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City of 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 Council Chamber, Civic Office, Waterdale, Doncaster DN1 3BU

Date: Thursday, 31st August, 2023

Time: 9.00 a.m.

BROADCASTING NOTICE

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Items for consideration		**Time/ Lead**
1.	Welcome, introductions and apologies for absence.	2 mins (Chair)
2.	Chair's Announcements.	5 mins (Chair)

Damian Allen
Chief Executive

Issued on: Tuesday 22nd August 2023

Governance Services Officer for this Meeting Jonathan Goodrum
Tel. 01302 736709
jonathan.goodrum@doncaster.gov.uk

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)
6.	Minutes of the Meeting of the Health and Wellbeing Board held on 8th June 2023. *(Attached – pages 1 – 8)*	2 mins (Chair)
7.	The Lived British Sign Language User - Doncaster & District Deaf Society Borough-wide - Update on Progress. *(Verbal update/Cover Sheet attached – pages 9 – 10)*	25 mins (Pauline Dunn)
8.	Update on Children & Young People's Mental Health and Wellbeing Strategy. *(Presentation/Papers attached – pages 11 – 22)*	25 mins (Martyn Owen/ Emma Price)
9.	Family Hubs and Start for Life Programme. *(Presentation/Cover sheet attached – pages 23 – 24)*	25 mins (Callum Helman)
10.	Fairness and Wellbeing Commission - Mid way Update. *(Presentation/Papers attached – pages 25 – 40)*	10 mins (Jon Gleek)
11.	A joined-up approach to developing our plans for health and wellbeing in Doncaster. *(Papers attached – pages 41 – 46)*	10 mins (Allan Wiltshire)
12.	Team Doncaster Dementia Strategy. *(Presentation/Papers attached – pages 47 – 84)*	30 mins (Mark Wakefield/ Joanne Forrestall/ Wendy Sharps/ Phil Brugh
13.	Alcohol Use in Over 50s Women - Emerging Trends in Doncaster. *(Presentation/Papers attached – pages 85 – 96)*	20 mins (Andy Collins/ Vicki Beere)
14.	Better Care Fund Plan 2023-25. *(Presentation/Papers attached – pages 97 – 132)*	10 mins (Mike McBurney)
	<u>For Information Only</u>:-	
15.	Health Protection Assurance Group Minutes of 19th July 2023. *(Papers attached – pages 133 – 142)*	

Date/time of next meeting: Thursday, 9 November 2023 9.00 a.m., Council Chamber, Civic Office, Waterdale, Doncaster DN1 3BU

Members of the Health and Wellbeing Board

Name	Job Title
Cllr Rachael Blake (Chair)	Portfolio Holder for Children's Social Care and Equalities
Anthony Fitzgerald (V-Chair)	Executive Place Director (Doncaster), NHS South Yorkshire ICB
Cllr Nigel Ball	Portfolio Holder for Public Health, Communities, Leisure and Culture
Cllr Sarah Smith	Portfolio Holder for Adult Social Care
Cllr Cynthia Ransome	Conservative Group Representative
Dr Rupert Suckling	Director of Public Health and Prevention, City of Doncaster Council
Toby Lewis	Chief Executive RDaSH
Andrew Bosmans	Healthwatch Doncaster
Karen Curran	Head of Co-Commissioning, NHS England (Yorkshire & Humber)
Richard Parker	Chief Executive of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Phil Holmes	Director of Adults, Wellbeing and Culture, City of Doncaster Council
Riana Nelson	Director of Children, Young People & Families, City of Doncaster Council
Chief Superintendent Ian Proffitt	District Commander for Doncaster, South Yorkshire Police
Ellie Gillatt	Group Manager, South Yorkshire Fire and Rescue
Dan Swaine	Director of Place, City of Doncaster Council
Dave Richmond	Chief Executive, St Leger Homes
Laura Sherburn	Chief Executive, Primary Care Doncaster
Lucy Robertshaw	Director (Arts & Health), Darts (Health and Social Care Forum Representative)
Cath Witherington	Chief Executive, Voluntary Action Doncaster
Dr Nabeel Alsindi	GP and Place Medical Director, NHS South Yorkshire ICB

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CITY OF DONCASTER COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY, 8TH JUNE, 2023

A MEETING of the HEALTH AND WELLBEING BOARD was held in the COUNCIL CHAMBER, CIVIC OFFICE, WATERDALE, DONCASTER DN1 3BU on THURSDAY, 8TH JUNE, 2023, at 9.00 a.m.

PRESENT:

Chair - Councillor Rachael Blake, Cabinet Member for Children's Social Care and Equalities

Councillor Nigel Ball, Cabinet Member for Public Health, Communities, Leisure and Culture
Councillor Sarah Smith, Cabinet Member for Adult Social Care
Councillor Cynthia Ransome, Conservative Group Representative
Dr Nabeel Alsindi, GP and Place Medical Director, NHS South Yorkshire Integrated Care Board (ICB)
Richard Parker, Chief Executive of Doncaster and Bassetlaw Teaching Hospitals (DBTH)
Phil Holmes, Director of Adults, Health and Wellbeing, City of Doncaster Council
Dave Richmond, Chief Executive of St Leger Homes of Doncaster
Andrew Bosmans, Healthwatch Doncaster
Rachael Leslie, Deputy Director of Public Health, City of Doncaster Council (substitute for Dr Rupert Suckling)
Ailsa Leighton, Director of Transformation, NHS South Yorkshire ICB (substitute for Anthony Fitzgerald)

Also in Attendance:

Mr D Wright
Mr M Dimaline
Mark Johnson, Choice for All Doncaster (ChAD) Support Group and the Learning Disability Partnership Board (LDPB)
Raymond Humphryes, Choice for All Doncaster (ChAD) Support Group and the Learning Disability Partnership Board (LDPB)
Councillor Glynis Smith
Annika Leyland-Bolton, Assistant Director Communities, Care and Support, City of Doncaster Council
Dr Victor Joseph, Public Health Consultant, City of Doncaster Council
Mike McBurney, Senior Policy, Insight and Change Manager (Strategic Commissioning), City of Doncaster Council
Louise Robson, Public Health Lead, City of Doncaster Council
Andy Brown, Senior Policy and Insight Manager, City of Doncaster Council
Sheena Clark, Policy and Insight Manager, City of Doncaster Council
Emily Adams, Policy and Insight Manager, City of Doncaster Council
Ruth Bruce, Doncaster Place Partnership
Fran Joel, Healthwatch Doncaster

Sian Owen, Healthwatch Doncaster
Hayley Waller, Policy and Insight Manager, City of Doncaster Council
Clare Henry, Public Health Principal, City of Doncaster Council

60 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and invited all attendees to make introductions.

Apologies for the meeting were received from Dr Rupert Suckling, Anthony Fitzgerald, Lucy Robertshaw, Cath Witherington, Ellie Gillatt and Toby Lewis.

Councillor Sarah Smith and Dr Nabeel Alsindi were welcomed as new Board members.

61 APPOINTMENT OF VICE CHAIR FOR 2023-24 MUNICIPAL YEAR

It was moved and seconded that Anthony Fitzgerald, Executive Place Director (Doncaster) for NHS South Yorkshire ICB, be appointed as Vice Chair of the Health and Well Being Board for the 2023/24 Municipal Year.

RESOLVED that Anthony Fitzgerald be appointed as Vice Chair of the Health and Wellbeing Board for 2023/24.

62 CHAIR'S ANNOUNCEMENTS

The Chair, Cllr Rachael Blake, thanked Cllr Andrea Robinson for her past contribution as a Board Member, having stepped down from her Cabinet position on the Council and therefore by default also ceasing to be a member of this Board.

Further to previous discussions by the Board regarding the measures being taken by partners to combat health inequalities, the Chair confirmed that health inequalities training had now been provided which had been well attended by partner organisations. A further training session was to be organised by Mandy Espey and Vanessa Powell-Hoyland for those who had been unable to attend the first event, and they would also be producing an e-learning package enabling the training to be undertaken remotely.

The Chair stated that she had recently taken up an opportunity to visit the Burns Medical Practice in Doncaster, which she had found to be incredibly insightful in terms of illustrating the current challenges and pressures being faced by surgeries and patients.

63 PUBLIC QUESTIONS

Mr Doug Wright addressed the Board and began by referring to the delivery of the five-year NHS Joint Forward Plan and associated funding challenges. He felt there was a sense of 'Groundhog Day' with plans of this nature, as this current document was just the latest in a long line of Plans produced over the last 10 years. Mr Wright stated that he had concerns over the financing behind the Plan, noting that the ICB had already been hit with a reduction in its finances from £30m to £20m. He was also concerned that there were no powers within this Board or any other forums to veto any

proposals laid down in the NHS Joint Forward Plan and there was seemingly no choice other than to note the contents.

Mr Wright also highlighted that 41% of the Doncaster population were currently living in relative poverty and he felt that this statistic was only going to worsen in the future.

He concluded by stating that he wished to thank this Board for all its work in trying to improve the outcomes for the people of Doncaster.

The Chair thanked Mr Wright for his statement and for his positive remarks about the work of this Board and then invited members of the Board to comment on the points raised.

With regard to the NHS Joint Forward Plan, Ailsa Leighton explained that while it was labelled as a South Yorkshire plan, there would be a strong focus on the priorities for Doncaster, with consultation and engagement being carried out on a local basis. This would include identifying the desired outcomes and improvements that were needed for Doncaster's population over the life of the Plan, with regular updates being brought to this Board for monitoring purposes.

Richard Parker explained that he was on the ICB as an acute trust representative and he gave an assurance that the ICB was absolutely focussed on deprivation. In relation to plans and strategies, he explained that the aim was to recognise Doncaster as a place in all the various Plans, learning from partners and making sure that our limited resources and finances were used wisely in the delivery of care. He stressed the importance of having a collective approach by all partners and not just focussing on the needs of each individual organisation. The NHS was effectively a partnership, and he felt that the five-year NHS Joint Forward Plan would provide a useful collective vision going forward.

Rachael Leslie outlined some of the actions being taken to help alleviate the impact of poverty on Doncaster's communities. She added that the Fairness and Wellbeing Commission would be looking at poverty in some detail.

Councillor Nigel Ball stated that his concern was over how we engage with communities to enable them to be co-authors of plans and strategies. He felt that if the desired aim was to have communities co-designing services and fully engaging with them, then plans needed to be much clearer and less complicated.

Dr Victor Joseph commented on the ways in which partners could address health inequalities, including helping their workforces to better understand the issues involved and changing mindsets to be more conscious of the health inequalities challenges.

The Chair then thanked everyone for their comments and confirmed that the Fairness and Wellbeing Commission's recommendations would be reported to this Board later in the year for consideration.

64 DECLARATIONS OF INTEREST, IF ANY

There were no declarations of interest made at the meeting.

65 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 9TH MARCH 2023

With regard to minute no. 53 (The Lived British Sign Language User), the Chair reminded members that the Board was due to receive a further report at its next meeting outlining the progress made in implementing the actions identified from the presentation it had received from Pauline Dunn of the Doncaster and District Deaf Society.

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 9th March, 2023, be approved as a correct record and signed by the Chair.

66 DONCASTER'S LEARNING DISABILITY PARTNERSHIP BOARD AND LIVED EXPERIENCE

The Board received a presentation by Mark Johnson and Raymond Humphryes from the Choice for All Doncaster (ChAD) support group and the Learning Disability Partnership Board (LDPB), supported by Cllr Glynis Smith and Annika Leyland-Bolton. Mark and Raymond outlined their lived experience as individuals with a learning disability and also gave further information on the work of Doncaster's LDPB.

Board members then asked Mark and Raymond questions about the work of the LDPB and on the actions that partner organisations and this Board could take to assist people with learning disabilities.

Having discussed at length a wide range of issues arising from the presentation, the Board agreed the following actions:-

- That the partner organisations represented on the Board assist in raising awareness of and publicising the LDPB to help the Board increase the proportion of service users/carers amongst its membership (information to be circulated to Board members for dissemination);
- That all partner organisations consider utilising Mark and Raymond's expertise in any workforce training events on the subject of Learning Disability and Autism.
- That partners give consideration to ways of encouraging newly qualified nurses with dual registration in learning disability and social work to work in Doncaster.
- Raise at Place Committee to discuss how to ensure that the LDPB is connected to decision making.
- With regard to commissioning and contracting and ensuring social value requirements reflect the aspirations of the LDPB – Rachael Leslie will ask to be invited to a future meeting of the Partnership to discuss.
- The Chair stated that she would like to have a conversation outside the meeting with Mark and Raymond about Due Regard Statements.
- That an update on this issue be brought back to the Board's meeting in November.

RESOLVED to note the contents of the presentation and agree that the above actions be taken forward by the relevant Board members.

67 THE ANNUAL REPORT ON ETHNIC MINORITY HEALTH IN DONCASTER

The Board received a presentation by Dr Victor Joseph which summarised the findings set out in the Annual Report on Ethnic Minority Health in Doncaster, produced by the Doncaster Minority Partnership Board, a copy of which was included in the agenda papers.

It was noted that the Annual Report of the work of the Minority Partnership Board supported actions to address health inequalities in Doncaster by addressing challenges identified through national disparity reports as well as from health needs assessment reports and recommendations.

The Report provided updates on achievements, challenges and actions being undertaken in Doncaster to improve health and reduce health inequalities among local minority groups.

During discussion, Members noted that there was a gap in terms of collecting lower-level ethnicity data and the 'big ask' of partners was to consider how the data already held could be used in a more efficient way to provide a clearer picture of the needs of minority groups in Doncaster. There was also scope for strengthening the strategic links between the Minority Partnership Board and partner organisations.

Arising from this discussion, the Chair proposed that a SMART action plan be produced and circulated to Board members as soon as available to help ensure that the issues raised were addressed.

RESOLVED to:-

1. Note the achievements and challenges still being faced in improving and protecting the health of minority groups in Doncaster;

2. Support actions to address the challenges for improving health and addressing health inequalities among minority groups in Doncaster; and

3. Request that a SMART action plan be produced and circulated to all Board members as soon as available to help ensure that the issues raised are addressed.

68 DEVELOPING OUR FIVE-YEAR NHS JOINT FORWARD PLAN FOR SOUTH YORKSHIRE

The Board received a presentation by Ailsa Leighton which outlined how the Five-Year NHS Joint Forward Plan (JFP) for South Yorkshire had been developed.

During discussion, Councillor Nigel Ball expressed concern over the low levels of consultation and engagement with the public/stakeholders during the development of the Integrated Care Strategy, and he stated that he also had concerns over whether the strategy and plan could be delivered in the face of current challenges. In response, Ailsa Leighton acknowledged that there was more to be done in terms of engagement and she stated that it was recognised that this needed to be continued on an ongoing basis with local communities.

The Board noted that Healthwatch Doncaster had been commissioned to assist in enhancing the consultation and publicity. Arising from discussion, Fran Joel offered to provide a report produced by Healthwatch for circulation to the Board which would give more detail on the engagement work undertaken in Doncaster to ensure all communities had an opportunity to engage.

Members also discussed the importance of producing an 'easy read' version of the JFP and of ensuring that the JFP was co-produced by stakeholders/communities. The Chair spoke of the need for the JFP to be honest and realistic in terms of its ambition and acknowledging the challenges that the NHS was currently facing and the impacts these were having on service delivery for patients. She also fully supported the previous comments that the Plan should be co-produced and made available in an 'easy read' format.

After Ailsa Leighton had confirmed that she would feed these comments back to the ICB and that a further update would be brought to this Board later in the year, it was

RESOLVED to:-

1. Note the engagement work to date, which builds on the approach taken to inform the Integrated Care Strategy; and

2. Note the work underway to develop the initial Five-Year NHS Joint Forward Plan for South Yorkshire.

69 DONCASTER HEALTH AND WELLBEING BOARD'S SECOND ANNUAL REPORT 2022-23

The Board received the Second Annual Report of the Doncaster Health and Wellbeing Board (2022-23) for the Board's comments and endorsement, prior to it being presented to the Full Council in July 2023.

Louise Robson informed Members that this was the second Annual Report for the Health and Wellbeing Board, and it highlighted the work of the Board during the last 12 months since the last report in July 2022. She stressed that this was still a work in progress and that several typographical errors had been identified and would be rectified prior to publication. The report was only a small snapshot of the ongoing work across some of the partner organisations to improve the health and wellbeing of the Doncaster population. The key going forward would be to build on the foundations of this Report and to address the health inequalities/priorities and to ensure that the work plan for the next year for the Health and Wellbeing Board reflected real needs and addressed those gaps. In concluding, Louise summarised the next steps and recommendations that were set out at the back of the Annual Report.

In referring to the next steps/recommendations in the Report, Rachael Leslie advised that an additional action would be included in relation to the production of an easy read version of the Health and Wellbeing Strategy.

The Chair suggested that it would be useful if all partner organisations could take the Board's Annual Report to their respective meetings for formal consideration and discussion, following its sign off in July.

RESOLVED to note and approve the contents of the Annual Report for final sign off by Full Council at its meeting on 13th July 2023.

70 BETTER CARE FUND END OF YEAR TEMPLATE

The Board received a presentation by Mike McBurney in relation to confirmation of end of year Better Care Fund (BCF) 2022/23 activity reporting and agreeing formal sign off of the BCF end of year template for 2022/23 by the Board as the accountable governance body for BCF locally.

It was noted that, broadly speaking, the BCF's aim was to make the most efficient use of health and social care resources by breaking down organisational barriers. In doing so, it assisted people to live independently in their communities for as long as possible and to deliver the right care, in the right place, at the right time.

During discussion, it was noted that the BCF Plan for 2023-25 would be brought to the Board's next meeting in August for consideration.

With regard to the performance indicator for the proportion of people discharged to usual place of residence (target 92.9%), which was shown as being on track to meet the target (performance 94.36%), Phil Holmes felt that there was scope for reviewing this target and improving performance even further against this indicator.

RESOLVED to note and consider the impact of BCF activity with regards to performance, income and expenditure during 2022/23 and formally agree sign off of the end of year template 2022/23.

71 UPDATE ON REFRESH OF JOINT HEALTH AND WELLBEING STRATEGY

The Board received an update from Andy Brown on the process and timeframe for developing the refreshed Health and Wellbeing Strategy. It was noted that the Board's views were being sought on the amount of detail to be included in the content of the Strategy and on the timeframe for which the Strategy should cover.

With regard to the proposed time period to be covered by the Strategy, members generally felt that it would be useful if this could be set at five years so that it mirrored that of the five-year NHS Joint Forward Plan.

In relation to content, members were of the view that a strong Health and Wellbeing Strategy was needed in its own right, rather than being light in detail or mainly signposting to other existing plans/strategies.

The Board also felt that the Strategy should be co-produced with a strong focus on lived experience and local issues in Doncaster, such as life expectancy of women. On this issue, the Chair proposed that a multi-agency supporting group focussing on lived experience be established to assist in the development of the Strategy.

RESOLVED that, subject to the above comments/actions, the update and proposed timeframe for development of the Health and Wellbeing Strategy be noted.

72 HEALTH PROTECTION ASSURANCE GROUP MINUTES OF 19TH APRIL 2023

The Board received and noted the minutes of the Health Protection Assurance Group meeting held on 19 April 2023.

73 DONCASTER SAFEGUARDING CHILDREN PARTNERSHIP ANNUAL REPORT 2021-22

The Board received and noted the Report of the Doncaster Safeguarding Children Partnership for the period October 2021 – March 2022.

(Meeting closed at 12.05 p.m.)

CHAIR:_____ DATE:_____

City of Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 31 August 2023

Subject: **The Lived British Sign Language User – Doncaster & District Deaf Society Borough-wide**

Presented by: **Pauline Dunn – Trustee, Secretary and Treasurer**

Purpose of bringing this report to the Board:- To receive an update on progress since the Board received the presentation by Pauline Dunn on the gaps, inequalities and access to services for the British Sign Language User living in Doncaster at its meeting in March 2023.	
Decision	
Recommendation to Full Council	
Endorsement	
Information	**YES**

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

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

At its meeting held on 9 March 2023, the Board welcomed Pauline Dunn of the Doncaster Deaf Society who provided an insight into the lived experiences of British Sign Language Users, highlighting gaps and inequalities.

Arising from Pauline's presentation and subsequent discussion, the Board agreed the following actions at its meeting in March and requested that an update on progress should be received at this meeting:-

Actions agreed by the Board on 9 March 2023:

1. Dr Alsindi communicate to all GPs the need to use BSL interpreters reiterating this is at no cost to the Practice;

2. Pauline Dunn to meet with Riana Nelson to address the issues with regard to Early Years, as well as picking up the culture issues highlighted within the presentation;

3. In their area of Adult Social Care, Annika Leyland Bolton would pick up on the learning lessons highlighted within the presentation, including the issues relating to pendant alarms, form filling and phone calls;

4. Richard Parker to contact the Head of Patient Experience to arrange a meeting between themselves and Pauline Dunn;

5. A report be brought back to the Health and Well Being Board at the September Meeting for an update and to see what changes had been implemented

Recommendations

The Board is asked to:-

Discuss and note the update on progress in relation to this matter and determine whether any further actions are required.

City of Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 31 August 2023

Subject: Update on Young People's Mental Health Strategy

Presented by: Martyn Owen and Emma Price

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

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

How will this contribute to improving health and wellbeing in Doncaster?
Based on the ambitions of young people, we have refined priorities for delivery in Year 2 of the strategy. We will set out the priorities and how these will be delivered.

Recommendations
The Board is asked to support the priorities and activities described in the presentation.

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City of Doncaster Council

NHS South Yorkshire Integrated Care Board

Updates for Health and Wellbeing Board

Martyn Owen
Emma Price

Children and Young People's Mental Health and Wellbeing Strategy: 2022-2025

Priorities and Projects Refresh

Summary of Year One: Successes and Learning

- Completion of actions across health, early help, and education.
- The use of a small implementation group has been key to ensuring targeted delivery.
- Delivery areas with a clear relationship to the parent strategy have been the easiest to drive forward.
- Future project planning will consider how to utilise current and future service plans to reduce pressure and cross-strategy delivery mechanisms to reduce duplication.
- Learning from this round of implementation will also help us to better consider delivery timeframes and better plan for disruptions.
- There is now also a clear requirement to strengthen systems and metrics related to impact. A clearer governance structure and revised role for the strategic group will strengthen the link between delivery and oversight.

Refreshed Priorities

Aim: Reduce systemic inequities in opportunities for positive mental health and wellbeing in Doncaster

Priority One

Deliver system-wide early intervention for whole family mental health and wellbeing that improves the resilience, communication and self-regulation skills of children, young people and their families.

Priority Two

Deliver mental health support services that provide both equitable access and outcomes for all and place voice and lived experience at the centre of provision for children, young people and their families.

- The overall aim of the strategy is to address inequities across the system.
- This is separated into two priorities encompassing early intervention and targeted services.
- The priorities are deliberately wide-scoped so that they are flexible and relevant to all partners.

