits a statutory return that confirms compliance with the national conditions; and updates on performance against the national indicators and the joint local BCF Plan. This report provides an update on the 2017/18 year end position as reported in the statutory returns and includes updated data and information where appropriate.

4) Key points from the quarterly returns submitted in 2017/18 are that the partnership continued to fully meet all of the national conditions for BCF and remained on track to meet the targets set out for the four national indicators.

5) ***Appendix 1*** provides the final out-turn position against the plan for 2017-18. The CCG considered how best to maximise resources at year end. This enabled costs of one of the transformation projects, the intermediate care transformation project, to be managed from other CCG resources and ensure that BCF was maximised to provide the resources required in 2018/19. In total £615k BCF has been carried forward within the non-recurring BCF reserve and are committed in 2018/19.

EXEMPT REPORT

6) The report does not contain any exempt information.

RECOMMENDATIONS

7) That the Board notes the final BCF out-turn position for 2017/18 and notes progress against the BCF national conditions and performance indicators; and progress in moving towards the wider integration of health and social care.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

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

BACKGROUND

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

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

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

12) There are a number of national BCF conditions that the partnership must meet and four key BCF national indicators which must be monitored and reported against. Each quarter the partnership submits a statutory return that provides details of performance against the national indicators and the partnership's local BCF Plan. This report provides an update on the 2017/18 year end position as reported in the statutory returns as well as an update on the outturn position against the BCF local plan.

UPDATE ON SPENDING PLANS FOR THE BETTER CARE FUND (BCF).

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

a) Plans must be jointly agreed
b) NHS contribution to adult social care is maintained in line with inflation.

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

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

a) Delayed transfers of care
b) Non-elective admissions (general and acute)
c) Admissions to residential and care homes
d) Effectiveness of reablement

15) ***Appendix 1*** sets out the final out-turn position against the plan for 2017-18. The CCG considered how best to maximise resources at year end and this enabled costs of one of the transformation projects, the intermediate care project, to be managed from other CCG resources; and ensure that BCF was maximised to provide the resources required in 2018/19. In total £615k BCF has been carried forward within the non-recurring BCF reserve and are committed in 2018/19.

PERFORMANCE AGAINST NATIONAL BCF CONDITIONS AND INDICATORS

16) The partnership submitted quarterly BCF statutory returns for 2017-18. The returns included an assessment of the extent the partnership is meeting the national conditions for BCF, an assessment of performance against the four BCF national indicators; and an assessment of performance against the agreed targets within the local BCF Plan. They also included an overall assessment of performance against the local BCF Plan for integrating health and social care. A summary of the position reported in the statutory returns for 2017-18 is as follows:

a) National Conditions for BCF

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

i) There are jointly agreed plans in place for working towards health and social care integration.

ii) There is agreement on the planned financial contribution from the CCG to social care in line with the BCF Planning Requirements.

iii) There is agreement to invest in NHS commissioned out of hospital services.

iv) Plans are in place and improvement activity is taking place to manage transfers of care.

v) The partnership has a signed off and legally binding section 75 agreement in place that governs the pooling of BCF monies between the Council and CCG.

b) National BCF Performance Indicators

The overall assessment of performance for all of the four national BCF indicators is that they are all on track to meet the planned target for the

quarter. ***Appendix 2*** provides details of performance trends for each of these indicators from March 17 to March 18. Key points for the indicators as reported in the statutory returns are as follows:

i) **Non-elective admissions:** There has been good progress in this area. For the 11 months ending 28th February non-elective admissions are 3.1% below the BCF target and 0.24% below the corresponding period in 2016-17. Avoidable emergency admissions are 6.6% lower than in 2016-17.

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

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

iv) **Delayed Transfers of Care (DTOC):** Doncaster health and social care partners continue to work effectively together to reduce Delayed Transfers of Care. Significant and sustained progress has been made with DTOC reduced to below the BCF target November 17 to February 18.

c) High Impact Change Model

The quarter four BCF return includes a maturity assessment of the partnership's progress in implementing a "High Impact Change Model," (HICM) a national initiative to improve flows of patients in and out of hospitals and to address issues relating to Delayed Transfers of Care. A project manager is working across health and social care to implement the HICM. The council has worked with the CCG and providers to establish a steering group to oversee the implementation, with a number of working groups established to drive change forward.

Key priorities have been identified and short term initiatives have been agreed to review the hospital discharge process, develop proposals for a swoop team to proactively challenge and discharge people from hospital beds and strengthen 7 day working arrangements within the hospital. A business case has been agreed to pilot a "HomeFinder" role to improve the discharge to home process and reduce delays into care homes.

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

The partnership is required to report on key areas of progress in delivering the local BCF Plan to enable the integration of health and social care. Significant work has taken place in 2017/18 in this area to move towards Doncaster's vision for integration. This includes:

- Substantial progress in the delivery of a shared care platform across Doncaster Health and Care partners. IT services will be interoperable to allow practitioners to access information in all care settings. Proof of concept will be via a 6 month pilot in the Rapid Response pathway within Intermediate Care which has recently gone live.

- Doncaster Health and Social Care Partners are working effectively together to reduce Delayed Transfers of Care. Significant and sustained progress has been made in reducing DTOC. In January 107 days were signed off, reduced from 535 days in August.

- The development of a suite of draft agreements: System Partnership Agreement, Commissioning Agreement and Provider Agreement.

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

IMPACT ON THE COUNCIL'S KEY OUTCOMES

17)

	Outcomes	**Implications**
	Doncaster Working: Our vision is for more people to be able to pursue their ambitions through work that gives them and Doncaster a brighter and prosperous future; • Better access to good fulfilling work • Doncaster businesses are supported to flourish • Inward Investment	None
	Doncaster Living: Our vision is for Doncaster's people to live in a borough that is vibrant and full of opportunity, where people enjoy spending time; • The town centres are the beating heart of Doncaster • More people can live in a good quality, affordable home • Healthy and Vibrant Communities through Physical Activity and Sport • Everyone takes responsibility for keeping Doncaster Clean • Building on our cultural, artistic and sporting heritage	None

	Doncaster Learning: Our vision is for learning that prepares all children, young people and adults for a life that is fulfilling; • Every child has life-changing learning experiences within and beyond school • Many more great teachers work in Doncaster Schools that are good or better • Learning in Doncaster prepares young people for the world of work	None
	Doncaster Caring: Our vision is for a borough that cares together for its most vulnerable residents; • Children have the best start in life • Vulnerable families and individuals have support from someone they trust • Older people can live well and independently in their own homes	None
	Connected Council: • A modern, efficient and flexible workforce • Modern, accessible customer interactions • Operating within our resources and delivering value for money • A co-ordinated, whole person, whole life focus on the needs and aspirations of residents • Building community resilience and self-reliance by connecting community assets and strengths • Working with our partners and residents to provide effective leadership and governance	None

RISKS AND ASSUMPTIONS

18) N/A

LEGAL IMPLICATIONS

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

FINANCIAL IMPLICATIONS

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

HUMAN RESOURCES

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

TECHNOLOGY IMPLICATIONS

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

HEALTH IMPLICATIONS

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

EQUALITY IMPLICATIONS

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

BACKGROUND PAPERS

25) NA

REPORT AUTHOR & CONTRIBUTORS

Jacqui Scott, Project Manager
Kathryn Black, Directorate Finance Manager
01302 862362
Jacqui.scott@doncaster.gov.uk

Dr Rupert Suckling Director or Public Health

Appendix 1: BCF Quarter 4 Out-turn Spend

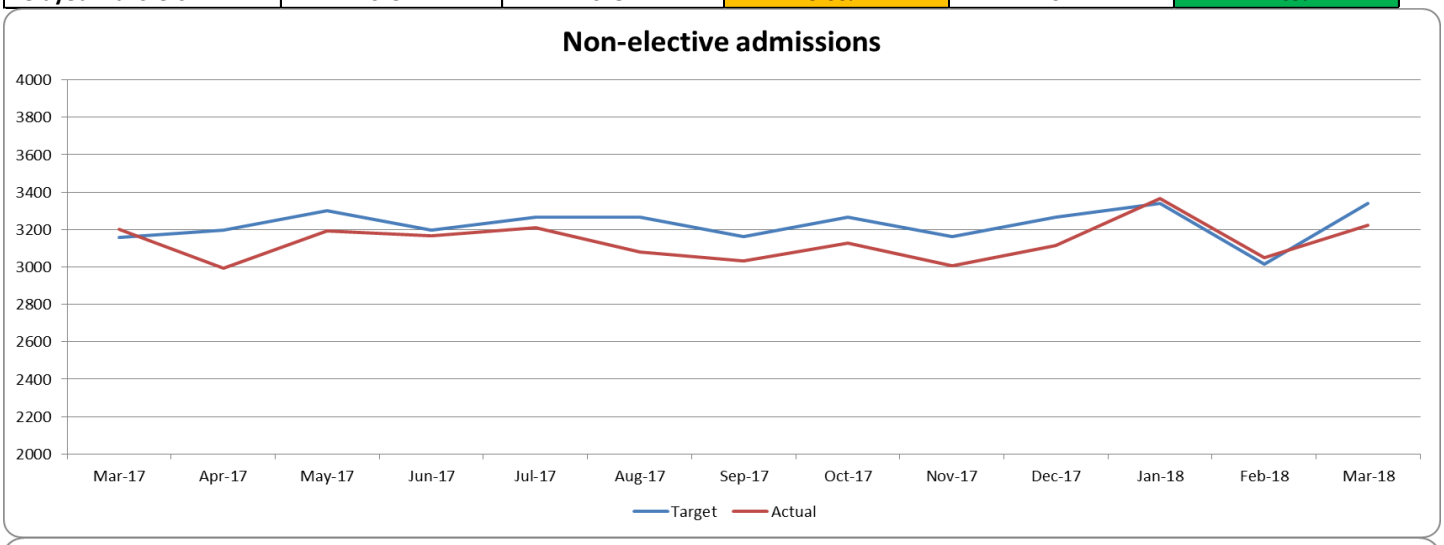
Project No.	Project Lead	Commissioning Lead	BCF Workstream	Plan 2017/18 £'000	Forecast Spend 2017/18 £'000	Variance 2017/18 £'000	Plan 2018/19 £'000
1	Anthony Fitzgerald	CCG	Community Aids and Adaptations	2,061	2,061	0	2,349
2	Anthony Fitzgerald	CCG	Carers Support Services & Breaks	844	844	0	844
3	Anthony Fitzgerald	CCG	COPD Early Supported Discharge (RDASH)	40	40	0	40
4	Anthony Fitzgerald	CCG	Dementia Services (RDASH)	2,019	2,019	0	2,019
5	Anthony Fitzgerald	CCG	Liaison Schemes (RDASH)	260	260	0	260
6	Anthony Fitzgerald	CCG	Care Home Liaison (RDASH)	244	244	0	244
7	Anthony Fitzgerald	CCG	Other Schemes ie Alzheimers & S256 contracts	205	205	0	205
8	Anthony Fitzgerald	CCG	Clinical Services Review Community based services - Mex Mont re-design (RDASH)	1,144	1,144	0	1,144
9	Anthony Fitzgerald	CCG	Assessment Unit Health Staffing	302	302	0	302
10	Anthony Fitzgerald	CCG	Single Point of Access	473	473	0	473
11	Anthony Fitzgerald	CCG	Respite Services (RDASH)	1,302	1,302	0	1,302
12	Anthony Fitzgerald	CCG	Discharge Schemes inc Early Supported Discharge	834	834	0	834
13	Anthony Fitzgerald	CCG	Bed Based Intermediate Care (RDASH)	3,418	3,418	0	3,419
14	Anthony Fitzgerald	CCG	Mental Health Crisis Services (RDASH	2,022	2,022	0	2,022
				15,168	**15,168**	**0**	**15,457**
1	Clare Henry	DMBC	Falls Development Programme (Age UK)	50	50	0	50
2	Lisa Swainston	DMBC	Round 2 Innovation Fund (Having a Good Day)	20	16	-4	0
3	Fay Wood	DMBC	Community capacity and well- being support / social prescribing	225	210	-15	240
4	Nick Germain	DMBC	Well North Project	262	262	0	167
5	Fay Wood	DMBC	Community mobile day service / borough wide	125	125	0	125
6	Fay Wood	DMBC	Dementia mobile day services	45	46	1	45
7	Vanessa Powell Hoyland	DMBC	Winter Warm	99	89	-10	85

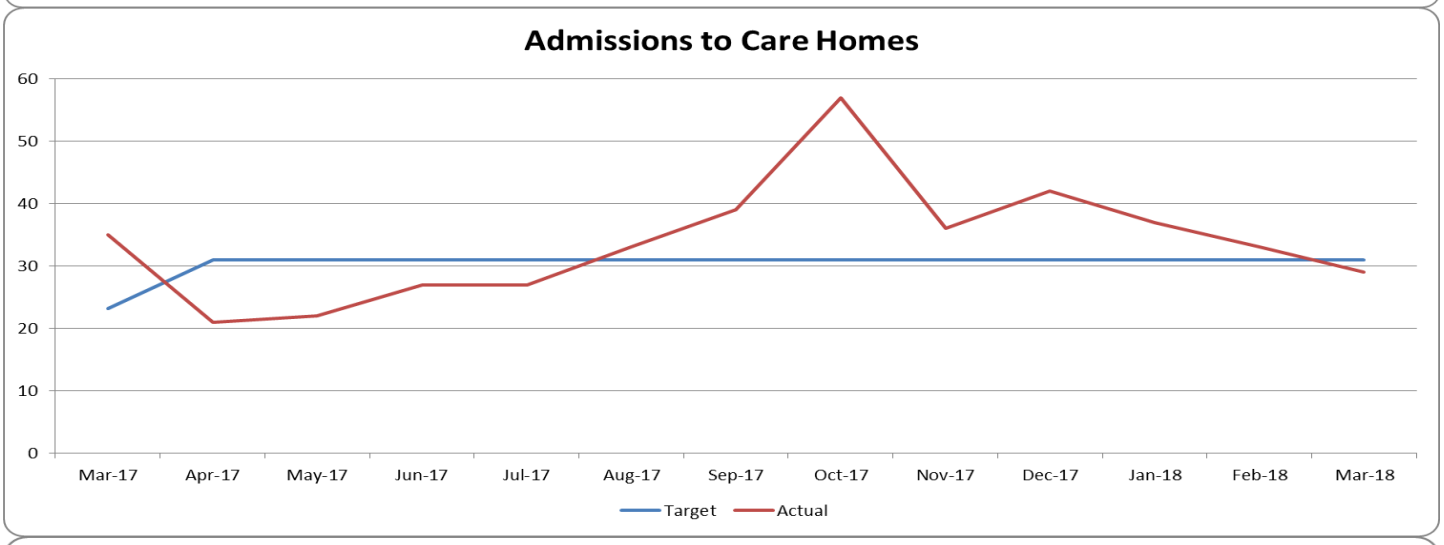
Project No.	Project Lead	Commissioning Lead	BCF Workstream	Plan 2017/18 £'000	Forecast Spend 2017/18 £'000	Variance 2017/18 £'000	Plan 2018/19 £'000
8	David Eckersley	DMBC	Phase 1 Review officers	50	37	-13	0
9	Rosemary Leek	DMBC	Dementia Friendly Communities programme	18	25	7	0
10	Rosemary Leek	DMBC	Enhancement of Dementia support services (Alzheimers dementia café's)	77	77	0	77
11	Rosemary Leek	DMBC	The Admiral service (making space)	88	88	0	88
12	Louise Shore	DMBC	Hospital based Social Workers	209	170	-39	213
13	Fay Wood	DMBC	Home from Hospital (Age UK)	50	50	0	70
14	Collette Taylor	DMBC	Direct Payment Support Unit and Business Support Unit temporary staffing	116	110	-6	118
15	Alan Wiltshire	DMBC	Integrated health and social care information management systems - (Caretrak)	50	50	0	50
16	Rosemary Leek	DMBC	Dementia Advisor (Peer Support pilot)	0	0	0	0
17	Sarah Sansoa	DMBC	Telecare Strategy	119	111	-8	150
18	Rachael Thompson	DMBC	HEART	531	506	-25	542
19	Rosemary Leek	DMBC	Dementia ccg post fully BCF funded	5	0	-5	0
20	Rosemary Leek	DMBC	Dementia Advisor (Age uk)	32	32	0	32
21	Rachael Thompson	DMBC	STEPS / OT service	1,334	1,393	59	1,510
22	Louise Shore	DMBC	RAPT	108	67	-41	110
23	Rachael Thompson	DMBC	(Positive Steps) Social care Assessment Unit	1,650	1,791	141	1,724
24	Louise Shore	DMBC	Hospital Discharge Worker	27	36	9	28
25	Rachael Thompson	DMBC	SPOC/One Point 1	90	66	-24	92
26	Debbie John-Lewis	DMBC	Intermediate Care and support strategy	170	170	0	170
27	Fay Wood	DMBC	Mental Health - Doncaster Mind	156	156	0	245

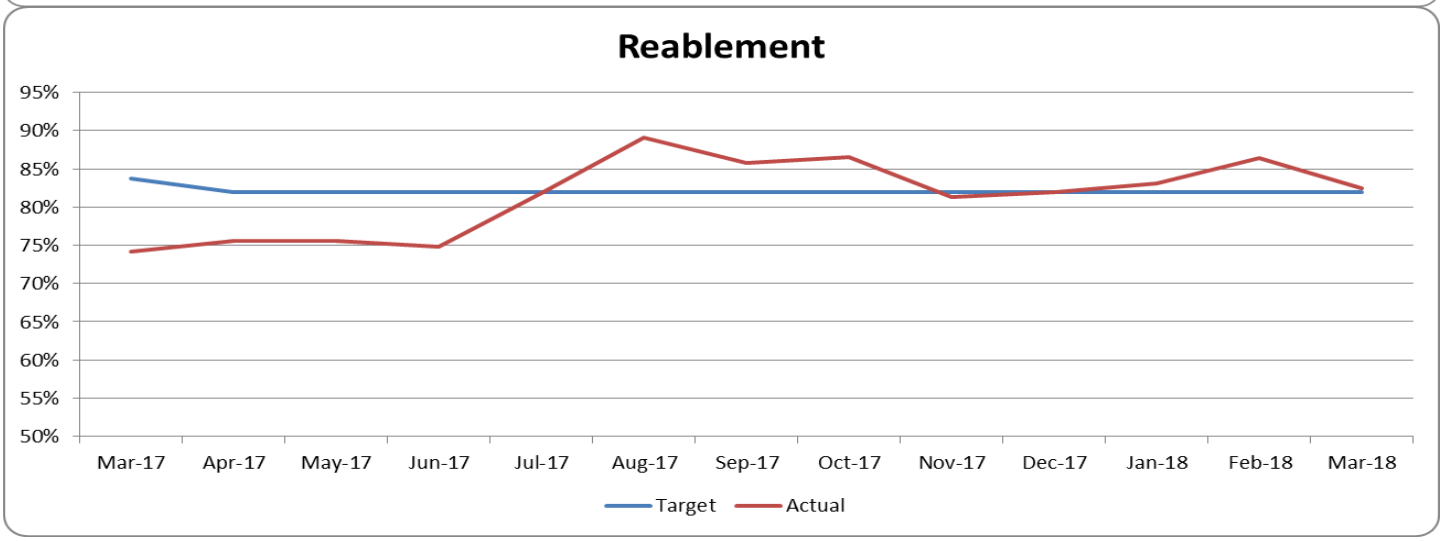
Project No.	Project Lead	Commissioning Lead	BCF Workstream	Plan 2017/18 £'000	Forecast Spend 2017/18 £'000	Variance 2017/18 £'000	Plan 2018/19 £'000
28	Fay Wood	DMBC	Mental Health - Changing Lives	105	105	0	0
29	Patrick Birch	DMBC	PMO (Programme Management Office and Development)	177	163	-14	181
30	Andy Collins	DMBC	Alcohol Safe Haven	15	5	-10	0
31	Karen Tooley/ Ian Campbell	CCG	Doncaster Intermediate Health & Social Care – Phase 3- testing the model	600	0	-600	0
32	Patrick Birch	DMBC	Procurement of a strategic partner to support DMBC and partners across the Doncaster Health and Social Care sector to deliver the Doncaster Place Plan.	500	498	-2	0
33	Fay Wood	DMBC	Information and advice kiosks	0	0	0	0
34	Vanessa Powell Hoyland	DMBC	Healthy homes healthy people	13	12	-1	0
35	Fay Wood	DMBC	Disabled Go	35	35	0	8
36	Lisa Swainston	DMBC	Dev & Enhancement of vibrant provider market	15	0	-15	0
37	Simon Marsh	CCG	Integrated Digital Care Record Pilot – Consultancy Support	0	0	0	0
38	Griff Jones	DMBC	Adults Health and Wellbeing – Creative Options for Learning Disability service users	0	0	0	673
39	Griff Jones	DMBC	CLS Community lead support	0	0	0	500
			UNALLOCATED				10
				7,166	**6,551**	**-615**	**7,302**
Minimum CCG Contribution TOTAL				**22,334**	**21,719**	**-615**	**22,759**
1	Keith Sinclair	DMBC - DFG	Disabled Facilities Grants - capital funding	2,118	2,118	0	2,272

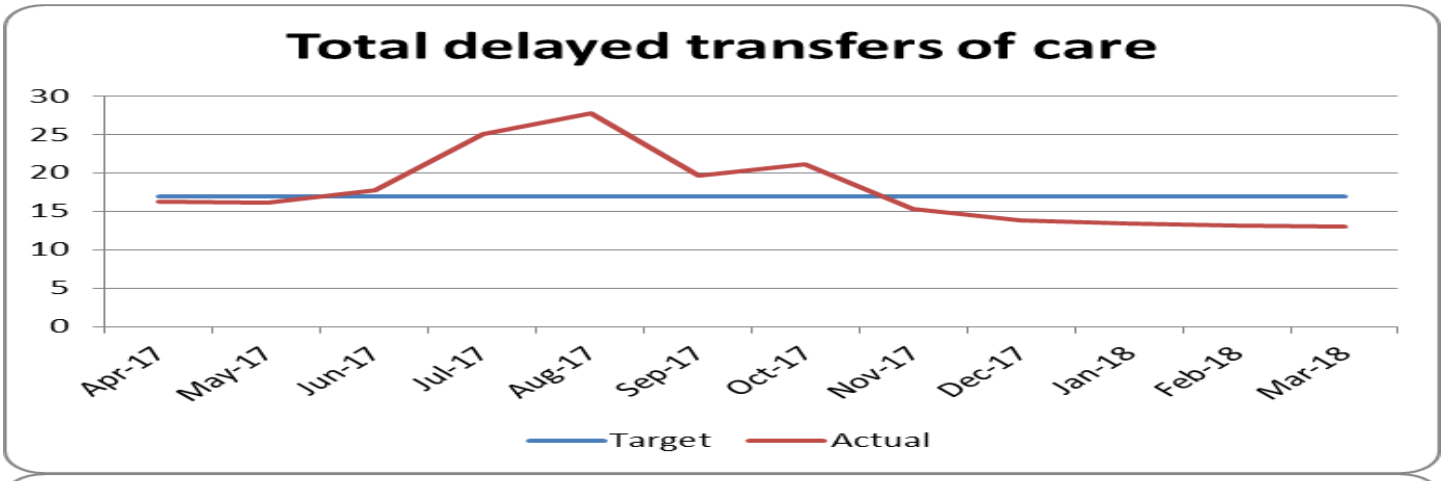
Appendix 2: Performance against national BCF indicators

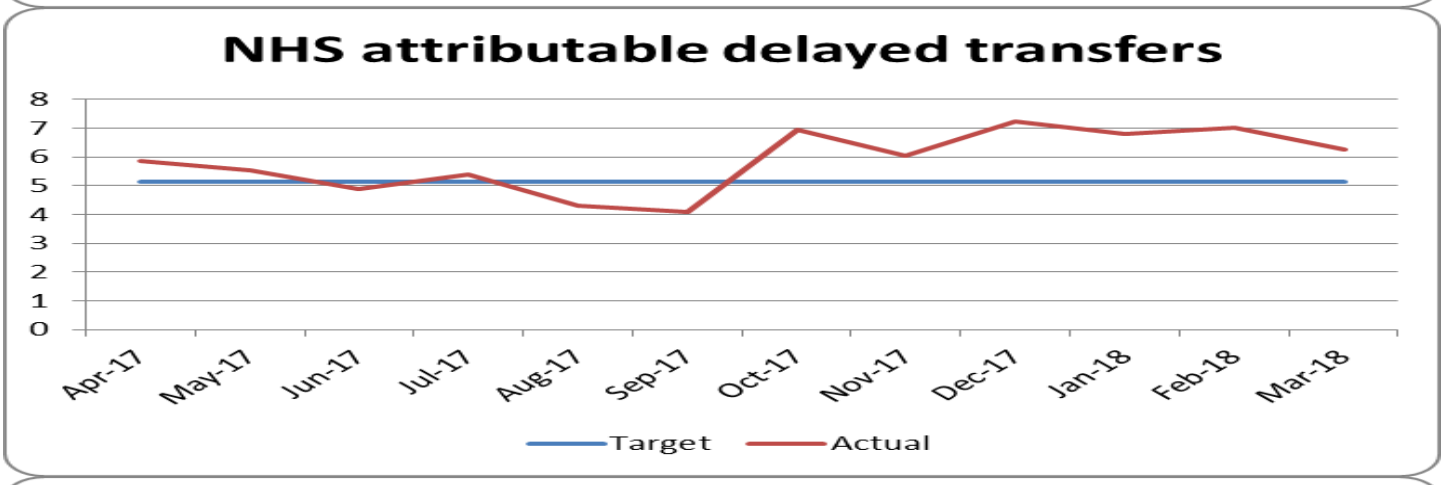
	2017-18 target	2017-18 actual	Var.	2016-17	Var.
Reablement	82%	81.49%	-0.63%	78.72%	3.51%
Admissions to care homes	371	403	8.63%	410	-1.71%
Non -elective admissions	38772	37554	-3.14%	37630	-0.20%
Delayed Transfers	6291	6484	3.06%	7024	-7.69%

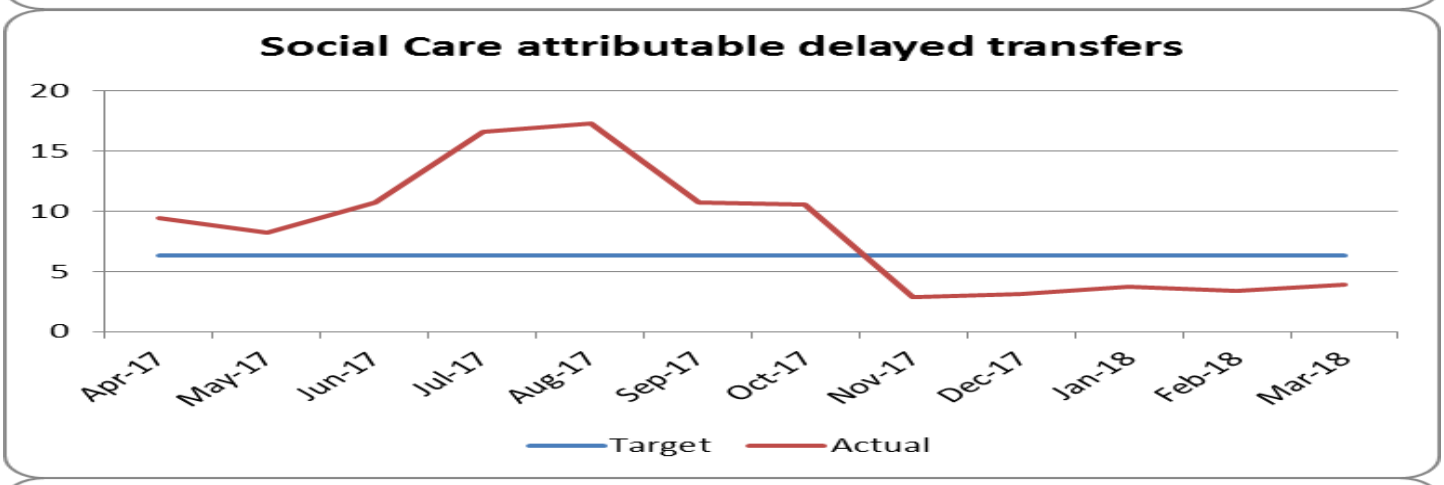


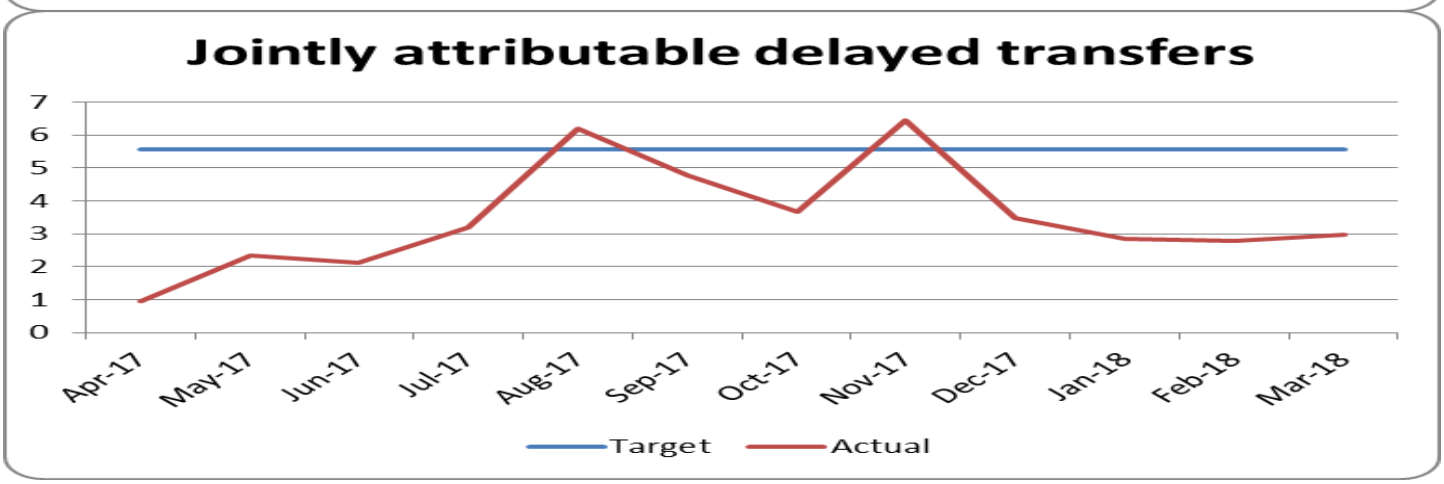





Total delayed transfers of care
30
25
20
15
10
5
0
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Target
Actual


NHS attributable delayed transfers
8
7
6
5
4
3
2
1
0
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Target
Actual


Social Care attributable delayed transfers
20
15
10
5
0
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Target
Actual


Jointly attributable delayed transfers
7
6
5
4
3
2
1
0
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Target
Actual

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 6 September 2018

Subject: Prevention

Presented by: Dr Rupert 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)	x
	Mental Health	x
	Dementia	x
	Obesity	x
	Children and Families	x
Joint Strategic Needs Assessment		x
Finance		x
Legal		
Equalities		x
Other Implications (please list)		

How will this contribute to improving health and wellbeing in Doncaster?
The Health and Wellbeing Board Outcome Framework and the Doncaster Place Plan both highlight the importance of prevention in meeting the triple aim of improving wellbeing, quality and maintaining financial grip. This report identifies the key developments in prevention and early help since the publication of the place plan and describes an emerging 'people powered' approach to prevention.