Strategic Priorities: Links to the 9 WELLBEING Ambitions

Wellbeing Ambition	Priorities Link
Wellbeing Hubs: Creating local hubs for young people, giving them somewhere to go, something to do and somebody to talk to.	Priority One
Emotions: Young people are aware of their emotions and how to express them in a healthy way.	Priority One
Learning: Educating young people, parents and carers, school staff, and professionals around supporting young people with their wellbeing.	Priority One
Listened To: Ensuring that young people have a say in decisions that are made around their mental health and wellbeing.	Priority Two
Be Kind to Yourself: Promote the importance of self-care in wellbeing.	Priority One
Empower: Allow young people to have their voices heard and to be involved in the strategic decision-making process.	Priority Two
Information: Raise awareness of the services that are available and invest in a young person dedicated digital platform led by young people where all information is connected.	Priority Two
Needs: Meet the basic human needs of all children and young people in Doncaster to ensure that they feel happy, healthy, safe, and supported.	Priority One and Two
Growth: Ensure that all children and young people have the support they need to grow and achieve their full potential.	Priority One and Two

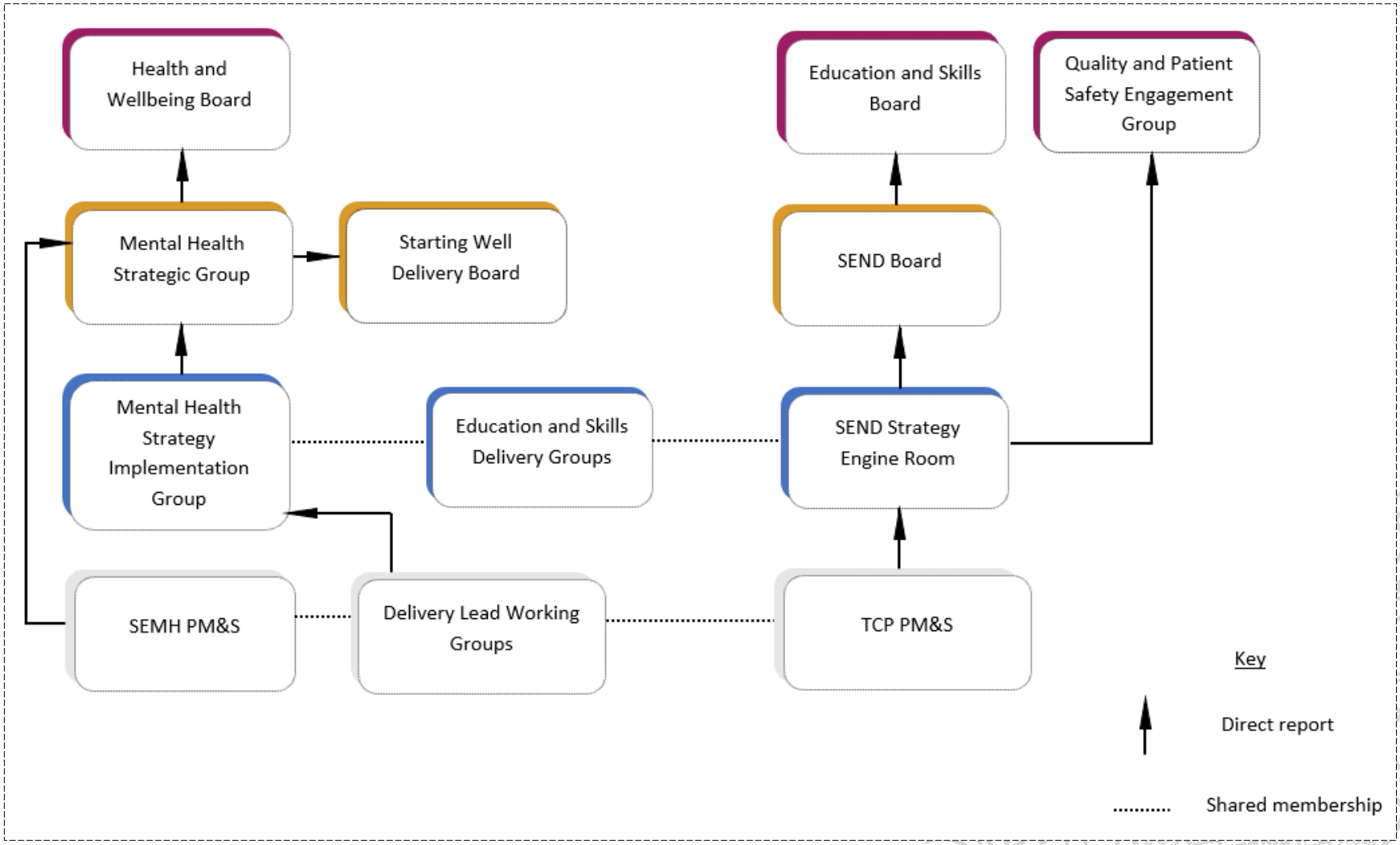
Projects: Priority One

Project	Rationale	Responsible Owner	Delivery Lead	Proposed Timeframe
Develop a local offer, in partnership with Integrated Care Systems, for infant, children, young people's mental health which outlines the support available in Doncaster.	To simplify for children, young people, and families the process of finding appropriate early intervention for mental health and wellbeing.	Emma Price	James Perkins	March 2024
Develop, in partnership with Integrated Care Systems, a broader offer to groups that experience barriers in accessing wellbeing support.	To help address the inequalities that emerge for children in Doncaster.	Lee Golze	Natasha Littlewood	August 2024
Develop a single system-wide early help mental health needs assessment so that children and young people are only required to tell their story once.	To address consultation feedback related to the organisation of early intervention and connectedness of the system.	Christina Harrison	Alison Tomes	August 2024

Projects: Priority Two

Project	Rationale	Responsible Owner	Delivery Lead	Proposed Timeframe
Develop a dedicated mental health service offer, with all partners and families, around early years which draws on support offered through parenting programmes, health visiting, perinatal mental health services, and family hubs.	To help address the inequalities that emerge in the early years for children in Doncaster.	Alison Tomes	Callum Helman	August 2024
Establish a co-ordinated approach to utilising local datasets to better inform service delivery and experience for children, young people, and families.	To address inequities in service experience for children, young people, and families and implement evidence informed policy.	Mental Health Strategic Group	Kate Featherstone-Bennett David Woodcock	August 2024
Establish a pilot scheme for dedicated pathways to mental health support services for individual communities based on provisional mapping and localities exercises.	To address inequities in service access for children, young people and families and implement evidence informed policy.	Christina Harrison	James Perkins Kate Featherstone-Bennett	August 2025

Refreshed Governance Structure



Feedback from Young Advisors

Video Message from Young Advisors

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City of Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 31st August 2023

Subject: Family Hubs and Start for Life Programme - Presentation

Presented by: Callum Helman, Transformation Manager Children, Young People, & Families Directorate

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)	
	Mental Health	
	Dementia	
	Obesity	
	Children and Families	X
Joint Strategic Needs Assessment		
Finance		
Legal		
Equalities		
Other Implications (please list)		

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

The Family Hubs and Start for Life programme helps meet commitments in The best start for life: a vision for the 1,001 critical days, published as government policy in March 2021. This programme is jointly led by the Department for Education (DfE) and Department of Health and Social Care (DHSC).

The programme's objective is to join up and enhance services delivered through transformed family hubs in local authority areas, ensuring all parents and carers can access the support they need when they need it.

The programme will:

- provide support to parents and carers so they are able to nurture their babies and children, improving health and education outcomes for all
- contribute to a reduction in inequalities in health and education outcomes for babies, children and families across England by ensuring that support provided is communicated to all parents and carers, including those who are hardest to reach and/or most in need of it
- build the evidence base for what works when it comes to improving health and education outcomes for babies, children and families in different delivery contexts

Recommendations

The Board is asked to note the contents of the presentation and Family Hubs/Start for Life contribution to a reduction in inequalities in health and education outcomes for babies, children and families.

City of Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 31 August 2023

Subject: Fairness and Wellbeing Commission – mid way update.

Presented by: Jon Gleek – Policy, Insight & Change

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)	
	Mental Health	
	Dementia	
	Obesity	
	Children and Families	
Joint Strategic Needs Assessment		
Finance		
Legal		
Equalities		
Other Implications (please list)		

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

In response to the pressing challenges faced by Doncaster, the Fairness and Wellbeing Commission was established to identify and address issues related to social and economic inequalities while promoting overall well-being in our city. As a collective endeavour, we have embarked on a transformative journey to create a fairer and more equitable community that thrives on unity and progress.

Tasked by the Health and Wellbeing Board, the commission is committed to conducting a thorough and independent assessment of the root causes of disparities in Doncaster and through research, data analysis, and inclusive community consultations, we have delved deep into the lived experiences and diverse perspectives of our residents.

Recommendations

The Board is asked to receive and note the update provided.

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Fairness & Wellbeing Commission

Fairness & Wellbeing Commission

Background, Methodology and Progress to date

Fairness & Wellbeing Commission

Why are we doing it

Post-pandemic: The COVID-19 pandemic has exacerbated and shone a light on existing systemic inequalities in our society. People from marginalised groups were been disproportionately affected by the pandemic, both in terms of their health and their economic well-being

The fairness commission aims to help to address systemic inequality in our society. By taking a step back and taking a deeper and longer term view, the fairness commission will help to develop policies that will make our society more fair and just for everyone.

The challenges of addressing systemic inequality are complex and long-term. The fairness commission provides a forum for stakeholders to come together, share their perspectives, and develop a more holistic and long-term approach to addressing these challenges.

Fairness & Wellbeing Commission

PURPOSE & SCOPE

Using the Well-being essentials in Doncaster Delivering Together as a framework, the Commission will:

Fairness & Wellbeing Commission

Commission structure

Structure of the commission and sessions

- '**resident voice**' very important to the commission – however commission members recognise this comes through a variety of different media, data and presentations.
- Involvement/input of intermediary organisations is useful to hearing resident voice but need to get to the '**why**' as well

Life course approach

It was decided in session1 that a '**life stage' approach** would allow the commission to be person centred and understand the **intersectionality** of different inequalities and disadvantages on individual residents.

'We need to appreciate that residents do not experience any one of their issues in isolation, but rather how they are impacted by an accumulation of issues'

Fairness & Wellbeing Commission

Mixed Method Approach

- Call for evidence
- Resident Voice – synthesis of existing
- Public Engagement:
  - Face to Face conversations
  - Online survey
  - Resident workshops and forums
- HDRC - Rapid Review of Evidence – “what works”
- Expert panels
- Front line staff workshops
- Data walks

Fairness & Wellbeing Commission

Resident Voice: the use of evidence-based personas

Personas are used as a way to summarise and communicate the qualitative and quantitative evidence that has been submitted to the commission; designed to give commission members the opportunity to understand and empathise with their persona, each of which represents a significant proportion of residents.

Lisa & Aiden

"we are behind on literally everything!
Money comes in, money goes out and then we are left counting down the days until the next pay day. Trying to catch up where we can. It's draining."

Smita

"I know that I'm strong. I manage things, I'm, you know, a multitask person-flexible; I am that person. But I'm finding it hard. I'm unable to think beyond it."

Andy

"As a person who was born in Doncaster, I now feel I no longer belong here when I go into the town centre. It's feels like an Eastern European city in parts where if you are English, you are unwelcome and unsafe."

Beth

"I would not live here if I had the chance...."

Dave

"Sometimes I just think about driving my car into a wall and not having to worry about any of this anymore"

The use of evidence-based personas is designed to assist in sense checking ideas and recommendations and help to avoid the pitfalls of designing future solutions based on anecdotal or extreme examples.

Fairness & Wellbeing Commission

1. **Setting the scene and understanding the baseline in Doncaster**

27th January 2023

2. Older Residents

Understanding lived experience and prioritising challenges

31st March 2023

3. Older Residents

Recommendations and Opportunities for Change

28th April 2023

4. Working Age

Understanding lived experience and prioritising challenges

May 2023

5. Working Age

Recommendations and Opportunities for Change

30th June 2023

6. **Children, Young People & Families**

Understanding lived experience and prioritising challenges

28th July 2023

7. Children, Young People & Families

Recommendations and Opportunities for Change

8th September 2023

8. **Review of recommendations and priorities for final report**

6th October 2023

9. **Final Report Presentation**

Autumn 2023

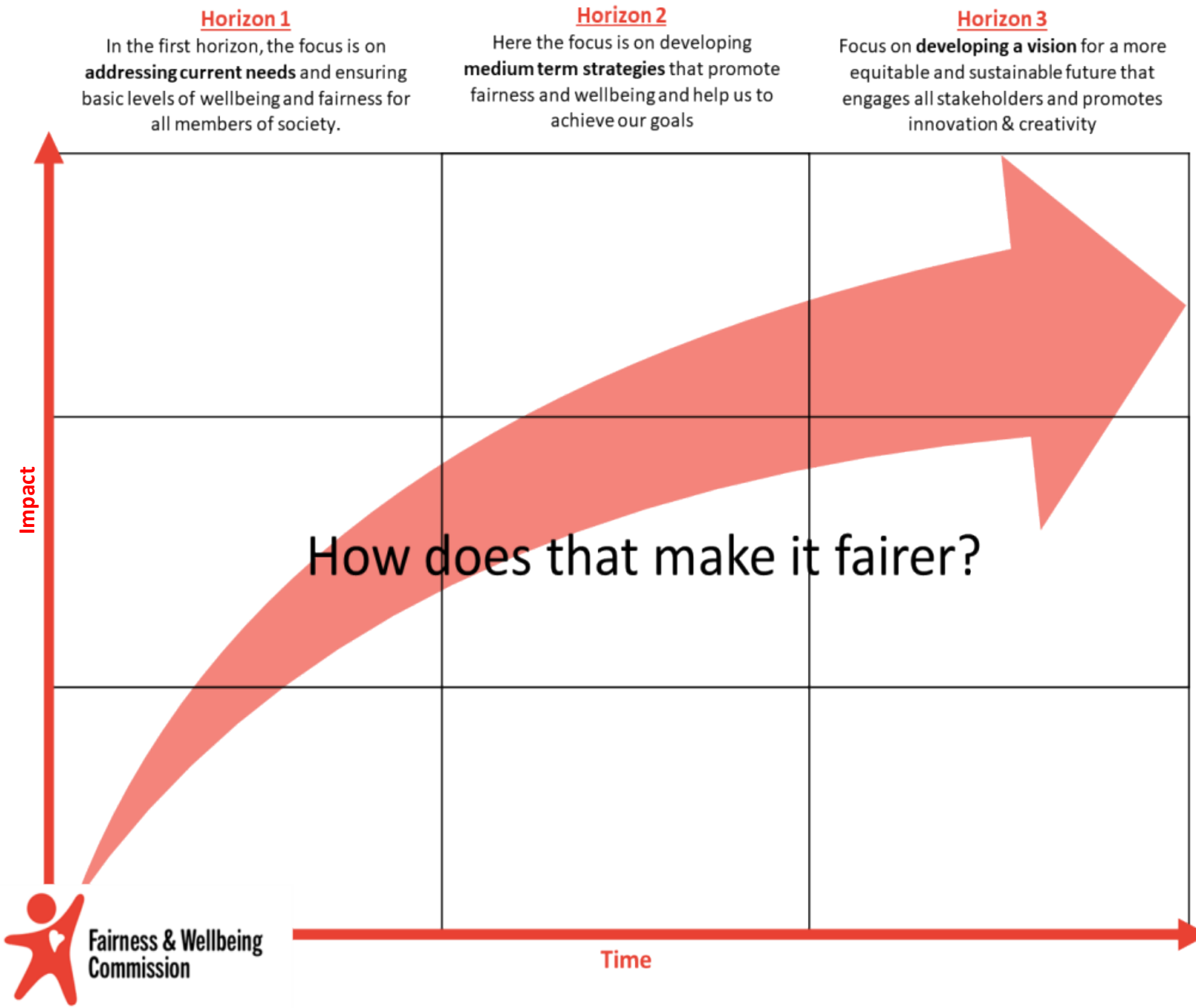
www.teamdoncaster.org.uk/doncaster-fairness-well-being-commission

Fairness & Wellbeing Commission

Recommendations

Recommendations:

- Taking on board all the varied evidence they have been presented, commission members are designing recommendations for each life stage
- Some of these are inevitably relevant to all ages or wider age categories.
- The framework they are using remain the Three Horizons model
- Council teams have supported refining ideas and suggestions into recommendations so far.
- There are different ‘types’ of recommendations:
  - some are quite specific initiatives,
  - some are more principles
  - Some are things to investigate or research further



Fairness & Wellbeing Commission

Emerging recommendations

Horizon 1: Current state requiring immediate change

In this section, the report highlights recommendations that address the most urgent needs of the community. These initiatives focus on

- enhancing data quality,
- improving accessibility to services,
- promoting socio-economic inclusion,
- fostering compassion in support, and
- making evidence-based decisions.

Additionally, strategies for

- Improved transport system,
- equitable employment opportunities, and
- transparent funding mechanisms are emphasised.

Horizon 2: Transitional/Disruptive Initiatives

These recommendations identify emerging trends and take the opportunity to lay the foundation for transformative change:

- re-evaluating funding models for the voluntary and community sector,
- developing a corporate social responsibility approach, and encouraging community-led support systems,
- a digital age transition,
- extended volunteering opportunities,
- and innovative public transport interventions

are presented to bridge the gap between the present and an inspiring future.

Fairness & Wellbeing Commission

Emerging recommendations

Horizon 3: Transformative and Imaginative Approach

This section introduces a set of higher-level design principles that serve as a 'north star' to guide the transformational journey. Emphasising imagination, inclusivity, sustainability, equity, empowerment, innovation, and holistic well-being.

Stakeholders are encouraged to embrace bold ideas, co-create solutions with residents, and foster a resilient and just society.

1. **Imagination and Aspiration:** Encourage residents and stakeholders to imagine and dream about the future they envision for Doncaster.
2. **Inclusivity and Co-Creation:** Foster an inclusive and collaborative approach to decision-making and service design.
3. **Sustainability and Resilience:** Prioritise initiatives that promote long-term sustainability, resilience, and adaptability to future challenges. Aim for solutions that have a lasting positive impact on the community.
4. **Equity and Social Justice:** Address systemic disparities and work towards creating a fair and just society for all residents.
5. **Empowerment and Ownership:** Empower individuals and communities to take ownership of their development and well-being.
6. **Innovation and Learning**: Embrace innovation and continuous learning to stay responsive to changing needs and opportunities. Encourage experimentation and knowledge sharing to find effective solutions.
7. **Holistic Well-being:** Promote a holistic approach to well-being that encompasses physical, mental, social, and economic dimensions. Recognize the interconnectedness of various aspects of life.

Fairness & Wellbeing Commission

Other considerations: local and regional landscape

Locally:

- Development of Health & Wellbeing strategy
- Fairness & Inclusion agenda
  - Choose Kindness movement
  - Protected Characteristics – locally adopted characteristics.
  - Inclusion & Fairness forum
  - Age UK – New Strategic Plan
  - Vol-Com infrastructure
  - Doncaster ICB Plan
- Community Prevention Model
- Year 2 'in focus' groups (Homelessness, Env, Edu & Skills, Economy)

Regionally (& nationally):

- New SYMCA Governance Model; opportunities to influence new detailed business plans
- SY ICP Partnership plan
- Political opportunities – e.g. lobbying and advocacy

Fairness & Wellbeing Commission

Next steps: mid-point update

ELT Update	24th July
Horizon Policy and Design Group	15th August
Health and Wellbeing Board	31st August
Overview and Scrutiny	7th September
Session 7: Children, Young People and Families; Recommendations and Opportunities for Change	**8th September**
Team Doncaster Exec	14th September
Session 8: Review of Recommendations and priorities for final report	**6th October**
Exec Board	Oct/November
Final Report	Late Autumn

City of Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 31 August 2023

Subject: A joined-up approach to developing our plans for Health and Wellbeing in Doncaster

Presented by: Allan Wiltshire – Policy, Insight & Change

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)	
	Mental Health	
	Dementia	
	Obesity	
	Children and Families	
Joint Strategic Needs Assessment		
Finance		
Legal		
Equalities		
Other Implications (please list)		

How will this contribute to improving health and wellbeing in Doncaster?
Doncaster's Health and Wellbeing Strategy is overdue and requires an update to reflect the significant events and changes that have taken place since its completion in 2016 The South Yorkshire Integrated Care Board has recently developed a South Yorkshire Integrated Care Strategy and a Five-Year NHS Joint Forward Plan for South Yorkshire. Following these statutory documents, the Doncaster Place Partnership is planning the development of a five-year integrated health and care place delivery plan specifically for Doncaster. This is an opportunity for a coherent and integrated approach to improving health and wellbeing outcomes for its residents.

Recommendations
The Board is asked to:- 1. Agree the proposals for the development of the HWB strategy and plan 2. Consider and agree indicative timescales

A joined-up approach to developing our plans for health and wellbeing in Doncaster

This briefing follows the discussion at June's H&WB board meeting and seeks to outline and confirm the following:

- context
- approach
- strategy development principles
- strategy development process
- progress
- an indicative outline of timescales and,
- Next steps

Context

Doncaster's Health and Wellbeing Strategy is overdue and requires an update to reflect the significant events and changes, e.g. floods, the COVID-19 pandemic, the cost-of-living crisis, and the formation of Integrated Care Boards (ICBs) that have taken place since its last iteration in 2016.

More recently, the South Yorkshire Integrated Care Board has developed a South Yorkshire Integrated Care Strategy and a Five-Year NHS Joint Forward Plan for South Yorkshire and following on from these statutory documents, the Doncaster Place Partnership is planning to develop a five-year integrated health and care place delivery plan specifically for Doncaster.

These initiatives at regional and local levels demonstrate the recognition of an evolving public health and healthcare landscape and the need for a more coordinated approach to help address health and wellbeing challenges.

Approach

The South Yorkshire Integrated Care Strategy and the Doncaster-specific plans (including the Health & Wellbeing Strategy) will provide an opportunity for collaboration between different stakeholders, including the City of Doncaster Council, Doncaster Place Partnership, health and social care providers, and community organisations, with a clear focus on the inclusion of the lived experience and resident voice within the decision-making process

By aligning these strategies and plans, Doncaster can ensure a coherent and integrated approach to improving health and wellbeing outcomes for its residents.

Strategy development principles:

- Clear focus on the resident voice and lived experience
- Collaborative production of content
- Identification and inclusion of specific issues relating to Doncaster
- Opportunities for Health Determinants Research Collaboration to be involved

Development process:

Our proposed plan outlines three key areas of joint working:

1. **Review and synthesise existing resident engagement (resident voice)**
   To date there has been extensive resident engagement undertaken to inform the development of the Borough Strategy (Doncaster Delivering Together most recently) and our Team Doncaster strategies (e.g., Economic, Transport, Culture, education, and skills etc).

To build on existing engagement efforts, there is a need to synthesise key themes and identify gaps in resident involvement to ensure that any resulting resident engagement has a meaningful input into the strategy and plan.

By taking this approach we will also negate the risk of consultation fatigue which could in fact incur a counter consequence of disengagement.

2. Review existing data sets and take account of new data

Existing sources and products of data related to health and wellbeing will be collected and analysed. This process will identify any gaps in the available data and explore opportunities for further analysis.

The updated Health and Wellbeing Strategy will incorporate the priorities identified by the Health and Wellbeing board to address the needs highlighted in the Joint Strategic Needs Assessment (JSNA). This will enable a targeted and evidence-based approach to tackle the local health challenges facing the community.

3. **Strategy Mapping:**

Existing strategies that contribute to improving health and wellbeing and addressing health inequalities (e.g., economic strategy) will be reviewed and mapped to ensure that where appropriate there is a clear line of sight, providing assurance against delivery of those health and wellbeing related priorities.

It is also anticipated that where appropriate, recommendations from the Fairness and Wellbeing commission will also be reflected within the plan.

Progress:

Community Engagement synthesis workshop (14 August)

Activity to map existing engagement efforts and synthesise key themes has already commenced with colleagues from across Team Doncaster (Localities, RDaSH, ICB, Healthwatch, DBTH etc) attending a workshop to present insight held by individual organisations in an effort to foster greater collaboration and shared thinking.

It was quickly recognised that collective engagement efforts are vast and as a result a series of draft principles for sustainable resident involvement were identified.

Openness/relationships/trust	Power to support resilience
Define the ask	Funding (reimburse time)
Create safe spaces	Build upon what we already know/what works to deepen our understanding and build an evolving conversation
Right person/place/time/method	Bold leadership – organisational development
Commitment to collaboration	Simple (appropriate) language

The insight gathered from the session will be communicated to partners and used to underpin the development of the HWB strategy.

Timescales for key milestones:

- 19th & 31st July – initial scoping and planning sessions
- 14th August initial resident engagement synthesis workshop
- September/October – further understanding of community priorities
- November – production of Fairness & Wellbeing Commission report TBC
- November-January 2024 – development of plan/strategies TBC
- Spring– plans produced ready for approval TBC

The above timescales are all dependent on the extent of engagement activity required and the release of updated Public Health outcomes data in September.

Next Steps:
It is proposed that a further update be presented to the Health and Wellbeing Board at their next meeting, where a draft outline of themes, based on the data, engagement and insight gathered will be presented.

The Health and Wellbeing Board is asked to:

- Agree above proposals and next steps for the development of the HWB strategy and plan
- Consider and agree indicative timescales (subject to the caveat outlined).

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City of Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 31 August 2023

Subject: Team Doncaster Dementia Strategy

Presented by: Mark Wakefield, Joanne Forrestall
Wendy Sharps, Phil Brugh

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

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

How will this contribute to improving health and wellbeing in Doncaster?
The Team Doncaster Dementia Strategy will focus on priorities identified by people living with dementia, their families and carers.

Recommendations
The Board is asked to:- Doncaster HWB board are asked to endorse the Strategy and the priorities within.

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Team Doncaster Dementia Strategy

2023-2025

Unlocking possibilities: A Person-centred Dementia Strategy

Doncaster Delivering Together

Team Doncaster

Contents

Foreword

Wendy Sharps

Person with dementia

Co-chair of Doncaster Dementia Collaborative

My name is Wendy, I was diagnosed with Lewy Bodies Dementia over 10 years ago at 40 years old, and I am a passionate advocate for all things dementia.

Getting diagnosed was a long five-year process, and since then I have had lots of different experiences with professionals that have been both positive and negative. In my opinion, those with good quality dementia training have a good understanding, seem clued up and treat me like normal. For those that haven't had good quality training people, more education and awareness is needed to understand people like me and not put us all in the same box.

I am delighted to be involved with the development of the Team Doncaster Dementia Strategy. Currently, I co-chair the Doncaster Dementia Collaborative and attend the Dementia Strategy Group meetings where myself and others work with local Health and Social Care services to lobby, raise awareness, and support change to those effected by dementia living in Doncaster.

Attending these meetings, I am treated like a normal person and because dementia really matters to me, I am happy that people listen to my thoughts.

I personally think it is important for people experiencing dementia, with their own diagnosis or as a family member or carer(s), to have their views and opinions heard. To me, this strategy has given more people in Doncaster the chance to share their voice and I hope that it is used to help shape future dementia services in Doncaster. Everyone with dementia should be able to access the right health, care, and support for them- not just a one-size-fits-all approach.

This strategy has been coproduced with other people like me and my family and I look forward to seeing how it will make things better for people with dementia in Doncaster.

Anthony Fitzgerald

Executive Place Director – Doncaster

NHS South Yorkshire Integrated Care Board

With the ageing population expected to rise over the next 10 years, a timely diagnosis for those with dementia is vital not only for them, but also for their family and friends. A timely diagnosis enables them to maximise control over their lives by planning ahead and accessing support to ensure that they can enjoy an active and independent life for as long as possible. This strategy has been drafted following extensive consultation with our partners and our population and sets out how we aim to make Doncaster the best place to live well with Dementia by working together across Health and Social Care.

The strategy sets out how we aim to do this and how we can provide the help and support that is needed in order to realise this aim. From prevention to diagnosis and to delivery of services, we must ensure that there is adequate and meaningful provision to help and support those with dementia, as well as their family and friends. Promoting self-care and self-empowerment is often a primary requirement for those who want to stay in their own homes. Family and friend carer(s) are influential in supporting those living with dementia and it is therefore key that we support them in their caring role.

I hope you will find this strategy informative and of interest. I believe that the more we engage and plan together with those who need our support, the better quality of life will be achieved for our population

Councillor Rachael Blake

Chair of the Health and Wellbeing Board

Dementia Friends, a national movement sponsored by the Alzheimer's Society, has five key messages:

1. Dementia is not a natural part of ageing
2. Dementia is caused by diseases of the brain
3. Dementia is not just about memory loss
4. It is possible to live well with dementia
5. There is more to a person than the dementia.

This Dementia Strategy sets out how local organisations will work together to ensure timely information, diagnosis, treatment and support but the overall goal should be helping Doncaster people and their families live well. This isn't always easy. Dementia affects everybody differently and the challenges we face in our lives are not shared equally. But we can do much more to be dementia-friendly. We can help Doncaster people live with dementia in the place they call home with the people and things that they love, in communities where they look out for one another, doing things that matter to them. Achieving this doesn't only require high quality healthcare, it's also about good housing, being able to get out and about, remaining connected with people and being recognised for the huge contribution people living with dementia have made and can still make to Doncaster life.

Wendy, on the previous page, is living testament to that. If you ever meet her face-to-face you will have no doubt that there is more to a person than the dementia! This strategy is about dementia but it's also about all of us and our human right, whatever our circumstances, to be understood and valued.

What is Dementia?

Dementia is an 'umbrella' word used for the 200+ conditions that cause symptoms when the brain cells cannot work the same.

Often, people start with minor challenges like memory loss, difficulty performing familiar tasks, problems with language and changes in personality.

For a dementia diagnosis, these are severe enough to affect everyday life. There may also be changes in mood and behaviour.

There is currently no cure or prevention for dementia, but a range of support is available for people with dementia and their carer(s) including risk reducing advice and guidance.

This strategy will underpin Doncaster's city-wide commitment to provide high-quality care and support for people with dementia and their carer(s).

Building on progress already made during the previous partnership strategy 'Getting There', this strategy seeks to improve the lives of people living with Dementia, their families and their carer(s) and will provide a call to action for continuous development in ensuring that people continue to live well and thrive.

This strategy has been co-produced with people living with dementia, their carer(s), commissioned and non-commissioned providers, the voluntary sector, Adult Social Care and other professionals, with a real focus on ensuring **dignity and compassion** is at the forefront of all care, treatment, support and decisions.

Vision

People living with Dementia and members of the Doncaster Dementia Collaborative agreed a vision statement to describe the aim of the strategy and its action plans:

"Striving to be the most Dementia Friendly City, adding years to life and life to years, for people living with dementia and their carer(s) living in Doncaster."

While the strategy will be in place until December 2025, it is recognised that adding years to life is a longer-term goal and hope that it is adopted in future strategies for years to come. The vision success measurements will be captured by the data and performance workstream.

Published by the Alzheimer's Society, the 'Dementia Friendly Communities' explores evidence from people with dementia about their experiences of living in their community and the ten key things they would like to see in a dementia-friendly community.

What has been achieved so far

The following achievements have been made since the implementation of the previous Dementia Strategy providing good foundations to build upon.

1. **Implemented the findings of the Blackfriars Consensus by producing a 'reduce your risk leaflet'**
2. **The Dementia Roadmap has been replaced with the Your Life Doncaster Dementia webpage which continues to provide advice and guidance**
3. **A pre-diagnosis service was commissioned in 2021 to compliment the already existing post-diagnosis service to strengthen the offer of support for those at differing stages of the dementia pathway**
4. **A total of 14091 people in Doncaster were trained to be Dementia Friends**
5. **A number of awareness raising events took (and continue to take) place**
6. **The Doncaster Memory Service (RDaSH) received accreditation through the Royal College of Psychiatrist's Memory Service National Accreditation Programme (MSNAP) and work to the standards**
7. **The Doncaster Dementia Collaborative group was launched in 2021 and continues to lobby for the rights of people with dementia and their carer(s)**
8. **Dementia is considered within a number of local strategies such as the Dementia Carer(s) Strategy**
9. **Specialist dementia roles are in place to provide specialist support to those with dementia and their carer(s)**
10. **The Voluntary Community and Faith sector have greater visibility and have been able to reach more people with dementia and their carer(s)**
11. **Lots of engagement and consultation work has been completed to understand the views of more people with dementia and their carer(s) which is helping to work towards true co-production**

Engagement

This strategy has been coproduced with the following people:

- People with lived experience of dementia
- Family and friends of people with dementia
- Carer(s)
- Accountable Care Partnership (current providers of commissioned services)
- Doncaster Dementia Collaborative (a group of people with dementia and people with an invested interest in dementia)
- Doncaster Dementia Strategy Group (a group of people with dementia and professionals from a wide range of organisations)

The co-production has focused on what is important to people with dementia.

An engagement exercise was commissioned by Doncaster Council and South Yorkshire ICB in summer 2022. This was undertaken by Healthwatch Doncaster and confirmed that much more work is required in Doncaster to support people and their carer(s) both prior to a potential dementia diagnosis supporting them through their journey and post diagnostically to ensure they receive the right information, advice, guidance, signposting, care and support. This engagement took in to account the views of over 200 people in Doncaster and formed the **Healthwatch Insight Report.**

To build on the findings above the **Doncaster Dementia Survey 2023** was carried out in March by Doncaster Council that gained insight from over 400 people in Doncaster. This built on the Healthwatch findings highlighting 5 key areas for priority as follows:

- Cross Cutting Themes
  - Coproduction
  - Health Inequalities
  - Workforce
  - Data and Intelligence
  - Dignity and Compassion
- Information Advice and guidance
- Receiving a diagnosis
- Support following diagnosis
- Support for carer(s).

Areas of Priority

Priority 1 – Cross-cutting Themes

What people with Dementia and their family/carer(s) told us

1.1 Co Production (see below co-production ladder)

Co-production is an equal relationship between people who use services and the people responsible for services. They work together, from design to delivery, sharing strategic decision-making about policies as well as decisions about the best way to deliver services. The co-production ladder below (inspired by Think Local Act Personal's [1]ladder of co-production) depicts how co-production should work. In Doncaster we are working towards co-production, but it is recognised there still is work to be done with us currently operating around the engagement and co-design stages.

Co-production - an equal relationship between people who use services and the people responsible for services.

Co-design - People have genuine influence in designing services based on their experiences and ideas, but not involved in 'seeing it through'.

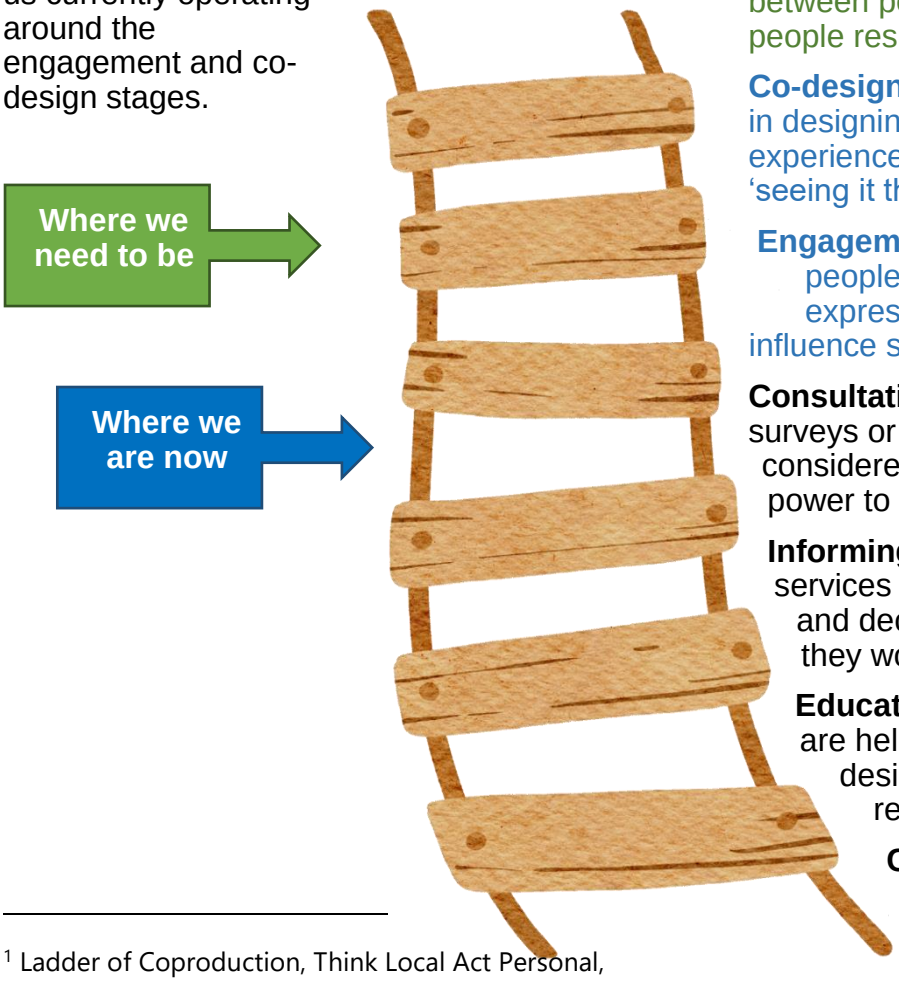
Engagement - in addition to 'consultation' people are given more opportunities to express their views and may be able to influence some decisions.

Consultation- People may be asked to fill in surveys or attend meetings, which may be considered tokenistic if they do not have the power to influence change.

Informing - The people responsible for services inform people about the services and decisions and explain how and why they work.

Educating - The people who use services are helped to understand the service design and delivery so that they gain relevant knowledge about it.

Coercion - people are passive recipients of services with little to no say.



[1] Ladder of Coproduction, Think Local Act Personal, 2021: Ladder of Coproduction | TLAP | social care (thinklocalactpersonal.org.uk)

1.2 Health Inequalities

It is recognised that health inequalities impact people with dementia in Doncaster. These are avoidable, unfair, and systematic differences in health between different groups of people within society. Health inequalities can lead to unequal outcomes, varied access to services, and poor experiences of care. leading to disparate outcomes, varied access to services, and poor experiences of care.

In Doncaster, 24 Communities have 50% or more of their population living in the most deprived 20% of the country. People living in deprivation will:

- lead shorter lives,
- typically live one third of their lives in poor health
- be less likely to attend outpatient hospital appointments

To tackle health inequalities, more engagement needs to be undertaken with these groups of people to fully understand barriers that need to be broken down.

The Health Inequalities and Inclusion Steering Group Launched June 2022 to:

- Build relationships, trust and connections across health and care, including residents and patients
- Increase awareness of services and support available to people – reiterating that does not always have to be health
- To reduce demand on health and care and improve outcomes

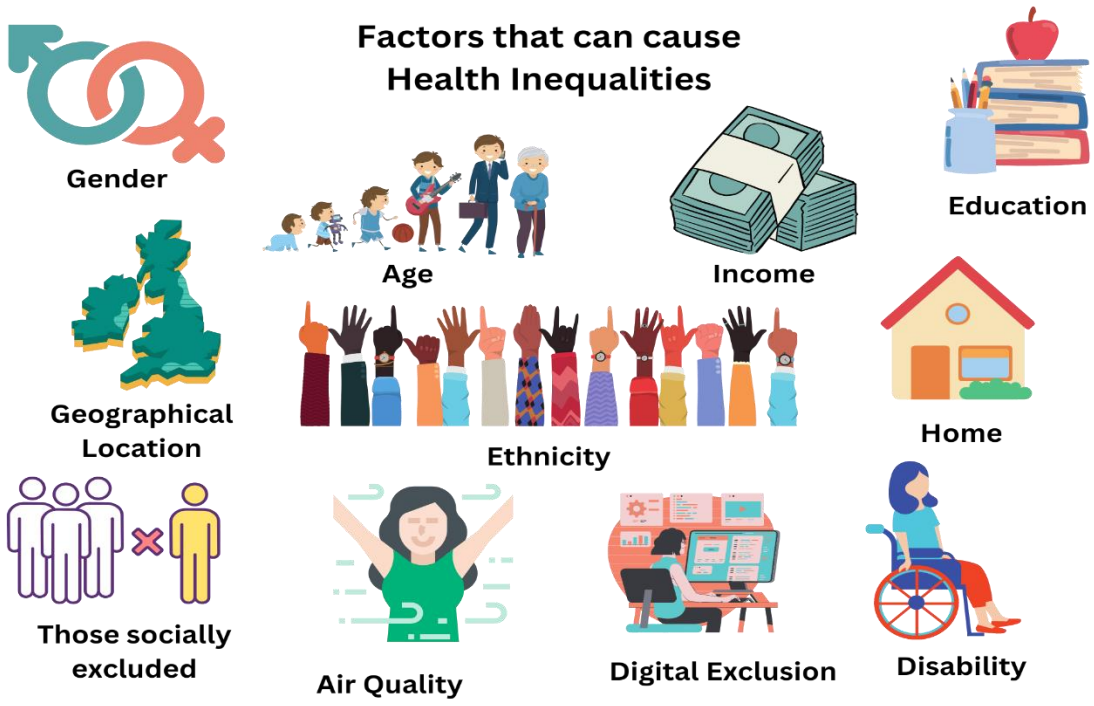
An example of the affect health inequalities may have on dementia is that of the LGBTQ+ population. Research suggests that LGBTQ+ people will experience difference challenges and concerns about dementia compared to the general population. The LGBT Foundation state that:

"LGBT people with dementia may experience additional layers of distress due to life-long health inequities and barriers to accessing healthcare. They may, even before being diagnosed with dementia, have felt unsafe expressing their identity for fear of discrimination and how others will treat them.

Some LGBT people may not remember that they have 'come out' and re-live fears and concerns about their sexual orientation including internalised homophobia or biphobia."

Championed by Care England and with accompanying training endorsed by Skills for Care, the **#PrideInCare** quality standard that enables organisations to be assessed as providing quality care and support to older LGBTQ+ people.

By researching and signing up to schemes like this, work can be done alongside partners, providers, and the voluntary/community sector in Doncaster to ensure people from all different backgrounds are able to live full, vibrant, and respected lives, free from isolation, loneliness, discrimination, and prejudice.



1.3 Workforce and Awareness

People in Doncaster feel the workforce could be better equipped to work with people with dementia. It is reported that sometimes, people with dementia and their carer(s) are treated poorly by staff through lack of insight and knowledge of dementia. People feel that staff should be more highly skilled to ensure that a high standard of care and support is delivered.

In addition to this, there is a lack of general awareness of dementia and associated symptoms by the wider community (in shops, restaurants and public places) which prevents community inclusion.

"My husband enjoys participating in normal family outings and events and playing his part, but we find staff particularly when we are eating out rush him to choose his food and don't understand when he wants to eat things in a bit of a different way" – wife of person with dementia, Dunsville.

1.4 Data and Intelligence

Data and Intelligence remains important to complement co-production and inform governance and future decision making around dementia. South Yorkshire ICB currently host a Dementia Dashboard used as part of contract monitoring. Partners should work collaboratively to provide relevant and up to date data and intelligence that is understandable to people with dementia and their carer(s).

1.5 Dignity and Compassion

People with dementia and their carer(s) have a right to be treated with dignity and compassion. In Doncaster, people with dementia feel they are often 'put in a box' with factors presumed on their behalf. Some people report that they are overlooked by professionals in appointments who assume the person with dementia lacks capacity and talk directly to the carer(s) or family member. Other people report that people with dementia, through lack of support, are put in positions where their dignity is compromised. In addition, people should be aware, empowered and supported to get the care they want at all stages of their dementia journey including at the end stages of their life.

What will we do to better address cross cutting issues?	
Cross-cutting issues will be addressed to reduce health inequalities and help people with dementia live better for longer. People with dementia and their carer(s) will be supported by well trained professionals and treated with dignity, compassion, respect and kindness.	
1	Doncaster will strive to work to strengthen co-production for dementia to ensure services and strategies are driven by people with dementia and their carer(s).
2	Ensure that dementia services are inclusive of everybody including people with protected characteristics, those experiencing significant poverty (core20 population), people from ethnic minority communities and inclusion health groups.
3	Promotion of courses for people with dementia, unpaid carer(s), family members, care and support staff, professionals and the wider public. Training provision in Doncaster will be co-produced with people with dementia and their carer(s) and evaluated to ensure training and development is of a high standard.
4	Develop health and social care Dementia Reporting Dashboards in line with the strategy and service implementation.
5	Ensure people with dementia are treated with dignity, respect and compassion, at service level with health, social care and support staff but also on a wider awareness-raising level with communities across Doncaster.

Priority 2 – Information, Advice and Guidance

What people with Dementia and their families/carer(s) told us.

People with dementia and their carer(s) feel that there are some good quality services available in Doncaster, but these are not promoted very well resulting in being overwhelmed, feeling helpless and not knowing where to turn.

> ***"Often there are great opportunities out there but again, information, and getting that information to people, is key." – carer(s), Doncaster***

People in Doncaster want to be able to access all relevant information relating to dementia support in one place, at a time that suits them. At present, people are finding out different pieces of information from a wide range of people at different times which can feel overwhelming. In addition, people want to be able to access information at their own pace, when they feel ready to do so.

> ***"My mum has had dementia for years and have no idea of any support both socially or financially she could be entitled to." – family member, Hatfield***

Information, advice, and guidance relating to social and finance support is lacking too, with people wanting to be given each piece of the 'jigsaw' to allow them to consider what is important to them. This also applies to information relating to future care options – people with dementia and their carer(s) should not only be aware of their current situation but how their needs may change in the future and what that might mean in terms of future support. This will allow people to make informed decisions and consider a range of different options.

> ***"It takes far too long to get information on what is out there, doctors could have a list of what is out there and hand a folder to the patient with all the info they need." – family member, Bessacarr***

The Your Life Doncaster Dementia Information web page is a good starting point, however, the information could be strengthened. Of the 409 people that completed the Dementia Survey, 66% did not know about the page and 19% felt it could be strengthened. People also felt that a lot of current information, advice and guidance is not simple to read and contains too many big words.

Risk-reduction and prevention information, advice and guidance could be strengthened in Doncaster in line with new data and research.

What will good information, advice and guidance look like?	
People with dementia and their carer(s) will have improved access to information, advice and guidance relevant to the Well Dementia Pathway.	
1	Information, advice and guidance will be of a good quality, written in simple to read language, accessible to anyone who needs it at a time that suits them.
2	Advice on reducing the risk of dementia will be available and stakeholders will strive to promote this messaging.
3	Access to information digitally will be available in one place (Your Life Doncaster). Access to information will also be available across locality hubs.