Recommendations
The Board is asked to NOTE the report, COMMENT on and SUPPORT the Doncaster 'people powered' approach to Better Lives.

This page is intentionally left blank

Better Lives – Progress on Prevention: Briefing for Doncaster Health and Wellbeing Board

Introduction

The purpose of this paper is to update the Health and Wellbeing Board of the progress made on prevention and early help as originally outlined in the Doncaster Place Plan (Oct 2016), to highlight key developments and potential next steps.

Background

The fact that 'prevention is better than cure' is widely quoted yet despite reductions in deaths from cardiovascular disease, cancer, motor vehicle accidents and tobacco most premature deaths in the UK can be attributed to a 'failure' of prevention. Overall reductions in premature mortality conceal differences in mortality in different populations groups with increased deaths from accidents, suicide and liver disease in young men and with the homeless often overlooked too.

In health a third of all deaths can be considered premature and related to four key risk factors smoking, physical inactivity, poor diet and alcohol abuse/misuse. These risk factors also cause long term conditions creating additional burdens on individuals, employers as well as health, care and 'Blue Light' services. A 2011 paper estimated these four risk factors cost the NHS £5.8b; for Doncaster it's estimated that these costs to the local NHS are in the order of £72m (with overweight and obesity £25.5m, smoking £16.5m, alcohol £16.5m and physical inactivity £4.5m).[1] Wider societal costs including impacts on adult social care are likely to be five times this approaching £360million. The costs are driven by the numbers of people with the risk factor i.e. smoking prevalence 19.7% or excess weight 71.5% together with the severity of the risk factor i.e. the number of cigarettes smoked.

The Wanless report in 2002 identified that two of the key drivers of health care costs were how well our health services became more productive and how well people became fully engaged with their own health.[2] However, even in the ' fully engaged' scenario health care spending would need to rise by 2.4% a year but this is significantly less than the 3.5% required under the 'slow uptake' model.

However, a focus on these behavioural risk factors alone may miss that approaches to psychosocial factors (stress), social cohesion and the 'causes of the causes' are equally if not more important (education, occupation, income, gender and ethnicity). Increasingly people are living with more than one health condition and/or risk factor, known as 'multi-morbidity' and it's not only mortality that is important but morbidity should also be considered, e.g. mental health conditions and musculoskeletal diseases.

[1] Peter Scarborough, Prachi Bhatnagar, Kremlin K. Wickramasinghe, Steve Allender, Charlie Foster, Mike Rayner; (2011) The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs, Journal of Public Health, 33 (4) 527–535, https://doi.org/10.1093/pubmed/fdr033

[2] Wanless D (2002). Securing our Future Health: Taking a Long-Term View. https://www.yearofcare.co.uk/sites/default/files/images/Wanless.pdf

Doncaster Reponses

The importance of prevention is recognised in the vision of the Doncaster place plan 2016-21:

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

This is further emphasised in the proposed approach to prevention (primary, secondary and tertiary) and early help with a focus on smoking and obesity (Appendix 1). There has been progress on early help and the 7 Areas of Opportunity have all identified prevention and demand management as key elements of those areas.

The Outcome framework for the Health and Wellbeing Board (a subset of Doncaster Growing Together) also recognises the importance of prevention (Appendix A). The June 2018 Board meeting identified the prevention and living well 'cell' as an area for future work.

The 'Overarching' Approach

There is local consensus as to the main contributors to health and wellbeing including clinical care, health behaviours, social and economic factors and the physical environment (table 1).

Table 1. Contributors to Health and Wellbeing

Clinical Care (20%)	Access to Care Quality of Care
Health Behaviours (30%)	Tobacco use Diet & Exercise Alcohol and Drug use Sexual activity
Social and Economic factors (40%)	Education Employment Income Family and Social Support Community Safety
Physical Environment (10%)	Air & Water Quality Housing and Transport

However, the recent commissioning and delivery of prevention approaches nationally and locally has been impacted by both reorganisation of the NHS and public health, a focus on the process of clinical care as well as austerity. Even more recently NHS England has taken an increasing role in prevention through approaches including the National Diabetes Prevention Programme. Unfortunately this can lead to not only a siloed organisational response to prevention, with the NHS taking responsibility for clinical care, public health the health behaviours and the council for social and economic factors and physical environment, but also a 'statist' response where induvial, family and community assets have been replaced by services.

Commissioners have innovated in an attempt to break down these silos. Commissioners have transferred commissioning responsibilities between themselves (with or without resources) have

invested their own resource in 'non-traditional' areas e.g. the CCG have invested in Fit Rovers, public health in maternal smoking and they have jointly used the flexibilities in the Better Care Fund e.g. approaches to reduce fuel poverty, social prescribing and community wealth building. Commissioners have also invested in 'Doncaster Talks' to understand the key drivers of health and wellbeing and how their service offer can support and build on individual, family and community assets and not disempower people. There is an increasingly dialogue with the Voluntary, Community and Social Enterprise (VCSE) sector and the faith sector. Finally a menu of prevention programmes has been proposed which will contribute to the life course approach to health and wellbeing. Together this has seen a widening of prevention from a focus on 'biomedical disease' processes to include approaches that may either reduce or delaying other complex issues e.g. domestic violence or the need for social care.

Progress against the Place Plan

The Doncaster place plan identified prevention and early help as a cohort of activity. Initially 10 areas for development were identified.

Initial piece of work	Progress
Renewed emphasis on the use of the full range of local authority powers planning, licensing, section 106 monies	
Agreement about brief and very brief interventions that could be wrapped into specification (primary, secondary care and social care)	
Prototyping the enhanced Safe and Well check delivered by the Fire Service	
Reviewing the lifestyle service offer (smoking cessation, physical activity, food, weight management and alcohol)	
Mainstream funding of social prescribing services complemented by community navigators and Asset Based Community Development	
Renewed emphasis on CVD risk reduction and particularly Blood pressure (going beyond QOF)	
Blue Light approach to resistant drinkers (assertive outreach)	
Employment support for those out of work linked to Sheffield City Region Pilot	
Focus on the first 1001 days	
Public Mental health and development of resilience in young people	

Taking Stock

Prevention refers to policies, practices, and interventions that reduce the likelihood that an individual, family or community will experience the outcome or condition of interest. It also means providing those who experience that outcome with the necessary resources and supports to stabilize them, enhance integration and social inclusion, and ultimately reduce the risk of the recurrence.

- Health starts long before illness in our homes, schools and workplaces
- Our communities or jobs shouldn't be hazardous to our health
- Everyone should have the opportunity to make the choices that allow them to live a long healthy life regardless of their income, education or ethnic background

Emerging Doncaster 'People Powered' approach to Better Lives

- **Build on Strengths and Assets.** Identify individual family and community strengths and co-create resilience/capacity/community wealth to increase health, social and financial inclusion e.g. Asset Based Community Development, Stronger families, healthy settings, healthy places and Well North.

- **Create the conditions.** Adopt a Health in All Policies approach to statutory roles e.g. the local plan, planning and licensing and non-statutory approaches e.g. Doncaster Growing Together (housing, employment, transport, community safety and financial security).

- **Community Wellbeing Hubs.** Build on existing statutory (e.g. primary care) and non-statutory hubs to align a network of community wellbeing hubs including access to Information Advice and Guidance resources e.g. Your Life Doncaster, technology and campaigns.

- **Civil Society Alliances.** Support and co-create alliances to address specific challenges e.g. Expect Youth, Loneliness Alliance, Safe and Well visits, Get Doncaster Moving, Good Food Doncaster, mental health and suicide prevention, smokefree places, Baby Friendly Initiatives, Best Bar None and responsible retailer schemes.

- **Community Navigation**. Continue to connect people to people and between people and both non-statutory and statutory services (e.g. wellbeing officers, social prescribing or recovery city in order to build connectedness, hope, identity, meaning and empowerment.

- **New 'practice' models and guidelines**. Use strengths based approaches, motivational interviewing, asset based community development, trauma informed practice, Making Every Contact Count together with life course specific approaches including patient activation and self-management.

- **Reorientate Health and Care Services.** Starting with clinical prevention services (secondary prevention) improve, integrate and incentivise identification and risk reduction approaches including NHS health checks, diabetes prevention, smoking cessation, 'Blue Light' approaches for resistant drinkers, employment support and weight management.

Possible next steps

R Suckling

Director of Public Health

28/08/2018

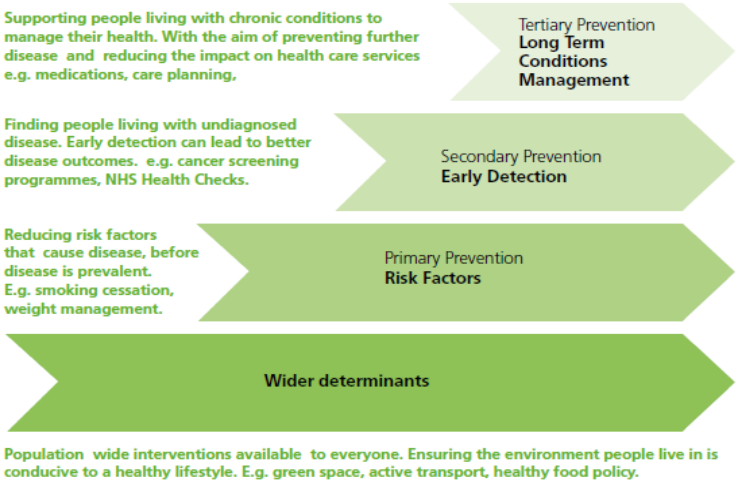
Appendix 1

Cohort A — Prevention and Early Help — 13

We recognise that in order to achieve our desired impacts, the shift in thinking around prevention needs to start now. We see prevention as the corner stone for all other offers for all the other health and social care work that we do.

Prevention at the heart of all we do

Our prevention approach is based on developing community assets and resilience, and on bringing together our response to the wider determinants of health. The Doncaster Health and Wellbeing board have adopted the following model to progress the Doncaster approach to prevention:



The focus initially in Doncaster will be smoking and obesity and it is likely that initial early work will see:

1. Renewed emphasis on the use of the full range of local authority powers planning, licensing, section 106 monies
2. Agreement about brief and very brief interventions that could be wrapped into specifications (primary and secondary care, plus social care)
3. Prototyping the enhanced Safe and Well check delivered by the Fire Service
4. Reviewing the lifestyle service offer (smoking cessation, physical activity, food, weight management and alcohol)
5. Mainstream funding of social prescribing services, complemented by community navigators and Asset Based Community Development
6. Renewed emphasis on CVD risk reduction and particularly Blood Pressure (going beyond QOF)
7. Blue Light approach to resistant drinkers (assertive outreach)
8. Employment support for those out of work linked to Sheffield City Region pilot
9. Focus on the First 1001 days
10. Public mental health and development of resilience in young people

Team Doncaster have also set an ambition to ensure an integrated response to those in Doncaster with the most complex need - individuals and families whose lives can become chaotic, highly complex, blighted by an interdependent combination of factors including drugs and alcohol misuse, mental ill health, homelessness and domestic abuse .This goes beyond existing early help, stronger families and the 2% the CCG use for case management and provides a common purpose and focus for a radical change in the offer for this group. Team Doncaster is working to develop a joint approach to this group. This will ultimately cover all of the three place plan cohorts describe above, but will start with a focus on early help and prevention, including primary, secondary and tertiary prevention – placing a focus on partnership action at key risky transition points in the lives of individuals and families. This will be taken forward through initial prototyping work late in 2016 and early 2017.

Appendix A

OUTCOME FRAMEWORK SUMMARY PAGE

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

Key (national benchmark used)

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

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

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

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 6 September 2018

Subject: Recovery City

Presented by: Dr Rupert Suckling/ Prof David Best

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

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

How will this contribute to improving health and wellbeing in Doncaster?
The presentation will provide the Board with the background on the recovery city movement, how the Borough is making progress to embed the CHIME principles (Connectedness, Hope, Identity, Meaning and Empowerment) into services and interventions, and highlights potential next steps.

Recommendations
The Board is asked to:- NOTE the report, and AGREE the next steps.

This page is intentionally left blank

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 6 September 2018

Subject: Oral Health Needs Assessment

Presented by: Dr Rupert 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)	x
	Mental Health	x
	Dementia	x
	Obesity	x
	Children and Families	x
Joint Strategic Needs Assessment		
Finance		x
Legal		
Equalities		x
Other Implications (please list)		

How will this contribute to improving health and wellbeing in Doncaster?
Doncaster currently has the highest number of children referred to hospital for tooth extraction under general anaesthetic in the country. Furthermore dental decay affects approximately 1/3 of all school aged children. Within the adult population vulnerable groups are also at high risk of developing oral health related problems, with our ageing population a particular concern in relation to cost. The recommendations within this report outline how reductions in oral health treatment can be maximised by implementing a range of preventative approaches.

Recommendations
The Board is asked to note the report and endorse the recommendations put forward in this report.

This page is intentionally left blank

Doncaster Oral Health Needs Assessment 2018

Public Health Directorate

1. INTRODUCTION

Since 1st April 2013, when the Health and Social Care Act 2012 came into force, the responsibility for oral health has been split between two organisations:

- NHS England has the statutory duty to commission the totality of NHS dental services
- Local authorities have the statutory duty (SI 3094, 2012) to
  a) secure the provision of oral health improvement programmes to improve the health of the local population and
  b) to secure the provision of oral health surveys

In 2015, Public Health England (PHE) published an oral health needs assessment for South Yorkshire and Bassetlaw which identified the need for a more local approach to develop an oral health improvement strategy to address the specific needs of the people of Doncaster. Therefore, a more focussed oral health needs assessment for was required to inform the local Doncaster oral health improvement strategy and action plan, and feed into the Joint Strategic Needs Assessment and Health and Wellbeing Strategies.

Within Doncaster Council (DC), the funding for oral health improvement is now embedded within the 0-5 health visiting service and 5-19 school nursing service, which will carry out oral health improvement activities as part of the national Healthy Child Programme.

PHE has a purely advisory role, and has local dental public health consultants who provide expert advice to local authorities, NHS England, Healthwatch and other partners. They have co-written this Oral Health Needs Assessment.

1.1 Key local documents

Oral health is a priority in Doncaster and underpins the council's vision to give every child the best start in life in the Doncaster Children and Young People's Plan, 2017-20 (Team Doncaster, 2017) with an awareness that poor oral health affects a child's ability to eat, sleep and socialise (Doncaster Starting Well Strategy 2017 – 2020; DC,2017). However, it isn't specifically mentioned in the Health and Wellbeing Strategy 2016-21 (DC, 2016).

1.2 Scope of this document

This oral health needs assessment will use a combination of epidemiological, corporate and comparative approaches and will concentrate on the following areas:

- A brief overview of the population of Doncaster (section 2)
- Description of the oral health of the population of Doncaster using national and local oral health data (section 3)
- A brief overview of primary and secondary oral healthcare services in Doncaster (section 4). It is beyond the scope of this needs assessment to look in detail at NHS dental services as this is now the remit of NHS England. However this is described in

some detail by the South Yorkshire and Bassetlaw Oral Health Needs Assessment (PHE, 2015). This is a very useful document and should be read in conjunction with this document to obtain a full understanding of NHS dental services in Doncaster.

- Patient and public experiences (section 5)
- An overview of oral health improvement programmes/activities provided by DC (section 6)
- An audit of DC oral health improvement programmes/activities against NICE guidance (section 7)

1.3 The problem

Despite improvements in oral health in England over the last forty years, many people continue to suffer the pain and discomfort associated with oral diseases, which are largely preventable. A healthy mouth and smile means that people can eat, speak and socialise without pain or discomfort and play their parts at home and in society. Oral health is an integral part of health and wellbeing and many of the key risk factors are associated with other diseases.

The distribution and severity of oral diseases varies between wards and within counties and regions. Unacceptable inequalities exist with more vulnerable, disadvantaged and socially excluded groups experiencing more oral health problems. As with health inequalities, oral health inequalities are not inevitable. They stem from inequalities in income, education, employment and neighbourhood circumstances throughout life and can be reduced. Focusing on the wider determinants of health and individual behavioural change approaches to improving oral health are necessary to achieve sustainable improvements in oral health related behaviours. Social, environmental, economic circumstances or lifestyle place vulnerable groups at high risk of poor oral health or make it difficult for them to access dental services.

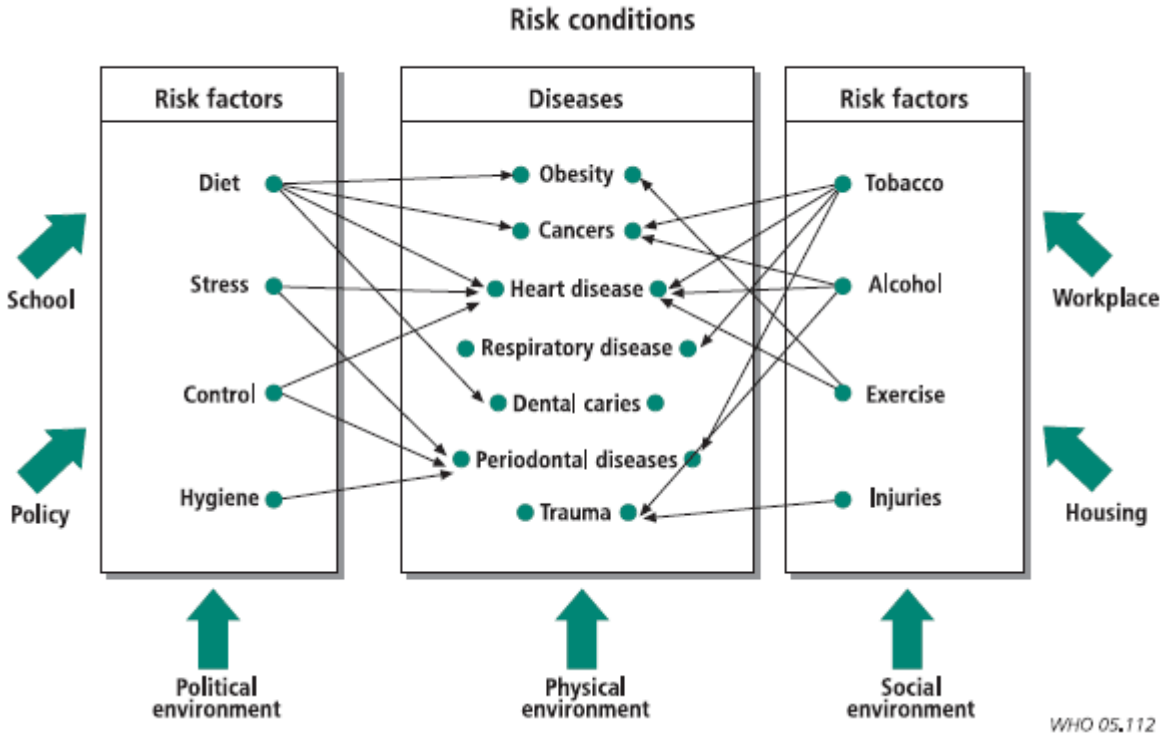
The two main oral diseases are tooth decay (dental caries) and gum (periodontal) disease. Whereas tooth decay tends to be a problem in the general population, gum disease is more prevalent in the older population. Both these diseases can lead to loss of teeth and both conditions are preventable.

There are other oral conditions that are not as widespread but do have an impact, sometimes significantly, on the population. The more serious conditions are mouth cancer and congenital deformities, such as cleft lip and palate. The less serious conditions are orthodontic problems e.g. crowded and misaligned teeth and tooth surface loss e.g. erosion due to dietary acids.

Tooth decay may be prevented by reducing the amount and frequency of consumption of sugary foods and drinks and optimising exposure to fluoride. Gum disease may be prevented by good oral hygiene and stopping smoking; and the risk of oral cancer may be reduced by stopping smoking, drinking alcohol within recommended safe limits, eating a healthy diet, and immunisation with the HPV vaccine, as mouth and oropharyngeal cancers have been linked to the human papilloma virus (HPV) transmitted through oral sex.

Oral diseases and conditions share common risk factors with other diseases such as diabetes, cardiovascular disease, cancer and obesity (figure 1). A common risk factor approach aims to control the shared risk factors thereby impacting on a multitude of conditions and diseases (Sheiham and Watt, 2000).

Figure 1: Common risk factors (Sheiham and Watt, 2000)



1.4 Vulnerable groups for poor oral health

Vulnerable groups are those people whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services. It is not possible to provide a comprehensive list of all these groups but they include those:

- who are older and frail, particularly the housebound
- who have physical or mental disabilities
- who have learning difficulties
- who are homeless or frequently move, such as traveller communities, immigrants, refugees, asylum seekers
- who have mental health problems, dental anxiety or dental phobia
- who are socially isolated or excluded
- from some black, Asian and minority ethnic groups, which may be related to cultural practices
- who have a poor diet
- who are obese

- who are, or who have been, in care (all ages)
- who use tobacco (smoked or smokeless) or misuse substances, including alcohol
- who have a medical problem which affects their oral health
- who live in a disadvantaged area or who are from a lower socioeconomic group

Co-morbidities, progressive medical conditions, dementia and increasing frailty contribute to more complex oral health needs and difficulties in accessing NHS dental services.

1.5 Key national guidance

Key guidance to support local authorities to meet the needs of their local population are listed below:

- Oral health: local authorities and partners (NICE, 2014)
- Oral health promotion in the community (NICE, 2016)
- Oral health for adults in care homes (NICE, 2016)
- Tackling poor oral health in children: local government's public health role (Local Government Association, 2016).
- Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities (PHE, 2014).
- Delivering better oral health: an evidence-based toolkit for prevention. PHE (2017).
- Improving oral health: a toolkit to support commissioning of supervised toothbrushing programmes in early years and school settings (PHE, 2016b).

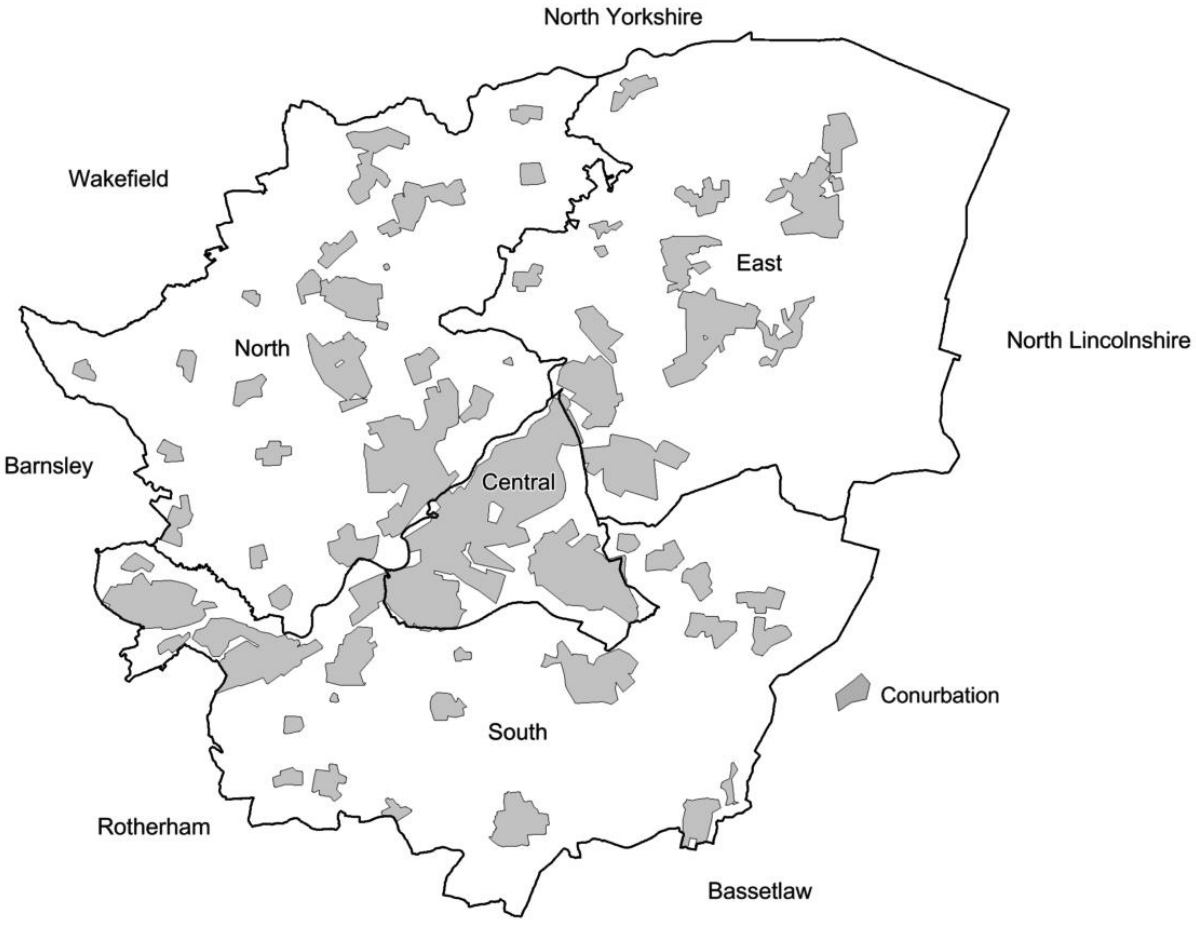
2. THE POPULATION OF DONCASTER

DC covers 219 square miles, featuring a wide range of urban, suburban and rural environments. Doncaster is a diverse and vibrant borough. It is of medium size compared to other boroughs in Yorkshire and Humber, with a mid-2016 population estimate of 306,397 (ONS, 2017).

Some areas within the Borough are relatively affluent compared to the national average, though other areas are amongst the most deprived in the country. No Doncaster communities are free of lifestyle or social problems but some areas have multiple and persistent issues afflicting people across the life course.

There are 4 neighbourhood areas defined by DC and used by the majority of corporate partnerships (Central, North, East and South) (figure 2). These have roughly equal populations, ranging from approximately 70,000 in the North to 83,500 in the South.