Priority 3 – Receiving a Diagnosis of Dementia

What people with Dementia and their families/carer(s) told us

Some people with dementia and their family/carer(s) have positive feedback about the actual diagnostic process, but it is felt that the diagnosis process is lengthy and difficult to achieve which can be frustrating and invalidating.

> ***"In my personal experience initial diagnosis of dementia is very difficult to get. Access to support for families may be available but only if you know what to look for and to access any of the above needed Mum to see a GP- 240 phone calls to be told there's no appointments available." – friend of person with dementia, Branton***

People in Doncaster also feel that more urgency should be given to diagnosing dementia to allow intervention as early as possible and reduce the risk of ending up in crisis. It is evident that there is a lack of signposting to pre-diagnostic services which would help to reassure and support people with dementia and their carer(s).

> ***"I think there should be more of an urgency for the diagnosis, the tablets, once given really help (or in our case have) there is no help or understanding from their local doctors." – Carer(s), Cantley***

It is also felt by people with dementia and their carer(s) that following diagnosis, there is often a delay with receiving support, causing people to feel lost in the system with no idea where they can turn for support.

> ***"Once a person has a diagnosis of dementia, there is very little professional support and advice. Services do not respond quickly enough, and the support given is somewhat variable between areas." – family member, Bennetthorpe***

The estimated prevalence of people in Doncaster with a dementia diagnosis is currently between 61% and 65%. This is slightly below the national ambition of 66.7% and below our South Yorkshire neighbouring authorities.

What will a good diagnosis of dementia look like?	
People with memory concerns will receive a timely diagnosis, which will trigger referrals to any relevant services.	
1	Doncaster will strive to improve the diagnosis rate to 75% in line with other South Yorkshire authorities.
2	Reduce the delay from the point of raising concerns to receiving a diagnosis, by working with health partners (GP Access, Clinics and Health Provision)**.**
3	Ensure the timely start of treatment and services for those diagnosed with dementia and their carer(s).

Priority 4 – Support with Diagnosis

What people with Dementia and their family/carer(s) told us.

People with dementia and their carer(s) were generally complimentary about staff and services but said the dementia pathway is difficult to navigate, resulting in feelings of confusion as to where they can turn for help. There are often long waiting times, and some people find support to be inaccessible.

> ***"Takes too long to get support for dementia patient with very little accessible support and funding" – carer(s), Balby***

People with dementia and their carer(s) are often passed from service to service before they are speaking with the relevant person who can help them. This sometimes leads to people 'giving up' and withdrawing from available support as it is too difficult to access. It is felt that the dementia pathway would be more easily accessed if people are provided one key contact with a vast local knowledge who could signpost to the right place.

> ***"I then had to ring every department of Doncaster Council for help and was passed from pillar to post. Again, a central contact who can signpost you to the help required." – family member, Bessacarr***

There are a number of issues with transport across the City for people with dementia and their carer(s) reporting that public transport buses have been cut, particularly in rural areas, which limits how accessible the community and services are.

In addition to this, people with dementia report quite a decline in the passenger transport services available to those who rely on such, whereby there are now less buses provided (some of which aren't accessible to people with mobility issues), and the reliability is lacking. It is confirmed that people are often picked up from home late and picked up from their service early to fit around other driver commitments which cuts down valuable time spent accessing necessary services and support.

> ***"There is only one bus (leger), which is very safe and nice drivers, but the buses quite often don't turn up when they have been booked, and we have no alternative to use taxis when the client is vulnerable." – family member, Mexborough***

It is recognised that people with dementia that live alone are at higher risk of being isolated and being in crisis.

It has been raised by people with dementia and their carer(s) that the dementia pathway is difficult to navigate, this barrier will be much larger for those living alone with no informal support network. Organisations and services could work more collaboratively to prevent people living alone being left in vulnerable situations.

People with dementia and their carer(s) also feel there are disparities with services delivered varying between areas. Services can often be concentrated more centrally and in more evolved/urban/connected areas. As the demographic in each area is different, there is a need for future services to meet locality need.

> ***"Lack of funding and services, certainly once you get outside the main towns or Cities like Doncaster. Insufficient specialised care for dementia patients in local areas. Taking someone out of their own area is frustrating as they don't know where they are going prefer not to have to go far" – family member, Thorne***

People with dementia have expressed the need for the availability of differing levels of support for people on different parts of the dementia pathway. It is felt that currently there is not much provision for those at the start or middle of the dementia pathway who are more physically able. This could present an opportunity for further stimulating activities and to help keep people living well at home for longer. Included in this is provision for those with Young Onset Dementia.

"There seems to be little in the way of activities for people in the early/ middle stages of the condition. More services should be available to access e.g. swimming." – person with dementia, Conisbrough

People with dementia and their carer(s) feel support around future care and support options could be more holistic and better personalised to allow people to live well after their diagnosis. People with dementia are not always made aware of what is available to them as an option (e.g. Direct Payments) which prevents more personalised care and support from taking place.

Activities offered can be very limited, particularly within a residential home setting and people are not provided with realistic expectations when they are considering their options. In addition to this, feedback highlighted that they were unaware of how the needs of a person with dementia can change over time leading to implications for people making decisions (e.g. selecting a home that offers both residential and nursing care to avoid a potential future move).

What will good support with diagnosis or memory concerns look like?	
People with dementia and their carer(s) will receive the right support for them to live well. People will be empowered to make informed decisions. Support will be easily accessed and tailored to meet the outcomes of people with dementia.	
1	People will have access to one point of contact for ongoing navigation to ensure they feel continually supported throughout their journey. This support will be available to people with dementia, people in the pre diagnosis pathway and their carer(s)/supporter.
2	Strengthen transport links in Doncaster for people with dementia to increase accessibility of services.
3	A multi-agency approach will be taken towards people with dementia that live alone to coordinate and ensure they have the same quality of care and support as those with an informal support network.
4	Work will be done to consider the impact of social isolation on people living with dementia or memory concerns.
5	Align services/support with the locality way of working to ensure support is built on assets within Doncaster Communities and gaps identified and addressed.
6	Support will be based on needs rather than a one-size-fits-all approach. People with dementia will receive support that they wish to receive aimed at their own level of need and interests.
7	People with dementia and their carer(s) will be fully supported to make informed decisions in relation to future care and support options.

Priority 5 – Support for Carer(s)

What people with Dementia and their family/carer(s) told us

Carer(s) of people with dementia do not feel well supported within their role and often struggle to access information, advice and guidance.

"Lack of support for families, particularly close family members of dementia sufferers." – family member, Bentley

Carer(s) of people with dementia feel too much is expected of them and that their needs are not considered during conversations and decisions about people with dementia.

"Too much care is expected from the husband / wife of the sufferer leading to mental health issues of the other partner" – family member, Sprotbrough

"Carer(s) needs should be included in all discussions" – professional, Doncaster

Some professionals feel that some carer(s) and family members aren't prepared enough to fully understand the effects of dementia.

"I've also recognised for a long time that families are unprepared for the change to their loved ones and the day-to-day routine, brought on as a result of dementia. Often worsening the outcome in relationships." – professional, Doncaster

What will good support for carer(s) and families look like?	
Carer(s) and family members of people with dementia will receive support to help maintain their role to the best of their ability. Carer(s) will have better access to information, advice and guidance. Carer(s) will be aware of the Carer Service in Doncaster and their rights to a carer conversation.	
1	In line with the Doncaster Carer(s) Strategy, carer(s) will be identified at the earliest opportunity to enable them to connect with support.
2	Carer(s) and family members will be fully prepared for the signs, symptoms, and emotional effects of dementia on them and the person with dementia.
3	Carer(s) and family members will have the skills and knowledge to be proactive when supporting the person with dementia.

Well Pathway

The Well Pathway (below) for Dementia is the NHS' five-year implementation plan which covers five key areas: Preventing Well, Diagnosing Well, Supporting Well, Living Well and Dying Well.
Our Strategy aims to align itself with this transformational framework and ensure that all Doncaster residents can live well with dementia within the community of their choosing and with the right support and care around them.

Photo Credit: Hannah Baines, City of Doncaster Council

NHS England Transformation Framework – THE WELL PATHWAY FOR DEMENTIA

PREVENTING WELL	DIAGNOSING WELL	SUPPORTING WELL	LIVING WELL	DYING WELL
Risk of people developing dementia is minimised.	**Timely accurate diagnosis, care plan, and review within first year.**	**Access to safe high-quality health & social care.**	**People with dementia can live normally in safe and accepting communities.**	**People living with dementia die with dignity in the place of their choosing.**
"I was given information about reducing my personal risk of getting dementia."	*"I was diagnosed in a timely way."* *"I am able to make decisions and know what to do to help myself and who else can help."*	*"I am treated with dignity & respect."* *"I get treatment and support which are best for my dementia and my life."*	*"I know that those around me and looking after me are supported."* *"I feel included as part of society."*	*"I am confident my end of life wishes will be respected."* *"I can expect a good death."*
WHAT DOES THIS MEAN FOR DONCASTER?				
• Awareness raising & risk reduction • Education • Public Health campaigns • Yourlife Doncaster Page • Accessible information to everyone	• Increased diagnosis rates • Pre-diagnostic service • Identification and referral • Working with Primary Care Networks • Development of Best Practice protocol • Harmonisation of GP registers and secondary care • Improve patient flow • 6 weeks RTT • Supportive assessment tools • Pro-active case finding • Diagnosis in care homes	• Work across the wider system to support people living with dementia and their carer(s) • Holistic MDT approaches • Improve information sharing/decision making • Ensure support is available to people with dementia and their carer(s) to navigate the system and understand their options for health, care and support. • Acute wards – effective discharge planning • Virtual wards • Ensure there is equity and availability of service • Coproduction of services, ensuring people living with dementia and their carer(s) are involved in designing, developing and renewing services • Personalised care • Promotion of self-care and self-treatment • Care planning and advanced care planning (ReSPECT)	• End of life care • Enhanced care in care homes • Woodfield 24 • Advanced care plan (ReSPECT)	
Health Inequalities, Digital & Social Isolation, Coproduction				

Data and Intelligence

There is an estimated 4517 people of all ages with Dementia in Doncaster. This can be split by older people (65+) and younger people (30-64) as below:

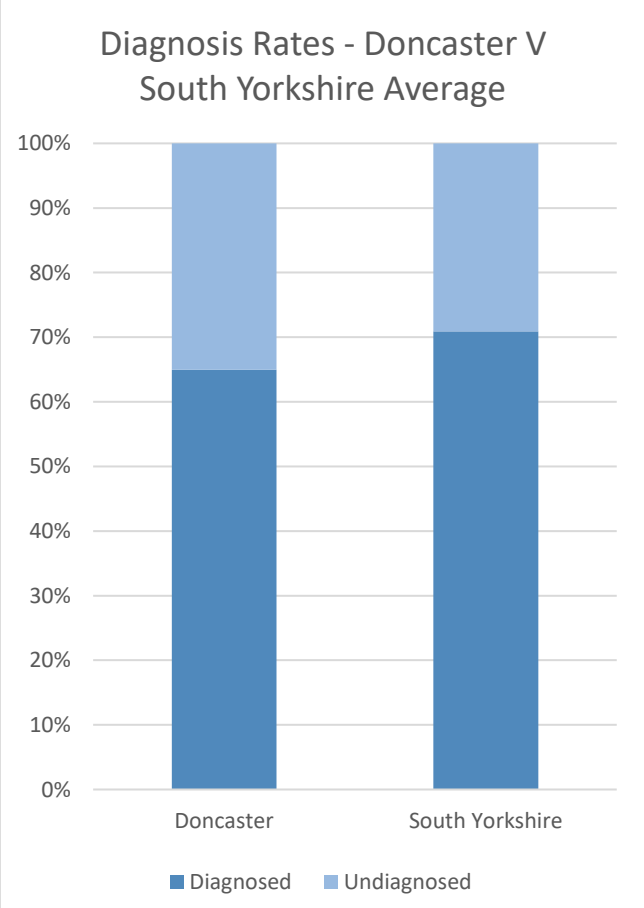
Late Onset Dementia

4347

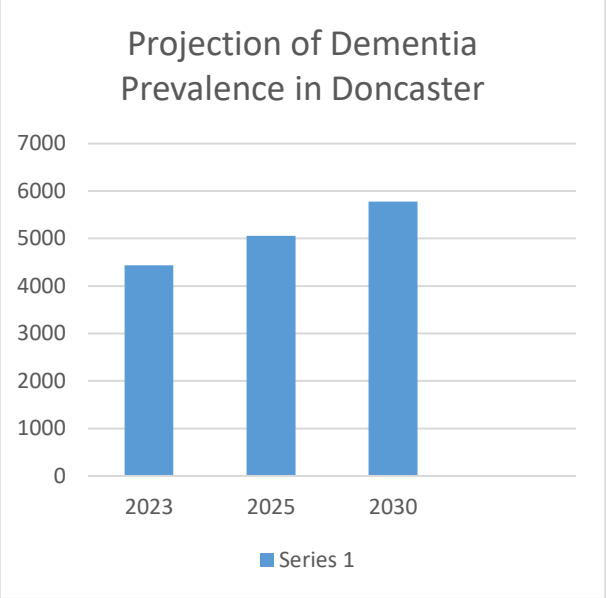
Young Onset Dementia

170

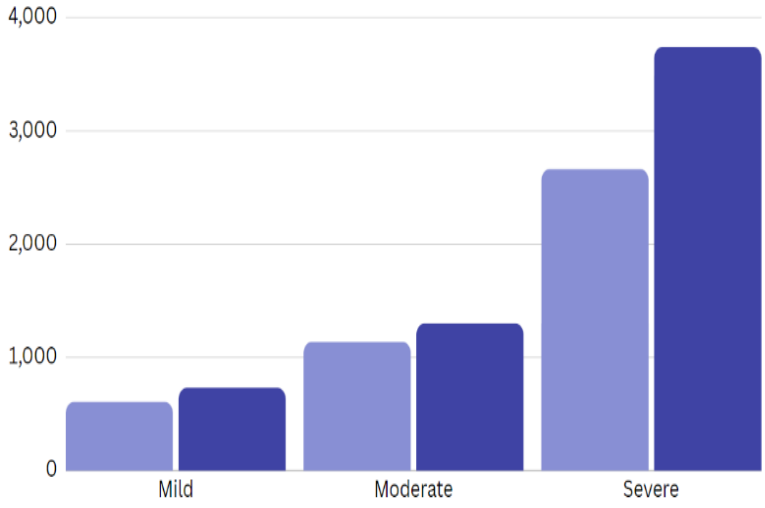
Of those people in Doncaster, 65% have a diagnosis of Dementia with 35% being undiagnosed. The South Yorkshire average of Barnsley, Doncaster, Sheffield and Rotherham is 70.9% of people diagnosed.



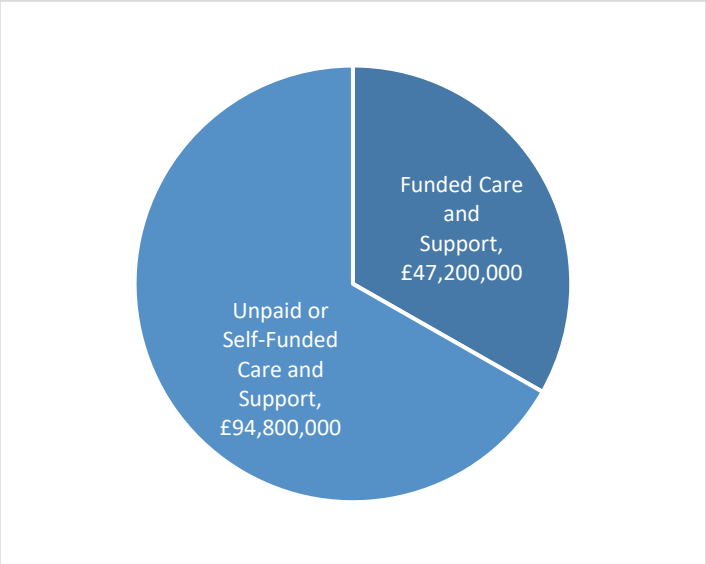
The number of Doncaster residents living with Dementia is estimated to increase 30% by 2030.



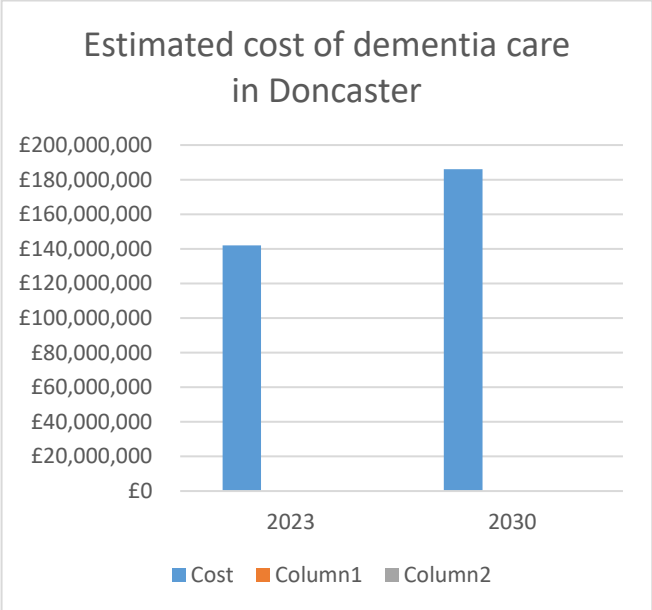
In line with the projected increases, it is also estimated that the number of people with “advanced” dementia will increase over double the rate that mild and moderate severities will.



According to the Alzheimer's Society[2], the cost of dementia care is currently £32,250 per person which totals to £143million in Doncaster. Data suggests two thirds of this cost is being currently met by people living with dementia and their families through unpaid or self-funded care and support.



With the projected increase of 30%, this would see the cost of dementia in Doncaster rise to an estimated £186million by 2030.



In 2019, the Alzheimer's Society commissioned the London School of Economics to undertake research around the cost of dementia care in the UK. The findings, Projections of older people with dementia and costs of dementia care in the United Kingdom, 2019–2040[3], can be found online.

What does the data mean for Doncaster?

Data suggests that people will live longer with dementia in Doncaster and could be the reason it is projected that there will be more people living with "advanced" dementia.

As the forecasted data reveals financial pressures alongside increasing numbers of people needing support, it is vital to consider models of care and support which will maximise people's independence and well-being and effectively manage demand for statutory services.

Work should be done locally, in collaboration with health colleagues, to fully understand the changing need in order to capture data and intelligence to inform future key decisions.

[2] https://www.alzheimers.org.uk/blog/how-much-does-dementia-care-cost Alzheimer's Society, 2021

[3] https://www.alzheimers.org.uk/sites/default/files/2019-11/cpec_report_november_2019.pdf 2019–2040, London School of Economics, 2019

National and Local Context

At present there are currently around 900,000 people in the UK with Dementia, which is projected to rise rapidly over the coming years. This will also see the cost of social care increase too.

Doncaster's Dementia Strategy has been developed in the context of other key national and local policies, which inform the way in which the plans are developed and put in place. National and local plans are focused on ensuring people are supported in the best way and to reach their health and wellness potential.

The strategy will be in place for 2 years to consider emerging national guidelines such as the upcoming National Dementia Strategy and Major Conditions Strategy which will seek to increase and improve life expectancy of those living with major conditions, including Dementia.

Following the government's **All our Health** call to action, guidance was released in 2022 to help health and care professionals prevent ill health, promote wellbeing and use their trusted relationships with individuals, families and communities to promote the benefits of focusing on dementia. This guidance also sets out clear and important actions that managers and staff holding strategic roles can take.

Health and Wellbeing Board Strategic Priorities and Wellbeing vision is:

'A strong local economy, progressive, healthy, safe and vibrant communities. All residents will be able to achieve their full potential in employment, education, care and life chances. 'All residents to be proud of Doncaster'

The ambition for Dementia in Doncaster is for people to agree with the following 'we' statements:

- *"We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it".*
- *"We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness".*
- *"We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live".*
- *"We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future".*
- *"We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part".*

Photo Credit: Hong Lok (Happy & Healthy) Luncheon Group

NHS England's **Long Term Plan** sets out a plan for improvement providing the opportunity to engage with those utilising such services to explore gaps and issues in order to improve them. This sees the NHS commit to the following vision and aims:

"We will go further in improving the care we provide to people with dementia and delirium, whether they are in hospital or at home."

Carer(s) support

- Evidence based interventions for carer(s)

Joined up coordinated care and inter Trust collaboration

- Integrated working: neurology, neuroradiology, and psychiatry in assessment of young onset dementia and Parkinson's Disease Dementia
- Personalised care planning and care coordination

Getting people home without unnecessary delay

- People with dementia stay in hospital twice as long as other older people
- Support delayed discharges for people with dementia

Primary care networks

- Improve dementia diagnosis pathways
- Improve diagnosis in frail/housebound
- Monitoring equipment

Care homes

- Improve diagnosis rates and advance care planning
- Support new models of treatment – specialist intervention for behavioural and psychological symptoms -as well as primary care models

Community MDTs

- Equitable access for people with dementia
- Staff training in dementia/personalised care delivery

Reducing unwarranted variation

- Targeted work on some Integrated Care Board's to improve diagnosis rates
- Memory service audits
- Black, Asian and minority ethnic groups
- NICE guidance implementation – access to post-diagnostic treatment and support
- Work to reduce discrimination against the oldest old

Other considerations

- Primary prevention – what's good for your heart is good for your head
- Transforming outpatients – difficulties for people with dementia to attend
- Stroke rehab – ensure dementia diagnosis is embedded in pathway
- Waste reduction – streamlining memory service pathways
- Volunteers – specific support / training
- Workforce training – use national Dementia Standards

In 2017, the All-Party Parliamentary Group published a **Creative Health Report** which demonstrated that the arts can keep us well, aid recovery and support better lives longer lived. The report recommended that clinical commissioning groups, NHS Provider Trusts and local authorities incorporate arts into their commissioning plans and redesign care pathways where appropriate.

Locally, the **Doncaster Culture Strategy, 2030,** builds on the Team Doncaster Borough Strategy setting a vision for Doncaster to flourish by expressing their own creativity and connecting through shared cultural experiences of power and meaning.

Photo Credit: James Mulkeen, darts

Making It Real (2018) describes a framework and a set of statements describing what good, citizen focussed, personalised care looks like from the point of view of people themselves. We want everyone in Doncaster to live good lives. As such, we fully support the shared vision of a better, brighter future adopted by *#SocialCareFuture* and we adapted this vision to make it our own. To help us make our vision a reality, we are embracing the Making It Real framework. We are tapping into 'Making it Real' to help us evaluate where we are now and understand what we need to do on our journey of continuous development.

The COVID-19 pandemic had a substantial impact on the ageing population which can be seen in both Alzheimer Society's '**Worst hit: dementia during coronavirus**' and Age UK's '**Impact of Covid-19 on older people's mental and physical health: one year on**' reports. The impact of COVID-19 on people with dementia is reported as follows:

- Increase in loneliness and isolation
- Deterioration in physical and mental health and cognitive function
- Increased pressure for paid and unpaid carer(s)
- Increase in the impact of the above on those with Health Inequalities

Launched in September 2021, **Doncaster Delivering Together** provides the guiding coalition document for Doncaster via our Borough Strategy. Developed in partnership with residents, elected members, public, private and third sector organisations. DDT focuses on understanding the variety of needs and aspirations within the borough, as well as what matters to people when it comes to improving the wellbeing of people and places.

The **Doncaster Place Plan, 2023-24,** lists Dementia as one of its key priorities under Mental Health in which it seeks to improve dementia diagnosis rates in Doncaster and achieve a 5% year-on-year increase in the number of adults and older people accessing community mental health services.

South Yorkshire ICS' Five Year Plan sets out the goal to improve care pathways for patients with dementia, with ongoing work in each Place to provide better support in the community for those living with dementia. As part of the out of hospital approach, each Place is developing and implementing plans to support people to age well.

Improving our digital services across Doncaster is also an essential enabler for the delivery of high-quality integrated care and seamless working for our health and care professionals. The Integrated Care Partnership in Doncaster have come together to develop a **digital strategy** to get the best use of technology across Doncaster to support service transformation and integrated, neighbourhood-based care.

The **Doncaster's All Age Carer(s) Strategy 2022- 2025** references carer(s) of people living with dementia as carer(s) with additional disadvantage declaring the need to improve these challenges faced. Actions from this strategy will be aligned to those of the carer(s) strategy to improve outcomes for carer(s) of people living with dementia.

Doncaster's **Locality Plans** initiate a way of locality working to ensure a consistent and co-ordinated service is provided to Doncaster residents but is also reflective of the needs of each locality. Services will be developed accordingly to reflect the needs of the population within each of Doncaster's localities.

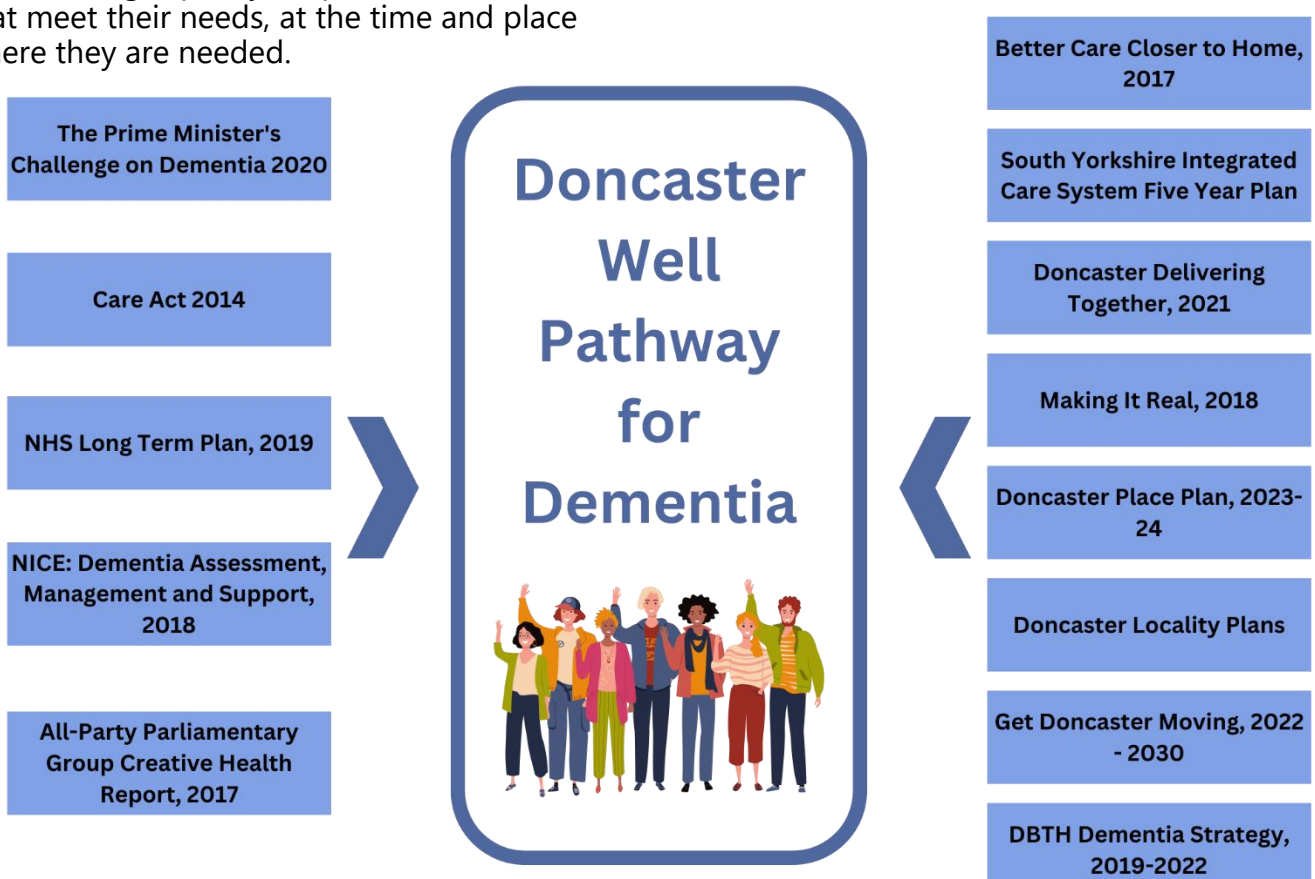
The **Get Doncaster Moving Strategy** provides opportunities for partnership working to keep people living with dementia active, independent and to ultimately live more healthy years of life.

Doncaster and Bassetlaw Teaching Hospital's Dementia Strategy 2019-22 The strategy references the whole delivery of care and would facilitate the seamless transition from primary to secondary care with the goal of reduction in serious incidents, falls and bed days.

The Palliative and End of Life Care Delivery Group are developing a Team Doncaster approach to be adopted across the city. The vision is for care and support to be tailored to community strengths to help residents maximise their independence, health, and wellbeing. Doncaster residents will have access to excellent community and hospital-based services when needed. When referring to those reaching the end of their life, it is crucial people and their family/carer(s) have access to high quality, responsive services that meet their needs, at the time and place where they are needed.

Housing Lin's '**Housing for people with dementia – are we ready?' report, 2021**, confirms the need for Dementia Care Pathways to link care and housing together. Health and care assessments, particularly at the post-diagnostic stage, should take into account the extent to which a person's accommodation is dementia-ready.

The report states that people living with dementia and their carer(s) do not always receive sufficient information and advice about housing implications at the point when they suspect or receive a diagnosis. The report provides practice examples to consider.



Workforce and Volunteering

Workforce Development

The new Workforce Strategy for 2023-2026 focuses on values-based recruitment with clear career pathways to provide the many talents the workforce needs to progress and develop. Through delivering the strategy, the changing expectations of people accessing care and support will be met with a strength-based approach focusing on individual outcomes.

Extension of Community Healthcare Outcomes (ECHO) Project

Extension of Community Healthcare Outcomes is an innovative and new way of learning in healthcare via video link, to form an online community, share best practices and support each other. Doncaster and Bassetlaw Teaching Hospitals Trust ECHO hub have recently launched 'Dementia and me' which explores how Dementia can affect the person, the teams caring for them, and their families. **For more information, please visit:**

Project ECHO (stlukeshospice.org.uk)

Opportunities for volunteering

There is a wealth of voluntary community-based services and support networks available throughout Doncaster. Raising the profile of Doncaster's many community-based assets, many of which are run by the voluntary sector, will be a key part of achieving this commitment. **To learn of volunteering opportunities across the city, please visit:**
https://www.voluntaryactiondoncaster.org.uk/volunteering

Communications and Engagement

Building on our commitment to co-production, a communications and engagement plan will be developed that spans the breadth of work and the communities the plans involve. The plan is building on work that is currently underway, and will make a commitment to the following:

Photo Credit: Home Instead, Dementia Awareness Day, May 2023

1. **Delivering regular updates to the wider community by Newsletter.**
2. **Sharing information about ways for more people to get involved at all levels of the strategy development and implementation.**
3. **Targeting groups who are currently under-represented to seek views, and keep informed of the work and progress or challenges.**
4. **Working with people with lived experience of all ages to make sure that engagement and communications are accessible and meaningful for them.**

Research and Innovation

Research

Research is vital to drive forward and evolve dementia services. Research should be embedded as a standard procedure within the Well Pathway (see page 15). People with dementia and their carer(s) should not be excluded from research opportunities.

Work will be undertaken with the Health Determinants Research Collaborative to help identify potential research opportunities.

Innovation

Where required, we will seek to find new ways of working that will serve people better. We will develop new models of support and service delivery through best practice, being creative and working across the health and social care system whilst ensuring a person-centred approach.

Technology

Technology has much to offer to people living with dementia and their carer(s): access to information, advice, and guidance, entertainment, as well as reassurance when a family member or carer(s) doesn't live close by. Used sensitively and thoughtfully, technology enhances rather than replaces human relationships and interactions.

Arts

The Arts have a valuable role to play in enhancing quality of life for people living with dementia and their family carer(s). They have the power to bring people together in the here and now, providing a way to stay connected with loved ones through shared experiences. The Arts can enliven, stimulate and enable people to express themselves creatively beyond words, enabling them to be seen for who they are beyond their diagnosis.

Photo Credit: James Mulkeen, darts

The Arts & Health Board works with key partners from Social Prescribing, Public Health, health professionals, voluntary/community sector, and cultural organisations to develop and deliver academically researched music programmes for adults living with dementia in Doncaster. Our vision is that everyone can access creative activities resulting in them feeling happier, healthier, and more resilient.

Keeping Active

With any type of dementia, keeping active both physically and mentally has a huge number of benefits. It can improve the health of your heart and blood vessels, help keep your bones strong (reducing the risk of osteoporosis) and prevent falls. In addition to this, keeping active can also improve sleep health.

Best Practice

Best practices are health practices, methods, interventions, procedures, or techniques based on high-quality evidence to obtain improved patient and health outcomes. By working with the Yorkshire and Humber Clinical Dementia Network, we will strive to adopt best practice where possible.

Action Plan

Cross-cutting Themes	
1.1	Doncaster will work to **strengthen co-production** for dementia to ensure services and strategies are driven by people with dementia and their carer(s).
1.2	Ensure that dementia services are **inclusive of everybody** including people with protected characteristics, those experiencing significant poverty (core20 population), people from ethnic minority communities and inclusion health groups.
1.3	**Promotion of courses** for people with dementia, unpaid carer(s), family members, care and support staff, professionals and the wider public. Training provision in Doncaster will be co-produced with people with dementia and their carer(s)'s and evaluated to ensure **training and development is of a high standard.**
1.4	Develop health and social care Dementia Reporting Dashboards in line with the strategy and service implementation.
1.5	Ensure people with dementia are treated with **dignity, respect and compassion**, at service level with health, social care and support staff but also on a wider awareness-raising level with communities across Doncaster.

Information, Advice and Guidance	
2.1	**Information, advice and guidance** will be of a good quality, written in simple to read language accessible to anyone who needs it.
2.2	Advice on reducing the risk of dementia will be available and stakeholders will promote this messaging.
2.3	Access to information digitally will be available in one place (Your Life Doncaster). Access to information will also be available across locality hubs.

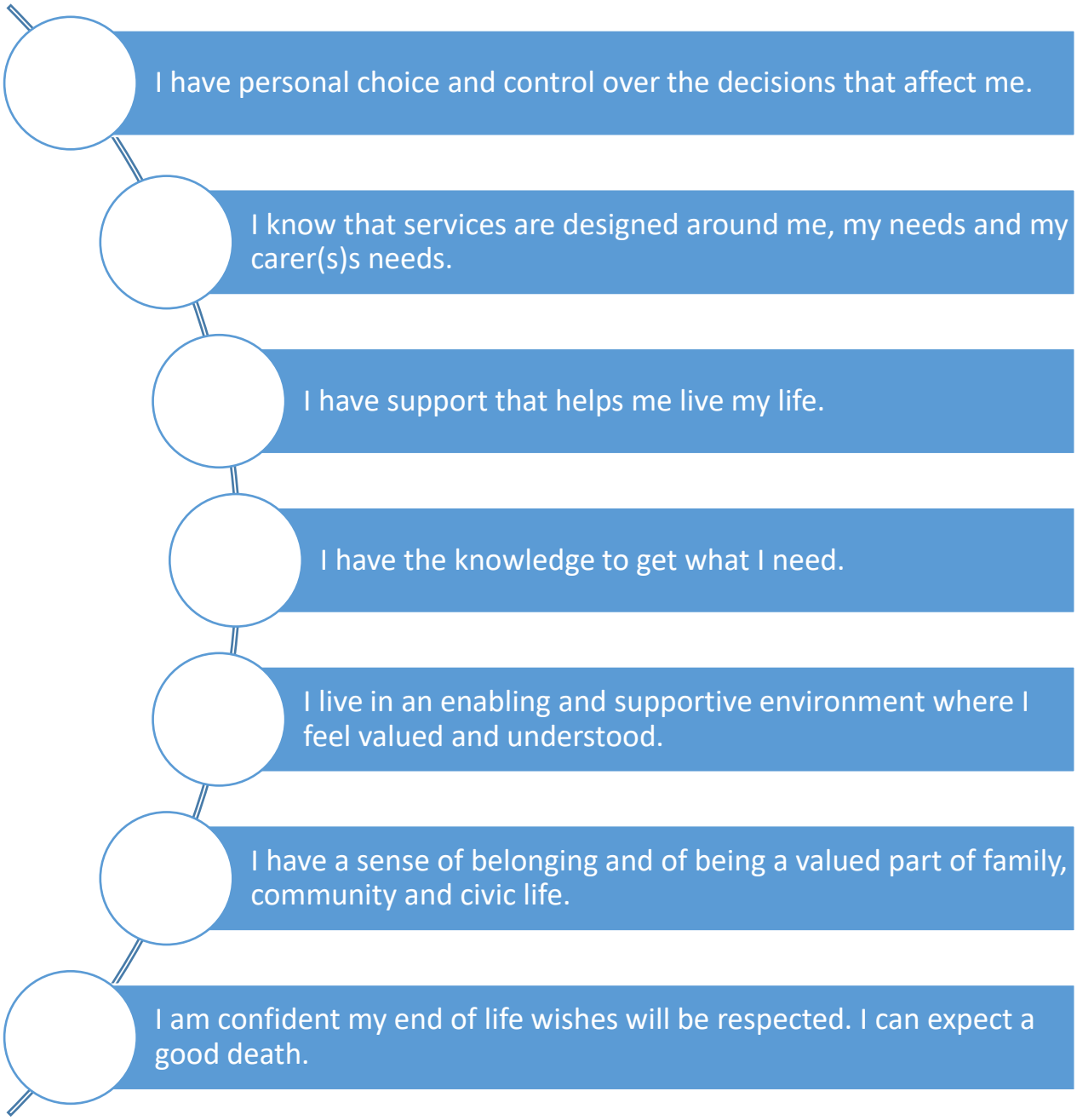
Receiving a Diagnosis	
3.1	Doncaster will maintain their **diagnosis rate** above the national average of 66.7% and work to improve this target to 75% in line with other South Yorkshire authorities.
3.2	Reduce the delay from the point of raising concerns to **receiving a diagnosis**, by working with health partners (GP Access, Clinics and Health Provision).
3.3	Ensure the timely start of **treatment and services** for those diagnosed with dementia.

Support Following Diagnosis	
4.1	People will have access to one point of contact for **ongoing navigation** to ensure they feel continually supported throughout their journey. This support will be available to people with dementia, people in the pre diagnosis pathway and their carer(s)/supporters.
4.2	Strengthen **transport links** in Doncaster for people with dementia to increase accessibility of services.
4.3	A multi-agency approach will be taken towards **people with dementia that live alone** to coordinate and ensure they have the same quality of care and support as those with an informal support network.
4.4	Align services/support with the locality way of working to ensure support is **built on assets** within Doncaster Communities and gaps identified and addressed.
4.5	Support will be **based on needs** rather than a one-size-fits-all approach. People with dementia will receive support that they wish to receive aimed at their own level of need and interests.
4.6	People with dementia and their carer(s) will be fully supported to make **informed decisions** in relation to future care and support options.
4.7	Consider the impact of **social isolation** on people living with dementia or memory concerns.

Support for Carer(s)	
5.1	In line with the Doncaster Carer(s)'s Strategy, **carer(s) will be identified** at the earliest opportunity to enable them to connect with support.
5.2	**Carer(s) and family members will be fully prepared** for the signs, symptoms and emotional effects of dementia on them and the person with dementia.
5.3	Carer(s) and family members will have the **skills and knowledge to be proactive** when supporting the person with dementia.

Outcomes

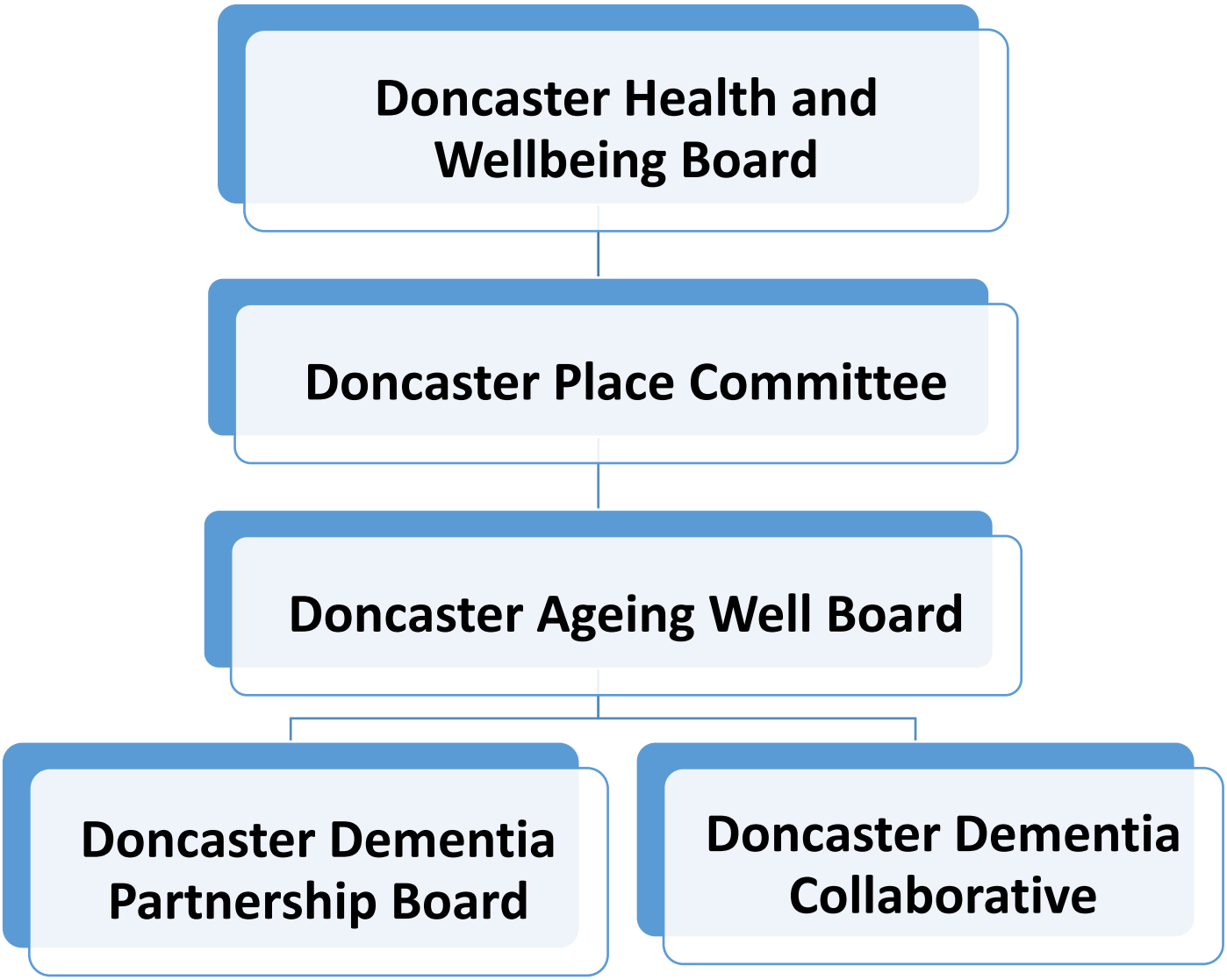
The following 'I' statements taken from the Care Act, 2014, will underpin this dementia strategy.



Governance

During the implementation of this strategy, appropriate leads will be identified through the Strategy Group and for each priority area to drive related actions forward.

The Doncaster Dementia Strategy Group will transform into the Dementia Partnership Board that will meet quarterly to discuss the strategy delivery plan and the delivery of strategy actions will be accountable to the below governance structure:



Acknowledgements

We would like to take the opportunity to express our gratitude to the people living with dementia, their carer(s), families/friends and the Doncaster Dementia Collaborative for sharing their experiences with Team Doncaster in order to shape Doncaster's Dementia Strategy.

And also, the organisations below who have contributed to the development of this strategy:

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City of Doncaster Council

Doncaster Dementia Collaborative

NHS South Yorkshire Integrated Care Board

Team Doncaster Dementia Strategy 2023-2025

Team Doncaster Dementia Strategy

Doncaster Dementia Collaborative

The Doncaster Dementia Collaborative (DDC) is a group formed from the voluntary, community & faith (VCF) communities and Health and Social care statutory and non-statutory organisations, to influence and support positive local change to those effected by dementia living in Doncaster.

Dementia Strategy Group

With representation similar to the DDC, the Dementia Strategy Group (DSG) solely discuss and provide insight to the development of the Dementia Strategy.

Healthwatch Insight Report 2022

- Lack of Support
- Lack of Information
- Navigating the System
- Assessment and Referral
- Diagnosis and Treatment
- Health Inequalities

Engagement with 253 people.

Strategy Priorities

- Information, Advice and Guidance
- Diagnosis of Dementia
- Support with my diagnosis
- Needs of Carers and Family

Cross Cutting Theme

- Health Inequalities
- Dignity and Compassion
- Workforce
- Data
- Co Production

Doncaster Dementia Survey 2023

People with Dementia, Carer and Family – 409 Responses

Stakeholder Survey – 37 Responses

Lived Experience

Wendy Sharps - Co-chair of Doncaster Dementia Collaborative& Doncaster Dementia Strategy Group

Phil Bargh – Member of Doncaster Dementia Collaborative & Doncaster Dementia Strategy Group

Current Commissioning

- Specifications developed alongside the strategy
- Market Event held with potential providers 7th March 2023
- Evaluation June 2023
- Contract Start Date – 01 October 2023

Pre & Post Diagnostic Service

Offering advice, guidance, care and support to people prior to a potential dementia diagnosis and post diagnosis for all levels of need (mild, moderate and severe) including Young Onset Dementia

Community Therapy and Support Service

Offering a range of support and interventions which might include peer support, cognitive resilience, befriending, respite and activities which supports people to live well in their communities and feel less isolated.

Unlocking the Possibilities : A Person Centred Dementia Strategy Action Plan Development

Priority Area	Suggested Lead
Information, Advice and Guidance	Doncaster Council
Diagnosing	Health (joint ICB/RDaSH)
Supporting	Joint – Health/Doncaster Council
Carers	Carer's Strategic Lead
Cross-cutting Themes	A lead on each cross-cutting theme to ensure consideration given within each priority area.