Figure2: Doncaster neighbourhood areas



Source: DC, 2015

The health of people in Doncaster is generally worse than the England average. Doncaster is one of the 20% most deprived districts/unitary authorities in England and about 24% live in low income families. Life expectancy for both men and women is lower than the England average, and is 10.7 years lower for men and 7.1 years lower for women in the most deprived areas than the least deprived areas. (PHE, 2016c).

Some of the main health issues in Doncaster are obesity, with 20% of year 6 children classified as obese; alcohol misuse, with adult-related harm hospital stays being above the national average; and smoking, with smoking–related deaths higher than nationally (PHE, 2016c).

3. ORAL HEALTH OF PEOPLE LIVING IN DONCASTER

3.0 Background

DC has a statutory duty to secure provision of oral health surveys: to facilitate the assessment and monitoring of oral health needs; the planning and evaluation of oral health promotion programmes; and the planning and evaluation of the arrangements for provision of dental services as part of the health service; and where there are water fluoridation programmes affecting the authority's area, the monitoring and reporting of the effect of water fluoridation programmes (SI 3094, 2012).

Annual surveys are carried out as part of the Dental Public Health Epidemiology Programme coordinated by Public Health England, with surveys of 5-year-old school children in mainstream schools being carried out every 2 years, and other population groups being surveyed in intervening years. These provide national, regional and local Doncaster data. The 5 year old data is required for the Public Health Outcomes Framework.

The following surveys have been carried out in recent years:

- 3 year olds were surveyed in 2013
- 5 year olds were surveyed in 2007/08, 2011/12 and 2014/15
- 12 year olds were surveyed in 2008/09
- Special support schools were surveyed in 2013/14
- Dependent older people were surveyed in 2015/16

The 2016/17 5-year old survey and 2017/2018 Adults in Practice survey have not been carried out in Doncaster due to issues in arranging a fieldwork team.

Data are submitted by providers and analysed by Public Health England. The data is publically available via this website: http://www.nwph.net/dentalhealth/

Decennial national adult and child dental health surveys commissioned by the Health and Social Care Information Centre are also carried out. The following national surveys have been carried out in recent years, providing data only at national and regional levels:

- Adult dental health survey 2009
- Child dental health survey of 5,8,12 and 15 year olds, 2013

In 2008, a postal survey of adult oral health was carried out across Yorkshire and the Humber, providing information on self-reported oral health.

3.1 Children

A commonly used indicator of unhealthy teeth is the dmft index. The average number of decayed (d), missing due to decay (m) and filled due to decay (f) teeth (t) may be calculated for a population. In 3, 5 and 8 year old children, this score will be for the baby or deciduous teeth (denoted dmft) and in 8, 12 and 15 year old children and adults this will be for the adult or permanent teeth (and denoted in uppercase as DMFT). Anyone who has one or more 'actively decayed teeth, teeth missing due to decay or filled teeth due to decay' (dmft >0) is referred to as someone with 'obvious tooth decay experience'. The proportion of the population with decay experience is the proportion with 'unhealthy teeth'.

3.1.1 Children aged 3 (2013 dental survey)

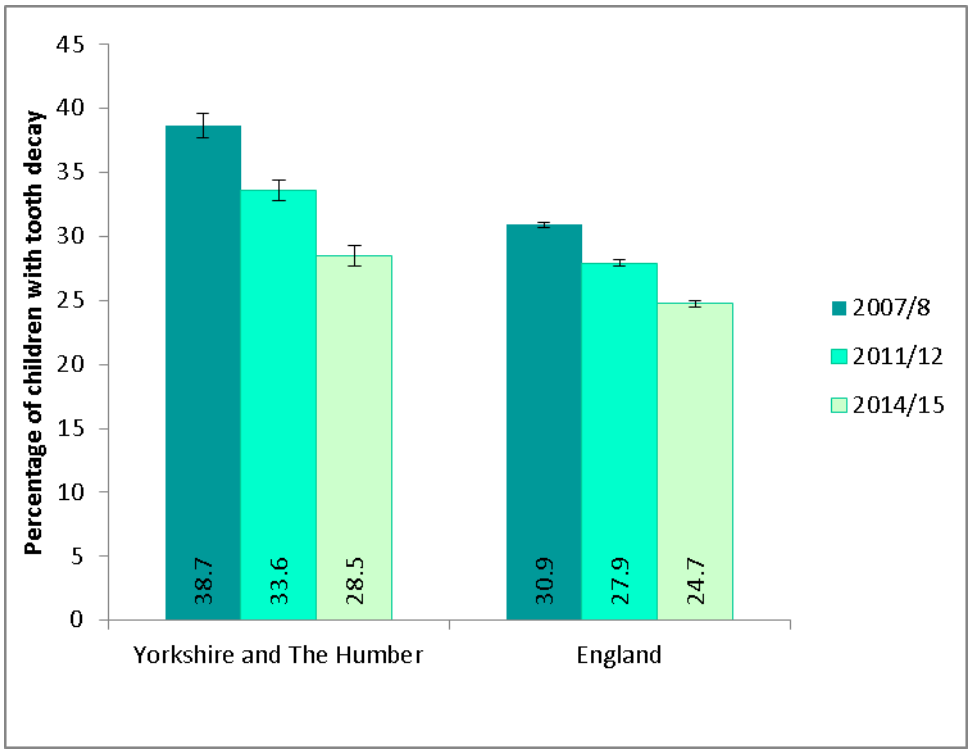
The prevalence of tooth decay experience in Yorkshire and the Humber (12.6%) was higher than the national average (11.7%), although differences across the local authorities could not be determined due to the small numbers of children participating.

3.1.2 Children aged 5 years (2008, 2012 and 2015 dental surveys)

National Dental Epidemiology Programme oral health data for 5-year-old school children living in Doncaster has been limited by the small sample sizes attained. A minimum sample of 250 children from a minimum of 20 schools is required. In 2015, only 227 children were consented and examined. This was less than in 2012 when 285 children were examined and 2008 when 372 were examined. This makes subgroup analysis for example at ward level problematic.

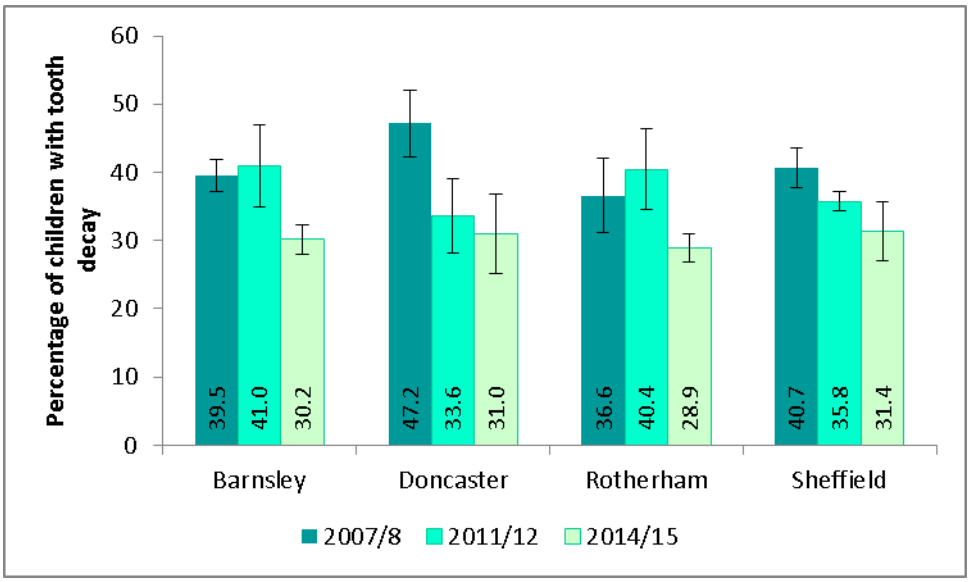
Doncaster and the Yorkshire and the Humber region as a whole has seen a reduction in the proportion of 5-year-old children with tooth decay (figures 3 and 4). However, 31.0% of 5-year-old children in Doncaster experienced tooth decay in 2015, which is higher than the average 5 year-old in England (25%) (PHE, 2017a).

Figure 3: The percentage of children aged 5 years with experience of tooth decay in 2008, 2012 and 2015 in England and Yorkshire and the Humber 2008, 2012 and 2015.



Source, PHE 2017a

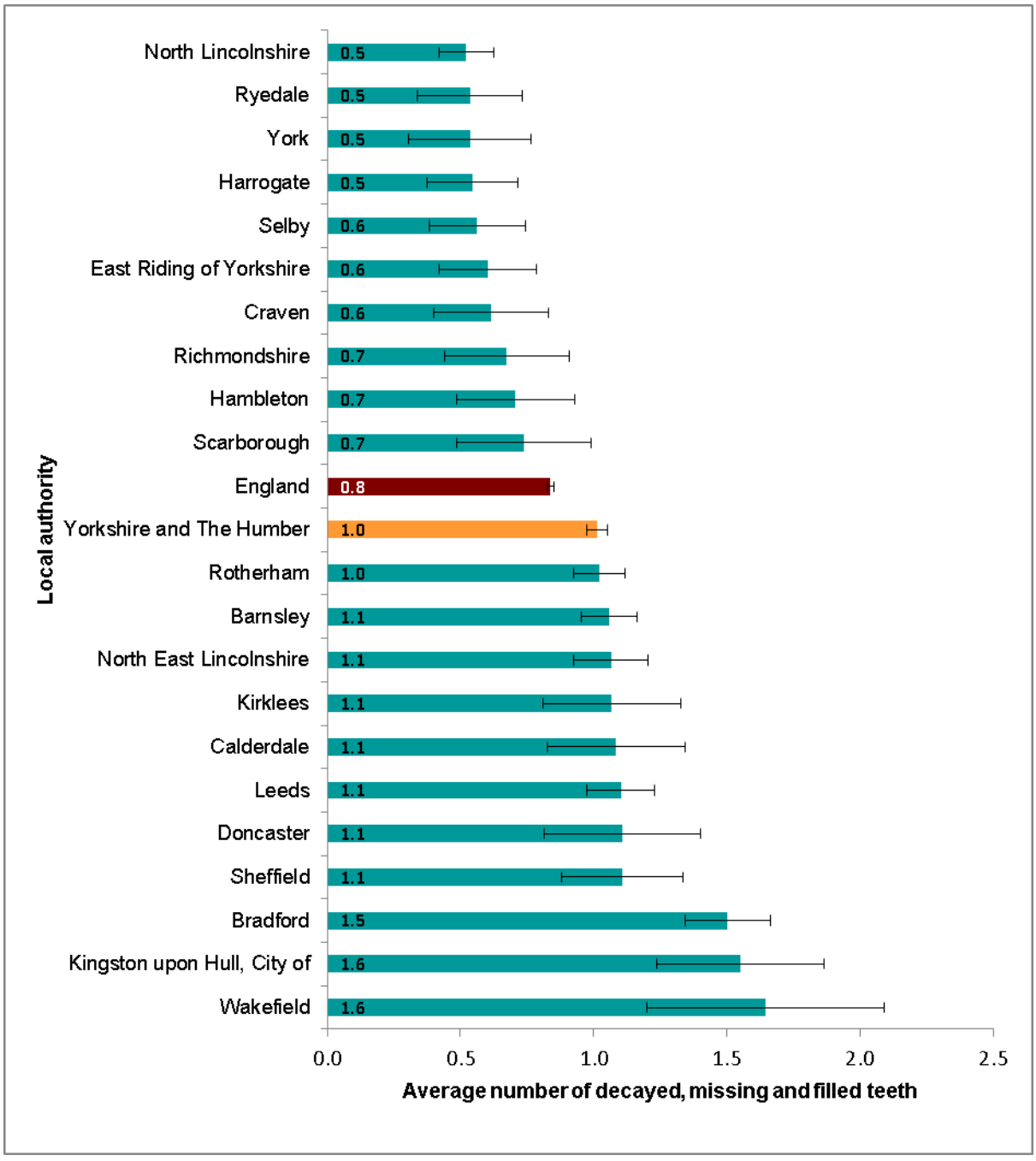
Figure 4: The percentage of children aged 5 years with experience of tooth decay in 2008, 2012 and 2015 in South Yorkshire.



Source: PHE 2017a

The average number of decayed, missing and filled teeth among 5-year-olds in Doncaster (1.1), was also higher than nationally (0.8) (although not statistically due to the low sample size) (figure 5). However this average figure masks the fact that those children who actually experience tooth decay (have one or more decayed, missing or filled teeth) typically have around 4 (3.6) teeth affected. Furthermore, it is not uncommon for a child to need to have every tooth extracted due to tooth decay under general anaesthetic.

Figure 5: Average number of decayed, missing and filled teeth among five-year-old children in Yorkshire and The Humber by local authority, 2015



Source: PHE 2017a

3.1.3 Children aged 5 years (2015) ward level data and deprivation

Due to the low sample size, there are no ward level data. However data have been grouped according to ward cluster (table 1) (PHE, 2017b). Although this table seems to suggest that the East part of the borough experiences better oral health than the rest of the borough, care should be taken because in Hatfield, Spotbrough, Stainforth and Moorends and Thorne the prevalence and average dmft were recorded as zero, but this is unlikely to be representative of the whole ward as less than 10 children were surveyed in each of these wards. In fact, 16 of the 21 wards had less than 15 children examined within them, making local analysis impossible.

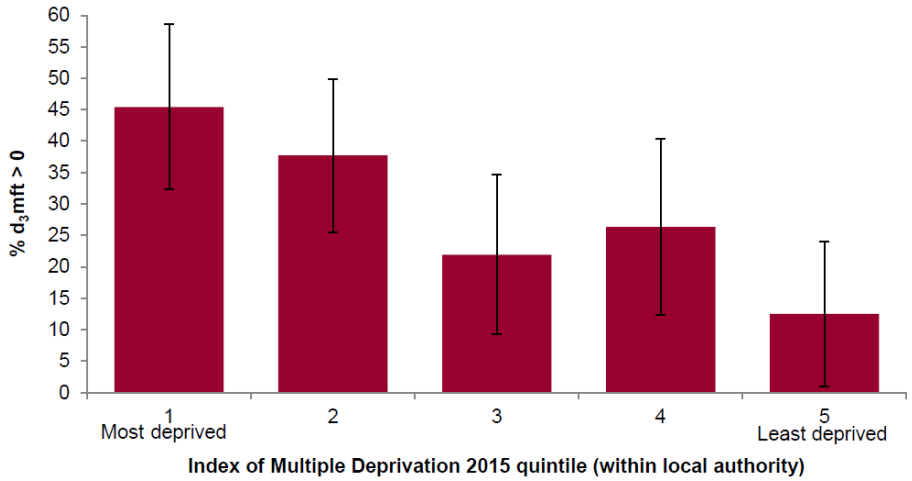
Table 1: Decay and severity by ward clusters in Doncaster local authority (PHE, 2017b)

Ward Cluster	Average d_3mft	% with decay experience	Average d_3mft in those with decay experience
Central	1.5	35.8	4.3
East	0.2	10.5	2.0
North	0.8	28.3	3.0
South	1.1	33.3	3.3

Source: PHE, 2017b

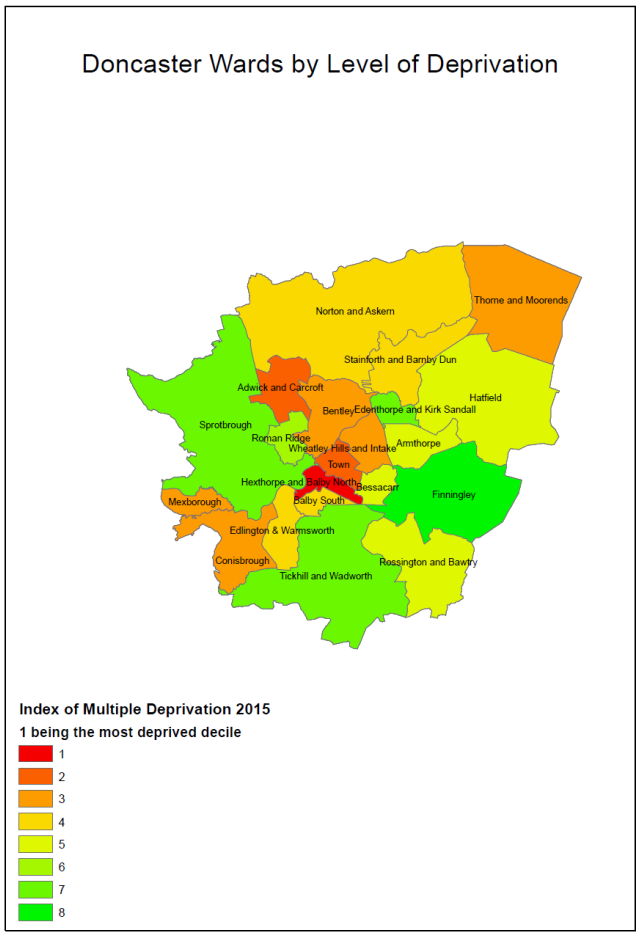
Poor oral health is related to deprivation, with children living in more deprived local authority areas experiencing poorer oral health than those from less deprived areas (PHE, 2016). In Doncaster prevalence of tooth decay was significantly worse for those living in the most deprived quintile than those in the least deprived quintile (figure 6). Figures 7 and 8 show deprivation by ward and lower super output area.

Figure 6: Prevalence of tooth decay by Index of Multiple Deprivation 2015 quintiles for DC.



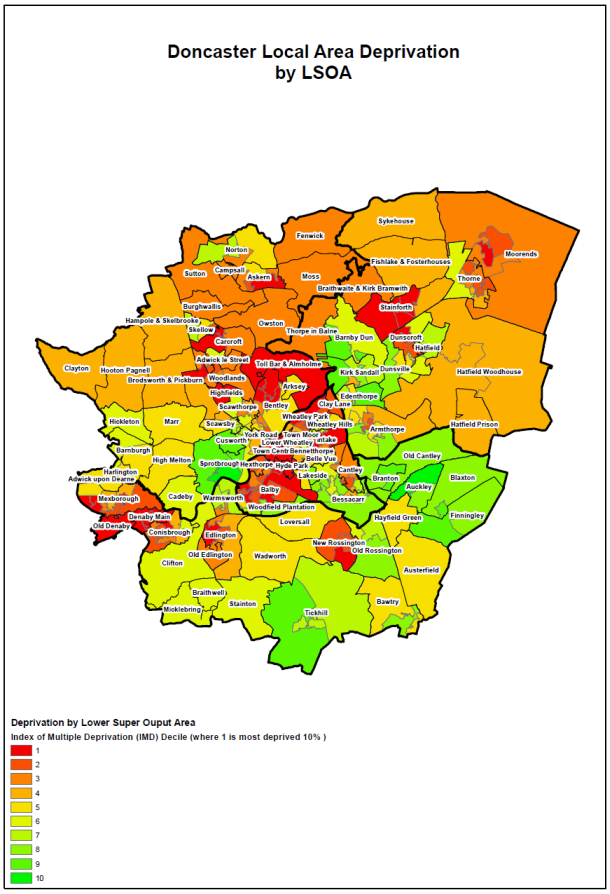
Source: PHE, 2017b

Figure 7: Doncaster wards by level of deprivation (IMD 2015)



Source: DC, 2017

Figure 8: Deprivation by lower super output area (IMD 2015)



Source: DC, 2017

3.1.4 Children aged 12 years (2008/09 dental survey)

A representative sample of 337 12-year old Doncaster children were surveyed in the 2008/09 survey**. T**he percentage of children aged 12 years with experience of tooth decay in Doncaster in 2008/09 was 53.5% which was higher than both for Yorkshire and Humber (44.7%) and England as a whole (33.4%). The mean D_3MFT was 1.24, which again was higher than Yorkshire and Humber (1.07) and England (0.74). For those with experience of tooth decay, each child had on average 2-3 teeth affected (2.32).

3.1.5 Hospital admissions for tooth extractions in children

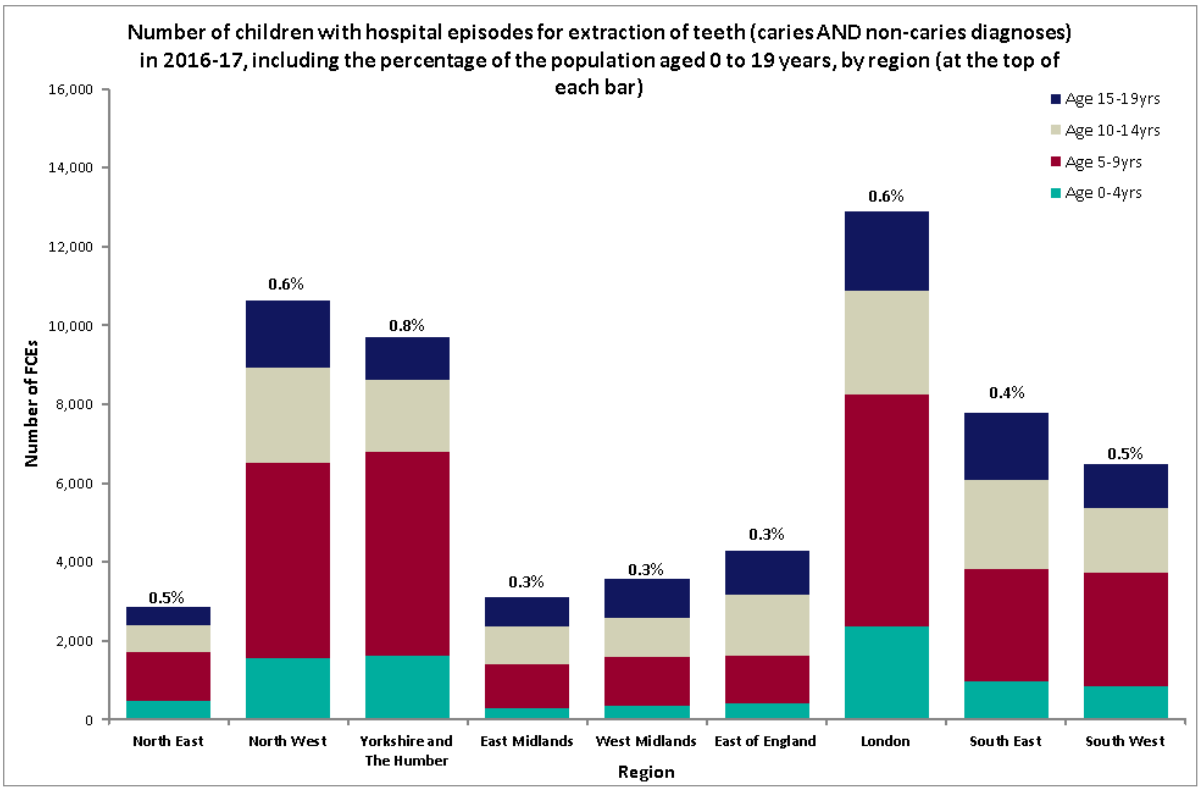
Children in Doncaster may attend hospitals in Rotherham, Barnsley, Sheffield or Bassetlaw for extractions due to tooth decay.

The extraction of teeth under general anaesthetic due to tooth decay is the most frequent reason for hospital admission in children aged between 5 to 9 years in England. A child in England has a tooth removed in hospital every 10 minutes due to tooth decay. As well as causing problems with eating, sleeping and smiling, around 60,000 days are missed from

school during the year (PHE, 2018). The cost of admissions for extractions to the NHS is around £35 million (Royal College of Surgeons, 2015).

In England overall, extractions for 0-19 year olds represent 7% of all hospital based procedures for that age band (2016/17). 0.8% of 0-19 year olds in Yorkshire and Humber underwent dental extractions (for tooth decay and other reasons) in 2016/17. The majority were in the 5-9 year age bracket. Yorkshire and Humber was the third highest region for numbers of children (0-19 years) having tooth extractions (figure 9) (PHE, 2018).

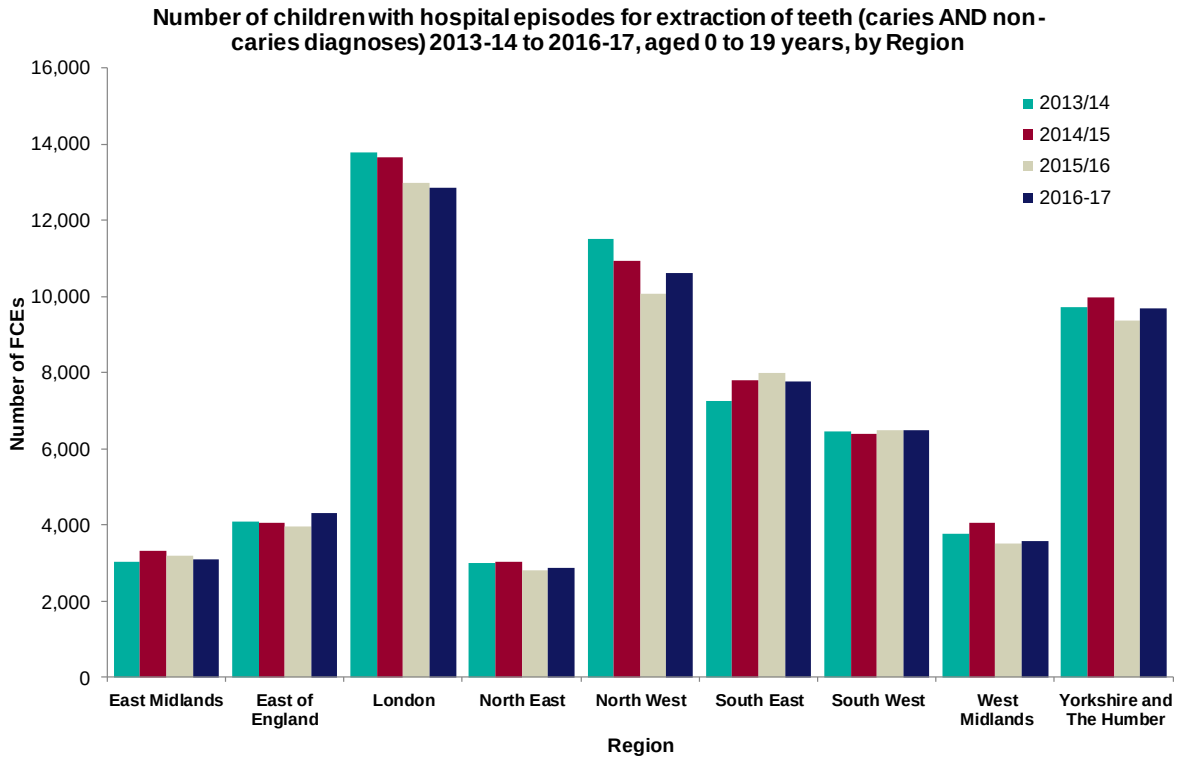
Figure 9: The number of children with hospital episodes for extraction of teeth (2016/17), including the percentage of the population aged 0-19 years by region.



Source: PHE, 2018

In Yorkshire and Humber there has been a recent increase in extractions (figure 10)

Figure 10: The number of children, by region, with hospital episodes for extraction of teeth (for tooth decay and other reasons) over the past four years.



Source: PHE, 2018

Overall in 2016/17 there were 1,135 finished consultant (hospital) episodes (FCEs) for extractions (all diagnoses) for 0-19 year olds in Doncaster. This equates to 1.6% of the 0-19 population, and was higher than the mean for England (0.5%) and Yorkshire and the Humber (0.8%). This was the highest level in the country along with Rotherham. The percentage of 0-19 year olds having FCE's for extractions (all diagnoses) has remained relatively constant for Doncaster since 2011 (PHE, 2018).

In 2016/17 the majority of extractions occurred in the 5-9 year olds age group. In 2016/17, 97.1% of FCE's for extractions in Doncaster had caries as the primary diagnosis for 5-9 year olds (i.e. the extractions were needed due to tooth decay). In 2016/17, 679 (3.5%) of 5-9 year olds in Doncaster had extractions for tooth decay This was the highest level in the country, much higher than the mean for England (0.7%) and Yorkshire and Humber (1.4%) (table 2) (PHE, 2018).

In some instances the data are an underestimate of the number of FCEs, as the Community Dental Service or General Dental Practitioners may provide the extraction service in hospital premises but the episodes may not be included in hospital data recording.

It is of concern that such high numbers of children are having teeth extracted due to tooth decay, given that it is entirely preventable. It is costly not only for the NHS, but it also has a high impact on families. Treatment under general anaesthesia can be a traumatic

experience for the child and their carers, carries a risk of life threatening complications, and is disruptive in terms of time taken off school and work.

Table 2: Percentage of South Yorkshire local authority 5-9 year olds who had an extraction due to tooth decay (2015/16 and 2016/17) (PHE, 2018).

Local authority	% of population aged 5-9 who had an extraction due to tooth decay (2015/16)	% of population aged 5-9 who had an extraction due to tooth decay (2016/17)
Rotherham	**3.2**	**3.3**
Doncaster	**3.3**	**3.5**
Barnsley	**2.2**	**2.6**
Sheffield	**1.6**	**1.8**
Yorkshire and Humber	**1.3**	**1.4**
England	**0.7**	**0.7**

Source: PHE, 2018

3.1.6 Vulnerable children

3.1.6.1 Minority ethnic groups

Among Yorkshire and Humber's 5 years olds in 2015 the proportion of children with tooth decay and the average number of decayed, missing and filled teeth was significantly higher in the 'Other ethnic group category (which included Chinese)' and 'Eastern European' and 'Asian/Asian British group' and Black/Black British ethnic groups than among other groups PHE, 2017a). This reflects the inequalities in oral health seen in different communities, which may be related to certain cultural practices.

3.1.6.2 Looked after children

There are approximately 485 looked after children in Doncaster (Department for Education 2015/16). Although looked after children experience similar health problems as children living in other family environments, they often enter the care system in a poorer state of health than other children because of poverty, abuse and parental neglect. Reports suggest they may experience poorer oral health. Frequent relocation within the foster care system could also make it more difficult for the children to complete their dental treatment, participate in school-based dental health programmes or obtain on-going preventive care. The NICE Public Health Guideline on Looked –after children and young people (NICE, 2015) raises concerns about:

- Access to dental care. Sometimes children need to travel considerable distances to access a dentist that has the capacity to take them. A looked-after child or young person may not attend a planned dental check for reasons relating to unplanned placement moves, fear, phobias or confidence issues. Missed appointments result in some dental practices 'de-registering' them (there is no longer 'registration' per se,

but practices usually maintain a voluntary list of regular patients which they would routinely see).

- Some dentists are reluctant to embark on a treatment programme if a child is in a short-term placement.
- There are particular needs around meeting the specialist dental needs of disabled children and young people.

Local authorities are responsible for making sure a health assessment of physical, emotional and mental health needs is carried out for every child they look after, regardless of where that child lives (Department of Health and Department of Education, 2015). The statutory health assessment should address: existing arrangements for the child's dental care appropriate to their needs, which must include routine checks of the child's dental health, and treatment and monitoring for identified dental care needs. To ensure the child's health plan is of high quality, the health assessment should include information held by community dental services and family dentists. The local authority that looks after a child must take all reasonable steps to ensure that the child receives the health care services he or she requires as set out in their health plan. Those services include dental care as well as advice and guidance on personal health care and health promotion issues. Foster carers and residential care staff should know it is their responsibility to make sure a child attends their health assessment and all dental appointments.

There are no local dental data for looked after children in Doncaster. The community dental services have traditionally provided dental services for those not already accessing dental care within the general dental services. However, now carers are advised to take children to their own dentist, or if the carer has no dentist, they can be referred into the community dental services

3.1.6.3 Special support schools

There are 5 local authority maintained special schools in Doncaster: Coppice School, Heatherwood School, North Ridge School, Pennine View School and Stone Hill School. The Community Dental Service has good links with these schools as well as with two independent residential special schools - Fullerton and Wilsic Special Schools.

In 2013/14 there was a national survey of special support schools, which examined 5 and 12 years olds There were no Doncaster level data for 5 or 12 years olds, but across Yorkshire and the Humber, 27.9% of 5-year-olds had tooth decay experience with each having a mean of 4.25 teeth affected (compared with 22.5%, 3.90 teeth for England) . Among 12-year-olds in Yorkshire and the Humber, 31.2% had tooth decay with a mean of 2.28 teeth affected (compared with 29.2%, 2.37 for England) .

Evidence suggests that children with additional needs, such as learning disabilities have similar tooth decay experience and are more likely to have their teeth extracted than their healthy peers (Nunn and Murray, 1987; Evans, Greening and French, 1991).

Although dental screening has been carried out in the past by the Community Dental Services, the effectiveness of dental screening has been questioned as many carers did not provide the positive consent required for an assessment to be carried out, and where tooth decay was discovered many children were not subsequently being taken to a dental practice for the treatment they required (Milsom *et al.*, 2006). Therefore, it was felt that there were better ways of working for this group of children, including encouraging paediatricians and school nurses involved with special schools to make a referral to the Community Dental Service for any children who have no dentist for an assessment and treatment.

3.2 Adults

3.2.1 Adult dental health survey (2009) – tooth decay, edentulousness and gum disease

The oral health of adults has improved significantly over the past 40 years as reported in the decennial national UK adult oral health surveys. No local clinical dental surveys have been undertaken of adults so the most recent data on adult oral health is drawn from the 2009 national adult dental health survey, which is reported at Yorkshire and the Humber level (NHS Digital, 2011).

In 2009 6% of adults in England were found to have no natural teeth (edentulous) with this figure rising to 7% in Yorkshire and the Humber. The proportion of adults with no natural teeth fell from 37% in 1968 to 6% in 2009. The fact that at least half of people aged 85 and over have retained some natural teeth has implications as many older people will have heavily restored (filled, crowned) teeth requiring future maintenance alongside continued preventative care. This may be difficult as patients become frailer, with increasingly complex medical histories; and mobility issues can affect access to dental services requiring domiciliary care.

Between 1998 and 2009 the prevalence of active tooth decay in adults in England fell from 46% to 28%. There were reductions across all age groups but the largest reduction was within the 25-34 year age band. The proportion with active tooth decay varied by age with the 25 to 34 years group having the highest prevalence, 36%, and those aged 65-74 years the lowest, 22%.

In 2009, 45% of adults with some natural teeth in England had mild gum disease, 9% had moderate disease and 1% had severe disease. Between 1998 and 2009 there was an overall reduction in the prevalence of moderate disease from 55% to 45%. However for more severe forms of disease an overall increase from 6% to 9% was observed. In Yorkshire and the Humber there was a greater proportion of adults with moderate and severe forms of gum diseases relative to the national average: 42% of adults had mild disease, 10% had moderate and 2% had severe disease.

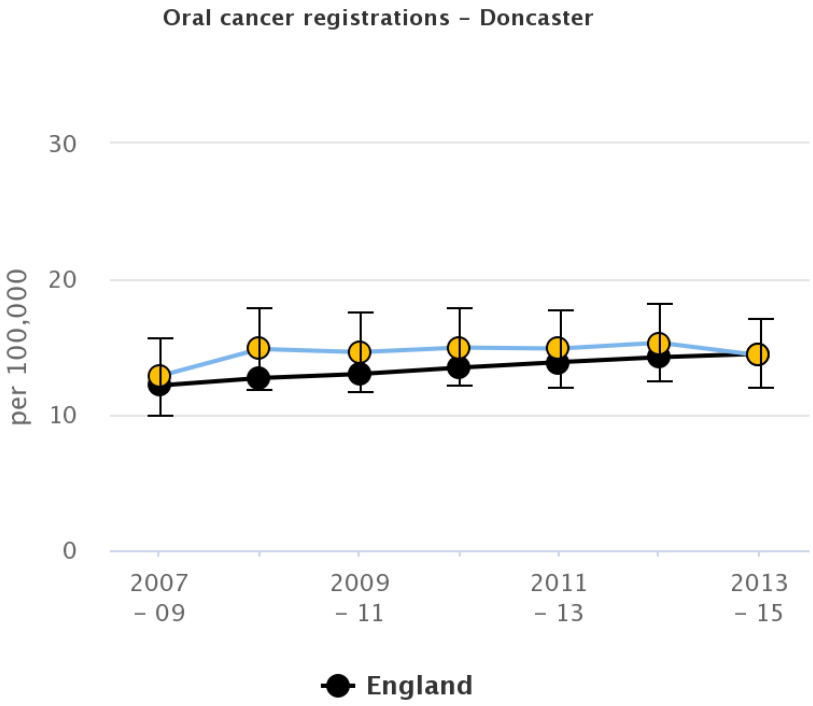
3.2.2 Mouth cancer

The main risk factors for mouth cancer are use of tobacco and excessive alcohol consumption. When used in combination, these act together to substantially increase the risk of mouth cancer by up to 40% (Blot, 1992). Smokers are 7-10 times more likely to develop mouth cancer when compared to people who have never smoked, and people who regularly use smokeless tobacco have 11 times the risk of a non-user (Johnson and Bain, 2000). Smokers are also at higher risk of developing gum disease. Mouth cancer is also linked with poor diet, infection with the Human Papilloma Virus (HPV) and excessive sun exposure (for cancer of the lip).

Mouth cancers make up 1 to 2% of all new cancers in the UK. Historically, mouth cancer has been twice as common in men as in women, with cancer incidence increasing with age. In the UK the majority of mouth cancers (87%) occur in people aged 50 or over, however mouth cancer is increasingly being seen in younger age groups and recently rates have increased from approximately 5,000 cases per year in the UK to more than 7,000. This has been attributed to HPV transmissions and increased excessive alcohol consumption and smoking amongst women. The risk of developing mouth cancer is greater in people living in areas of deprivation. This may be because people living in more deprived areas are more likely to smoke and have higher levels of alcohol consumption (Cancer Research UK, 2014).

Mouth cancer incidence rates in Doncaster have increased over the last 10 years. Between 2013 and 2015, there were 14.4 new cases per 100,000 population (figure 11). This was similar to the national levels (14.5) and equated to 124 new cases diagnosed in Doncaster. Between 2013 and 2015, there were 4.0 deaths per 100,000 population which again, was similar to England (4.4), and equated to 35 deaths (PHE, 2017c).

Figure 11: Trend in mouth cancer incidence rates in Doncaster and England (Doncaster is the coloured spots).



Source: PHE, 2017c

Doncaster has a higher level of adult smokers than nationally, 19.8% compared with 15.5% (Annual Population Survey, 2016). Doncaster is currently in the process of updating its Tobacco Control Plan, in light of the new National Plan for England (July, 2017). Doncaster has an effective Stop Smoking Service, and in addition commissions Officers from Trading Standards within the Council who focus on enforcement and education around illicit tobacco. The Doncaster Tobacco Control Alliance will be focussing on implementing guidance from the new National Plan.

Doncaster also experiences high levels of alcohol misuse. Doncaster has a significantly higher level of admission episodes for alcohol-related conditions than nationally (803 compared with 647) (PHE 2015/16). The Doncaster Substance Misuse Strategy 2014-17 (DC, 2014) aims to take action where immediate and universal change is needed to ensure that local areas are able to tackle local problems, reduce alcohol-fuelled violent crime on the streets, and tackle health inequalities. It hopes to secure industry's support in changing individual drinking behaviour and support individuals to make informed choices about healthier and responsible drinking, so it is no longer considered acceptable to drink excessively.

Given that HPV is associated with many oropharyngeal cancers and some mouth cancers, it is hoped that the HPV vaccination programme delivered to girls in Year 8 and primarily aimed at cervical cancer will also protect against these. Table 3 shows that the levels of immunisations in Doncaster exceed the public health outcomes framework target, and almost reach the WHO target.

Table 3: Percentage of target population having HPV vaccination 2015/16 (cohort 13, dose 1).

Local Authority	Percentage of target population having HPV vaccination (%)
Barnsley	87.40
Doncaster	89.50
Rotherham	89.40
Sheffield	90.10
WHO target	90.00
PHOF target	86.80

Source: PHE, 2017

3.2.3 Vulnerable adults

No local dental data is available for vulnerable adults. It is expected they will experience poorer oral health and access dental services less regularly.

3.2.3.1 Special needs

The community dental service has strong links and accepts referrals from the Hesley Villiage, a purpose built supported-living service for younger adults with a learning disability, often with autism and complex communication issues and other needs including behaviour that may challenge.

The Doncaster Community Dental Service has an oral health educator who works with residential homes for adults with additional needs to train carers in oral health and support in devising individual care plans for patients seen within the Community Dental Service.

3.2.3.2 Vulnerable Older people

Many older people live at home and rely on support from carers for their meals and daily care. Often oral health becomes neglected and dental care can prove challenging as those who are housebound are reliant on domiciliary dental care.

Older people may become more vulnerable if they move into a care home or have a period of time in hospital, as again they will be reliant on staff to help them maintain their oral health. More than half of older adults who live in care homes have tooth decay compared with 40% of over seventy-fives who do not live in care homes. People living in care homes or in hospital are at greater risk of oral health problems for several reasons:

- Long-term conditions (including arthritis, Parkinson's disease and dementia) can make it harder to hold and use a toothbrush, and to go for dental treatment.
- People now keep their natural teeth for longer, but this can mean they need more complex dental care than people who have dentures.
- Many medicines reduce the amount of saliva produced and leave people with a dry mouth.

All residents should have an oral health assessment when they move into a care home or hospital (NICE and Social Care Institute for Excellence (2016) . Data are not currently available to determine if oral health assessments are being undertaken in Doncaster, and whether residents are accessing regular dental care. Currently only 1 NHS dental practice in Doncaster and the Community Dental Services provide domiciliary care for those who are unable to visit a dental practices for regular care.

The 2015/16 oral health survey of older people collected oral health information about older people (aged 65+) who live in their own homes in the community but who have a mild level of dependency on external services to allow them to do this. 691 people took part in Yorkshire and the Humber, of which 32.4% had no natural teeth in either jaw (compared with 27% for England). 1.5% had no natural teeth or replacements which was again higher than nationally (1.2%). Nationally, 16% of 65-74 year olds, 13% of 75-84 year olds and 11% of 85+ year olds said they occasionally or more often avoided meals or had interrupted meals due to their teeth. 9.1% of people said they had current pain, and 7.4% had evidence of the presence of either a visible pulp, ulceration of the oral mucosa due to root fragments, a fistula or an abscess. 68% of 65-74 year olds, 67% of 75-84 year olds and 60% of 85+ year olds said they had seen a dentist in the previous 24 months.

3.2.3.3 Dementia

Maintaining oral health for people with dementia can be challenging. As dementia progresses, the person may lose the ability to clean their teeth, stop understanding that their teeth need to be kept clean, or lose interest in doing so. Carers may need to take over this task. There may come a time when the person with dementia is unable to say that they are experiencing pain or discomfort in their mouth or teeth. They will need to rely on other people to notice and interpret their behaviour and to arrange a visit to the dentist if necessary. There are several behavioural changes that may indicate that someone with dementia is experiencing dental problems. These may include: refusal to eat (particularly hard or cold foods); frequent pulling at the face or mouth; leaving previously worn dentures out of their mouth; increased restlessness, moaning or shouting ; disturbed sleep; refusal to take part in daily activities; aggressive behaviour. People with dementia are also likely to have increased problems with bruxism (grinding teeth), chewing and swallowing and denture wearing (FGDP, 2017).

In the early stages of dementia, most types of dental care are possible. However in the middle stages the focus of treatment is likely to be on prevention of further dental disease. Some people may require sedation or general anaesthesia for their dental treatment. The decision will be based on the individual's ability to co-operate, dental treatment needs, general health and social support. It is during the middle stages that issues around consent to treatment may also start to arise. Treatment at later stages focuses on prevention of dental disease, maintaining oral comfort, and provision of emergency treatment. Some dentists will see people at home. This can be less stressful and confusing for the person, and may increase co-operation. Care homes have a duty to ensure that their residents' healthcare needs are met (Alzheimers Society, 2015). Dementia friendly dentistry :good practice guidelines have been recently published by FGDP (2018).

3.2.3.4 Drug and alcohol dependency

Those suffering from drug or alcohol dependency often experience poor oral health, due to neglect of their general and oral health. They are more likely to seek treatment only when in pain, and often have high treatment needs. Furthermore, alcohol is a major risk factor for mouth and oropharyngeal cancer. Doncaster has a higher level of admission episodes for alcohol-related conditions than nationally (PHE, 2015/16)

3.2.3.5 Gypsy and traveller community

There is a gypsy traveller population in Doncaster who are likely to have high dental needs and are more likely to seek emergency dental care than regular dental care. There are sites at:

- Lands End, Thorne
- Little Lane Road, Clay Lane
- Nursery Lane (New Traveller), Sprotbrough
- White Towers, Armthorpe

There are also three residential sites these are:

- Mount Pleasant, Moorends
- Cow House Lane, Armthorpe
- Orange Croft, Tickhill

3.2.3.6 Roma Community

Roma communities have been settling in Doncaster since at least 2008. There are no estimates of the Roma population resident in Doncaster. However, it is likely to be in the hundreds, with almost 200 (mainly Slovak) Roma pupils attending Doncaster schools. Between 2015 and 2016, there were 360 arrivals from Romania. Doncaster's Roma community have migrated from Slovakia, the Czech Republic and latterly Romania.

Between 2015 and 2016, there were 360 arrivals from Romania. There are sizeable populations particularly in Hexthorpe and Hyde Park (South Yorkshire Roma Project, 2017).

Most parts of the country have very few Roma residents whilst Doncaster has one of the highest proportions of its population from Czech Roma communities. Sheffield and Rotherham also have large Roma communities.

Roma populations suffer significant direct and indirect discrimination and prejudice and experience higher levels of poverty than the general population, making them vulnerable to exploitation**.** Uptake of preventative services such as immunisation and screening is low, and levels of tobacco and drug use are high. Hepatitis B levels are higher than the general community.

Focus groups carried out a few years ago suggest that health problems experienced are similar to the general population except that certain conditions and behaviours are more prevalent, including poor dental health (Fundacion Secretariado Gitano, 2009). Health services report a tendency in the Roma population not to prioritise their own health and many are not registered with GPs. Anecdotally a high number of children undergo dental general anaesthetics for multiple tooth extractions. This may be related to poor diet, and irregular attendance at dental practices. There are also certain cultural practices such as placing sugar strips to rot down deciduous (baby) teeth. Regular dental care is necessary to promote preventive measures and to identify tooth decay early so that teeth can be restored rather than extracted.

A significant proportion of Roma adults have no English language skills and those who can speak English are often not fluent although language skills have tended to improve over time. Educational attainment of Roma pupils is also below average.

There is currently no specific work around oral health targeting the Roma community. However, in Sheffield resource leaflets in Roma Slovak have been developed with basic oral health messages and information on how to access an NHS dentist.

3.2.3.7 Mental health problems

There are no local data on the oral health needs of people with mental health problems. However, there are a number of people who suffer from dental anxiety or phobia. The terms dental anxiety, dental fear and dental phobia are often used interchangeably. Anxiety is a reaction to unknown danger, fear is a reaction to a known danger, and phobia is an extreme reaction resulting in avoidance or endurance of dental care with significant discomfort (Klinberg, 2008). The 2009 dental health survey of adults in England, Wales and Northern Ireland found that 12% of adults had a score of 19 or above on the modified dental anxiety scale (MDAS) indicating extreme anxiety or phobia (Humphris *et al.*, 1995; Nuttall *et al.*, 2011). Accessing dental care for these patients can be challenging, and they are often managed by the Community Dental Service and they may require intravenous sedation to enable treatment to be completed. In Sheffield there is a bespoke service for

anxious or phobic adult patients incorporating dental nurse-led CBT. In Doncaster, many of these patients are managed by treating under intravenous sedation.

3.2.3.8 Homeless

The number of statutory homeless households in Doncaster 2015/16 was 139 (Department for communities and local government, 2015/16). Homelessness has a significant negative impact on an individual's oral health, and creates barriers to accessing dental care. It has a considerable adverse effect on quality of life and the ability to move on from homelessness. The Healthy Mouths research study into the oral health of 262 people experiencing homelessness in London (Groundswell, 2017) found that 90% had issues with their mouth since becoming homeless and 70 % had lost teeth since becoming homeless (15% pulled their own teeth out). High rates of drug and alcohol use compounded the issues. Only 35% were able to clean their teeth twice a day, and a quarter had not been to the dentist for over 5 years. 58% were unclear what they were entitled to with NHS dentists, 21% had been completely unable to function in the last year due to oral health issues, and alcohol and drugs were often being used to manage dental pain.

3.2.3.9 Asylum seekers

Some asylum seekers are housed and supported in Doncaster through the Home Office dispersal system. Published Home Office figures show that at the start of October 2017, 309 people were being supported in Doncaster while awaiting a decision on their claim [known as Section 95 support]: 300 people were being accommodated, and there were nine people receiving subsistence-only support i.e. no accommodation. There were fewer than five unaccompanied asylum seeking children [UASC] being looked after by the local authority at the end of March 2017. These are children who are in the UK without family and have claimed asylum in their own right. They are separate to the dispersal system for asylum seekers described above. Those granted protection by the Home Office may stay in the area as refugees. Other groups of refugees are resettled directly from another country. For example, through the Syrian Resettlement Programme 19 resettled Syrians arrived in Doncaster during the past year [October 2016 - September 2017] (Migration Yorkshire, 2017).

Dental problems are commonly reported amongst refugees and asylum seekers. Oral health is often neglected as a result of the challenging circumstances people have experienced. Health services have a duty to serve the needs of the local population, including asylum seekers (Faculty of Public Health, 2008). However, accessing dental care can be a challenge due to language barriers and a lack of understanding over entitlements and charges for NHS dental care.

3.2.3.10 Overweight and obese

People who are overweight or obese, are in a high risk category for tooth decay as they may be consuming higher amounts of sugary foods and drinks, and more frequently. Furthermore, they often have co-morbid problems which may affect their oral health, for example diabetes which is associated with a greater risk of periodontal disease.

22.9% of reception children and 35.9% of year 6 children were overweight or obese compared with 22.6% and 34.2% nationally (National Child Measurement programme 2016/17). Figures for adults over 18 from the Active Lives Survey (Sport England, 2016) suggest that 73.4 % of Doncaster's adults are overweight or obese compared with 61.3% nationally.

A bariatric patient can be defined as someone who has limitations in health and social care due to physical size, health, mobility and environmental access, and will have needs that are in excess of the safe working load and dimensions of any supporting surface e.g. mattress, toilet frame or commode. Those with a BMI of 50 may be housebound and require specialist care and support. The Yorkshire ambulance service has vehicles available for transporting bariatric patients.

Bariatric patients may currently have difficulties accessing routine dental care as:

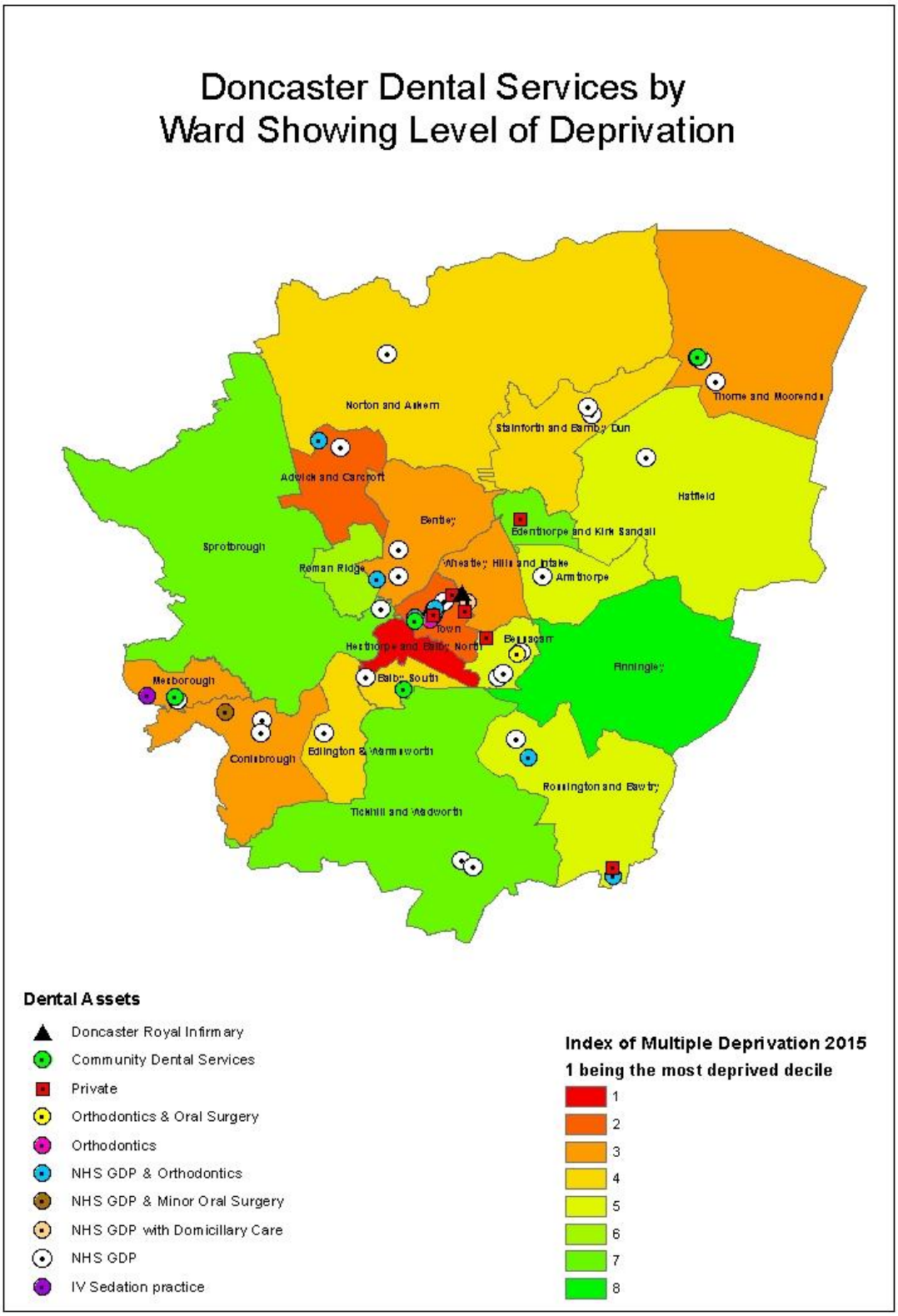
- Normal dental chairs will not support their weight or facilitate their size.
- Many dental practices are based in converted houses which do not have disabled access or adequately wide doors for patients.
- Dental practices do not have links with the bariatric ambulance service for transporting patients.

Currently some bariatric patients may receive domiciliary visits by local dentists, however only assessments and basic care is possible as there are often bed-bound. Patients requiring restorations (fillings) or extractions would usually need to be treated within a dental clinic. However the nearest service with a bariatric dental chair is provided by Leeds Salaried Dental Service. This may be provided by more local community dental services in the future.

4. DENTAL SERVICES

All NHS dental services are commissioned by NHS England and Figure 12 shows the locations of services (both NHS and private) superimposed onto maps showing deprivation (IMD, 2015) by ward (2015). There are 38 NHS general dental practices distributed across the borough, of which: 1 also provides domiciliary care for the whole of the borough; 1 also provides minor oral surgery; and 7 of which also provide some orthodontic care. 1 practice provides purely NHS orthodontic care and 1 provides both NHS orthodontic care and oral surgery. There is no database of practices offering private dental care, however many NHS dental practices also offer an element of private care. In addition there are also around 6 fully private general dental practices. The community dental service runs from a base and 3 satellite clinics at Mexborough, Thorne and Balby; and secondary care dentistry is provided at Doncaster Royal Infirmary.

Figure 12: Location of dental services (both NHS and private) by ward by deprivation (IMD, 2015)



Source: DC and NHSE, 2017

4.1 Primary care

4.1.1 General dental services

NHS general dentist practitioners work under general dental service or personal dental service contracts and are contracted to provide an agreed annual number of Units of Dental Activity. They receive one UDA for every band 1 course of treatment, 1.2 UDAs for every band 1 urgent course of treatment, three UDAs for band 2 treatments and 12 UDAs for band 3 treatments. Patient's pay a band charge depending on the extent of their treatment requirements. These reflect the time and material costs for the different complexities of treatment.

Band 1: £21.60. Includes an examination, diagnosis and advice. If necessary, it also includes x-rays, scale and polish, application of fluoride varnish or fissure sealants and preventive advice and planning for future treatment.

Band 1 urgent: £21.60. Most urgent treatments can be done in one appointment. However, if more than one visit is required and the patient returns to the same dentist to complete their urgent treatment, the Band 1 urgent charge is all that they should pay.

Band 2: £59.10 covers all treatment covered by Band 1, plus additional treatment, such as fillings, root canal treatment, gum treatment and removing teeth (extractions).

Band 3: £256.50 covers all treatment covered by Bands 1 and 2, plus more complex procedures, such as crowns, dentures and bridges.

If, within two months of completing a course of treatment, the patient needs more treatment from the same charge band or a lower one such as another filling, they do not have to pay anything extra. However, after two months of completing a course of treatment, they will have to pay the NHS charge band for any dental treatment received.