Following governance structure within the strategy.

Unlocking the Possibilities : A Person Centred Dementia Strategy

- Launch W/C 02 October 2023
- Alongside the two new commissioned services
- This links with International Day of Older Persons (IDOP) & the Age Friendly workstream.
- 12 month review including Doncaster Dementia Survey

City of Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 31/08/23

Subject: Alcohol use in over 50s women - Emerging trends in Doncaster

Presented by: Andy Collins, Public Health and Vicki Beere, CEO Project 6

Purpose of bringing this report to the Board	
Public Health is concerned by the increasing number of female alcohol related hospital admissions compared with the Yorkshire and Humber region.	
Decision	
Recommendation to Full Council	
Endorsement	
Information	Yes

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

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

Doncaster is bottom of all South Yorkshire LA's and is 3rd worst in the country for healthy life expectancy for females 2018-2020 (latest available data).

It is estimated that alcohol costs the NHS here in Doncaster £17.2 million a year. Alcohol related hospital admissions are preventable which will reduce the health cost burden but also benefits the individual and their families.

Recommendations

The Board is asked to:-
Raise awareness across the Partnership of the impact of females and alcohol and health burden.
Give thought on approaches to encourage women to access community alcohol support.

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City of Doncaster Council

Alcohol use in over 50s women - Emerging trends in Doncaster.

Andy Collins, Public Health
Vicki Beere, Project 6

Liver Disease Profiles

Data view Compare areas

Geography Districts & UAs in Yorkshire and the Humber region

Topic Liver Disease

Indicator

Hospital admission rate due to liver disease (Female) New data 2021/22 Directly standardised rate - per 100,000

Areas: All in Yorkshire and the Humber region | All in England

Display: Table | Table and chart

Show 99.8% CI values

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	32,288	114.3	111.7	117.0
Yorkshire and the Humber region	–	3,840	140.3	130.2	150.7
Leeds	–	750	204.8	166.5	245.2
Doncaster	–	320	204.4	144.9	269.1
Kingston upon Hull	–	200	175.9	116.8	241.6
Scarborough	–	95	164.3	110.8	226.5
Sheffield	–	380	147.0	119.2	177.0
York	–	140	141.8	91.0	199.5
Rotherham	–	185	140.0	100.2	184.3
Calderdale	–	150	137.1	86.1	194.6
East Riding of Yorkshire	–	280	136.1	100.1	175.4
Richmondshire	–	30	126.9	51.4	225.2
Wakefield	–	220	122.4	99.8	147.5
Selby	–	60	121.1	55.8	200.2
North East Lincolnshire	–	95	112.6	58.2	176.0
North Lincolnshire	–	105	112.6	68.5	163.5
Kirklees	–	235	111.2	84.0	141.1
Hambleton	–	65	109.3	46.2	185.1
Barnsley	–	135	107.7	74.2	145.8
Ryedale	–	40	107.7	40.0	193.6
Bradford	–	245	96.3	68.8	126.6
Harrogate	–	85	94.4	62.2	132.3
Craven	–	20	71.3	24.9	135.0

Source: Calculated by Office for Health Improvement and Disparities (OHID): Health & Social Care from data using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Local Alcohol Profiles for England

Data view ▼
Compare areas

Geography
Counties & UAs in Yorkshire and the Humber region

Topic ▼
Hospital Admissions

Indicator
Admission episodes for alcohol-related conditions (Narrow) (Female) 2021/22 Directly standardised rate - per 100,000 ▼

Areas: **All in Yorkshire and the Humber region** | All in England
Display: **Table** | Table and chart

Show 99.8% CI values

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	96,230	341	339	343
Yorkshire and the Humber region	–	10,385	381	374	389
Rotherham	–	656	489	452	528
Barnsley	–	600	481	443	521
Doncaster	–	722	468	434	504
Sheffield	–	1,178	456	430	483
Bradford	–	1,059	424	399	450
North Yorkshire Cty	–	1,405	411	389	434
Kingston upon Hull	–	501	407	372	445
Wakefield	–	621	351	323	379
North East Lincolnshire	–	271	330	292	372
East Riding of Yorkshire	–	622	327	301	354
Kirklees	–	689	323	299	348
Calderdale	–	342	319	286	354
Leeds	–	1,151	305	288	323
North Lincolnshire	–	267	302	266	341
York	–	303	299	266	335

Source: Calculated by OHID: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

Local Alcohol Profiles for England

Data view
Compare areas

Geography
Counties & UAs in Yorkshire and the Humber region

Topic
Hospital Admissions By Age-Group

Indicator
Admission episodes for alcohol-related conditions (Narrow) – 40 to 64 years (Female) 2021/22 Directly standardised rate - per 100,000

Areas All in Yorkshire and the Humber region | All in England

Display Table | Table and chart

Show 99.8% CI values

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	55,545	597	592	602
Yorkshire and the Humber region	–	6,146	687	669	704
Doncaster	–	455	892	811	978
Rotherham	–	394	886	801	979
Sheffield	–	708	845	784	910
Barnsley	–	349	835	749	928
Bradford	–	660	797	737	860
Kingston upon Hull	–	317	789	705	881
North Yorkshire Cty	–	826	729	679	781
Wakefield	–	367	624	561	691
East Riding of Yorkshire	–	372	612	551	678
North East Lincolnshire	–	163	604	514	706
Calderdale	–	201	549	476	631
Kirklees	–	392	549	496	606
North Lincolnshire	–	157	538	456	630
York	–	164	517	441	603
Leeds	–	621	513	473	555

Source: Calculated by OHID: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Local Alcohol Profiles for England

Data view
Compare areas

Geography
Counties & UAs in Yorkshire and the Humber region

Topic
Key Indicators

Indicator
Alcohol-specific mortality (1 year range) 2021 Directly standardised rate - per 100,000

Areas: All in Yorkshire and the Humber region | All in England

Display: Table | Table and chart

Show 99.8% CI values

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	7,556	13.9	13.6	14.2
Yorkshire and the Humber region	–	876	16.6	15.5	17.8
Doncaster	–	69	22.7	17.6	28.8
Wakefield	–	78	22.7	17.9	28.3
Calderdale	–	45	21.1	15.4	28.3
Kirklees	–	86	20.7	16.6	25.6
Kingston upon Hull	–	44	18.6	13.5	25.0
Barnsley	–	44	18.3	13.2	24.6
Sheffield	–	87	17.6	14.1	21.7
North Lincolnshire	–	31	17.1	11.6	24.4
Bradford	–	80	16.6	13.1	20.7
Leeds	–	113	16.2	13.3	19.4
Rotherham	–	36	13.9	9.7	19.3
North Yorkshire Cty	–	93	13.7	11.0	16.9
North East Lincolnshire	–	18	11.9	7.0	18.9
York	–	20	10.4	6.3	16.1
East Riding of Yorkshire	–	32	8.7	5.9	12.4

Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

Home | NDTMS reports | Reporting timetable | SPOC | ViewIt | Monthly provisional statistics | Parental substance misuse | Value for Money | Other

ViewIt - information restriction guidelines apply

Adult profiles: Adults in treatment - Doncaster - Female - All in treatment

+ Supporting information

View data | Download data

Numbers in treatment | Geographic comparison

(●) Adult (18+) ( ) Young people (<18)

Geographic area: Yorkshire & the Humber

Local Authority: Doncaster

Key Indicator Categories: Headline figures

Key Indicator: Adults in treatment

Substance category: Alcohol only

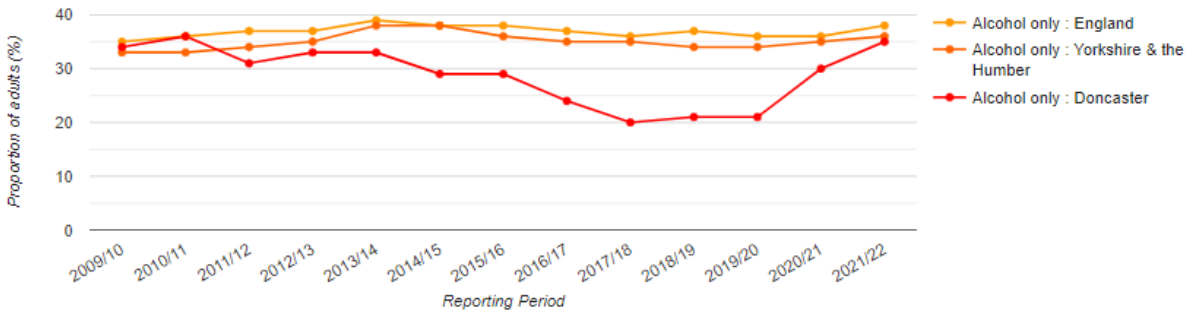
Sex: Female

Alcohol only users

Area: England | Yorkshire & the Humber | Doncaster

Substance categories: Opiate | Non-opiate only | Alcohol only | Non-opiate & alcohol

Apply Filters



Substance category	Area	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)	2021/22 (%)
Alcohol only	England	35	36	37	37	39	38	38	37	36	37	36	36	38
Alcohol only	Yorkshire & the Humber	33	33	34	35	38	38	36	35	35	34	34	35	36
Alcohol only	Doncaster	34	36	31	33	33	29	29	24	20	21	21	30	35

What does the research show? Drink Wise Age Well

- Most adults over 50 drinking harmfully/hazardously had not been screened by health care professionals in the previous 12 months
- Most adults asked (73%) had no idea what safer drinking levels were
- Engagement in services increased in specialist services for the over 50's
- Hospital admissions reduced for those engaging with alcohol treatment (52% - 16%)
- https://www.drinkwiseagewell.org.uk/media/publications/pdfs/evaluation-report-2015-2020.pdf

What does the research show? A system designed for women?

- Services are often gender blind and designed for the needs of male opiate users
- Women face additional barriers such as domestic/sexual abuse/violence, shame and stigma
- Recommendations of the above report include:
- Providers need to provide flexible and female only spaces plus the capacity for female key workers
- Women with lived experience should be involved with designing services and pathways
- https://www.wearewithyou.org.uk/who-we-are/research/research-report-a-system-designed-for-women/

What does our Doncaster service provision tell us?

- Project 6 has been delivering bespoke support to over 50's alcohol users for over a year
- We have supported 112 over 50's and 46 were women
- We have supported 250 people and 107 women in total…
- **Common issues for women are**
- Isolation/loss/breakdown of relationships
- Shame/Stigma
- Feeling stuck/lost/loss of status or purpose in early retirement
- Managing Menopause

Our outcomes for women

- Women reported valuing a more accessible, bespoke, non-clinical service
- 87% of women agreed or strongly agreed that their mental health had improved
- 75% of women agreed or strongly agreed that their physical health had improved

- https://vimeo.com/852992091/1caaf259ed?share=copy

- https://vimeo.com/852994510/3617c7ffc7?share=copy

project 6

City of Doncaster Council

Doncaster
Health and Wellbeing Board
Date: 31/8/2023

Subject: Better Care Fund Plan 2023-25

Presented by: Mike McBurney

Purpose of bringing this report to the Board	
Decision	No
Recommendation to Full Council	No
Endorsement	Yes
Information	Yes

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

How will this contribute to improving health and wellbeing in Doncaster?
The Better Care Fund (BCF) enables people to stay independent for longer and improves hospital discharge and reablement pathways through services across health, public health, and adult social care. Broadly speaking BCF's aim is to make the most efficient and effective use of health and social care resources by breaking down organisational barriers. In doing so it assists people to live independently in their communities for as long as possible and to deliver the right care, in the right place, at the right time.

Recommendations
1.1 That the board acknowledges sign-off of the BCF plan.

1.2 That the board notes a Section 75 agreement between South Yorkshire Integrated Care Board will be signed no later than 31st October 2023, that will include details of the new national conditions and metrics.

1.3 That the board reviews progress of Doncaster's BCF plan for 2023-25 and evaluation of BCF performance at future meetings.

City of Doncaster Council

Report

Date: 31/08/2023

To: The Doncaster Health and Wellbeing Board

Report Title: Better Care Fund Plan 2023-25

Relevant Cabinet Member(s)	Wards Affected	Key Decision?
Cllr Sarah Smith Cllr Rachael Blake	Boroughwide	No

1. EXECUTIVE SUMMARY

1.1 The Better Care Fund (BCF) plan and subsequent quarterly statutory return are the responsibility of the Health and Wellbeing Board. The BCF planning requirements and financial allocations for 2023-25 were issued by NHS England and NHS Improvement for return of submission on the 28th of June 2023.

1.2 The financial allocations for Doncaster are as follows:

Funding source	Income Year 1	Income Year 2
Disabled Facilities Grant	2,782,137	2,782,137
Minimum NHS Contribution	28,996,056	30,637,233
iBCF	16,310,384	16,310,384
Local Authority Discharge Funding	2,286,690	3,795,906
ICB Discharge Funding	1,711,000	2,774,000
Total	**54,112,550**	**56,299,660**

The minimum required to be spent from minimum ICB allocations is:

	Year 1	Year 2
NHS commissioned out of hospital spend from the minimum ICB allocation	8,239,857	8,706,233
Adult Social Care services spend from the minimum ICB allocations	9,573,771	10,115,647

1.3 The BCF national conditions and metrics have changed, these are:

- Avoidable admissions data (indirectly standardised rate of admissions per 100,000 population). The ambition is to have a phased improvement of 7% by quarter 4, factors supporting this improvement is the development of the virtual ward, the neighbourhood delivery model, focusing on community assets to improve health outcomes.

- Falls (emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000). The system wide frailty network is planned to deliver a 5% reduction in the standardised rate in 2023-24. A review of local pathways for falls with a focus on increasing activity, prevention, early identification, and intervention with support from the system wide frailty network.
- Discharge to usual place of residence (percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence). There is a quarterly improvement from baseline of 92.77% to 95% end of year 2023/24. We will work with existing health and care providers to deliver proactive care in the community for multi-morbid and frail individuals, we will fully implement hospital discharge policy and service specification.
- Residential admissions (long term support needs of older people aged 65 and over met by admission to residential and nursing care homes, per 100,000 population). The implementation of discharge to assess across all pathways this year will ensure that a timely review of pathway 2 admissions will support more people to return home in a timely way and positively impact upon transfers from short stay to permanent admissions to improve performance. The dementia diagnosis and treatment offer across Primary Care Networks (PCNs) to support in the development of best practice protocol.
- Reablement (Proportion of older people 65 and over who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services). Recognising data quality has been an issue in previous years, plans and actions are in place to improve reporting on reablement outcomes for people across all partners and commissioned services. Further develop the neighbourhood delivery model, enabling people within communities, together with organisations, to become equal co-commissioners and co-producers focussing on the holistic wellbeing, fitness and physical and mental health making the use of all assets to improve community outcomes.

1.4 Submission Timetable

The submission of Doncaster's BCF plan has been overseen by members of the Joint Commissioning Operational Group (JCOG).

BCF planning submission 2023-25	28th June
National assurance completed	28th July
Approval letters issued 2023-25	8th September
Quarterly reporting to resume	1st October 2023
Section 75 agreements to be signed off	31st October

1.5 Doncaster BCF Plan

Given that funding announcements were brought forward, the majority of existing schemes have been rolled over into 2023-25 with an uplift for inflation where appropriate. The final plan is required to be submitted to NHS England on a spreadsheet template with supporting narrative, however, for ease of review and comment, the key information has been extracted and attached as appendices:

Appendix 1: BCF narrative plan

Appendix 2: Financial summary detailing the budget plan for Doncaster Council and NHS South Yorkshire for BCF, iBCF and Disabled Facilities Grants.

2. EXEMPT REPORT

2.1 There are no exemptions or confidential information contained within this report.

3. RECOMMENDATIONS

3.1 That the board acknowledges sign-off of the BCF plan.
3.2 That the board notes a Section 75 agreement between South Yorkshire Integrated Care Board will be signed no later than 31st October 2023, that will include details of the new national conditions and metrics.
3.3 That the board reviews progress of Doncaster's BCF plan for 2023-25 and evaluation of BCF performance at future meetings.

4. WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4.1 BCF plans address health inequalities and improved outcomes for vulnerable groups such as people experiencing homelessness, mental health challenges, learning disabilities and autism.
4.2 BCF is actioned jointly with a focus on working age and older adults.
4.3 BCF places emphasis on integrated working to improve outcomes for local people. Most notably improving discharge, reducing the pressure on urgent and emergency care and social care, supporting intermediate care, unpaid carers and housing adaptations.
4.4 Additional funded support is available to reduce delays in discharge, improve prevention, manage overall system flow and improve integration between health, housing and adult social care services.
4.5 Improved Better Care Fund (IBCF) is ringfenced to reduce seasonal pressures, support hospital discharge and sustainability of the social care market.
4.6 Disabled Facilities Grants (DFG) as part of BCF is ringfenced to enable housing authorities to continue to meet their statutory duty.
4.7 Adult Social Care Discharge Funding (ASC DF) as part of BCF is ringfenced to build additional social care and community based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvements for patients.

5. BACKGROUND

5.1 The BCF is a single pooled budget for health and social care services to work strategically in local areas, based on a plan agreed between the NHS and local authority which is then signed off by the Health and Wellbeing Board. The BCF comprises a substantial level of funding in order to support health and social care integration.
5.2 BCF takes a strategic approach to integrated commissioning with reporting and planning jointly agreed by South Yorkshire Integrated Care Board (SY ICB) and City of Doncaster Council Chief Executive prior to sign off of plans from the HWB.
5.3 Broadly speaking BCF's aim is to make the most efficient and effective use of health and social care resources by breaking down organisational barriers. In doing so it assists people to live independently in their communities for as long as possible and to deliver the right care, in the right place, at the right time.

6. OPTIONS CONSIDERED

6.1 As national planning guidance and planning submission being brought forward, there is little alternative to continuing existing schemes between 2023-25.

7. REASONS FOR RECOMMENDED OPTION

7.1 There are limited timescales and notice periods required to end contracts.

8. IMPACT ON THE COUNCIL'S KEY OUTCOMES

Great 8 Priority	Positive Overall	Mix of Positive & Negative	Trade-offs to consider – Negative overall	Neutral or No implications
Tackling Climate Change	✓			
BCF provides fuel poor and vulnerable private sector owner occupied households with grant funding to repair/replace boilers and/or heating systems and other energy measures, including but not limited to boilers on prescription.				
Developing the skills to thrive in life and in work	✓			
BCF provides capacity and expertise to raise the profile of apprenticeships in health and social care, expand opportunities for apprenticeships into new vocational areas and ensure that apprenticeships form a core part of workforce planning and development arrangements going forward.				
Making Doncaster the best place to do business and create good jobs	✓			
BCF mitigated staffing capacity risks and market sustainability within adult social care by uplifting national living wage rates to support workforce retention through investment from the ASC DF.				
Building opportunities for healthier, happier and longer lives for all	✓			
BCF enables people to stay independent for longer and improves hospital discharge and reablement pathways through services across health, public health and adult social care.				
Creating safer, stronger, greener and cleaner	✓			

communities where everyone belongs				
BCF has recently commissioned a piece of engagement work which has informed the development of a Doncaster dementia strategy and future procurement of dementia services for pre and post diagnostic interventions and community therapies support service.				
Nurturing a child and family-friendly borough	✓			
BCF provides access to counselling for children under 12 that has reduced waiting times and improved the standard of counselling. The vulnerable adolescents project reduces the number of adolescents entering the care system through a therapeutic preventative approach. Doncaster's single 1001 days offer has improved antenatal and postnatal pathways around family hub services and childcare placements.				
Building Transport and digital connections fit for the future	✓			
BCF part funds the implementation of digital record sharing over five systems which include the DBTH clinical portal and RDASH System One. This will give Doncaster health and care professionals access to alerts, allergies, appointments, care plans, co morbidities, diagnoses, discharge information, encounters, medications, referrals and vaccinations.				
Promoting the borough and its cultural, sporting, and heritage opportunities				✓
Comments:				
Fair & Inclusive	✓			
BCF funds the stronger community wellbeing service that works with community adult learning disability teams and sensory teams. The Gypsy Roma Traveller (GRT) link workers provide workforce training in how to open communications with GRT groups and break down barriers with activities including health fayres, translation services, skills and training and further research into mental health/ suicide prevention.				

9. LEGAL IMPLICATIONS

Section 1 of the Localism Act 2011 provides the Council with a general power of competence, allowing the Council to do anything that individuals generally may do. Section 111 of the Local Government Act 1972 gives the Council the power to purchase goods and services. The Care Act 2014 places a number of duties to promote an individual's wellbeing, ensuring care and support provision is integrated together with other health provision.

Section 75 of the NHS Act 2006 allows partners (NHS bodies and Councils) to contribute to a common fund which can be used to commission health and social care related services.

10. FINANCIAL IMPLICATIONS HR 21/07/23

NHS England have confirmed allocations of funding that forms part of the Better Care Fund Plan for both 2023/24 and 2024/25. The table below shows the combined budgets allocated to Doncaster City Council and Doncaster Integrated Care Board (ICB) along with the previous year's underspend of Disabled Facilities Grant (DFG):

Funding source	**2023/24**	**2024/25**
Local Authority - Disabled Facilities Grant	2,782,137	2,782,137
Local Authority - Disabled Facilities Grant b/f	2,026,282	0
Local Authority - Minimum NHS Contribution (BCF)	9,521,000	10,058,000
ICB - Minimum NHS Contribution (BCF)	19,475,056	20,579,233
Local Authority - iBCF	16,310,384	16,310,384
Local Authority Discharge Funding	2,286,690	3,795,906
ICB Discharge Funding	1,711,000	2,774,000
Total	**54,112,550**	**56,299,660**

The conditions of the funding are set out in guidance provided by NHS England and a detailed plan has been submitted as per the deadline highlighted in para 1.4. Further conditions of the funding require sign off by the Health and Wellbeing Board and a Section 75 agreement between the Council and the ICB by 31st Oct 2023.

Quarterly monitoring reports are expected to resume for quarter 2 in 2023/24 whereby both expenditure and targets/progress against the metrics will be submitted to NHS England.

The Local Authority allocations formed part of the Council's Revenue Budget 2023/24 – 2025/26 and Capital Strategy and Capital Budget 2023/24 – 2026/27 agreed by full Council on 27th February 2023.

11. HUMAN RESOURCES IMPLICATIONS

There are no specific human resource implications in relation to this report.

12. TECHNOLOGY IMPLICATIONS

There are no specific technology implications in relation to this report.

13. RISKS AND ASSUMPTIONS

The risk of not completing the BCF plan 2023/25 is that regional and national assurance cannot be granted.

14. CONSULTATION

The annual return and narrative have been discussed at JCOG with initial feedback also being received from the regional Better Care Fund Manager.

15. BACKGROUND PAPERS

Not applicable

16. GLOSSARY OF ACRONYMS AND ABBREVIATIONS

BCF – Better Care Fund

SY ICB - South Yorkshire Integrated Care Board

HWB - Health and Wellbeing Board

IBCF - Improved Better Care Fund

DFG - Disabled Facilities Grants

ASC DF - Adult Social Care Discharge Funding

HICM - High Impact Change Model

DBTH – Doncaster Bassetlaw Teaching Hospital

RDaSH – Rotherham, Doncaster and South Humber

GRT - Gypsy Roma & Traveller

JCOG – Joint Commissioning Operational Group

17. REPORT AUTHOR & CONTRIBUTORS

Mike McBurney, Senior Policy Insight and Change Manager (Strategic Commissioning)
01302 736830; michael.mcburney@doncaster.gov.uk

Contributors: Joint Commissioning Operational Group representatives from commissioning and finance colleagues within Doncaster Council and South Yorkshire Integrated Care Board.