Although cost may be perceived as a barrier to dental care, NHS dental care is free for people: aged under 18, or under 19 and in qualifying full-time education; pregnant or who have had a baby in the previous 12 months; staying in an NHS hospital with treatment carried out by a hospital dentist; attending an NHS hospital dental service outpatient department (however, people may have to pay for dentures or bridges). It is also free if the person or their partner (including civil partner) receive, or the person is under the age of 20 and the dependent of someone receiving: income support; income-related employment and support allowance; income-based jobseeker's allowance; pension credit guarantee credit; or universal credit and meet the criteria. It is also free for those with a valid NHS tax credit exemption or HC2 certificate and some costs may be met for those with an HC3 certificate.

4.1.2 Community Dental Services

The Community Dental Services which operate from the Flying Scotsman, and clinics at Thorne, Mexborough and the Opal Centre (Tick Hill Rad, Balby) provide special care dentistry and primary care for groups of people who cannot be treated in the general dental services due to complex needs. They include:

- children with physical or learning disabilities or medical conditions,
- children who are looked after or on the at risk register,
- children with extensive untreated tooth decay who are particularly anxious or uncooperative,
- adults with complex needs who have a proven difficulty in accessing or accepting care in the general dental services, including adults with moderate and severe learning and physical difficulties or mental health problems and severe dental anxiety,
- adults with medical conditions who need additional dental care and housebound people.

Comprehensive dental treatment (extractions and restorative treatment) and exodontia (extractions only) under general anaesthetic for special care adults and children from Doncaster is provided at Doncaster Royal Infirmary, following a dental pre-assessment within CDS. The comprehensive dental treatment list for children is Consultant-led.

There has been a recent service review by NHSE and a new CDS specification is to be issued for all CDS's across Yorkshire and the Humber. It is planned that the CDS will carry out all dental assessments for dental GAs in the future.

4.1.3 Prison dental services

There are 4 prisons in and around Doncaster: HMP Doncaster; HMP Lindholme; HMP Moorland and HMP Hatfield, which has two sites, Hatfield and the Lakes.

HMP Doncaster

HMP Doncaster is a category B local prison for adult males with a capacity with an operational capacity of 1,145. The prison is managed by Serco and the primary healthcare provider is Nottingham Healthcare NHS Foundation Trust. Approximately 28% of prisoners are on remand, therefore, have short-term care needs. *Time for teeth* are subcontracted to provide dental care and currently provide eight sessions of dental care every week. Oral health promotion, including written material is provided.

It is a needs-led service and appointments are allocated by a Nurse-led triage system organising routine and emergency appointments. A barrier to effective service delivery is that staff servicing the dental provision are not always consistent which can result in a lack of integration with the rest of healthcare.

HMP Lindholm

HMP Lindholme is an adult male category C prison with an operational capacity of 997. Notable demographics are that 30% of the population is black minority ethnic (BME) higher than the national average of 11% in the prison population. Primary medical care is provided by Nottinghamshire Healthcare NHS Foundation Trust. *Time for teeth* are subcontracted to provide dental care. The dental team deliver six sessions a week over three days from an on-site clinic.

HMP/YOI Moorland

HMP/YOI Moorland is a category C prison with an operational capacity of 1006. Notable demographics are that 25% of the population is black minority ethnic (BME) higher than the national average of 11% in the prison population.

The primary healthcare provider is Nottinghamshire Healthcare NHS Foundation Trust. *Time for teeth* are subcontracted to provide dental care. Dental sessions are delivered by a dentist and dental nurse on Tuesdays (all day), Wednesdays, Thursdays and Fridays (am only) from an on-site clinic.

HMP/YOI Hatfield

HMP/YOI Hatfield is a category D open resettlement prison for men, located near Doncaster. The prison is split over two sites. The Lakes site is a reception/induction facility where prisoners typically reside for three months before transferring to the Hatfield main site. The facility has an operational capacity of 310. The primary healthcare provider is Nottinghamshire Healthcare NHS Foundation Trust. The healthcare model states that any healthcare service should be equitable across both sites. *Time for teeth* are subcontracted to provide dental care. There are currently no dental facilities at HMP/YOI Hatfield, so prisoners are escorted on a bus to attend the dental clinic at HMP/YOI Moorland. Prisoners need to be provided with a license to attend dental appointments. There have been concerns about the compromised dignity of prisoners with this arrangement and the prison Governor has reported a desire for alternative service delivery pathways to be explored.

The prison population includes a large number of people from more deprived communities. Poor oral health is associated with deprivation, and more vulnerable groups experience poorer oral health and access dental services less. Furthermore many people within the prison population have lifestyles which are not conducive to maintaining good oral health, including risk factors such as increased smoking prevalence, increased substance use and frequent and high consumption of sugar poor tooth brushing habits which make them more susceptible to oral diseases including tooth decay, gum disease and mouth cancer. Although prisons promote healthy food options at mealtimes, most prisoners report high sugar intake between meals. Evidence supports the view that high levels of oral disease impacts on a prisoner's quality of life. Prisoners have, on average, 4.2 decayed or unsound teeth and approximately 60% of prisoners have at least one such tooth. This compares to a national average of 1.5 decayed or unsound tooth per adult and 55% of the population having one such tooth (Walker and Cooper, 2000). Findings from recent surveys and needs assessments from Wales (Wilson, 2014) and Scotland would echo the findings in the

literature concerning increased oral health needs of the prison population. Only about a quarter (26%) of respondents participating in Welsh oral health surveys felt their dental health was very good/ quite good (compared to 73% of Welsh respondents in the Adult Dental Health survey). Oral health has been shown to improve the longer a prisoner is in prison with convicted prisoners having better oral health than short stay remand prisoners. Prisoners who are incarcerated for longer may have on-going assessment and treatment they would not access outside the prison environment. A survey of remand prisoners showed that they use services more in prison than they do outside and over half (54%) reported that their last dental treatment was during a previous conviction (PHE, 2014).

4.1.4 Urgent dental care

The urgent care dental service in South Yorkshire and Bassetlaw consists of three elements: a call answering service, an appointment booking service and a clinical service. Calls are triaged through NHS 111 provided by Yorkshire Ambulance Service using national protocols. The personal details of people needing an urgent dental appointment are then emailed to the Doncaster Dental Access Centre, which is provided by The Rotherham NHS Foundation Trust. A dental care professional from the dental access centre then telephones the patient to offer an appointment at their nearest provider. The clinical service is provided in hours and out of hours by the Doncaster Dental Access Centre, Taptonville House Dental Practice in Sheffield and Wright Dental Care in Worksop on occasional weekends. There are also in-hours access appointments commissioned from dental practices in Barnsley, Rotherham, Doncaster and Bassetlaw. Patients pay for treatment in the same way as for general dental services.

The urgent dental care service for Yorkshire and Humber is currently under review and redesign by NHS England and a new service is planned from April 2019.

4.1.5 Availability and Access to general, urgent and community dental services

Availability and access to NHS dental services is essential for patients to receive preventative advice and interventions such as fluoride varnish, and ensures early identification and treatment of oral health problems. Equitable access to dental services is an important factor in reducing oral health inequalities.

Figure 11 shows that there is an NHS dental practice sited in every ward except Finningley, Roman Ridge, Edenthorpe and Kirk Sandall, Wheatley Hills and Intake and Hexthorpe and Balby North. The latter two wards have high levels of deprivation and consequently experience poorer oral health. The majority of Sprotbrough is also poorly served with dental care, and the northern part of this ward experiences higher levels of deprivation and oral health.

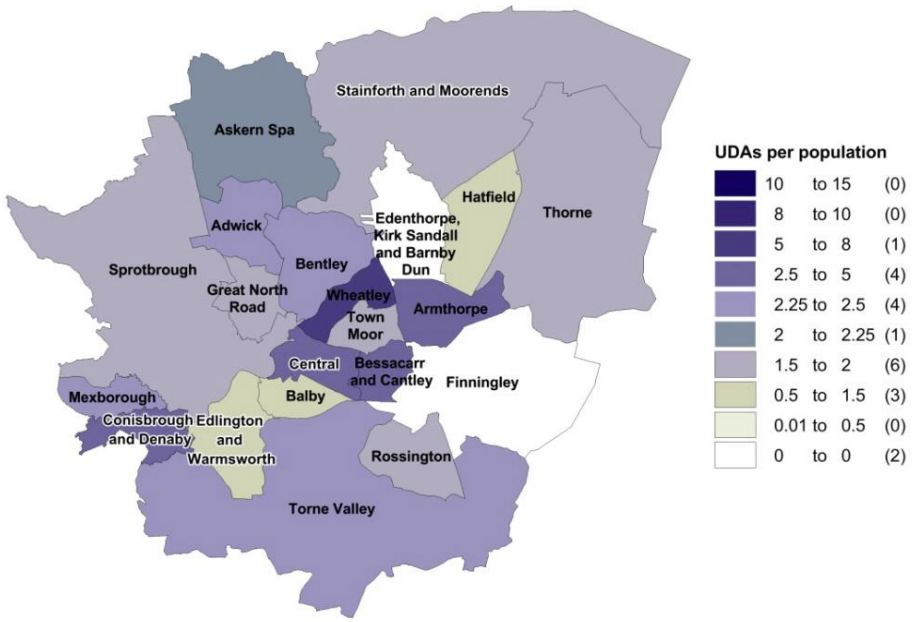
The average number of Units of Dental Activity (UDAs) commissioned per person in Doncaster is similar to neighbouring local authorities (table 4), however, the levels of UDAs commissioned by ward do not equate to the relative need (figure 13). For example, the most southern part of Doncaster is relatively less deprived and consequently would be expected to have better oral health, yet it has a relatively high level of UDAs commissioned. There appear to be no UDAs commissioned in Finningley or Edenthorpe, however these are also less deprived areas which may have lower dental need.

Table 4: Average number of UDAs commissioned per person 2015/16

Area	Average no. of UDAs commissioned per person
Bassetlaw	1.5
Barnsley	2.2
Doncaster	2.1
Rotherham	1.7
Sheffield	1.9

Source: NHS England, 2016

Figure 13: UDAs commissioned per population in Doncaster by ward, 2012/13



Source: PHE, 2014

Also despite the relatively high numbers of UDAs commissioned overall, the proportion of decayed teeth that were filled in 5 year olds in Doncaster (2015) was only 13.1%, although this was higher than England (12.0%) and Yorkshire and Humber as a whole (10.4%). This needs further investigation. Furthermore, fee paying adults were more likely to have a band 1 course of treatment, that is, not need any dental treatment after examination, than fee paying adults. Proportionately more fee exempt adults had band 3 courses of treatment, reflecting the fact that people from more deprived backgrounds are more likely to have greater oral health needs. Fee exempt adults are also more likely to have urgent dental care, indicating they are more likely to attend a dentist with a problem rather than attending regularly for routine dental check-ups. This may also reflect the accessibility of the urgent care service provided at the Flying Scotsman. (SYB OHNA, 2015).

Access to primary care dental services has been a key issue both nationally and locally. Substantial investment has been made since March 2006 to increase access to dental care. The indicator used to assess dental access in terms of utilisation of general and community dental services is the number of unique people accessing (using) dental services over the previous 24 months for adults and over the last 12 months for children. This metric is based upon NICE recall guidance, which recommends the longest interval between dental examinations for adults should be 24 months and 12 months for children.

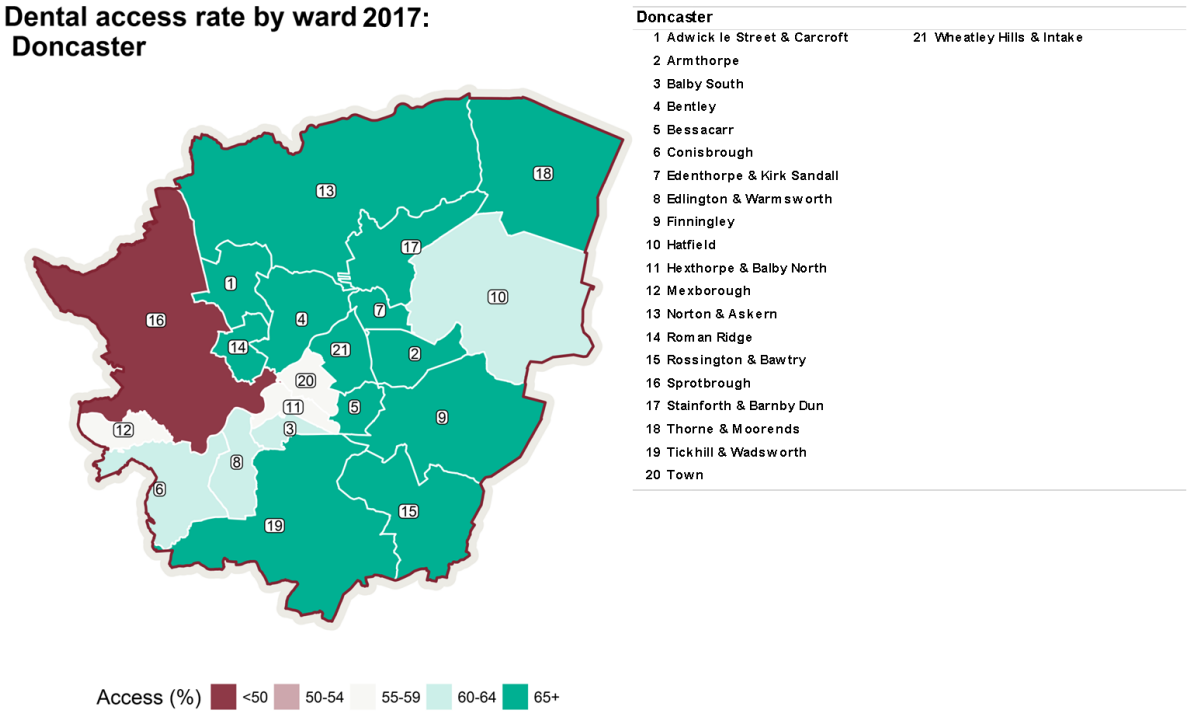
Access to NHS dental care in Doncaster has remained relatively constant, with around 65% of children having accessed dental care over a 12 month period and 69% of adults accessing care over a two-year period (Table 5). The access rates are similar to neighbouring local authorities. However, the access rates for children and adults in Doncaster have been consistently higher than the averages for England. The access rates reflect the widespread availability of NHS dental care in Doncaster. This data does not include figures for patients attending the 6 private dental practices (as this data is not available), therefore, the true percentage of Doncaster's child and adult population accessing dental care (both NHS and private) will be higher than those figures in table 5. Figure 14 shows that people from Spotbrough in particular are struggling to access to access NHS dental services, which may be linked with the limited availability of NHS dental practices in the area.

Table 5: Percentage of children and adults accessing NHS dental care

Area	Children seen in the previous 12 months as a percentage of the population				Adults seen in the last 24 months as a percentage of the population			
	30 Jun 2016	30 Sep 2016	31 Dec 2016	31 Mar 2017	30 Jun 2016	30 Sep 2016	31 Dec 2016	31 Mar 2017
Barnsley	65.8	65.6	65.4	65.2	63.6	63.3	63.4	63.4
Doncaster	65.7	66.0	64.9	64.3	69.4	69.4	69.3	69.0
Rotherham	61.2	61.6	61.5	61.2	60.5	60.4	60.3	60.2
Sheffield	64.9	64.9	64.7	65.7	58.7	58.7	58.8	59.3
NHS England North (Yorkshire and Humber)	62.7	62.8	62.7	63.2	56.9	56.9	56.8	56.9
England	**57.6**	**57.6**	**57.8**	**58.2**	**51.4**	**51.3**	**51.4**	**51.5**

Source: NHS Digital, 2017

Figure 14



Source: PHE, 2017

Patients are no longer officially 'registered' with a dental practice, but patients tend to be associated with particular dental practices for their routine dental care.

General dental practices provide information to the NHS Choices website regarding whether they are able to take on new patients and the facilities they offer including access for disabled patients. It is the responsibility of the practice to keep this information up to date, but many practices have not done this recently. Following a recent request from NHS England to update NHS Choices, information was acquired concerning which practices are taking on new patients in Doncaster (Table 6). There were 3 practices taking on adults and 4 taking on children. However, 9 practices had not recently updated their status on NHS Choices, so it was impossible to say whether or not they are taking on patients.

Table 6: Number of general dental practices taking on new patients

Is the practice taking on new patients?	Number of practices
Yes taking on new patients - adults	3
Yes taking on new patients – children	4
Not taking on any patients	26
No data	9

Source: NHS Choices, 2017 (16.10.17)

It is important to note that there will never be 100% of the population accessing NHS dental care due to:

- Some people preferring to opt for private dental care, especially for cosmetic procedures.
- Some people do not wish to access regular routine dental care, opting to attend urgent dental care services only when in pain. This may be due to anxiety, phobia, lifestyle and cultural issues, and cost. However, many people in Doncaster qualify for free NHS dental treatment as described earlier.

NHS England is currently looking at access to NHS dental care and urgent dental care across Yorkshire and Humber. More detailed ward level access data will be obtained and used to inform future primary care dental service provision. Dental access remains a problem for many people, especially those in the more vulnerable groups. It is recognised that dental

services are demand led, but that they should be increasingly targeted towards those whose oral health is poor or who are at higher risk of developing disease.

However, improving access to dental care does not necessarily equate with improvements in oral health as dental services tend to be more treatment -focussed. Improving oral health and reducing oral health inequalities requires a more prevention-focused primary dental care service working in line with *Delivering Better Oral Health* (PHE, 2017), and local authority-led oral health improvement programmes within the community. However, the local authority focus at present is focussed on improving the oral health of children and young people rather than a whole life-course approach.

4.1.6 National Contract Reform

New NHS dental contract prototypes for general dental services are being tested which aim to change the focus of dental service provision from the delivery of treatment to a more preventive approach. The idea is to promote a shared responsibility to improve and maintain patients' oral health. Although initially planned to be introduced in 2018, the new contract is now likely to be delayed. There are currently 3 dental practices testing the prototype dental contract in South Yorkshire.

4.2 Secondary care

Secondary care dental services such as oral and maxillofacial surgery and specialist orthodontic services are provided at Doncaster NHS Foundation Trust Hospital. Consultant/Specialist Paediatric dentistry and treatment by specialists in special care dentistry is provided by the Community Dental Services. However for other specialist services such as restorative treatment (covering crowns, bridges, dentures, root canal treatment, treatment of gum conditions), paediatric dentistry (secondary/tertiary care), oral medicine, oral pathology, oral microbiology, and oral radiology, patients are referred to the Charles Clifford Dental Hospital in Sheffield. The vast majority of care is undertaken on an outpatient basis. The most frequent oral surgery procedures are dental extractions, the majority of which are carried out in 5 to 9 year olds (see section 3).

5. PATIENT AND PUBLIC INVOLVEMENT

5.1 Postal survey 2008

A postal survey of adult oral health was conducted across the region in 2008 (YHPHO, 2008).

Overall 25.8% of participants in Doncaster rated their oral health as fair, poor or very poor compared with the Yorkshire and the Humber average of 25.3%. Doncaster residents were more likely to report poorer oral health than those living in other areas of South Yorkshire.

Doncaster data from the Yorkshire and Humber Adult Oral Health Survey 2008 when compared with Yorkshire and the Humber as a whole (in brackets):

- 70.9% reported they had visited a dentist in the last year (73.4%)

- Of those with no natural teeth 45.5% reported their last visit was at least 5 years ago (46.2%), despite the need for a mouth check (e.g. to detect signs of early cancer) even if no teeth are present.
- 68.2% reported visiting the dentist for regular check-ups (68.9%).
- 22.7 % visited the dentist only when they had problems (19.6%).
- 70% had not experienced difficulties accessing routine care or 62.4% had no difficulties finding care when they were having problems, which was similar to Yorkshire and Humber
- 75.4% did not have problems accessing NHS dental care (excluding orthodontic treatment) for their children under 18 years (71.4%).
- Barriers to accessing dental care included: no dentists taking on patients (56.7%), cost (30.6%), lack of time or inconvenient surgery opening hours (17.2%), dentists only treating privately (30.0%).

5.2 Healthwatch

Healthwatch Sheffield has reported on disabled access to dental services in South Yorkshire and Bassetlaw (2016) which involved a small number of service users in Doncaster. It highlighted the need for dental practices to ensure they made necessary adjustments at their practices to improve accessibility and highlighted a training need among dental professionals to ensure patients received better care.

5.3 Pupil Lifestyle Survey

A health-related behaviour survey of young people of primary and secondary school age was carried out by the Schools Health Education Unit (SHEU) in 2015 and 2017. 3628 children took part in the 2017 survey, however not all the schools took part in both surveys. The results below show the 2017 data with the 2015 data in brackets.

Primary schools

- 4% (3%) of pupils responded that they usually clean their teeth ‘less than once a day’.
- 78% (79%) of pupils responded that they usually clean their teeth at least twice a day.
- 75% (78%) of pupils responded that they visited the dentist in the last 6 months.
- 8% (9%) of pupils responded that they last visited the dentist more than a year ago a
- 4% (3%) said they have never been to the dentist
- 71% (72%) of pupils responded that they last went to the dentist for a check-up.

Secondary schools

- 2% (2%) of pupils responded that they usually clean their teeth 'less than once a day’.
- 82% (81%) of pupils responded that they usually clean their teeth at least 'twice a day’.

- 90% (87%) of pupils responded that they last visited the dentist in the 6 months before the survey.
- 3% (5%) of pupils responded that they last visited the dentist more than a year ago
- 1% (1%) said they have never been to the dentist.
- 77% (79%) of pupils responded that they last went to the dentist for a check-up.

6. ORAL HEALTH IMPROVEMENT

6.1. Oral health promotion in primary care

Frequent exposure to fluoride, regular brushing with a fluoride toothpaste, a healthy diet and routine dental care contribute to improved oral health outcomes and a reduction in oral health inequalities. The importance of appropriate preventive programmes and high quality dental services is reflected in the government's current reform plans.

Historically, primary care general dental services have been treatment focused. The current dental contract was designed to encourage primary care dentists to focus on prevention and health promotion and carrying out fewer interventions. However, while the contract has removed incentives for over-treatment, there is still limited incentive for the general dentist to take a more preventative approach. Preventive activity undertaken within general dental services tends to be largely undocumented and has traditionally been based on oral health education. However, publication of the Delivering Better Oral Health toolkit (PHE, 2017) for the dental team has encouraged practices to practise evidence-based prevention, involving tailored oral health advice including discussing dietary choices, tobacco and alcohol use and signposting to services e.g. stop smoking services as appropriate; as well as preventive interventions such as fluoride varnish application.

Evidence from systematic reviews shows that application of fluoride varnish between two and three times a year can reduce tooth decay by 37% in baby teeth and 43% in adult teeth. Therefore evidence based guidance for dental professionals recommends application of fluoride varnish twice a year for all children between 3 and 16 years and two or more times for all children (0 to 16 years) at higher risk of tooth decay. For adults with a higher risk of tooth decay, it is recommended that fluoride varnish is applied twice a year. Fluoride varnish applications are available as part of NHS dental treatment and are free for children and any adults who are exempt from payment charges.

Doncaster has seen an increasing trend in fluoride varnish application, but there is still room for further improvement (Table 7). Other local authorities have increased the uptake of fluoride varnish through dental practice audits to increase awareness among dental practitioners and social marketing campaigns to raise awareness' among children and carers.

Table 7: The trend in percentage of child courses of treatment that contain fluoride varnish (NHS Digital, 2017)

Year	2012/13	2013/14	2014/15	2015/16
% of child courses of treatment that contained fluoride varnish application	58.3%	unavailable	55.9%	57.90%

6.2 DC Oral health improvement services

DC is responsible for securing the provision of oral health improvement programmes to improve the health of the local population in Doncaster. It previously had a dedicated oral health promotion team, however re-structuring has led to oral health improvement now being embedded into the Healthy Child Programme which the Council has commissioned Rotherham Doncaster and South Humber NHS Foundation Trust to provide. This comprises the 0-5 health visiting service and the 5-19 school nursing service. There is also an oral health lead and public health improvement coordinator with a focus on oral health within the Children Young People and Families team in Public Health.

Commissioning Better Oral Health for Children and Young People (CBOH) (PHE, 2014) and Oral Health: Local Authorities and partners (NICE, 2014) provide guidance for local authorities on commissioning evidence-based oral health improvement programmes. The guidance advocates a population approach with advice and actions for all, with additional interventions aimed at those at higher risk of developing oral disease, which is referred to as proportionate universalism (Marmot, 2010). The evidence-based oral-health improvement interventions are summarised in table 8, together with their overall level of evidence-based recommendation and details of any of these programmes taking place in Doncaster.

Table 8: Evidence-based oral health improvement interventions (CBOH, 2014)

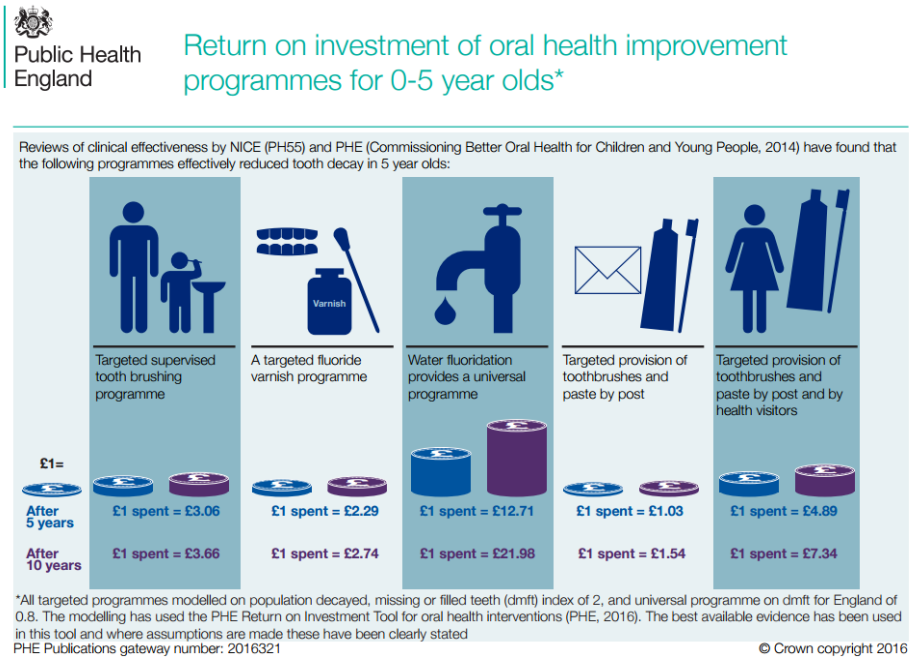
Ottawa Charter Principle	Oral health improvement intervention	Overall level evidence-based recommendation in CBOH	Details of any interventions taking place in Doncaster
Reorienting health services	Targeted community-based fluoride varnish programmes	Recommended	No activity. Encouraging uptake of fluoride varnish at local dental practices through outreach work at Edlington Hilltop.
	Targeted provision of toothbrushes and toothpaste (through postal schemes or through health visitors)	Recommended	Health visitor packs: Universal provision through distribution at First Friends groups at family hubs or 12 month review.
	Targeted community-based fissure sealant programmes	Limited value	No activity
	Targeted community-based fluoride rinse programmes	Limited value	No activity
	Facilitating access to dental services	Limited value	Promotion of NHS Choices to find a dentist through training and signposting through toothbrushing clubs and community work
	Using mouth guards in contact sports	Limited value	No activity
Developing personal skills	Oral health training for the wider professional workforce (e.g. health education)	Recommended	Oral health and nutrition training from Pubic Health's Children, Young People and Families Team available to anyone who has a role in supporting or caring for a young person.
	Integration of oral health into targeted home visits by health/social care workers	Recommended	Distribution of oral health packs by health visitors at 12 month checks and though First Friends groups at family hubs.
	Social marketing programmes to promote oral health and uptake of dental services by children	Limited value	No activity
	Person-centred (one-to-one) counselling based on	Limited value	No activity

	motivational interviewing outside of dental practice settings		
	One off dental health education by dental workforce targeting the general population	Discouraged	No activity
Creating supportive environments	Supervised tooth brushing in targeted childhood settings	Recommended	Toothbrushing clubs set up in nurseries and schools
	Healthy food and drink policies in childhood settings	Recommended	Opportunities through the Healthy Living, Healthy Lives accreditation scheme for schools, colleges and early years providers
	Fluoridation of public water supplies	Recommended	No activity
	Provision of fluoridated milk in schools	Limited value	No activity
	Fluoride toothpaste and toothbrushes provided in food banks		No activity
Build healthy public policy	Influencing local and national government policies	Recommended	The South Yorkshire Healthy Workplace Award PHE led sugar reduction programme
	Fiscal policies to promote oral health	Emerging	Soft drinks sugar levy introduced nationally in April 2018
	Infant feeding policies to promote breast feeding and appropriate complementary feeding practices	Emerging	Health visiting service and maternity service both have The Baby Friendly Initiative accreditation at level 3. Family hubs have recently been awarded the level 1 award, and are currently working towards level 2. Breastfeeding welcome scheme being relaunched.
Strengthening community actions	Targeted peer (lay) support group/peer oral health workers	Recommended	No activity
	School or community food cooperatives	Emerging	No activity

6.2.1 Interventions with a proven return on investment

The interventions which PHE has shown to be most cost-effective are illustrated in figure 15. Of these, Doncaster currently only has provision of toothpaste and toothbrush packs by health visitors and targeted supervised toothbrushing clubs. In addition, they are also providing oral health and nutrition training, and are involved in community outreach work and provide a health and wellbeing accreditation scheme for schools, colleges and early years, and a healthy workplace award.

Figure 15: Return on investment of oral health improvement programmes infographic



Source: PHE, 2016

6.2.2 Targeted supervised toothbrushing programme

Tooth brushing clubs were set up in 25 nurseries across the borough in 2017 by the Children and Young People's Public Health Team. Following new guidance from PHE on best practice (PHE, 2016), a new local Doncaster Toothbrushing Club Toolkit (including a settings agreement with DC, model information and consent form and quality assurance checklist) was developed and distributed to current clubs from December 2017 along with refresher training. New nurseries and schools are also now being invited to set up clubs. 12 new schools were recruited in March 2018, with over 1,300 children taking part.

6.2.3 Brush Book and Bedtime packs.

In Doncaster, a scheme called Brush Book and Bedtime packs historically involved the distribution of free fluoride toothpaste, toothbrushes and a bedtime book (toothbrushing related) to children via health visitors.

The brush book and bedtimes packed commenced in 2015. Currently Public Health funds the items required for the packs which include 'Dinosaur Douglas and the beastly bugs' book, the 'Tell me about Children's teeth' leaflet, a toothbrush and toothpaste. The health visiting team ensure every child receives a pack at either a First friends group at their local family hub, or at their 1 year review visit if they haven't received them through First Friends.

The content of the pack has recently been reviewed to ensure the appropriateness of the leaflet and strength of fluoride toothpaste included. The aim of this programme is to reduce tooth decay in early years. Research suggests that having tooth decay at an early age is a strong predictor of tooth decay in adulthood. The effectiveness of the distribution of free fluoride toothpaste and toothbrushes to children in reducing decay experience has been confirmed (Ellwood *et al*. 2004).

6.2.4 Oral health and nutrition training

The Children Young People and Families team within Public Health are currently running an on-going training programme to raise awareness of current health issues surrounding children's oral health and nutrition. The aim of the training is to ensure the Doncaster children's workforce is delivering the most up to date key messages based on government recommendations and advice. The training is available to anyone who has a role in supporting or caring for a young person. The training is available for free, and currently 4 training packages are on offer, Early Years, Parents and Carers 0-19, Professionals 0-19, Professionals 5-19.

6.2.5 Community Outreach Project at Edlington Hilltop

Oral health is being addressed through a community project at Edlington Hilltop. An oral health passport containing a comic strip story about going to the dentist for the first time has been developed in collaboration with a local artist, which will be given to children along with oral health packs. There are also classroom activities planned with local schools. The aim of the project is to raise awareness of oral health, promote prevention and encourage families to attend the dentist regularly.

6.2.6 Healthy Learning, Healthy Lives (HLHL)

HLHL is Doncaster's health and wellbeing accreditation scheme designed for schools, colleges and early years providers. It has replaced Doncaster's Healthy Schools Programme.

It aims to improve the health of local children by providing free support and guidance to education settings, including a comprehensive website.

Every local education setting will be encouraged to gain a HLHL accreditation that demonstrates their commitment to promoting the health of the children and families they work with. HLHL will help schools and early years settings improve the oral health and nutrition of children by providing the right information, guidance and resources to do so and by providing clear standards for practice within the accreditation scheme.

As part of the programme, local organisations will have FREE access to:

- A new website with resources, evidence and contacts designed specifically for your setting.
- An accreditation scheme that ensures providers can meet national and local standards and priorities.
- Online support to identify strengths and areas for improvement, with help to achieve this.

6.2.7 The South Yorkshire Healthy Workplace Award

The South Yorkshire Health Workplace Award gives a framework for businesses to work towards in order to build good practice in workplace health and wellbeing.

This award supports all types of employers, whether public, private sector or voluntary sector, small, medium or large organisation. It recognises the efforts made and provides three levels of certification of achievement: bronze, silver or gold.

This award is designed around 5 core principles. It will:-

- Make workplace wellbeing a mutual commitment between employer and employee
- Reward improvement as much as achievement
- Be based on a personalised improvement plan, based on the workplace health and wellbeing priorities and intentions of the business and its workforce
- Be evidence based
- Look to the future health of the workforce

It is achieved by:

- Using existing organisational and health data to develop health and wellbeing priorities for its workforce

- Production of an action plan to inform priorities/options which will recognise effort and commitment on the part of the workforce and the business.
- Rewarding progress and achievement over an agreed time period

In exchange for an organisation's commitment the workplace health offer is as follows:-

- Free workplace visit – a short meeting involving initial discussions around workplace health and how changes can be tailored to fit each business
- Share workplace health information – provide access to a suite of information and resources which can help organisations to develop health and wellbeing programmes and help to address business priorities as determined by the action plan.
- Accredit businesses with a good practice award and award with a certificate of achievement

6.2.8 Water fluoridation

It is clear from the figure 15 that the biggest return on investment would be water fluoridation. Water fluoridation differs from the other modes of increasing fluoride exposure in that it is a universal approach which doesn't require any behavioural change but simply requires the use of tap water in food/drink as part of normal daily life. The 2015 Cochrane review (Iheozor-Ejiofor Z et al., 2015) concluded that the introduction of water fluoridation resulted in children having 35% fewer decayed, missing and filled baby teeth and 26% fewer decayed, missing and filled permanent teeth. They also found that fluoridation led to a 15% increase in children with no decay in their baby teeth and a 14% increase in children with no decay in their permanent teeth. Other systematic reviews and reports (Rugg Gunn and Do, 2012; Griffen et al., 2007; PHE, 2014) also support the findings that levels of tooth decay are lower in fluoridated areas. There also appears to be some evidence that water fluoridation reduces the inequalities in dental health across social classes (McDonagh et al. , 2000; Hausen, 2003; Riley et al., 1999; Jones and Worthington, 1999; McGrady et al, 2012; PHE, 2018).

Doncaster has very low levels of the natural mineral fluoride in its water supplies, however this is too low to be of any benefit to dental health. Therefore, it would be necessary to artificially top up the fluoride levels in the water to 1mg/L to have the optimal effect of preventing tooth decay. Local authorities are responsible for conducting public consultation on water fluoridation schemes and for ongoing chemical costs. PHE pays the capital costs for setting up the fluoride dosing plants. The feasibility of water fluoridation is dependent on the logistics of sites of water treatment works, pumping stations and water flows, and this would need to be explored before further discussions around water fluoridation.

7. AUDIT AGAINST NICE GUIDANCE

Table 9 is a rapid audit of oral health improvement activities in Doncaster against the NICE guidance on oral health: local authorities and partners (NICE, 2014). Each NICE recommendation has been described in terms of what is happening in Doncaster, where there are gaps in provision, and opportunities to address these gaps.

Table 9: An audit of oral health improvement in Doncaster against NICE guidance (2014)

Recommendation	Sub-recommendation	Doncaster activities	Gaps in provision and opportunities to address them
1. Ensure oral health is a key health and wellbeing priority	Oral health a core component of Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy (HWS)	Oral health is a priority in Doncaster and underpins the council's vision to give every child the best start in life (Doncaster Children and Young People's Plan, 2017-20) with an awareness that poor oral health affects a child's ability to eat, sleep and socialise (Doncaster Starting Well Strategy 2017 - 2020, DMBC,2017).	Oral health isn't specifically mentioned in the Health and Wellbeing Strategy 2016-21 (DMBC, 2016). Ensure oral health included in future Joint Strategic Needs Assessments and Health and Wellbeing Strategies.
	Set up a stakeholder group that has responsibility for an oral health needs assessment and strategy		Consider setting up an Oral Health Improvement Group (OHIG).
2. Carry out an oral health needs assessment	Define scope	South Yorkshire and Bassetlaw OHNA (2015) available.	Consider setting up an oral health improvement group to consult with.
	Integrate into JSNA and HWS		This Doncaster OHNA will need to inform JSNA and HWS
	Practise cyclical planning		This Doncaster OHNA will inform the oral health strategy and action plan.
3. Use a range of data sources to inform the OHNA	Use of demographic and deprivation profiles	Current data in this OHNA	
	Use national oral health surveys	Current data in this OHNA	The 2016/17 5-year-old survey and 2017/18 survey of adults in practice have not been commissioned, so Doncaster data will be unavailable. It will be important to ensure the 2018/19 5-year old survey takes place (with a large enough sample)

			as it is a requirement for the Public Health Outcomes Framework.
	Use of demographic and socioeconomic data to determine need	Data used in this OHNA	
	Use local expertise and lifestyle surveys	Health watch survey (2016), 2008 postal survey of adult oral health and pupil lifestyle survey (SHEU 2015,2017)	
	Seek advice on survey design and collection, analysis and interpretation	PHE Consultant in dental public health and national PHE dental epidemiology team advised.	
4. Develop and oral health strategy	Strategy based on OHNA		Oral health action plan to be developed in response to the OHNA
5. Ensure public service environments promote oral health	Free drinking water; providing sugar-free food, drinks and snacks, including from vending machines; encouraging breastfeeding.	Health visiting service and Maternity service both have The Baby Friendly Initiative accreditation at level 3. Family hubs have recently been awarded the level 1 award, and are currently working towards level 2. Breastfeeding welcome scheme due to be relaunched this year. NHSE bans on sale of sugary drinks in NHS hospitals from July 2018.	More progress possible. Provide free drinking water in all family venues. Discussions to be held around the National Drinking Water Scheme. Consider reduction of sales of high sugar food/drinks in council premises. Endorsement of healthy food policies in council and other establishments, including gyms and care homes. Encourage dental practices to become part of the breastfeeding friendly initiative. Use national campaigns such as national smile month, mouth cancer action month, Stoptober and Change4Life to promote oral health in public places.
	Use levers to address oral health and wider determinants of health e.g. local planning decisions for fast food outlets	Policy has been written in the draft Local Plan to address the proliferation of Hot Food Takeaways and the refusal of applications within 400m of a Secondary School. Public Health currently	No current activity - seek opportunities

		comment on all Hot Food Takeaway applications recommending refusal.	
	Linking in with other sectors e.g. supermarkets to promote oral health		No current activity – seek opportunities.
6. Include information and advice on oral health in all local health and wellbeing policies	Advice for children and adults based on Delivering Better Oral Health (DBOH) and common risk factors	Healthy Learning , Healthy Lives accreditation for schools, colleges and early years includes food, drink and snack policies Toothbrushing club policies based on DBOH (PHE, 2017) and PHE guidance on supervised toothbrushing schemes (PHE, 2016).	More progress possible e.g. policies on infant feeding; looked after children; obesity; childcare services; primary and secondary education; safeguarding; care at home; health and social care assessments; food policies at drop in centres, lunch clubs, leisure centres, and food banks; carer centres.
7. Ensure frontline health and social care staff can give advice on the importance of oral health	Training for frontline staff, including understanding link between health inequalities and oral health and high risk groups; and being able to advise carers on oral care	Nutrition and oral health training for Early Years, Parents and Carers 0-19, Professionals 0-19, Professionals 5-19.	More progress possible e.g. training for health visitors, school nurses, care home staff. Include Making Each Contact Count and use of Change4life food scanner. Development of conversation guides for health visitors to use at mandated health assessments. Work with Local Dental Committee and Local Dental Network to: promote Delivering Better Oral Health in dental practices; increase uptake of fluoride varnish, and promote dental attendance before age one as part of NHSE's Starting Well Core programme. Training for care home staff for older people and children. Develop links with CCG

			to promote oral health through GPs and other services. Work with local pharmacies to promote oral health and signposting to dental care as part of the Healthy Living pharmacy campaign.
8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health	Ensure oral health in care plans and in line with safeguarding policies		More progress possible e.g. building oral health into all care plans for those in residential care and hospitals. Promotion of oral health using Mouth Matters and Caring for Smiles. Encourage NHSE to develop a Residential Oral Care Scheme (ROCS). More work is required to understand the needs of vulnerable adults. Work with paediatric GA providers to provide oral health promotion for families of children attending for extractions under general anaesthetic. Raise awareness of dental neglect being a sign of wider neglect. Distribution of oral health packs via foodbanks. Oral health training for foster carers, encouraging them to take children to own general dentist or access the community dental services.
	Ensure service specifications promote oral health	Oral health improvement embedded into Healthy Child Programme	Ensure specific reference in service specifications for oral health improvement

			programmes, monitoring and quality assurance.
9. Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health	Based on Delivering Better Oral Health	Nutrition and oral health training for Early Years, Parents and Carers 0-19, Professionals 0-19, Professionals 5-19. Training for setting up toothbrushing clubs Encourage use of e-learning for health oral health resource for early years	Develop conversation guides on oral health for health visitors to use at mandated health assessments Seek opportunities for training those working with adults.
10. Promote oral health in the workplace	Work with occupational health services to promote and protect oral health		No current activity – seek opportunities
	Provide information and advice on oral health and accessing dental care	Nutrition and oral health training for Early Years, Parents and Carers 0-19, Professionals 0-19, Professionals 5-19.	Cascade information to people and workpaces through a range of media on oral health and how to access dental care
	Allow employing paid time off work for dental appointments		Investigate opportunities
	Ensure the workplace environment promotes oral health	South Yorkshire healthy workplace award. Sugary drinks will not be sold in NHS hospitals from July 2018.	
11. Commission tailored oral health promotion services for adults at high risk of poor oral health	Use OHNA to identify areas and groups		Limited by lack of Doncaster level oral health survey data on adults
	Tailored interventions		Need to plan targeted interventions for vulnerable groups. Develop oral health resources for Roma Slovak community.
	Ensure services promote and protect oral health	Practical skills training for parents/carers on cooking healthy meals, budgeting and shopping smart. Information for women to maintain a healthy diet/weight	Need to link in e.g. with drug and alcohol services

		preconception and during pregnancy	
	Ensure local care pathways encourage people to use dental services		Partnership working with NHS England through the local dental network and NHSE's oral health improvement group to ensure appropriate services. Develop an Oral Health Improvement Group to facilitate partnership working. Build links with the CCG.
12. Include oral health promotion in specifications for all early years services	Promotion of oral health and training of staff	Nutrition and oral health training available for Early Years, Parents and Carers 0-19, Professionals 0-19, Professionals 5-19.	Ensure oral health in specifications for health visitors and school nurses, early years services, children's centres and nurseries
13. Ensure all early years services provide oral health information and advice	Based on Delivering Better Oral Health; understanding that good oral health contributes to better overall health	Nutrition and oral health training advice for early years has been updated in line with Delivering Better Oral Health: promotion of breastfeeding; moving on to solids; moving from bottle to cup; healthy food; role of fluoride in preventing decay; sugar free medicines, accessing dental care.	Ensure providers are disseminating current advice appropriately, and evaluate progress
14. Ensure early years services provide additional tailored information and advice for groups at high risk of poor health	Identify high risk areas and groups in OHNA		It is essential that in future the 5-year-old survey is routinely commissioned, as no survey was commissioned in 2017/18
	Tailored and culturally appropriate advice for families		Develop Roma Slovak oral health resources.
	Provide toothbrushing packs e.g. through midwives and health visitors	Oral health packs distributed to all children through First friends groups at family hubs or at 12 month review.	Consider providing targeted take home oral health packs for children attending toothbrushing clubs and family hubs . Consider distributing oral health packs through food banks.
15. Consider supervised	Use OHNA to identify areas where children at		It is essential that in future the 5-year-old

toothbrushing schemes for nurseries in areas where children are at high risk of poor oral health	highest risk of poor oral health		survey is routinely commissioned, as no survey was commissioned in 2017/18
	Commission scheme in early years settings in high risk areas	Toothbrushing clubs set up in nurseries and schools. Developed Doncaster Toothbrushing club toolkit to reflect new PHE guidance, and local training provided.	Further clubs to be set up in nurseries and schools. Quality assurance assessments of toothbrushing clubs to be carried out termly by settings and once a year by DC.
16. Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health	Target to areas of high risk of poor oral health, monitor and evaluate		Consider setting up a scheme once PHE Community fluoride varnish toolkit is published (in press).
17. Raise awareness of the importance of oral health as part of a 'whole school approach' in primary schools	Policies and procedures promote oral health e.g. food and drink	The health learning, healthy lives accreditation aims to improve the oral health of local children by information, guidance, support and standards for education settings.	Seek opportunities to set up toothbrushing clubs, promote classroom activities and whole school food policies. Engage schools with national campaigns such as National Smile Month and Change4Life.
	Displaying oral health information for children and carers including how to access dental care		No current activity – seek opportunities
	Teaching oral health in the curriculum based on Delivering Better Oral Health	Oral health resources for KS1 and KS2 developed and piloted	Complete development of oral health resources and roll out to schools. Link local dental practices with schools to provide classroom sessions.
18. Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health	Train staff in oral health	Oral health resources for KS1 and KS2 developed and piloted	Complete development of oral health resources and roll out to schools.
	Set up toothbrushing schemes or fluoride varnish programmes	Toothbrushing scheme currently being expanded to involve schools	Ongoing plan for future training and quality assurance needed.
	Opportunities for parents to learn about oral health		Engage parents as part of a 'whole school approach'. Incorporate oral health into new starter events, possibly provide oral health packs for

			children to take home, involve parents/carers in developing school food policies
19. Consider supervised toothbrushing schemes in schools where children are at high risk of poor oral health	OHNA to identify areas	Toothbrushing scheme currently being expanded to involve schools	Ongoing plan for future training and quality assurance needed.
20. Consider fluoride varnish schemes for primary schools in areas where children are at high risk of poor oral health	Target to areas of high risk of poor oral health		Consider setting up a scheme once PHE Community fluoride varnish toolkit is published (in press).
21. Promote a 'whole school' approach to oral health in all secondary schools	Policies and procedures promote oral health e.g. food and drink		No current activity – seek opportunities.
	Incorporate oral health into curriculum		There are no specific oral health topics, however there are opportunities to link in with e.g. biology, health and social care and child care subjects. Possible involvement in secondary school oral health promotion project with University of Sheffield (BRIGHT). Engage schools in national campaigns e.g. National Smile Month and Change and Give up Loving Pop
	School nurses to encourage good oral health	Nutrition and oral health training available for Professionals 0-19, Professionals 5-19.	
	School leavers informed about accessing dental services		Action required - seek opportunities
	Oral health training for school staff		Action required. Link in with diet, alcohol, sexual health.
	Influence planning decisions e.g. location of fast food outlets near to schools		Action required – seek opportunities

8. CONCLUSIONS

- DC recognises the importance of good oral health to ensure every child has the best start in life.
- There is currently no oral health improvement group (OHIG) in Doncaster to facilitate partnership working.
- Children and adults in DC experience some of the poorest oral health in the country. Children in the most deprived areas of the city had average tooth decay levels around 3 times higher than those living in the least deprived areas.
- Doncaster has the highest level of extractions under general anaesthetic due to tooth decay amongst 5-9 year olds in the country.
- Doncaster has seen an increasing trend in mouth cancer among men and women and sees high levels of tobacco and alcohol use which are the main risk factors.
- Local Doncaster data on nationally recognised groups within the community at even higher risk of poor oral health is lacking. These include: looked after children; children and adults with special needs, travellers, those suffering from drug and alcohol abuse, and older people in care homes and hospitals.
- Doncaster is well serviced by NHS dental care, with many practices able to take on new patients. However, the levels of Units of Dental Activity commissioned by NHSE by ward do not equate to the relative need. There is also limited domiciliary provision.
- Access to NHS primary care dental services are higher than nationally and has remained relatively constant around 65% for children (previous 12 months) and 69% for adults (previous 24 months).
- Healthwatch Sheffield's South Yorkshire Survey (2016) has highlighted the need for practices to improve accessibility for disabled patients and training amongst dental professionals to ensure patients receive better care.
- DC is already involved in the following evidence-based oral health improvement interventions: provision of toothbrushes and toothpaste through health visitors, oral health training for the wider professional workforce; supervised toothbrushing scheme; and food and drink policies in childhood settings as part of the Healthy Living Healthy Lives Accreditation. However, the following are not currently undertaken in Doncaster: targeted community fluoride varnish programme; water fluoridation; targeted provision of toothbrushes and toothpaste by post; breast feeding peer support and health trainers supporting to access dental services.
- There are opportunities for DC to lead the way in encouraging healthy eating, and there may be opportunities to promote this in other public settings e.g. leisure centres.

9. RECOMMENDATIONS

- Develop an Oral Health Improvement Group (OHIG) to facilitate partnership working with stakeholders in Doncaster, NHSE's oral health improvement group and the local dental network.
- Ensure oral health continues to be included in future Joint Strategic Needs Assessments and Health and Wellbeing Strategies.
- Use this OHNA to develop a Doncaster Oral Health Improvement Strategy and Action Plan.
- Ensure all oral health improvement programmes and activities are evidence-based, quality assured and evaluated.
- Ensure participation in the PHE Dental Public Health Epidemiology Programme, to support the public health outcomes framework and to enable evaluation of programmes.
- Consider evidence-based oral health programmes which have an identified return on investment not currently undertaken in Doncaster:
    a. Targeted community fluoride varnish programme
    b. Investigate the feasibility of water fluoridation
    c. Targeted provision of toothbrushes and toothpaste by post.

- Bridge the gaps in provision of oral health improvement identified through the audit against the NICE guidance on oral health: local authorities and partners:

    - Encourage more public service environments to promote oral health through provision of free drinking water, providing sugar-free snacks, including from vending machines and encourage breastfeeding.
    - Seek opportunities to influence the wider determinants of poor oral health e.g. though local planning decisions for food outlets near schools.
    - Work with other sectors e.g. local supermarkets to promote oral health.
    - Ensure oral health is mentioned in DC policies on: infant feeding; looked after children; obesity; childcare services; education; safeguarding; care at home; health and social care assessments; food policies at drop in centres, lunch clubs, leisure centres and food banks, and carer centres, and adult care services.
    - Encourage healthcare providers to have discussions around oral health where appropriate and ensure frontline workers are trained in oral health, alcohol and tobacco awareness as part of Making Each Contact Count. Improve signposting to stop smoking and alcohol services.
    - Develop conversation guides for health visitors to use at mandated health assessments.
    - Work with the local dental committee and local dental network to promote delivery of oral health improvement in line with Delivering Better Oral Health, around promotion of fluoride varnish application, and encouraging parents/carer

to bring children to the dentist before their first birthday as part of NHSE's Starting Well Core Programme.

- Develop links with local pharmacies and the CCG to facilitate oral health improvement through GPs, pharmacies and other services.
- Consider extending/ additional ways of distribution of toothbrush and toothpaste packs e.g. through school toothbrushing clubs, food banks
- Improve oral health for those in residential care and hospitals though training to build oral health into all care plans for those in residential care and hospitals, promotion of Caring for Smiles and Mouth Care Matters and encouraging NHSE to consider development of a Residential Oral Care Scheme.
- Continue to work with paediatric GA providers to provide oral health promotion for families of children attending for extractions under general anaesthetic. Raise awareness of dental neglect being a sign of wider neglect.
- Provide oral health training for foster carers.
- Cascade information to people and workplaces through a range of media on oral health and how to access dental care. Investigate opportunities for more flexible working arrangements to allow people to attend dental appointments.
- Investigation of the local oral health needs for vulnerable children and adults, (including looked after children, asylum seekers, travellers). Plan targeted oral health interventions for groups at high risk of poor oral health e.g. Roma Slovak community, and those suffering from drug and alcohol, through partnership working with existing programmes.
- Work in partnership with the local dental network (NHSE) and NHSE's oral health improvement group to develop care pathways for vulnerable groups to access dental services. Improve access to domiciliary care, care for those with disabilities and bariatric dental care. Improve signposting to NHS care through NHS Choices and other social media.
- Continue to support the Healthy Learning, Healthy lives accreditation
- Further develop the supervised toothbrushing scheme in nurseries and primary schools, and encourage schools to sign up to a whole school approach where oral health is also embedded in whole school food policies and classroom teaching. Ensure training for staff in settings and quality assurance is maintained. Link local dental practices with schools to provide classroom input. Incorporate oral health into new starter events and provide oral health packs to take home, and involve parents/carers in developing school food policies.
- Encourage oral health promotion in secondary schools through involvement with University of Sheffield's oral health promotion research project (BRIGHT), and seek other opportunities to raise awareness of oral health through biology, health and social care and child care lessons.
- Encourage more patient and public involvement through partnerships e.g. working with Healthwatch.
- Raise the profile of oral health through national campaigns e.g. National Smile Month, Mouth Cancer Action Month and Change4Life.

- Repeat this oral health needs assessment in 2021.

10. REFERENCES

1. UK Government. Health and Social Care Act 2012, c.7. 2012
2. SI 3094 (2012). *NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and local Healthwatch Regulations 2012* . The Stationary office, London. Available at: http://www.legislation.gov.uk/uksi/2012/3094/made [Accessed 03.04.18]
3. Team Doncaster (2017). *Doncaster Children and Young People's Plan 2017-2020.*
4. DC (2016). Doncaster Health and Wellbeing Strategy 2016-21.
5. DC (2017). Doncaster starting well strategy 2017-2020.
6. PHE (2015). *South Yorkshire and Bassetlaw Oral Health Needs Assessment* [Online]. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/463067/South_Yorks___Bassetlaw_oral_health_needs_assessment.pdf [Accessed 24.4.17].
7. PHE (2016a). *Local health and care planning: menu of preventative interventions*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf [Accessed 24.4.17].
8. Sheiham and Watt (2000). The common risk factor approach: a rational basis for promoting oral health. Community Dentistry and Oral Epidemiology, 28 (6): 399-406.
9. NICE (2014). NICE public health guideline 55. *Oral health: local authorities and partners.* Available at: https://www.nice.org.uk/guidance/ph55 [Accessed 24.4.17].
10. NICE (2016). NICE guideline 48: Oral health for adults in care homes. Available from https://www.nice.org.uk/guidance/qs151 [Accessed 14.11.17].
11. PHE (2016b). *Improving oral health: a toolkit to support commissioning of supervised toothbrushing programmes in early years and school settings.* Available at: https://www.gov.uk/government/publications/improving-oral-health-supervised-tooth-brushing-programme-toolkit [Accessed 15 March 2018].
12. Local Government Association. (2016). *Tackling poor oral health in children: local government's public health role.* Available at: http://www.local.gov.uk/sites/default/files/documents/tackling-poor-oral-health-d84.pdf [Accessed 24.4.17].
13. PHE(2014). *Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities.* Available at: https://www.gov.uk/government/publications/improving-oral-health-an-evidence-informed-toolkit-for-local-authorities [Accessed 24.4.17].
14. NICE (2016). *Oral health promotion in the community*. Available at: https://www.nice.org.uk/guidance/qs139 [Accessed 11.06.18].
15. PHE (2017). *Delivering better oral health: an evidence-based toolkit for prevention.* Available at: https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention [Accessed 24.4.17].