Lead Officer: Phil Holmes Director of Adults Health and Wellbeing

APPENDIX 1

Doncaster Better Care Fund Narrative Plan

2023 -25

1. BCF Governance

Better Care Fund (BCF) planning documents have received delegated sign off from Doncaster Health and Wellbeing Board (HWB). This follows consultation with officers across NHS South Yorkshire and relevant directorates within City of Doncaster Council such as Public Health and Adults Health and Wellbeing directorates, referred to throughout the BCF plan as the Local Authority (LA). It has been jointly developed with partners including NHS Trusts, social care, third sector organisations and the South Yorkshire Integrated Care Board (ICB). Established in July 2022, the ICB is responsible for planning and funding NHS services in South Yorkshire along with partner board members Healthwatch and Rotherham Doncaster and South Humber NHS Trust (RDaSH).

Doncaster HWB provides strategic assurance of BCF planning and reporting activities. There has been a number of stakeholders contributing towards the narrative plan, spending plans and BCF forecasted metrics. Plans have been informed by a refresh of our Doncaster Joint Strategic Needs Assessment and insights from what Doncaster communities have told us matters to them. It builds on all our existing strategies and plans and is aligned to the recently published South Yorkshire Integrated Care Partnership Strategy.

Stakeholders meet on a monthly basis at the Joint Commissioning Operational Group (JCOG) such as NHS South Yorkshire, Doncaster and Bassetlaw Teaching Hospital (DBTH), the LA and RDaSH. There are also contributions to the plan from stakeholders across Doncaster's voluntary community sector representatives, housing and Disabled Facilities Grant (DFG) leads.

2. Key Priorities

The key priorities for 2023-25 draws together the key workstreams and governance reporting across health, social care and public health life stage plans in order to understand the challenges, achievements and opportunities in Doncaster. This shapes how we collectively meet priorities and develop new ways of working across Doncaster as well as the services we commission and deliver. The BCF plan works across place, building on the foundations set out in the Place Plan, the Commissioning Strategy and the South Yorkshire Integrated Care Plan (ICP).

A key change since the previous BCF plan is the introduction of the One Doncaster Plan which replaces the Doncaster Place Plan as a long-standing strategic document that BCF schemes support. Community care and support networks are more prominent than ever in the plans to maximise independence and health and wellbeing with a priority around preventive approaches to improve outcomes and reduce health inequalities. There are 5 pillars within the One Doncaster Plan:

- Understand our communities: To strengthen community voices, using population health data to better understand health inequalities to focus action and resource allocation.

- Connecting people: To build on relationships, networks, and trust between partners and then to connect communities together.
- Access to services: To be inclusive, to make sure that no one is left behind with a focus on our Core20 and inclusion health communities.
- Shared approach: Commitment to the Doncaster shared care record supporting people to tell their story once.
- Model of delivery: To move towards a more needs-led, compassionate social model. Agree what to stop doing to create capacity for wider partnership working.

3. Overall BCF approach to integration

In Doncaster we have a joint Ageing Well delivery plan which identifies key areas within BCF, by working together as commissioners we will achieve the below commissioning vision:

"Doncaster ageing population will receive person centred flexible and integrated care and support in their own home that aims to maximise their health, wellness and independence"

We have robust joint commissioning arrangements across a number of services within Doncaster including but not limited to residential and nursing care and domiciliary care. This provides the market with clear direction and a seamless transition for people if they move from social care funding to health funding. It also provides the opportunity for joint market development and quality improvements. As part of the market sustainability fund, the LA and the ICB took steps to address the cost pressures within the market and utilised funding to increase care fees in line with the outcome of the fair cost of care, completed in 2022 and funded by the Adult Social Care Discharge Fund (ASC DF). These actions were in line with our joint ambition to increase capacity within the market and provide sustainable services within Doncaster.

Planning for BCF within Doncaster is completed jointly between the LA and the ICB. We have arrangements in place to discuss any proposals through the Joint Commissioning Operational Group (JCOG). Any proposals are considered across the partnership to ensure they deliver outcomes in line with our ambitions for Health and Social Care in Doncaster. The vision for Health and Care in Doncaster for 2023-25 has a clear ambition for all partners to prioritise prevention and have a population health management approach in order to impact on outcomes and reduce health inequalities:

"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"

The Doncaster Borough Strategy 2030 was launched in 2022 and describes the collective effort, through Team Doncaster, to improve the wellbeing of everyone in the borough. The Healthy and Compassionate quadrant within the Borough Strategy Team Doncaster partners include:

- NHS South Yorkshire Integrated Care Board
- Doncaster Metropolitan Borough Council
- Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Primary Care Doncaster Limited

- Voluntary Action Doncaster
- Healthwatch Doncaster
- FCMS Ltd
- St Leger Homes Doncaster

Partners come together as members of the Doncaster Place partnership board which provides the formal leadership for Doncaster and is responsible for setting strategic direction and agreeing the broad objectives for Doncaster. It provides oversight for all Doncaster partnership business, and a forum to make decisions together on those matters which are best tackled collectively. There is a clear joint commitment of working together and a number of the key actions are also reflected across Doncaster place. The progress and impact of this joint working is monitored monthly by the Place Committee, who are able to unblock any areas that prevent this joint approach.

Both the dementia insight report and the findings of the survey have directly shaped the strategy priorities and specifications for both the pre and post diagnostic service and community therapy and support service, this will ensure that the commissioned service will deliver on the aims and vision of the strategy along with wider system/partnership working as the strategy won't be delivered by commissioned services alone.

4. BCF integrated case studies

a. *Dementia Service*

The dementia service is a partnership of 6 providers working together under an alliance agreement as a joint commissioning arrangement with commissioning leads from ICB and LA. This was commissioned jointly with providers RDaSH, Alzheimer's society, Making Space, Choices for Doncaster and Age UK. A recent engagement piece captured the voice of people living with dementia with the aim to improve their lives and inform future procurement of dementia services, namely pre/post diagnostic service and community therapies support service. This has highlighted areas of improvements to services and improve flow of information, support, navigating the system referral, assessment/ diagnosis and treatment process.

b. Frailty Project

It has been recommended that earlier identification of those at risk of falls/ deconditioning and improved coordination across system partners is needed. This includes using evidence-based interventions to help resident's rehabilitation and therefore lessen injuries due to falls. Improved access to preventative services, more efficient and consistent referral routes into reablement services will lead to increased professional knowledge of local services and place level services around frailty and new ways of working. The project is linking into appreciative inquiry work within Be Well Teams supporting 5 ways to wellbeing as part of health checks from GP surgeries. The project supports Primary Care Networks in early identification, multi-disciplinary approach, new way of working on a borough wide basis through social prescribing and a falls specialist contract. It is now standard practice to review tier 1 data in one place between DBTH and RDaSH (acute data) with South Yorkshire falls meeting taking place on a monthly basis with an overall blueprint for South Yorkshire. The frailty oversight group will develop and deliver a frailty action plan focussing on the following key areas:

- Early identification and prevention
- Multi-disciplinary team working
- Community voice

c. Vulnerable Adolescents

Child protection numbers are rising in Doncaster meaning a different way of working is needed with children and families by bringing a number of different service areas together. A new youth and adolescent board have been established with work undertaken with the teams to find a way for children to stay in their own home and target support with families.

The operating model is developed from individual therapeutic support plans as a flexible approach to create a sense of sustainability for young people in their family network with a focus on urgent intervention cases. The team takes a systemic whole family, trauma informed approach based on delivering individual therapeutic support plans developed through psychological formulation. Models of intervention include a number of different approaches such as relationship-based interventions to promote change, behavioural /parenting work, individual therapy adult or child with an attachment and trauma-based difficulties.

Vulnerable adolescents project has bespoke family intervention plans and outcomes framework which reviews the number of closures at 3-month, 6 month and 12-month intervals. Since becoming operational in April 2022, the team have worked with 61 families and 114 children and young people. Two young people have unfortunately entered the looked after children system, however, in 98% of cases intervention is currently enabling young people to remain living safely at home. This demonstrates the efficacy of the current approach, as the vast majority of children are diverted from the trajectory of becoming looked after and indicates the current model of practice is delivering sustainable change for young people.

5. National Condition 2 – Enabling people to stay well, safe and independent at home for longer through BCF schemes

Locality plans have been developed in conjunction with residents and set out what we will be doing to improve communities over the next two years. Partners engaged with communities through a number of different ways and the learning has been fed into individual locality plans. The themes identified by communities from engagement around health are listed below and feed into the Doncaster One Plan:

- Develop neighbourhood health services
- Improve communication and continually promote and improve personal wellbeing
- Continually promote positive health strategies and initiatives
- Raise awareness of and provide support to access local services and support
- More activities for the elderly, those isolated and lonely
- Increase awareness of being active and the benefits to mental health and wellbeing
- Promote and support access to apprenticeships and employment opportunities
- Raise awareness and publicise community mental health

Outcomes and impact on people:

- To take every opportunity to better support people in order to avoid crisis
- To support people to remain at home where possible
- To reduce the number of people waiting in hospital beds, who are fit to return home
- To support people to return to their usual place of residence
- To be able to care for people close to home to prevent people needing to be transferred away from Doncaster

The localities model takes an asset-based approach, with 100 community explorers supporting the top 30 areas of deprivation in Doncaster. Success stories include positive activity groups, access to green space such as a community led walking programme, embedding asset-based community development (ABCD) into amenities, access to the internet, clubs and groups. There has been a significant number of referrals in relation to weight management through health checks where 1: 1 support is provided for 6 weeks from the point of referral and peer groups have been established for long term conditions such as COPD, CVD and diabetes. Locality investment has extended over 55 community groups, participatory budgets have been launched supporting 140 groups and 4 host organisations for initiatives such as warm spaces. This is led by evidenced based community centred principles of local decision making, with citizens participating in deciding how public money is spent and encouraging greater opportunities for co-creating initiatives.

Locality development has 3 key elements:

- To empower and engage communities through Asset Based Community Development
- Integrated local delivery to provide a joined-up response and keep the person and family at the centre
- Commissioning and investment to give people more opportunity to shape communities

Short Term Enablement Programme (STEPS) contributes to non-elective admissions, reablement and discharge indicators. The features and benefits of the service includes a triage role and case management with an assessment period up to 6 weeks. The case manager reviews and tailors longer term support for locality teams and undertakes care act assessments to broker support such as referrals into the wellbeing team or financial assessments. The project has experienced a number of reforms such as Transfer of Care Hub, which has impacted how the team receive referrals. Improvements have been made to workforce sustainability to provide front line support staff by offering additional contracted hours, meaning there is less staff on rota, but more hours delivered. Quality assurance and reviews are being picked up in between direct care hours which is more proportionate due to post COVID step down procedures.

Workforce challenges are being addressed with allied health professionals being trained to provide low level movement and handling. Upskilling opportunities are being made available such as therapy training that allows people to be able to make decisions as a permissive culture. During COVID there was relaxed entry level qualifications and experience in care, these principles are continuing for people transitioning from other sectors such as food catering and hospitality. The team promote the benefits of working in health and social care through the Proud to Care campaign which also forms apart of mandatory induction programmes.

The transfer of care hub is bringing in partners from community health, therapy to make joint decisions about people's needs and pathways with cases of no right to reside in hospital reducing. We are following this up between 2023-25 by dealing with long term needs after discharge and introducing single handed care for therapists making better use of aids and adaptations. There are partner calls 3 times a week with any blockages or differences of opinion being dealt with at head of service level, attended by assistant director level and community nursing teams to help with proposing suggestions outside of the norm. For example, Positive STEPS service sometimes receive inappropriate referrals out of DBTH meaning reablement criteria needs to be changed to reflect pathway needs. There has been an increase in patient complexities which takes increased amount of time to assess/ discharge appropriately due to housing issues raised such as hoarding.

NHS health system Nerve Centre has now extended to staff, for example, information around ward beds to improve efficiencies and reduce duplication of tasks with accurate data for referrals and discharge pathways. Partners from community health, therapy are now making joint decisions about people's needs and pathways based on a describe not prescribe model with community support included in that discussion to assist in developing a positive risk-taking culture. The strategic enablers which will underpin all priority actions include:

Workforce: To analyse and understand system wide workforce priorities and to develop a Place wide workforce strategy. We are exploring 7 days working within the Integrated Discharge Team to offer continuity of staff with full knowledge of process and review current working arrangements such as length of time cases are held post discharge to support concentration on discharge to assess model and manage increasing demands on the team. There is a focussed effort in Doncaster to try to return people to their own homes for discharge dependent on availability of support and resources to do so. More support has been made to get people home in a timely manner by recruiting additional roles for people waiting for care packages in brokerage, for example specific timeslots for medication such as Parkinson's disease.

Estates: To make best use of our collective assets, to plan and deliver integrated services in the right places. Internal discharge co-ordination within the hospital trust has delayed discharge and frequent issues with availability of transport and medications being ready has impacted significantly on the number of discharges achieved. Discharge lounge is to be open earlier to support discharges before 10am and maximise use of transport throughout the day. Further work will be undertaken in 2024 to develop discharge to assess and reducing complex assessments taking place in the acute settings. Senior Managers from all partners are to discuss new ways of working and sign up to increasing community support for assessment post discharge.

Finance: There is a shared commitment to work together at place level to make the most effective use of our resources, enhancing productivity and value for money. BCF funded scheme Sheffield City Church Council are working proactively to support people following hospital discharge with some great examples of innovative working and we are already starting to see improvements with pathway 0 and pathway 1 with more timely discharges, reduced bed delays, strengths-based approach and improved integrated relationships. It has been reported due to the cost-of-living crisis, people are returning items rather than keeping them despite the benefits and safeguards they bring.

Digital: Digital services will empower Doncaster people to maximise their own health and wellbeing and enable our teams to deliver high quality integrated care. IT solutions are accessible for health and social care staff to share information and access up to date timely progress from other professions to reduce volume of phone calls to wards, saving time and informing plans and assessments. Further investment in telecare and pendants will remove the need for a formal care package such as community district nursing or occupational therapists. Yorkshire Ambulance Service refer low level triage/ heart responders which makes a difference to the cost to the Ambulance Service, allowing them to deal with life critical events. The service is currently going through a restructure with dedicated responders and installers currently undertaking a dual role with further management structure, recovery and improvement report completed and awaiting approval to commence. There is a new call centre system trialling telecare equipment, working with the hospital falls GPS pendant and tracking app. This requires patients to have mental capacity and has certain obstacles to overcome such as personal data infringements. This new intervention will reduce costs, get people home quicker, remove the need for multiple aids such as bed senses starting with 100 units which should enable swifter discharge without waiting for installation of lifeline units. Intelligence in the service has improved with a detailed approach to collecting reablement data with referrals being taken from Doncaster and Bassetlaw Teaching Hospital, STEPS, Tickhill Hospital, Mexborough Hospital, Barnsley Hospital and self-referrals.

6. Capacity and Demand for intermediate care to support people in the community

A clear strategy and implementation plan for whole system discharge planning has been signed off to improve the alignment to home first principles and best practice. Home First review demand and capacity for each discharge pathway, including the overall skills and workforce needed to meet those demands now, and in the future. The plan is to maximise pathway 1 discharges, access to recuperative care at home services, and improve integration of the transfer of care hub and single point of contact. There will be a review around the current rehabilitative care at home service, to include therapy resource and utilisation and system oversight of discharge ready date. As a system we will develop internal professional standards for discharge, with clear timescales for all partners to ensure improved oversight arrangements are in place, including admitted care home residents and better utilisation of EDD as a driver for discharge.

There will be defined roles and responsibilities of the site team and divisional teams in patient flow management, including proactive capacity planning across 7 days. This will help further develop appropriate patient flow policies and procedures, including escalation and full capacity protocol. Understanding the daily capacity requirements for all services will support forward planning of capacity to manage forecast demand. Work is in progress to develop real time core datasets, displayed in all appropriate areas to support the management of effective manage patient flow. There will be a suite of reports to enable the system to understand capacity and demand, including constraints, to support effective planning and oversight across each of the key workstreams to provide assurance for agreed system wide improvement plans.

There is a clear strategy and implementation plan for Urgent and Emergency Care (UEC) model following a whole system process mapping exercise and UEC redesign to determine how patients should enter the system, ensuring right clinical first team. This will assist the other workstreams to design their service to meet the demand including a workforce review

to develop internal professional standards that reflect the whole trust, to include a review of access and response times for diagnostics utilising 7 day standards.

A revised operating model for the frailty pathway from the request for urgent and emergency care to patient returning to their home and establish a frailty assessment model, to include same day emergency care. This will include redefining inpatient ward processes to ensure all patients have clear plans including criteria for discharge through effective and consistent board rounds. Length of stay reviews will be undertaken twice weekly over 7, 14 & 21 days. There will be a development of a process to ensure all delays and appropriate actions are taken to reduce delays and review of the discharge lounge to understand the lack of utilisation and to develop a revised operating model with a roll out of virtual wards across all wards.

Emergency Care Improvement Support Team led a system review for Doncaster in January 2023 where they made recommendations around the key priority areas of focus. There was a commitment to Doncaster Concordat, signed by all system partners and a commitment from senior responsible owners and project management support from across the system with the urgent and emergency care improvement programme board to be established with monthly reporting to the A&E delivery board. Work is progressing to develop appropriate patient flow policies and procedures, including escalation and full capacity protocol. Understand the daily capacity requirements for all services to support forward planning of capacity to manage forecast demand (including weekend planning).

7. Provide the right care in the right place at the right time

A significant focus of our use of BCF funding has been to improve market shaping and commissioning of adult social care and support, helping providers with recruitment and retention to ensure sustainable care capacity and prevent market failure. We have also maintained a strong focus on preventing, reducing and delaying needs through investment in a range of intermediate care services that are designed both to pre-empt crisis (and avoid admission) and to enable recovery (and avoid re-admission).

The High Impact Change Model (HICM) is a critical element of our home first community model. Bed based services contribute to the overall success of our shared outcomes framework for the intermediate care service. There is an agreed approach to implementing the BCF Policy objectives, including a capacity and demand plan for intermediate care services. This ensures that people are supported to maintain their independence and live at home, preventing admissions to acute care and supported to return home as early as possible. It reduces the number of people requiring long term care and support more people to remain at home following an episode of intermediate care. When intermediate care is needed people receive a simple, responsive and flexible service resulting in improvements to their functioning and quality of life.

HICM has significant implications for social care practice such as focused activity on the early discharge planning and trusted assessors which supports our care and health systems to manage patient flow and discharge. This includes planning in advance for residents who require elective care to ensure timely discharge and to ensure that support is in place in the community. There still remains capacity issues in embedding trusted assessors within the care home and home care sectors and community single point of access. However, we recognise this is crucial to enable early engagement with patients, families and carers so that they can consider their options for future care and discharge.

Since previous assessments against the HICM, more data on capacity and demand is available and distributed across the system to help manage pressures daily. An improved list of patients requiring support after discharge is being shared across partners to allow daily review and support to help move patients through the system and reduce blockages. The actions agreed and associated with the HICM are all linked to the Home First Board, this has resulted in the development of the transfer of care hub, and we are now looking at redesigning pathways to ensure that we have adequate patient capacity and that we reduce duplication and highlight areas of opportunity as we head into the winter months. This will involve better linkage with housing services, housing teams, acute hospital housing pathways and mental health, processes including a regular review.

Daily system surveillance is coordinated by the ICB through a system escalation report. This report is based on operational pressures which triggers escalation thresholds against a framework linked to capacity and demand across Doncaster health and social care. Daily dashboard reports are issued widely across Doncaster partners to alert capacity issues, promote escalation discussions and gain partner support.

As a system Doncaster responds to capacity and demand through system flow monitoring meetings that are now starting to include some further pathway 0 data for the first time, which are reported to the chief operating officers regularly. In addition, weekly system partner calls are held with operational managers to discuss current state and support required with further escalation calls added as need be.

Interdependencies exist between BCF funded projects such as the home first strategic change manager as data sharing and access to records are essential as are interdependencies with urgent and emergency care programme of work. BCF funded neighbourhood frailty project manager has interrogated Integrated Care Board data that has led to further data requests from the Yorkshire Ambulance Service to try and understand what is happening in the system. For example, overall numbers have been reducing but treat on scenes has increased.

There could be strategic improvements with early intervention and crisis response management being more proactive with better acknowledgement of the third sector plays in reducing demand with more efficient and consistent referral routes into reablement services. This is why in part BCF funded project Inclusion and Fairness forum was incorporated into the Voluntary Action Doncaster business case. This project aims to increase resident's choice in community services and contribute to agendas such as loneliness, social isolation and the reduction of non-elective hospital admissions, these are representative of the three life stages, starting well, living well and ageing well. They also provide strategic representation across seven strategic meetings in Doncaster:

- Safer Stronger Doncaster
- Children's and Families Strategic Partnership Board
- Enterprising Doncaster
- Health and Wellbeing Board
- Joint Commissioning Management Board
- Doncaster Integrated Care Partnership Board
- Team Doncaster

BCF funded system flow work will expand and be more resilient over the winter period. We will aim to include more prediction of estimated discharges where data allows to support

planning by services ahead of time as well as expanding current acute system flow analysis to mental health. Through BCF funded ISAT Wellbeing Officers we are able to develop sustainable partnership data sharing across the system by having a shared set of data asks and requirements. For example, improved quality of life, increased independence, reduction in social isolation, reduction in secondary care attendance and reduction in unnecessary admission into long term care.

A shared understanding of the discharge to assess pathways will be in place by end of October 2022. Predictive model and mental health flows are to be developed over the coming months and some basic analysis in place for use this winter. The monitoring work will never be complete as there are degrees of data maturity we should be seeking to build across the system. We know when we will be successful through system stakeholders holding one version of the truth on capacity and demand information and more crucially sharing the same insights. The end outcome is to develop a system that is more able to proactively manage capacity and demand across the system, with fewer escalation issues.

8. BCF funding to ensure duties of the care act are being delivered

Discharge funding is being used to support a very significant fee increase across homecare, care home, extra care housing and supported living provision. This increase (26% for homecare provision) fully addresses the cost of care identified by the recent DHSC exercise. This will better ensure that care capacity is there to support onward discharge, particularly increasing flow along pathway one of the discharges to assess model.

We're working across all partners to improve the end-to-end experience that Doncaster people have, from the first moment they need support from Urgent or Emergency Care to the point where they are back to living the life that they choose. This involves planning for discharge from the point of admission, ensuring a strong and consistent focus in NHS wards, bolstering a single point of access to enable transfers of care to community health and social care services, and maximising the capacity of those services both through increased investment and greater efficiency. Partners have informally agreed with formal sign off will take place at Doncaster's Urgent and Emergency Care Board on 7th July 2023.

All partners are continuously reviewing how the greatest impact can be achieved in terms of reducing delayed discharges through urgent and emergency care board and home first board. This includes how Doncaster will utilise discharge funding in regard to wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients. The use of the additional discharge grant is in line with grant conditions with the fund being used to continue schemes started in 22/23 that is now categorised as existing in 23/24.