16. NICE (2016). *Oral health promotion in the community.* Available at: https://www.nice.org.uk/guidance/qs139 [Accessed 24.4.17].
17. PHE (2017a). *National Dental Epidemiology Programme for England: oral health survey report of five-year-old children in Yorkshire and the Humber 2015*. Available from: https://www.gov.uk/government/publications/oral-health-survey-report-children-in-yorkshire-and-humber-2015 [Accessed 15.03.18].
18. PHE (2017b). Dental health profile. Available from: http://www.nwph.net/dentalhealth/5yearoldprofiles/Yorkshire%20and%20the%20Humber/2015/Doncaster%20LA%20Dental%20Profile%205yr%202015.pdf [Accessed 05.04.18]
19. Royal College of Surgeons (2015). Dental facts and stats: children in England. Available at: https://www.rcseng.ac.uk/dental-faculties/fds/faculty/government-relations-and-consultation/dental-facts-and-stats-on-children/ [Accessed 24.04.17].
20. Department of health and Department of Education (2015). Promoting the health and well-being of looked-after children. Statutory guidance for local authorities, clinical commissioning groups and NHS England (Department of Health and Department of Education, 2015). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf [Accessed 24 April 2017].
21. NICE (2015). Looked-after children and young people. Public Health Guideline [PH28]. Available at:https://www.nice.org.uk/guidance/ph28 [Accessed 24.04.17].
22. Milsom KM, Threlfall AG, Blinkhorn AS et al. (2006). The effectiveness of school dental screening: dental attendance and treatment of those screened positive. *British Dental Journal* **200**: 687 – 690.
23. Office for National Statistics (2017). Population Estimates for UK, England and Wales, Scotland and Northern Ireland. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland [Accessed 18.09.17].
24. DMBC (2015). Doncaster Health and Wellbeing Board: Pharmaceutical Health Needs Assessment (2015-2018).
25. PHE (2016c). Doncaster Health Profile
26. Team Doncaster (2017). Indices of multiple deprivation. Available form: http://www.teamdoncaster.org.uk/indices-of-multiple-deprivation [Accessed 18.09.17].
27. PHE (2018). Hospital episode statistics: extractions data 0-19 year olds, 2011/12-2016/17. Available at: http://www.nwph.net/dentalhealth/Extractions_270317.aspx [Accessed 11.06.18].
28. Cancer Research UK (2014). Mouth and oropharyngeal cancer.
29. PHE (2017c). Oral health profile: oral cancer registrations and mortality for Doncaster. Available from: https://fingertips.phe.org.uk/profile/oral-health/data#page/4/gid/1938133054/pat/6/par/E12000003/ati/101/are/E08000017/iid/92953/age/1/sex/4 [Accessed: 19.09.17].
30. DC (2014). Doncaster Substance Misuse Strategy 2014-17 .
31. Nunn J, Murray J (1987). The dental health of handicapped children in Newcastle and Northumberland. British Dental Journal., 162:9-14

32. Evans D, Greening S, French A (1991). A study of dental health of children and young adults attending special schools in South Glamorgan. *International Journal of Paediatric Dentistry*, 1:17-24.
33. NICE and Social Care Institute for Excellence (2016). *Improving oral health for adults in care homes. A quick guide for care home managers.*
34. Dental Public Health Intelligence Programme website. Available at: http://www.nwph.net/dentalhealth/ [Accessed 14.11.17].
35. Sport England (2016). 2.12 - Percentage of adults (aged 18+) classified as overweight or obese – current method. Public Health England (based on Active Lives survey, Sport England). Availablefrom:https://fingertips.phe.org.uk/search/obesity#page/3/gid/1/pat/6/par/E12000003/ati/102/are/E08000017/iid/93088/age/168/sex/4 [Accessed 13.11.17)
36. PHE fingertips (2015/16). Hospital admissions for alcohol-specific conditions – all persons. Available from: https://fingertips.phe.org.uk/search/alcohol#page/3/gid/1/pat/6/par/E12000003/ati/102/are/E08000017/iid/92906/age/1/sex/4 [Accessed 13.11.17].
37. Annual population survey (2016). Smoking prevalence in adults – current smokers. Available from: https://fingertips.phe.org.uk/search/smoking#page/3/gid/1/pat/6/par/E12000003/ati/102/are/E08000018/iid/92443/age/168/sex/4 [Accessed 13.11.17].
38. NHS Digital (2011). Adult dental health survey 2009. Summary report and thematic series. Available from: http://digital.nhs.uk/catalogue/PUB01086 [Accessed 05.04.18].
39. Humphris G, Morrison T, and Lindsay S (1995) The Modified Dental Anxiety Scale: validation and United Kingdom norms. *Community Dental Health,* 12: 143-50.
40. Klinberg G (2008). Dental anxiety and behaviour management problems in paediatric dentistry – a review of background factors and diagnostics. *European Archives of Paediatric Dentistry*, 1: 11-15.
41. Nuttall N *et. al* (2011). *Access and barriers to care – a report from the Adult Dental Health Survey 2009.* The health and social care information centre.
42. Alzheimers society (2015). *Dental care and oral health*. Factsheet 448LP.
43. Groundswell (2017). *Healthy mouths report: executive summary.*
44. Healthwatch Rotherham (2014). *Access to dental practices.*
45. Healthwatch Sheffield (2016). *Disabled access to dental services in South Yorkshire and Bassetlaw.*
46. Dental Public Health Intelligence programme website: http://www.nwph.net/dentalhealth/
47. Fundacion Secretariado Gitano (2009) *Health and the Roma Community, Analysis of the Situation in Europe. Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia, Spain. Madrid*: FSG
48. Faculty of Public Health (2008). *The health needs of asylum seekers.* Available at: http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf [Accessed 15.03.18]
49. YHPHO (2008). The dental health of adults in Yorkshire and the Humber in 2008. YHPHO.
50. *Walker, A. and Cooper, I. (eds.) (2000) Adult Dental Health Survey: oral health in the United Kingdom 1998, London: The Stationery Office.*

51. Wilson M, 2014. Oral Health Needs Assessment of the Prison Population in Wales: Executive Summary and Recommendations. Available at: http://www2.nphs.wales.nhs.uk:8080/DentalPublicHTDocs.nsf/($All)/26F88A56A05D4ACE80257CBC0033A3DC/$File/Oral%20Health%20Needs%20Assessment-%20Prison%20Population%20of%20Wales%202013%20Executive%20Summary%20and%20Recommendations%2016.04.14.pdf?OpenElement [Accessed 090118].
52. Public Health England (2014) Health and Justice Health Needs Assessment Template: Adult Prisons Part 2 of the Health and Justice Health Needs Assessment Toolkit for Prescribed Places of Detention, PHE London. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331628/Health_Needs_Assessment_Toolkit_for_Prescribed_Places_of_Detention_Part_2.pdf [Accessed November 2015].
53. Public Health England (2016). National dental epidemiology programme for England: oral health survey of 5 year old children 2015. A report on the prevalence and severity of dental decay. London. Public Health England.
54. Blot W (1992). Alcohol and cancer. *Cancer Research*; 52:2119-*23.*
55. Johnson N, Bain C. Tobacco and oral disease. British Dental Journal; 189 (4):200-6.
56. *FGDP (2017). Dementia friendly Dentistry: Good Practice Guidelines.* FGDP, UK.
57. Migration Yorkshire (2017). *Doncaster Local Migration Profile Summary Document – December 2017*
58. South Yorkshire Roma Project (2017). *Roma in Doncaster. Mapping services and local priorities.* Migration Yorkshire and University of Salford.
59. McDonagh et al. (2000) *A Systematic Review Of Public Water Fluoridation.* NHS Centre for Reviews and Dissemination. University of York.
60. Hausen H (2003). Some evidence that water fluoridation reduces inequalities in dental health across social classes. Evidence-Based Dentistry ;3:41-42
61. Iheozor-Ejiofor Z et al. (2015). *Water fluoridation for the prevention of dental caries*. Cochrane Library.
62. McGrady et al (2012). The association between social deprivation and the prevalence and severity of dental caries and fluorosis in populations with and without water fluoridation. *BMC Public Health* **12**:1122
63. Riley JC, Lennon MA, Ellwood RP (1999). The effect of water fluoridation and social inequalities on dental caries in 5-year-old children. *Int. J. Epidemiol.* ; 28:300-5
64. Jones CM, Worthington H (1999). The relationship between water fluoridation and socioeconomic deprivation on tooth decay in 5-year-old children. *British Dental Journal* 186:397-400
65. Rugg-Gunn A and Do L (2012). Effectiveness of water fluoridation in caries prevention. *Community Dentistry and Oral Epidemiology*; 40(Suppl. 2): 55-64
66. Griffin SO, Regnier E, Griffin PM, Huntley V (2007). Effectiveness of Fluoride in Preventing Caries in Adults. *Journal of Dental Research* ; 86: 410-415
67. PHE (2014). Water fluoridation. Health monitoring report for England 2014.
68. PHE (2018) |Water fluoridation. Health monitoring report for England. Available from: https://www.gov.uk/government/publications/water-fluoridation-health-monitoring-report-for-england-2018. [Accessed 11.06.18].

This page is intentionally left blank

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 6 September 2018

Subject: Report of the HWB Steering Group and Forward plan

Presented by: Dr Rupert Suckling

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

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

How will this contribute to improving health and wellbeing in Doncaster?
This report provides an update on the Doncaster Clinical Commissioning Group's Primary Care Commissioning Committee, Work & Health, the Well Doncaster annual report and the minutes from the last South Yorkshire and Bassetlaw, Sustainability and Transformation Partnership, Collaborative Partnership Board meeting. It also provides a forward plan for the Board.

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

This page is intentionally left blank

Doncaster Council

Agenda Item No. 13
6 September 2018

To the Chair and Members of the HEALTH AND WELLBEING BOARD

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

EXECUTIVE SUMMARY

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

EXEMPT REPORT

2. N/A

RECOMMENDATIONS

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

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

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

BACKGROUND

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

   The Steering group has had one meeting since the last Board in June 2018 and can report the following:

Doncaster Clinical Commissioning Group Primary Care Committee

The Health and Wellbeing Board has the opportunity to sit on the Doncaster CCG Primary Care Committee. Nominations are welcome for Board members who want to fulfil this role. Nominations to Jonathan Goodrum by 19th September 2018.

Work and Health

The Doncaster Local Integration Board (LIB) has been operational now for just over 6 months. It was created as a requirement of the Working Win Programme, and will become the umbrella board for all employment (including employment and health) related activity in Doncaster. Its purpose is to ensure that Doncaster's health and employment systems are integrated by supporting the work of member organisations to respond to the needs and issues present within the local economy and labour market. Building from the Stronger Families Board, the LIB includes all the main partner organisations plus South Yorkshire Housing Association who are delivering Working Win and Reed in partnership who deliver the Work and Health Programme. The LIB is currently focussed on the performance of the two main contracts, the integration of a range of employment programmes and the services that support activity through a service directory.

Working Win offers:

- One-to-one support to suit individual needs and employment goals
- Working with the individual and their health care team to manage any difficulties
- Help finding a job if individuals are not in paid employment, and continued support once in work
- Help to continue working with a health condition
- Benefits advice to find out if work could increase incomes
- Help talking to employers about specific needs at work
- Meetings over the phone or in person at a convenient location

How does the trial work?

The Health-led Employment Trial is a randomised control trial, meaning people who take part will be randomly placed into one of two research groups. One group will receive the new services and the other group will be provided with information about existing services in their area.

Who is the trial for?

- People with a mental health and/or physical health condition
- People who are out of work and want to work; or working and want support to continue working
- People registered with a GP in Barnsley, Bassetlaw, Doncaster, Rotherham or Sheffield.
- People aged 18+ at the time of referral

How to get involved?

To find out more information please speak to your GP or local health professional or to contact the Health-led Employment Trial team directly, please visit www.workingwin.com or ring us on 0114 290 0218.

Health partners are asked to consider who is best placed to support the integration between health and employment sectors.

Well Doncaster Annual Report

The annual report for Well Doncaster is provided for information. This is a partnership between the Doncaster, Public Health England and the University of Manchester and is a response to health inequalities in the North of England. Doncaster is one of 9 pathfinders and the report demonstrates the progress made in last year and proposes a set of future actions and activities.

South Yorkshire and Bassetlaw Shadow Integrated Care System Collaborative Partnership Board

The minutes from the June 2018 meeting are attached for information.

Forward Plan

In light of the development of the outcomes framework the proposal is that the forward plan should be reviewed following the performance report and a schedule of agenda items developed.

OPTIONS CONSIDERED

6. None

REASONS FOR RECOMMENDED OPTION

7. None

IMPACT ON THE COUNCIL'S KEY OUTCOMES

8.

	Outcomes	**Implications**
	All people in Doncaster benefit from a thriving and resilient economy. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	The dimensions of Wellbeing in the Strategy should support this priority.
	People live safe, healthy, active and independent lives. • *Mayoral Priority:* Safeguarding our Communities • *Mayoral Priority:* Bringing down the cost of living	The Health and Wellbeing Board will contribute to this priority
	People in Doncaster benefit from a high quality built and natural environment. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	The Health and Wellbeing Board will contribute to this priority
	All families thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	The Health and Wellbeing Board will contribute to this priority
	Council services are modern and value for money.	The Health and Wellbeing Board will contribute to this priority
	Working with our partners we will provide strong leadership and governance.	The Health and Wellbeing Board will contribute to this priority

RISKS AND ASSUMPTIONS

9. None

LEGAL IMPLICATIONS

10. No legal implications have been sought for this update paper.

FINANCIAL IMPLICATIONS

11. No financial implications have been sought for this update paper.

HUMAN RESOURCES IMPLICATIONS

12. No human resources implications have been sought for this update paper.

TECHNOLOGY IMPLICATIONS

13. No technology implications have been sought for this update paper.

EQUALITY IMPLICATIONS

14. The primary care committee and the Working Win approach both address the needs of some of the most vulnerable people in Doncaster. Assessing the impact of these approaches will be important.

CONSULTATION

15. None

BACKGROUND PAPERS

16. None

REPORT AUTHOR & CONTRIBUTORS

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

Louise Robson, Public Health Theme Lead, Public Health
01302 734015 louise.robson@doncaster.gov.uk

Dr Rupert Suckling
Director Public Health

This page is intentionally left blank

Well Doncaster Annual Report 2017/18

Vanessa Powell-Hoyland
Emma Nicholas

EXECUTIVE SUMMARY

Well North and Pathfinders continue to embrace a set of principles which, at their heart, seek to empower local people. Trusting communities to shape their futures through creating a culture of enterprise and creativity and building strong connections, especially with the private sector and social businesses.

Continued conversations with the community have identified local priorities and strengths and have lead to co-produced solutions. Many priorities for Denaby from conversations in 2015 have been met and there has been significant progress against subsequent plans. June 2017 saw the programme undertake further conversations across the community to ensure the work remains grounded in the community voice.

2017/18 has seen progress in a range of social opportunities in Denaby and in the collaboration between new and existing groups. The volunteer run Community Library is sustainable, the programme is supporting a calendar of community organised events and there here has been an increased focus on enterprise and links with the business sector to support people into employment and self-employment. Community space has been developed through art and community activity has been supported through the final year of the Community Micro Grant.

Work has begun to support fundamental skills such as literacy as 2017 saw a focus on adult literacy framed around the family, linking with early year's provisions, schools and adult and family learning.

The Crags Site Management Plan sets out a long term timeline and plans are in place for 2018/19 to see tree clearing and planting, initiate wild life groups and develop links with local schools.

In 2018/19 Well Doncaster is moving to link with wider programmes across the borough that are drawing partners together to create holistic, preventative, social models of support. More can be done to support people to manage their own health and Well Doncaster will continue work with partners to develop self-management in the areas of focus.

In 2018/19, as well as continuing to work in Denaby Well Doncaster will enter a new phase as it expands its reach into four other wards in the borough; Edlington, Balby, Bentley and Stainforth. Work in 2018/19 will focus on scoping and understanding these communities, working with local partners to identify each communities priorities and understand where and how to apply the learning from Denaby.

The programme will continue its commitment to robust and innovative approaches to evaluation and will be working to raise the profile of the learning it has gathered through publishing and sharing its findings.

This Annual Report makes a number of recommendations for 2018/19.

BACKROUND

Well North is a collaboration between local areas, Public Health England and The University of Manchester which focuses on people and communities. It recognises that everyone wants a comfortable home, a good job and a healthy life to enjoy with family and friends. But life isn't always equal or fair and people who get a raw deal often lose health, happiness and hope.

Well North believes that people and places can change for the better and that local people are the solution. Creating better health and wellbeing is about being part of a vibrant and connected community and living in a pleasant environment and is more than if we smoke, take exercise or eat healthier. Health means tackling debt, lack of jobs, missed educational opportunities, poor housing and loneliness.

Well North follows an asset-based approach to develop communities along these lines, building on the positives in life that create wellbeing and protect health. Denaby Main, in the West of Doncaster, was the initial area of focus.

OUTCOMES

The objectives of Well Doncaster are to;

- Address inequalities, improving the health of the poorest, fastest
- Increase resilience at individual, household and community levels
- Reduce worklessness, a cause and consequence of poor health
- Evaluate, replicate and scale-up Well Doncaster in other suitable areas

By adhering to the principles and focusing on the determinants of health and wellbeing, Well Doncaster can contribute to the complex outcomes relevant to many people and services;

- Reducing demand on unplanned healthcare (reducing the number of A&E attendances and emergency admissions)
- Reduced demand on social care (reducing the number of long term residential placements and increasing the number of people with direct payments)
- Reducing the number of people receiving out-of-work benefits (reducing the numbers claiming Job Seekers Allowance, Employment Support Allowance and Incapacity Benefit).

THE STORY THIS YEAR

Work in Denaby has moved forward, a review of the community conversations of 2015 was followed by sense check in 2017 at a community event to celebrate the first year of the community micro grant. Many of the original Community Explorers returned to continue the conversations in Denaby and get a sense of impact.

The review showed that many of the community priorities have been met. The development of 'Destination Denaby' has been advanced through the development of public spaces through a 33m mural in the shopping precinct, the installation of green gym equipment on Flower Park, a 10 year plan for the Crags and the development of the community allotments.

The community micro grants supported residents to create new and support existing community groups offering a host of social opportunities to Denaby.

2017/18 saw an increased focus on building a culture of enterprise in Denaby, through the commissioning of 'Get Denaby Enterprising' and supporting residents into self-employment.

Denaby Community Library continues to grow with a strong group of volunteers delivering activities, support and information to Denaby residents. Denaby Reads has been working in the community focusing on innovative approaches to developing literacy skills. Fundamental skills such as cooking were address through a series of cook and eat session in partnership with Denaby Family Hub.

In 2016 Doncaster's health and care organisations produce a five year forward Place Plan, Well Doncaster actively incorporates the Place Plan vision that care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing.

Well Doncaster offers opportunity for all partners to deliver a more collaborative community system focused on improving health outcomes for residents.

THE STORY THIS YEAR

Well Doncaster is supported by Team Doncaster and is working to influence ways of working and embed our approaches and learning into core services as examples of good practice.

Well Doncaster's community insight and health priorities offers a validated methodology to address the health inequalities within our communities. We are working closely with strategic partners and communities to ensure co-produced and joint commissioned services are tailored to meet the communities needs and reduce duplication.

As the work in Denaby continues the programme had begun to look to share and apply the learning from Denaby into other communities in the borough.

Referring back to our original analysis four new wards were selected; Edlington, Balby, Bentley and Stainforth. Each community has their own strengths and challenges. Initial work has started to understand these strengths and challenges by working closely with local people and organisations.

We continue to use a variety of evaluation approaches to understand what works for who and in what circumstances.

We want to be able to use the learning from the work in Denaby in other areas and be able to be responsive and thoughtful to the needs of communities. We used a grounded theory approach to help us understand data and co-produce interventions and approaches.

To strengthen the evaluation, Well Doncaster is incorporating a Realist approach which helps us recognise and begin to account for wider influences. Communities and individuals are complex and it is not enough to simply ask 'does it work?' We also need to understand 'what works, for whom, how, to what extent and in what contexts?' This means we are developing theories about how something works and then testing it through interviews, observations and other data.

KEY ACTIVITY

DESTINATION DENABY

To support 'Destination Denaby' Grays Court was identified as an area that needed brightening up and residents liked the idea of a mural which highlighted Denaby's history. With this in mind Well Doncaster commissioned Doncaster artist Mandy Keating to design a bespoke piece of art along a 33 metre wall that runs the length of the precinct.

A series of workshops were arranged across the community and primary schools to understand how the community saw Denaby and what was important to them and inform the design.

From August-November 2017 Mandy and volunteers, including the Well Doncaster Team, worked to transform the wall with images representing Denaby's past, present and future which included silhouettes of real Denaby residents into the design. Mandy said of the process "Some images of people were very recognisable, such as Deacon riding a scooter and probably helped to secure support from some of the younger residents. Whilst the images of Jim, the older gentleman with his walking stick, was claimed to be several other older gentlemen in Denaby! I liked that people claimed ownership of a character on the wall. To me it meant acceptance of the design and ownership of it too".
To celebrate its completion a event was held at local social Café The Hot Chocolate Lounge located on Grays Court. Residents shared their appreciation for the mural and that it had transformed Grays Court into somewhere you want to spend time and be proud of.

Well Doncaster worked with Denaby's Craganour TARA, Doncaster Council's Communities Team and Ward Members to respond to the needs of the community and installed outdoor gym equipment in Flower Park. The equipment was launched with fitness sessions and is well used by the young people of Denaby.

The Crags continue to be a priority for the community and a 10 year Site Management Plan has been developed which included plans for planting, clearing, increasing footfall and creating a feeling of safety. A number of community events have been held on the crags and businesses have been onsite volunteering their time to painting and clearing entrances to create a more inviting atmosphere.

GET DENABY ENTERPRISING

In August 2017 Well Doncaster commissioned local social enterprise Aspiring2 to deliver 'Get Denaby Enterprising', an approach which offers tailored, one to one business start-up and enterprise support. To help people start thinking about enterprise Aspiring2 initiated the £10 Challenge where residents received £10 to raise as much money as they could for a good cause of their choice. 34 participants raised a total profit of £1385.64 through handmade crafts, baking and holding community events for 15 good causes, leading to a 407% return of investment.

Building on this momentum Aspiring2 rolled out a series of workshops supporting budding entrepreneurs to develop their business ideas, access support around marketing, HMRC and bookkeeping leading to a business plan and an opportunity to apply for a Well Doncaster funded Start-up Micro Grant. The grants are for up to £500 to remove the barrier of start-up costs and applications are reviewed by a panel of local business owners. In the first 8 months 45 people have engaged with this approach, 13 have completed the series of workshops, 9 successful start-up grants and 10 new businesses are registered and trading.

An important part of 'Get Denaby Enterprising' has been the establishment of Denaby Business Club which has gone from strength to strength as new and established business owners meet once a month to support each and network.

Aspiring2 have also been working with local secondary School De Warrene Academy to cultivate an entrepreneurial spirit and 11 pupils created their own events company and will deliver a community event for local residents celebrating the Royal Wedding.

Get Denaby Enterprising will be extended for another year and will become Get Doncaster Enterprising as it widens its focus to the other areas of Well Doncaster.

COMMUNITY MICRO GRANTS

August 2017 saw the first anniversary of Denaby Micro Grant. The grant offers local community groups to apply for up to £500 to support initiatives, projects and events. The Micro Grants applications are reviewed monthly by a panel of local residents. The grant is due to end in the June 2018 and to date there have been 30 successful applications ranging from gardening supplies to create community hanging baskets, sports equipment for local football and cricket clubs and art supplies. To celebrate all that the community have been achieving through the Micro Grant, Well Doncaster hosted a celebration event in August 2017 and invited all the successful Micro Grant applicants to showcase and promote their work to the wider community.

COMMUNITY SPACE

A key part of 2016/17 activity was establishing Denaby Community Library and Hub as a key asset for the community. The space has gone from strength to strength with the library open four days a week and being supported by 6 volunteers, steps are now being made to create a service level agreement with local social enterprise ReRead to manage the library completely. Library staff and volunteers run activities for children and young people throughout the year and local community groups use the space to meet with b:Friend using the space every Thursday morning for older residents to come together with befrienders, Wednesday Denaby Bumping Space meet offering peer support to all ages and Citizens Advice Bureau deliver generalist advice one day a week. The community have come to see the Community Library and Hub as much more than just a library.

DENABY READS

In May 2017 Denaby Reads began to work with the community using innovative approaches to engage residents in developing a love of reading and improve literacy skills. The team have embedded themselves in the community and have linked with local primary schools to initiate reading and homework clubs at the library and provide opportunities for families to read and learn together. The approach is flexible to the needs of the community and seeks to develop reading skills by trying different techniques and removing barriers to learning.

NORTH CLIFF ALLOTMENTS

2017 saw the establishment of Friends of North Cliff Allotments and the group successfully applied for funding to develop the plots and hold events to engage with the community. A Healthwatch Micro Grant was used to support the opening launch event and purchase a Pizza oven, Seed Funding was used to purchase more equipment and Tesco Bags for Life funding funded the incredibly successful Winter Wonderland event in December 2017.

Winter Wonderland saw the community allotments transformed by dozens of Christmas trees, elves and Santa's workshops, Santa's grotto and 3 live reindeer. The event was a huge success with nearly 500 people attending and 360 of whom were children from local schools and nursery's. It was a an excellent example of what can be achieved through partnership working as the Friend of North Cliff, Denaby Family Hub, Well Doncaster, Doncaster Council and community members worked together.

The site continues to develop through ground works and clear ups. Community volunteers have also finished building a chicken shed ready for a family of chickens to live on site. Two local schools visit the site as part of their curriculum and produce grown on site has been donated to community groups where it is cooked and provides hot meal to residents. Future plans are to have a small orchard on the site with fruit trees donated by Landscape Partnership and planted with the support of volunteers.

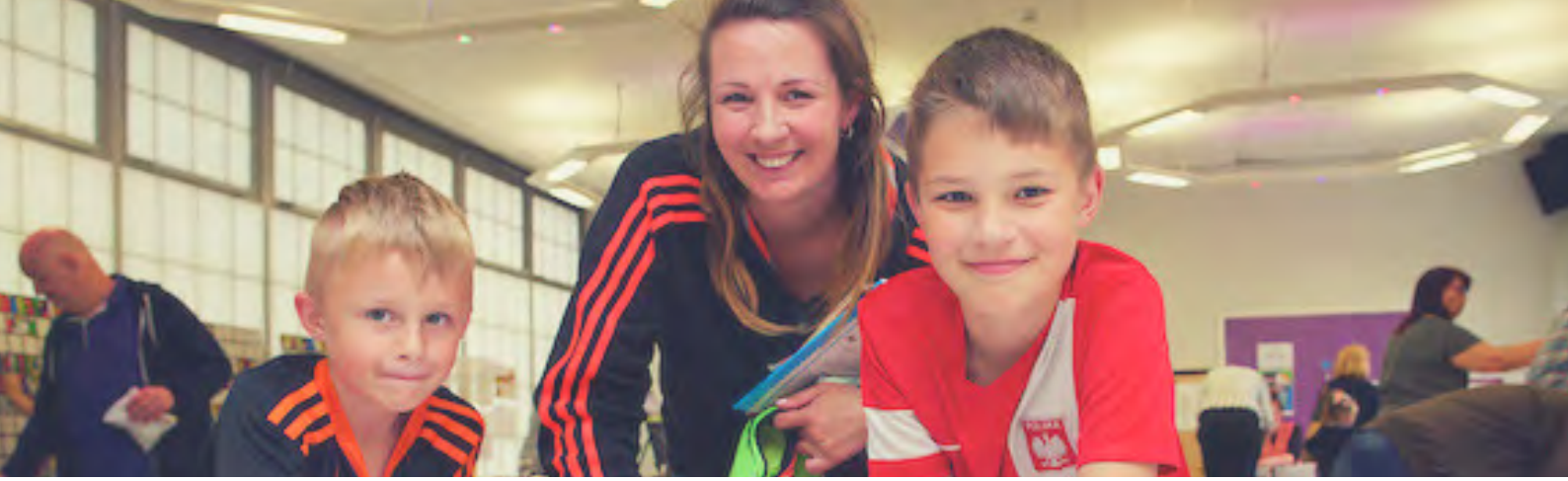
CONCLUSION

Many of the priorities raised in the community conversations over the years have been met and there has been significant progress against the plans developed by community partners. The themes from the conversations are still relevant and have been expanded through more recent conversations. These themes will broadly define the work of Well Doncaster in Denaby for the next 12 months.

Community involvement continues to be a key strength of the project as Well Doncaster continues to accumulate community insight to drive the work in Denaby. The Micro Grant has provided an opportunity for community groups to spring up and develop as local people are stepping forward to lead the change they want to see, and there is real potential to further identify and develop leadership in the community. 2017/18, has seen an increased focus on work and enterprise, to support people into employment and self- employment and fundamental skills such as literacy as literacy underpins social mobility, civic participation, parenting and employability.

A secondment from the Starting Well Service has been key in strengthening links between Well Doncaster, the community and local services. This has provided a permanent, proactive and responsive presence in Denaby which has aided the development of relationships of trust through the community.

Well Doncaster continues to act as a 'lightning rod' for action and to help coordinate services so that support is there for people when they need it. This will continue in 18/19 and have a wider focus in the new areas of the borough the programme is beginning to work with. Well Doncaster will continue to contribute to wider programmes and services in the Borough, drawing partners together to create holistic, preventative ways of working and develop a thriving third sector which can respond to the needs to the community.



RECOMMENDATIONS

Recommendation	Detail
Strengthen co-production and co-design with the local community	The community conversations have given a deep insight into Denaby and aided the design of the community offer. A sense check undertaken would help to understand any gaps and aid the development of a 3-year forward plan. This will • Capture a community perception of impact • Reflect on progress and achievements across the themes • Provide an opportunity for the community to shape the plans within the themes
Co-produce an operational plan incorporating the 5 geographical areas.	Working with people to develop an operation plan for the 5 Well Doncaster areas. We will work together to ensure community health priorities are identified and addressed.
Create a strategic plan to maximise impact on 1,001 days and the links with schools	The greatest way to narrow health inequalities is to ensure that all children have the best start in life. In Denaby Main, good relationships are in place with the Hub Children Centre and the local Primary Schools. A local plan for the 5 Well Doncaster communities will map out the vision, activities, gaps and outcomes to make the most of these important assets.
Strengthen the culture of enterprise in the 5 Well Doncaster Communities and draw on expertise and assets in the business sector	Raising levels of employment will be the key to a sustainable, long-term change (raising aspirations, generating household income and drawing more disposable income to the area). Services will need extending to offer employment and self-employment and links will need strengthening with local and larger businesses across the Borough.
Raise the profile of Well Doncaster.	Well Doncaster is an extremely successful example of Community Asset Based Development and needs to be communicated across partners, stakeholders and dissemination into the public domain. • Write a dissemination plan • Write up Appreciative Inquiry for publication
Collaborate with other projects in Doncaster that share the ethos and principles of Well North	Well Doncaster is one of a number of examples using a community and asset-based approach to achieve health, social and/or economic improvements in Doncaster. There are opportunities to collaborate with these other projects and add mutual value.
Align with other Doncaster Council programmes	Well Doncaster is one of a number of locality/place-based approaches in Doncaster; continue to work closely with Team Doncaster and to ensure alignment with Communities, Community Led Support and Commissioning.

THE WELL DONCASTER TEAM

Dr Rupert Suckling
Director of Public Health, Doncaster Council

Vanessa Powell-Hoyland
Well Doncaster Project Manager, Doncaster Council

Karen Seaman,
Well Doncaster Development Manager, Doncaster Council

Emma Nicholas
Public Health Improvement Officer, Well Doncaster, Doncaster Council

Well Doncaster

South Yorkshire and Bassetlaw Shadow Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

8 June 2018

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Decision Summary

Minute reference	Item	Action
44/18	**CEO ACS Report** After discussion it was agreed that a financial briefing paper for AOs and CEOs should be prepared by 15th June 2018.	**JC**
45/18	**Overview of Health and Wellbeing in South Yorkshire and Bassetlaw** After discussion the Chair highlighted that the ICS needs an understanding of the issues involved at each 'place' in the system and we need to gain agreement on the issues we will address as a system. The Chair informed members that a population health timeout will be arranged for members to debate this matter and identify the priorities we will progress so we are able to get some movement by September 2018.	**WCG**
46/18	**AHP launch of the strategy and council for AHPs in South Yorkshire and Bassetlaw** The Chair thanked Suzanne Bolam for her `attendance and her presenting at this meeting. The Chair confirmed the presentation would be circulated to members after the Collaborative Partnership Board meeting.	**JA**
47/18	**ICS Capital Bids update** Chris Edwards thanked the teams involved for their work in collating the bids. He added that the bids will be categorised and prioritised for discussion at the Executive Steering Group meeting on 19th June 2018.	**AP/CE**
48/18	**Hospital Services Review** Members agreed that a high level briefing paper for Governing Bodies and Boards should be drafted and circulated on Monday, 11th June 2018. The briefing paper should identify key items that the HSR is asking Governing Bodies and FT boards to progress. Governing Bodies and Boards should forward their support of the HSR and any comments they may have that detail how we respond to the HSR as an ICS and how we progress work from September 2018. Comments should be forwarded to Lisa Kell. The pathway scheme hub and scope should be referenced that it is the NHSI model and this should be identified in the documentation.	**AN** **All** **AN**

	The Collaborative Partnership Board: • Noted the background, process, next steps and timeline set out within the paper and the receiving of the report at this meeting. • Chief Executives and Accountable Officers agreed to confirm with Alexandra Norrish if they wish the Independent HSR Director, Professor Chris Welsh to attend their respective Boards /Governing Bodies after the 8th June 2018.	**CEs/AOs**
51/18	**Finance Update and System Control Totals – summary** • Note that all 12 partner organisations signed up in principle to the recommendations by 31 May which was notified to NHSE/I. Formal approval needs to be undertaken in June through Trust Boards, Governing Bodies and the SYB ICS governance processes.	**JC**
53/18	**South Yorkshire and Bassetlaw Local Maternity System (LMS): summary of 18/19 deliverables and transformation funding** Proposals for discussion will be brought to the next Executive Steering Group meeting on 19th June 2018.	**CE**
55/18	**Date and Time of Next Meeting** Will Cleary-Gray asked members if they are unable to attend would they please send a deputy to the meeting. The August meeting will be the last meeting before new meeting arrangements are put in place.	**ALL**

South Yorkshire and Bassetlaw Shadow Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

8 June 2018

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash **CHAIR**	South Yorkshire and Bassetlaw Shadow ICS	ACS Lead/Chair, Sheffield Teaching Hospitals NHS FT, CEO	✓		
Adrian Berry	South West Yorkshire Partnership NHS FT	Deputy Chief Executive		✓	
Adrian England	Healthwatch Barnsley	Chair		✓	
Ainsley Macdonnell	Nottinghamshire County Council	Service Director	✓		Anthony May CEO
Alexandra Norrish	South Yorkshire and Bassetlaw ICS	Programme Director - Hospital Services Review	✓(pt)		
Alison Knowles	Locality Director North of England,	NHS England	✓		
Alan Davis	South West Yorkshire Partnership NHS FT	Director of Human Resources		✓	Adrian Berry
Andrew Hilton	Sheffield GP Federation	GP		✓	
Andrew Pepper	South Yorkshire and Bassetlaw ICS	Strategic Finance Lead	✓(pt)		
Ann Gibbs	Sheffield Teaching Hospitals NHS FT	Director of Strategy		✓	
Anthony May	Nottinghamshire County Council	Chief Executive		✓	
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher	✓		
Brian Hughes	NHS Sheffield Clinical Commissioning Group	Director of Commissioning	✓		Maddy Ruff/Tim Moorhead
Catherine Burn	Voluntary Action Representative	Director	✓		
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer	✓		
Chris Holt	The Rotherham NHS FT	Deputy Chief Executive & Director of Strategy and Transformation	✓		Louise Barnett
Clare Hodgson	EMAS	Assistant Director of Strategy Development & Commercial Services	✓		
Clare Morgan	Sheffield Teaching Hospitals NHS Foundation Trust	Programme Director (Chief Executives Office)		✓	
Clive Clarke	Sheffield Health and Social Care NHS FT	Deputy CEO			Kevan Taylor

David Purdue	Doncaster & Bassetlaw Teaching Hospitals NHS FT	Deputy Chief Executive/COO		✓	Richard Parker
Des Breen	SYB ICS	Medical Director	✓		
Diana Terris	Barnsley Metropolitan Borough Council	Chief Executive		✓	
Greg Fell	Sheffield City Council	Director of Public Health	✓		John Mothersole
Frances Cunning	Yorkshire & the Humber PHE Centre	Deputy Director – Health & Wellbeing	✓		
Helen Stevens	South Yorkshire and Bassetlaw Shadow ICS	Associate Director of Communications & Engagement		✓	
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer	✓		
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer	✓		
James Scott	South Yorkshire and Bassetlaw Shadow ICS	Senior Programme Manager	✓		
Jane Anthony	South Yorkshire and Bassetlaw Shadow ICS	Corporate Committee Administrator, Executive PA & Business Manager	✓		
Janet Wheatley	Voluntary Action Rotherham	Chief Executive		✓	
Jeremy Budd	NHS Barnsley CCG	Director of Accountable Care	✓		Lesley Smith
Jeremy Cook	South Yorkshire and Bassetlaw Shadow ICS	Interim Director of Finance	✓		
John Mothersole	Sheffield City Council	Chief Executive		✓	
John Somers	Sheffield Children's Hospital NHS Foundation Trust	Chief Executive	✓		
Jo Miller	Doncaster Metropolitan Borough Council	Chief Executive		✓	
Julia Burrows	Barnsley Council	Director of Public Health	✓		
Karen Taylor	South West Yorkshire Partnership NHS FT	Director of Delivery	✓		Alan Davis
Kathryn Singh	Rotherham, Doncaster and South Humber NHS FT	Chief Executive	✓		
Kevan Taylor	Sheffield Health and Social Care NHS FT	Chief Executive		✓	
Lesley Smith	NHS Barnsley Clinical Commissioning Group	SYB ACS System Reform Lead, Chief Officer, NHS Barnsley CCG		✓	
Lisa Kell	South Yorkshire and Bassetlaw ICS	Director of Commissioning Reform	✓		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive		✓	
Maddy Ruff	NHS Sheffield Clinical Commissioning Group	Accountable Officer		✓	
Matthew Groom	NHS England Specialised Commissioning	Assistant Director		✓	
Matthew Sandford	Yorkshire Ambulance Service NHS Trust	Associate Director of Planning & Development		✓	Rod Barnes

Mike Curtis	Health Education England	Local Director		✓	
Moira Dumma	NHS England	Director of Commissioning Operations		✓	
Neil Taylor	Bassetlaw District Council	Chief Executive		✓	
Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		✓	
Paul Smeeton	Nottinghamshire Healthcare NHS Foundation Trust	Executive Director	✓		
Richard Henderson	East Midlands Ambulance Service NHS Trust	Chief Executive		✓	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	✓		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS FT	Chief Executive	✓		
Richard Stubbs	The Yorkshire and Humber Academic Health Science Network	Chief Executive	✓		
Rob Webster	South West Yorkshire Partnership NHS FT	Chief Executive		✓	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive	✓		
Roger Watson	East Midlands Ambulance Service NHS Trust	Consultant Paramedic Operations		✓	Richard Henderson
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health		✓	Jo Miller
Ruth Hawkins	Nottinghamshire Healthcare NHS FT	Chief Executive		✓	
Sandra Crawford	Nottinghamshire Healthcare NHS FT	Associate Director of Transformation Local Partnerships Division		✓	Paul Smeeton
Sarah Halstead	NHS England Specialised Commissioning	Senior Service Specialist and RightCare Associate	✓		Matthew Groom
Sarah Turner-Saint	Chesterfield Royal Hospital NHS FT	Head of Communications	✓		Simon Morritt
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive		✓	
Simon Morritt	Chesterfield Royal Hospital NHS FT	Chief Executive		✓	
Steve Shore	Healthwatch Doncaster	Chair		✓	
Susan Bolam	Doncaster & Bassetlaw Teaching Hospitals NHS FT	Head of Therapies	✓(pt)		
Teresa Roche	Rotherham Metropolitan Borough Council	Director of Public Health	✓		
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		✓	
Will Cleary-Gray	South Yorkshire and Bassetlaw Shadow ICS	Sustainability & Transformation Director	✓		

Minute reference	Item	Action
40/18	**Welcome and introductions** The Chair welcomed members to the meeting. The Chair also greeted Professor Ted Baker, Chief Inspector of Hospitals, Dr Malte Gerhold, Executive Director of Strategy and Janet Ortega, Head of Integrated Care from the Care Quality Commission. Dr Malte Gerhold informed members that he and his Care Quality Commission colleagues were at the meeting to observe as partners and not in their role as inspectors.	
41/18	**Apologies for absence** The Chair noted the apologies for absence.	
42/18	**Minutes of the previous meeting held 13th April 2018** The minutes of the previous meeting were agreed as a true record and will be posted on the website after this meeting. **www.healthandcaretogethersyb.co.uk**	
43/18	**Matters arising** **Communication and Engagement:** **Draft Communication Plan for ICS Launch** The Chair sought agreement from members for the ICS launch to take place in September 2018, this was due to the delay regarding the financial framework, clarification of ICS regulations from NHSE/I and what transitional arrangements will be in place for level 2 and level 3 systems by September 2018. Members were in agreement. All other matters arising are on this agenda.	
44/18	The Chair invited the Care Quality Commission (CQC) to introduce themselves to members and regarding their presence at this meeting. Dr Malte Gerhold said that the CQC team is here to listen and learn. As a regulator the CQC is committed to change and transformation and the achievement of this is enshrined in the CQC's strategy. The CQC is being proactive on how change and transformation is achieved e.g. in the Framework for Health there is great emphasis on collaborative working and sharing insight on the quality of care, access, being familiar with geographical areas and the organisations involved therein. The CQC is also reviewing health and social care systems in 20 local areas to find out how services are working together to care for people aged 65 and older. Dr Malte Gerhold added that the CQC would like to engage with the SYB ICSs leadership in a two way approach: • To have one point of contact for the CQC and vice-versa, • Share issues regarding good and bad quality, understanding concerns regarding quality and priorities. There will be an element of listening and learning and the relationship between the two organisations will evolve over time. Dr Malte Gerhold suggested the possibility of working with SYB ICS on 2 or 3	

	of its priorities that are challenging across the area. Professor Ted Baker commented that the CQC has publically voiced their support of collaboration and integration as the key to delivering quality care. The CQC supports the SYB ICS agenda and wants to be helpful and not put barriers in the way but must also maintain their regulatory duty. Professor Baker added it was helpful to be here at this meeting listening and learning. The Chair gave a presentation which updated the CQC visitors of the current position of SYB ICS which included information pertaining to budget, population, staff/partners and organisations across the system, SYB ICS architecture and relationships, SYB ICS development timeline, developing an integrated care system, North STP comparison, SYB ICS priorities and the SYB ICS next steps. The Chair requested a representative from each 'place' to provide a brief verbal update regarding their Accountable Care Partnership (ACP) progress: <u>Sheffield – Brian Hughes</u> The ACP board is strong and consists of 6 partners; the board is looking to include a voluntary sector representative. The ACP received a whole system CQC report yesterday which identified a number of challenges but has further strengthened the ACP strong partnership ties. There is an acknowledgment that the ACP has a strong presence at place and in the SYB ICS system. <u>Bassetlaw – Catherine Burn and Idris Griffiths</u> The ACP board is a strong partnership and its chair is Catherine Burn Director lead for the Bassetlaw community and voluntary sector (BCVS).The board is supported by a Memorandum of Understanding and has a programme director in post. Members have developed good relationships and they are very engaged with the ACP. The board is working with partners to address the wider determinants of health i.e. substance misuse and drug distribution in the community, employment of Bassetlaw's 100 most challenging unemployed, housing and local community developments, schools and colleges to set up a children's summit, obesity, mental health and youth aspiration. <u>Rotherham – Chris Edwards</u> The ACP system board has been meeting for one year and started meeting in public in April 2018. The ACP board has one full member representing the voluntary sector. The Board has prepared a Memorandum of Understanding and members have agreed in principle how they will work together. The Memorandum of Understanding is a morally binding document and not legally binding. The first Rotherham Place Plan was agreed 18 months ago and a redraft of the Plan is expected at the ACP board for approval in July 2018. <u>Doncaster – Jackie Pederson</u> In Doncaster there is a real identification and sign up to the health and social care Place Plan in the wider context of living, working, learning and caring in Doncaster. The ACP has a legal agreement in place regarding joint commissioning with the Local Authority. The ACP has 7 priority areas which partners are focussing on which require assessment before they are rolled out. Traction is being achieved in intermediate care and this can be evidenced by the reduction of hospital admissions and quicker discharge. The ACP is currently looking at consolidating estates, communications and back office functions across health and care. <u>Barnsley – Richard Jenkins</u> The ACP board is in its third year and has made good progress through close working with partners across Barnsley. Barnsley has some of the most deprived areas in the South Yorkshire and Bassetlaw area and to provide the best outcomes for local people the ACP relationship is evolving further around integrated working. Providers are working closely together on: cardiovascular, frailty and neighbourhoods and are piloting ways of working in the most deprived areas e.g. focussing on a test bed regarding the pathway of individual	

	cases The Chair added that it could be useful for the CQC to assist and help Barnsley regarding this testbed initiative as this is the direction that SYB ICS would like to move towards. However, Professor Ted Baker noted that the ACP is not a legal entity and the CQC have to regulate through legal entities. The CQC want to support collaboration at all levels but the nuance of how they do this at all levels will require exploration to ensure that it fits within its regulatory powers and the established legal frameworks. It was suggested that the CQC could be involved in the development of the clinical networks (based upon on the hospitals review). The Chair thanked members for their updates. **National Update** **CEO ACS Report** The Chair gave his Chief Executive Officers report to the meeting. This monthly report provides members with an update on: • The work on the Shadow ICS CEO over the last month. • A number of key priorities not covered elsewhere on the agenda. The report gave a concise update to members regarding the: • ICS assurance • National ICS leads meeting – June 2018 • Capital Bids • ICS Management Structure • Future of Commissioning SYB Workshops • NHS England and NHS Improvement • Four new systems announced as ICSs • Non-Executive Directors and Lay Members event • Hospital Services Review update • Pathology Services • Hyper Acute Services The Chair invited Alison Knowles to update members regarding ICS assurance. Alison Knowles said that in April 2018 she had represented SYB ICS at a meeting with Richard Barker, Regional Director (North), NHSE and Lyn Simpson Executive Regional Managing Director (North), NHSI. The meeting went well and was instrumental in SYB sICS achieving level 2 assurance from NHSE/I. The Chair added: • transformation funding as a level 2 ICS is only marginally more than as a shadow form, • £5.7m of PSF is linked to system financial performance After discussion it was agreed that a briefing paper for AOs and CEOs should be prepared by 15th June 2018. This will enable a consistent message to be given across all organisations. The briefing paper will help AOs and CEOs inform their boards and governing bodies with the detailed information they require in order to obtain their agreement to supporting being part of a level 2 ICS. Members were in agreement that the paper should contain: • The key FAQs to enable AOs and CEOs to inform their board members with the level of detail they require. • How the ICS will utilise transformational funding. • What will be the key items that the System Efficiency Board will be	**JC**

	progressing for 20218/19. • Risk profile for organisations. • A view on the system improvement plan from NHSE/I. The Collaborative Partnership Board noted the update. **ICS System Design** The Collaborative Partnership Board noted this document from NHSE/I that outlined the STP "must dos" and ICS "should dos" relating to their key activities and functions for their next phase of work and requesting input at a variety of upcoming events about the emerging content and early thoughts for communicating the message. **SYB integrated care system progress and next steps** The Collaborative Partnership Board noted this report from Matthew Swindells, National Director, Operations and Information, NHS England and Ben Dyson, Executive Director of Strategy, NHS Improvement regarding the next steps on the development of Integrated Care Systems.	
45/18	**Overview of Health and Wellbeing in South Yorkshire and Bassetlaw** The Chair welcomed Greg Fell, Director of Public Health Sheffield City Council and invited him to give his presentation entitled 'Strategic Needs Assessment' to the meeting. After his presentation Greg Fell asked members to reflect on the top 10 things he outlined in his presentation namely: 1. Objective should be **to bend the multi morbidity curve** - prevent, avoid, delay 2. **Prevention** - primary, secondary, tertiary. Not "something the DPH does". NHS70 plan should focus on prevention 3. **Proportionate universal offer**. All services. 4. **System response to multi morbidity**. Generalist / specialist. **Person centred approach** 5. **Push hard on health** in all policies 6. **Children**, best start, upstream. **Adverse Childhood Experiences** 7. Link **medical to social** - housing, debt advice, skills and employment. 8. For hospital care - **why not home, why not now** 9. **Community services in different venues** - pharmacies, community centres, libraries 10. **Focus on incident events, burden of illness** – not managing conditions A question was raised regarding which intervention had the earliest impact in terms of improvement measured by time. Greg Fell responded saying that stopping smoking cigarettes could give an improvement to population health over the next 5 to 25 years, by managing the clinical risk in relation to blood pressure could show a tangible improvement over 18 months to 5 years. After discussion the Chair highlighted that the ICS needs an understanding of the issues involved at each 'place' in the system and we need to gain agreement on the issues we will address as a system. The Chair informed members that a population health timeout will be arranged for members to debate this matter and identify the priorities we will progress so we are able to get some movement by September 2018. The Collaborative Partnership Board noted they key messages from the JNSA and considered the extent to which these can help shape strategic direction. The Chair thanked Greg Fell for his presentation and information he has shared with members.	**WCG**
46/18	**AHP launch of the strategy and council for AHPs in South Yorkshire and**	

	Bassetlaw The Chair welcomed Suzanne Bolam, Head of Therapies, Doncaster & Bassetlaw Teaching Hospitals and invited her to give her presentation to this meeting. Alison Knowles said that it was important to have a representative from NHSE Primary and Social Care on the Council. Suzanne Bolam would ensure there is representation from NHSE Primary and Social Care. Rob Barnes noted that representation from paramedics linked into this network and would liaise with Suzanne Bolam directly regarding this aspect. The Collaborative Partnership Board endorse: The AHP Strategy The formulation of an AHP Council Each 'place' partner to nominate their representative to sit on the AHP Council. The Collaborative Partnership Board recognised that the nursing and midwifery profession could benefit from a similar strategy and they were informed that this has been recognised by the LWAB and the workforce workstream. The Chair thanked Suzanne Bolam for her `attendance and her presenting at this meeting. The Chair confirmed the presentation would be circulated to members after the Collaborative Partnership Board meeting.	**JA**
47/18	**ICS Capital Bids update** The Chair welcomed Andrew Pepper to the meeting and invited him to give his presentation to this meeting. Andrew Pepper summarised the process that the capital bids will undertake: 1. All bids must be ranked by the ICS 2. Demonstrating value for money (vfm) is key 3. Large bids usefully phased into discrete schemes and/or be supported by alternative source of funding 4. Priority recommendations being formed for Executive Steering Group on 19 June 5. Further regulator engagement session (end of June) 6. Submission 16 July 7. Lots of work still to do – including refining vfm, consolidating bid writing, finalising estate strategy and ensuring templates completed Chris Edwards thanked the teams involved for their work in collating the bids. He added that the bids will be categorised and prioritised for discussion at the Executive Steering Group meeting on 19th June 2018. He agreed to share information on the individual bids received if the individual bidders agree in principle. The Chair thanked Andrew Pepper and Chris Edwards for their presentation and attendance at this meeting.	AP/CE
48/18	**Hospital Services Review** Members agreed that a high level briefing paper for Governing Bodies and Boards should be drafted and circulated on Monday, 11th June 2018. The briefing paper should identify key items that the HSR is asking Governing Bodies and FT Boards to progress. Governing Bodies and Boards should forward their support of the HSR and any comments they may have that detail how we respond to the HSR as an ICS and how we progress work from September 2018. Comments should be forwarded to Lisa Kell.	AN All

	The pathway scheme hub and scope should be referenced that it is the NHSI model and this should be identified in the documentation. The Collaborative Partnership Board: • Noted the background, process, next steps and timeline set out within the paper and the receiving of the report at this meeting. • Chief Executives and Accountable Officers agreed to confirm with Alexandra Norrish if they wish the Independent HSR Director, Professor Chris Welsh to attend their respective Boards /Governing Bodies after the 8th June 2018.	AN CEs/AOs
49/18	**STP Refresh** The Collaborative Board Partnership Board received the Draft Refresh SYB ICS STP Plan from Lisa Kell, Director of Commissioning, SYB ICS. Lisa Kell asked members to forward any comments they have regarding the draft directly on to her. The Collaborative Partnership Board: • Considered the ICS refresh plan document which has been circulated as a first draft and noted that further work is required. • Noted the draft was being shared to obtain initial high level views regarding the overall framing, context and content and whether there are any key themes missing/gaps or issues. • Noted the timeframe for expected completion of the plan of end of September 2018. The Chair thanked Lisa Kell for her report.	
50/18	**ICS Operational Plan** Alison Knowles was invited to comment regarding the SYB ICS Operational Delivery Plan (ODP). Alison Knowles said that the ODP will be on the agenda for discussion at the Executive Steering Group on 19th June 2018. The ODP sets out the key deliverables, risks, issues and mitigating actions in order to deliver a balanced system from a finance, performance, and transformation and delivery perspective. The information contained in the plan is at a point in time and as such the financial performance has moved on. The ODP allows the assurers to understand the level of risk for SYB ICS. The ODP will be used as part of the quarterly assurance for the ICS going forward. The Collaborative Partnership Board noted the Operational Plan for 2018/19. The Chair thanked Alison Knowles for her report.	
51/18	**Finance Update and System Control Totals – summary** The Collaborative Board Partnership Board received this report from Jeremy Cook, Interim Finance Director, SYB ICS. The Collaborative Partnership Board noted the following recommendations to be considered by the provider Trust Boards and CCG Governing Bodies during June 2018: a. Note that significant progress has been made securing recognition of material issues associated with the new Financial Framework for ICSs in particular Rotherham FT control total and the need to reduce the impact of risk in the way that the Provider Sustainability Fund (PSF) is weighted; b. Note the assurance given by NHS Improvement and NHS England for South Yorkshire to be designated as a 'go live' ICS;	

	c. Confirm that the benefits of remaining an ICS are greater than the level of risk imported on the revised options and that parties agree to enter into a system control total; d. Note that a "system improvement plan" will need to be developed in return for the adjustment to the system plan figure in respect of the Rotherham FT control total; e. Confirm that the preferred option is Option 3 (50% partial PSF). Under this option the level of opportunity from transformation funding (£7.0m) is greater than the PSF at risk (£5.7m). f. Note that all 12 partner organisations signed up in principle to the recommendations by 31 May which was notified to NHSE/I. Formal approval needs to be undertaken in June through Trust Boards, Governing Bodies and the SYB ICS governance processes. The Chair thanked Jeremy Cook for his report.	JC
52/18	**ICS Highlight report** Will Cleary-Gray, Director of Sustainability and Transformation introduced the Workstream Highlight Report to the meeting. The Chair added that this report will be at the top of the next agenda at the next CPB meeting. The Collaborative Partnership Board noted the highlight report.	
53/18	**South Yorkshire and Bassetlaw Local Maternity System (LMS): summary of 18/19 deliverables and transformation funding** The Chair invited Chris Edwards to update members. Chris Edwards was pleased to inform members that South Yorkshire and Bassetlaw Local Maternity System has been granted £762k funding from the Maternity Transformation Programme and it is up to the ICS Leadership Team to decide how the overall package is allocated. He added that proposals for discussion will be brought to the next Executive Steering Group meeting on 19th June 2018.	**CE**
54/18	**To consider any other business** There was no other business brought before this meeting.	
55/18	**Date and Time of Next Meeting** The next meeting will take place at 9.30am to 11.30am on 10th August 2018 in the Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU. Will Cleary-Gray asked members if they are unable to attend would they please send a deputy to the meeting. The August meeting will be the last meeting before new meeting arrangements are put in place. The Chair thanked the CQC team for their attendance at this meeting.	**ALL**

APPENDIX A

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2018/19

Date	**Board Core Business**		**Partner Organisation and Partnership Issues**	**HWBB Steering Group Work plan**
	Meeting/Workshop	**Venue**		

4th October 2018	**Workshop**
	Mental Health Improvement plan and Mental Health Concordat
		Venue tbc	• Plans and reports from
			  ○ CCG
			  ○ NHSE
			  ○ DMBC
			  ○ Health watch
			  ○ RDaSH
			  ○ DBH
			• Safeguarding reports
			• Better Care Fund
			• DPH annual report
			• Role in partnership stocktake
			• Wider stakeholder engagement and event
			• Relationship with Team Doncaster and other Theme Boards
			• Relationship with other key local partnerships
			• Health Improvement Framework
			• Health Protection Assurance Framework
			• Wellbeing and Recovery strategy
			• Adults and Social care Prevention Strategy
			• Housing
			• Environment
			• Regeneration
				• Areas of focus – schedule of reports and workshop plans
				• Integration of health and social care (BCF)) workshop plan
				• Other subgroups – schedule of reports
				• Communications strategy
				• Liaison with key local partnerships
				• Liaison with other Health and Wellbeing Boards (regional officers group)
				• Learning from Knowledge Hub

APPENDIX A

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2018/19

15th November 2018	**Board Meeting** • Outcomes framework update tbc • Health and social care /BCF update • Safeguarding reports (adults/children) • Health Inequalities Update • Feedback from October workshop (Mental Health Improvement) • HWBB Steering group update	Civic office rooms 007a and 007b		
6th December 2018	**Workshop** Topic tbc	Venue tbc		
17th January 2019	**Board meeting** • Outcomes framework update • Health and social care /BCF update • HWBB Steering group update • Motor Neurone Disease Charter Update tbc	St Catherine's House, Balby tbc		

Forward Items: Missed Appointments update: June 2019/Motor neurone disease charter update tbc

APPENDIX A

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2018/19

2018/19 Health and Wellbeing Board: future meetings

15th November 2018 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

17th January 2019 (Venue: St Catherines House, Balby, Doncaster)

14th March 2019 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

Health and Wellbeing Workshop Dates – Topics/ venues to be confirmed

4th October 2018 9-12 noon Mental Health Improvement plan and Concordat

6th December 2018 9-12 Topic tbc

This page is intentionally left blank