There are various funding streams which support Doncaster's winter plan with the ASC Discharge Fund element of BCF making up over a third of Doncaster's winter plans contribution, it is therefore difficult to say specifically what the discharge fund alone supports as funding streams have been pooled together based around whole system flow. The plan was signed off by urgent emergency care board in March and was agreed by system partners.

Stretching metrics have been agreed locally for all BCF metrics based on current performance, local priorities, expected demand and capacity and planned BCF funded services and changes to locally delivered services based on performance to date. Plans include the expansion of virtual wards and at the same time reviewing pathways out of

Yorkshire Ambulance Service and expanding provision to meet that demand, through the expansion of urgent community response.

Review of the bed base and funding of existing intermediate care will enable us to build on better forecasting demand to meet winter pressures. There is further investment into a BCF funded discharge coordinator role to expand the size of the discharge lounge, which will improve flow in line with meeting key performance indicators. This will meet occupancy targets, reduce the average number of daily beds occupied and increase capacity to deflect patients into same day health centre additional appointments. Equally the BCF funded carers lead will provide strategic oversight of initiatives for unpaid carers and create efficiencies for health and social care teams.

Doncaster carried out a local cost of care exercises to provide that understanding of inflationary pressures and was undertaken in consultation with providers. The care home market has seen additional monies provided by BCF to support workforce recruitment and retention, National Living Wage and increasing cost pressures.

We will be publishing our Market Position Statement (MPS) in the Autumn of 2023 with an annual refresh. This will provide an overview of the current services operating across Doncaster, as well as providing key indicators to the market in terms of what the future needs and demands are for Doncaster. The MPS will be publicised to ensure that it reaches a wide audience to encourage new providers into the city, as well as to stimulate interest and further enhance the market provision across all services.

On a bi-monthly basis meetings are held with care homeowners and Senior Management from both City of Doncaster Council and South Yorkshire ICB (SYICB). Additional specialist meetings are also arranged at the care homeowner's request. On a quarterly basis meetings are held with care home registered managers and operational commissioning team, workforce development and other health and social care professionals to support and provide pertinent information and advice about any new work streams or changes in guidance and procedures across Adult Social Care and Health.

9. Supporting unpaid carers through BCF

Doncaster carers wellbeing service is the main source of support for unpaid family carers in Doncaster and they complete all carer assessments. We recognise the significant and vital contribution carers make in our communities, and we value the support they offer to the person they care for, which often prevents, reduces and delays the need for more formal services. We also know that being a carer can be tough at times, so we want to make sure carers have the support they need to look after their own health and wellbeing, and to continue in their caring role for as long as they are willing and able to do so. This is why BCF supports personalised carer support through the carer's innovation fund which aims to remove barriers and waiting times for support to enable carers to continue within their caring role and to do the things that matter most to them. The service provides more in-depth support with the service serving carers face to face, within groups, online or over the telephone.

Doncaster's All Age Carers Strategy, 2022- 2025 'we hear, we listen, we care, if you care' has been co-produced with Doncaster carers, to improve the experience of caring in Doncaster. Carers are key members of the team around the person they support, but the role can significantly impact their own life, health and wellbeing. A carers action group has been established for carers to have their say and be listened to as experts by experience.

This enables carers to have the choice to be involved in all workshops and other engagement opportunities and have a safe place to talk and be signposted to relevant services. A strategy has been developed and led by people with lived experience and reflects the national and local priorities.

Engagement and feedback were gathered through online semi structured interviews with carers, online questionnaires, focus groups and in depth follow up interviews. This involved the carers strategic lead and carer representatives attending meetings, having group discussions as well as in-depth conversations with carers about their experiences. Carers from all types of caring circumstances were involved to ensure a holistic view, this included carers from ethnic minority carers, young carers, older carers, carers for those with mental illness, carers for those with dementia and further carers with a range of protected backgrounds.

Some of the challenges in accessing evidence are carers often do not see themselves as a carer; many carers report that it takes a long time for them to recognise and accept being a Carer. Carers are often not identified as carers when engaging with health and social care support this means that professionals do not have an understanding of their caring role, the challenges that can come with caring and how best to support carers. Whilst some schools identify and work with young carers there continues to be a number of schools which do not readily recognise or support young carers. Health, social care, and housing services do not identify carers and as a result, do not support them to maintain their wellbeing.

Improvements have been made in service the carers wellbeing service provides bespoke carer support rather than the traditional offer to carers that was not consistently well connected with assets within localities. The implementation of the carer's wellbeing service has evidenced a need for additional BCF funding to support carers within adult learning disabilities teams. There are 147 carers who are in the main aged 80 + years of age, quality conversations and sensitive support relating to future planning is needed with this cohort of carers. Many of these carers do not use IT and require a more bespoke service such as home visits.

10. Disabled Facilities Grant

Disabled Facilities Grants (DFG) promotes integration between occupational therapy and housing. For 2022/23, Doncaster's housing adaptations policy has been amended to permit discretionary grant funding if works exceed £30k subject to sufficient funds being made available to meet this demand. This is prudent with supply and installation costs increasing in recent years and the complexity of needs for disabled applicants, particularly children. In addition, there has been changes to assist with relocation and funding of equipment or adaptations that fall outside the mandatory grant criteria.

We have adapted our service so that our technical officers spend the majority of their time processing DFG, upon receipt, these are allocated to our officers usually within a week with urgent referrals prioritised. During COVID 19 we altered our way of progressing DFG completing most of the application form via the phone, so the time spent at service users' home is minimal in terms of collecting proof of financial information and obtaining signatures. This has helped speed up the process, which is vital to help keep people safe and independent in their homes and has prevented hospital and care homes admissions. Carrying out essential adaptations has reduced reliance on social care system and improves the quality of life of not only the disabled person but their spouses, carers and family alike.

Any complex referrals for adaptations are visited with equipment provided promptly to help those in most need to live independently for longer and improve quality of life for the disabled person and their families. If work schedules are overwhelmed, then approved contractors are used however this is often not needed as staffing capacity are at sufficient levels. The majority of referrals from housing associations are coded and work issued without a visit needing to take place. For instance, if a referral with pictures of the bathroom is received for a bath to be replaced with a level access shower, the service can raise an order using our schedule of rates and submit to our contractor upon receipt of an asbestos report.

Trying to facilitate hospital discharges can at times be problematic, therefore, a multi-agency response was set up to look at how we could improve the process where we jointly develop the hospital discharge pathway protocol, with regular meetings held with the NHS foundation Trust. One of the strategy action plan themes are homes being more accessible and inclusive in their design, able to meet residents' current and future housing needs. This includes implementation of the recommendations of an accessible housing service review covering the accessible housing register and aids and adaptations.

The aids and adaptation team and strategic housing team have worked closely together for many years. This has enabled the inclusion of specific properties or specification requirements into the Councils own new build, housing association, and acquisition programmes, which has delivered a number of properties to meet the needs of people and families with disabilities across the borough.

Hospital discharges minor works are continuing to provide an efficient and effective service for Doncaster's most vulnerable populations. By working in an integrated way with Public Builders Management (PBM) it has helped to speed up processes such as sending digital images of homes for urgent orders.

The housing adaptations team take referrals from health professionals with allocated spend based on recommendations from occupational therapists across health and social care. The project has increased business support within the housing adaptations team, to accelerate the processing of referrals received for adaptations for disabled and older persons and assist in the overall delivery of adaptations.

There are more telephone assessments rather than home visits, meaning referrals are being received quicker leading to longer waiting lists. External contractors have exclusively been utilised in extensions with PBM delivering all other adaptations. However, external contractors are now picking up level access showers which has reduced waiting times from 3 months to 28 days, helping to alleviate the backlog alongside extending the PBM team from 9 teams to 12 teams.

The Regulatory Reform (Housing Assistance) Order 2002 permits Local Authorities the power to adopt a policy to apply a much-simplified system, such as waiving means testing for a specified amount. This venture will fast track appropriate adaptations, reducing delays and enabling those requiring essential adaptations to regain their independence faster.

The rationale behind the figure of £5,000 is that the related administrative process of means testing can cost more than the value of a grant for smaller works and result in a significant slowing of the delivery process. Along with the above statement, the figure of £5,000 is also used, as above this, costs are registered as a local land charge and there is a requirement to repay monies if the property is sold within ten years. Adaptations and equipment that are

provided in a timely manner, help those in most need to live independently for longer, and improve quality of life for a disabled person and their families. Adaptations can reduce hospital admissions and reduce the amount of care provision required and provide a long-term saving for both LA and the ICB. Consequently, the quicker adaptations are delivered, the sooner those receiving will benefit however, supporting evidence has to be provided of all bank accounts. The evidence needs to be up to date and often it is not, resulting in officers making several journeys in an attempt to get the correct and up to date information required. The cost of journey time travelling, and mileage incurred would also have to be taken into account, resulting in delays getting approval for the proposed works. Removal of the test of resources will result in an ongoing loss of income, however this needs to be balanced with the reduction in activity needed to administer. The reduction in activity will free up the officers to carry out further additional surveys and other activities and of greater importance is the reduction in the time a person has to wait for a visit to be carried out to start the process. Considering the time taken to administer this as a process it is therefore recommended that this means test is ceased for all proposed works that have a value of less than £5000. This £5000 limit will capture the vast majority of DFGs provided and will significantly speed up the time taken to process DFG applications for the benefit of customer. The most common adaptations are altering bathrooms into wet rooms, installing stairlifts or ramping entrances. Where these works cost less than £5,000, the proposal is that the disabled person is subject to a fast-track application, without the need for a means test, resulting in a person receiving essential adaptations sooner.

11. BCF initiatives that supports equality and address health inequalities

There is extensive evidence that connected and empowered communities are healthier communities. Communities that are involved in decision-making about their area and the services within it, that are well networked and supportive and where neighbours look out for each other, all have a positive impact on people's health and wellbeing. There is a diverse range of community interventions, models and methods which can be used to improve health and wellbeing or address the social determinants of health. Below are the key elements of community centred approaches:

- Recognise and seek to mobilise assets within communities. These include the skills knowledge and time of individuals, and the resources of community organisations and groups
- Focus on promoting health and wellbeing in community settings, rather than service settings using non-clinical methods
- Promote equity in health and healthcare by working in partnership with individuals and groups that face barriers to good health
- Seek to increase people's control over their health and lives
- Use participatory methods to facilitate the active involvement of members of the public

Community centred approaches involve building on community capacities to act together on health and the social determinants of health. It includes community development, asset-based approaches, social action, and social networks. These approaches work by connecting people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation. Embedding community centred approaches in how we work with communities' challenges traditional ideas of health improvement by working with communities to shape more effective health care and welfare services. Focusing on improving health and wealth and ensuring all residents have the

opportunity to be part of vibrant, connected communities, and living in pleasant environments, rather than a deficit-model of tackling specific health issues in isolation.

Participatory budgeting is a form of citizen participation in which citizens are involved in the process of deciding how public money is spent. Local people are often given a role in the scrutiny and monitoring of the process following the allocation of budgets. Evidence has shown that even on a smaller scale, participatory budgets have contributed to improving the self-confidence of individuals and organisations, improving intergenerational understanding, encouraging greater local involvement through increased volunteering and the formation of new groups, increasing confidence in local service providers, and increasing control for residents over the allocation of resources. The locality investment community grant provides an opportunity for smaller, less-resourced community groups in Doncaster to make a difference. The process provides an easily accessible and alternative method compared to the traditional written application. Applicants are required to complete an application of their choice (video/verbal/presentation/ written application). Applicants will be asked to submit a full cost breakdown with anonymised applications reviewed and scored by a locality community-led panel.

41.3% of the Doncaster population live in the most deprived 20% of communities nationally. Healthy life expectancy for women living in deprived areas of Doncaster is the third worst in England at 56 years. This means that women living in deprived communities will live 24 years and men 21 years in poor health, resulting in poor outcomes for people, which impacts on them individually and their families and also drives significant demand for health and care services. 1 in 3 children are living in fuel, bed and food poverty, impacting on their early childhood development and future health and wellbeing as adults. In response BCF has funded health inequalities lead role to work with health and care, communities themselves, Team Doncaster and third sector partners and there is a clear commitment from the Doncaster Place Committee and from the Health and Wellbeing Board to thread health inequalities through all that we do.

DBTH and RDaSH have had board workshops, focusing on health inequalities and what it means for their trusts and core business. They have also invested in a joint consultant in Public Health, who is also linked into the Public Health Team in Doncaster Council. This post will support analysis of waiting list data and support both trusts to apply a population health management approach to operational delivery of planned and unplanned care. This will facilitate a better understanding of who is on waiting lists in terms of areas of deprivation and ethnicity and also who is using emergency pathways. Reviewing the way that they work with their patients, recognising the importance of better understanding the challenges that people from Core20 communities and inclusion health groups face, when it comes to accessing and experiencing services. There is a commitment to embedding coproduction and including people with lived experience in service development and delivery.

Each of the Primary Care Networks (PCNs) have a designated health inequalities lead. The place inequalities lead is working with each PCN to develop their action plans and support them to be more focused on Core20 populations and inclusion health groups (e.g., people experiencing homelessness and rough sleeping, Gypsy Roma Traveller (GRT), sex workers, asylum seekers, prison leavers and people affected by addiction). Funding has been secured to support PCNs and localities to develop plans which focus on developing more personalised care for patients, particularly Core20 and inclusion health groups. The north locality held a workshop in March 2023, which included a wide range of partners, such as PCNs, secondary care, community services, locality teams, Team Doncaster, third sector

partners, maternity, family hubs, Healthwatch and many more. The aim was to build connections and increase awareness of all of the services available in the community, which could support the health and wellbeing of people accessing primary care and perhaps reduce pressure on primary care. An action plan will be co-produced with the wider community partners, it is proposed that the locality workshops will be rolled out across east, south and central localities. Health inequalities lead is attending all GP target training sessions in June 23 to increase awareness of health inequalities and gather enthusiasm and support from PCNs for the workshops which will run in September.

Taking time to listen to the challenges our Core20 and inclusion health communities have when it comes to accessing healthcare has been and will continue to be an important element of the work to tackle health inequalities. It takes time to build trust and understanding, especially when some communities are fatigued with people and services coming out to ask them the same questions. Feedback is that they answer the questions, but never hear from people again and also that nothing happens. We are committed to being held to account for listening and for coming back with updates on what can and cannot be done. Key challenges to accessing services include transport, lack of buses, no money for buses, caring responsibilities, literacy, language and interpretation, lack of flexibility, inability to navigate healthcare pathways, cultural sensitivities, digital and social isolation.

There is definitely no one size fits all, so it is important we take the time to work with wider groups, often through trusted community leaders. There are plans to work more closely with the third sector over the next 12-months. Relationships are building with Healthy her Muslim Ladies, People Focused Group (including people with mental health disorders, learning disability and autism, GRT and complex lives (people experiencing homelessness and rough sleeping).

Two GRT community link workers have been funded by BCF until April 2024. GRT communities experience significant marginalisation and hate crime, resulting in social exclusion and lack of access and good experience of healthcare. It is proposed to work with PCNs and healthcare organisations to improve awareness of GRT culture and in turn improve access and experience of healthcare. There are plans to focus on Core20 plus5, including maternity and early cancer diagnosis, access to primary care, elective care, workforce and children and young people, activities include:

- Health fairs
- Translation
- Reviewing available data
- Education skills and training
- Deeper dive into mental health/ suicide prevention in GRT communities

Much of the GRT link workers early work involved partnering on health initiatives which target underrepresented groups which had obvious synergies for this project. For example, collaborating with the cancer alliance based in Sheffield meant there was an increase of GRT patients taking up cervical screenings. This work was championed by Dr David Crichton who has lived experience of working with members from the GRT community.

The relationships and connections made between partners and with communities are embedded and there is recognition that good awareness and trust with communities is essential to success. This team now focus on wider Core20plus5 programme, which does include flu, covid and pneumonia vaccinations but also includes maternity continuity of care,

annual health checks for people with severe mental illness, early cancer diagnosis and blood pressure case finding and lipid management. Development is underway to create a Doncaster focused training video to support increasing awareness of health inequalities. Cross partner forum to coordinate community engagement across Doncaster is set up, focusing on Core20 and inclusion health groups. Forum members include Health Watch, DBTH, RDaSH, Adult Social Care, PCNs, Team Doncaster and Voluntary Action Doncaster. The group will build on excellent work of Team Doncaster, supporting development of a standard Doncaster approach to gathering intelligence from communities, which will inform service development and delivery.

There is much work to do to support health and care staff to be aware of the levels of poverty in Doncaster and to understand the impact this has on the ability for people to navigate health and care. Equally further developing and raising awareness of 'Your Life Doncaster' will be key for staff and residents as a self-serve community online directory. Developing a compassionate approach and embracing the 'Be Kind' campaign are an important element of building trust and relationships with our communities' who find our services to reach and will require a partnership approach.

There is a need to build relationships, trust and connections across health and care, including residents and patients. This started by increasing awareness of the services and support available to people with the aim to reduce demand in health and care and improve outcomes. We have increased awareness around health inequalities and impact of poverty, Core20 populations and inclusion health groups with an importance placed on partnership working and integration. We reach out to communities' who find our services hard to reach or access.

Doncaster is striving to better understand the tough lives that many people are living and why they find our services hard to reach e.g., transport, translation, digital and social exclusion. We need better understanding of different communities, Core20 and inclusion health groups and their unique cultures and challenges created with digital models of care and virtual consultations. We will ensure that health inequality is a key part of all transformation priorities and that all partners prioritise prevention and a population health approach to improve outcomes and reduce health inequalities.

We have set up an inclusive cancer screening network to develop culturally appropriate videos for Core20, ethnic minority and inclusion health groups, it is hoped that once the connections are made, we can roll out Core20plus5. NHSE have supported a cervical screening pilot in principle taking screening to trans men, Afghan refugees and women accessing complex lives and changing lives services. The Core 20 plus 5 population groups experiencing poorer than average health access, includes Doncaster residents with conditions including, cancer, respiratory disease and cardiovascular disease. By using the health profiles to generate insights (population health management approach), the Doncaster priorities are around the clinical areas of health inequalities, such as:

- Maternity
- Severe mental illness
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case finding
- Smoking cessation

BCF funded project Be Well Doncaster has been working with community organisations and set up community-based peer groups for wellbeing, fibromyalgia, diabetes and chronic obstructive pulmonary disease (COPD) across each locality and an online hidden conditions peer group. The peer groups provide education, information, and an opportunity for peer support to enable better self-management. A range of communication and marketing material including videos and flyers have been developed to launch the text self-referral service. This allows residents to text a free number to request to meet with a coach. It is hoped this approach will raise the profile of Be Well Doncaster across partners and with residents to increase referrals from outside the PCNs, widening the reach of Be Well Doncaster. Well Doncaster team have continued to support the third sector using community centred approaches and offering support in accessing funding, public health guidance updates and building community resilience as groups continue to make a return to their communities. We will develop a culture of improvement and collaboration which is inclusive of our people, and which drives the delivery of timely access to high quality and safe care. This work will improve access, reduce assessments and ensure interventions are readily available.

- Enhance the understanding of health inequalities in Doncaster.
- Establish links with existing groups and partners to standardise approaches to address health inequalities and promote inclusion in accessing and receiving health care.
- Demonstrate progress against nationally and locally defined Health Inequality targets and objectives, including Core 20 plus 5 by working with existing teams and partnerships.
- Use the opportunities available through Anchor Institutions to enhance the health and wellbeing of Doncaster people, particularly where there is opportunity to narrow health inequalities and address the wider determinants of health and wellbeing.

Health inequalities has been raised as an important public health intervention which was highlighted through community insights such as Joint Strategic Needs Assessment, our borough wide listening exercise Doncaster Talks and appreciative inquiries. These have helped to inform the local priorities related to health inequality and equality for people with protected characteristics within integrated health and social care services. Respondents emphasised the need for Doncaster to be Disability Friendly and more community cohesion, with a small number of comments praising the co-ordination of health and support services but that more can be done for vulnerable cohorts (to help homelessness, addiction and mental health). This theme encompassed responses that the public felt were missing from a health point of view with a large number of people highlighting the need for more social care, particularly funding for and access to care services.

Addressing inequalities enables local communities to do more and promote inclusion, equality and diversity that, in turn, will improve the health of individuals. Be Well Team, Wellbeing Officers and Healthier Doncaster are examples of BCF funded programmes to support strategic collaboration between local areas, public health and educational institutions. The high-level aims are to:

- Reduce inequalities, improving the health of the poorest fastest
- Increase resilience at individual, household and community levels
- Reduce rates of worklessness, a cause and consequence of poor health

The Healthier Doncaster programme seeks to tackle the underlying causes of ill health through behaviour change techniques such as motivational interviewing, coaching and brief intervention. Both programmes utilise resources from link workers who co-ordinate with local priorities having particular regard to the needs of Black, Minority Ethnic groups.

We look to commission projects and programmes of work that support an increase in healthy life expectancy and a reduction of the number of mortality rates in under 75's. Consideration needs to be given to the impact of the pandemic on health and social care, where instances of burnout are reported, and primary care services are really stretched. We are seeing elective waiting lists backlogged and workforce shortages meaning attention to health inequalities is sometimes secondary to meeting our service offers.

Building community capacity and support is therefore important to Doncaster's response with locality teams engaging community leaders across grass root organisations, social enterprises and charitable organisations in how we can best provide solutions to multifaceted, socio economic, challenges. Locality teams fund a variety of posts through BCF including voluntary community social enterprise pharmacy teams, care coordinators, community connectors, health and wellbeing coaches and social prescribers.

Doncaster has strong leadership and commitment to partnership working to improvement of health and wellbeing of underserved communities, where we create an environment where they have a freedom to innovate health and social care offers. For example, BCF funded project Complex Lives which provides mental health support across housing especially for those in transitions and complex rehabilitation and recovery pathways as part of the homelessness and rough sleeping strategy. The delivery plans include prevention, accommodation and care and support, to convene of a range of multi-agency forums to drive forward delivery.

Team Doncaster continues to work in partnership across health and social care to further develop services, so everyone has the opportunity to age well, have a good quality of life and to be able to live as long and as independently as possible. Older people have told us that they feel that they have aged, lost some independence and have reduced ability to do things that they enjoy doing. The ongoing vision for Doncaster residents is that they will receive their health and social care in a cohesive, integrated, coordinated way, eliminating inefficiency and waste by providing a model that supports people remaining safely at home, wherever possible, with an increase in strength based preventative activity.

Doncaster have developed an evidenced base outcomes framework to shape and drive our work in reducing health inequalities and build stronger, more resilient communities linked to our wellbeing goals. By focusing on community centred approaches at an individual, community and organisational level, we have the best chance of closing the health gaps that have only widened since the COVID-19 Pandemic. BCF funded projects help to bridge the gap between existing health inequalities and improve resident's healthy life expectancy.

APPENDIX 2

Financial Summary 2023-25

Source of Funding	Scheme Type	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Additional LA Contribution	DFG Related Schemes	2,026,282	0
DFG	DFG Related Schemes	2,782,137	2,782,137
iBCF	Enablers for Integration	1,262,800	1,262,800
	Home Care or Domiciliary Care	1,573,200	1,573,200
	Integrated Care Planning and Navigation	770,812	770,812
	Personalised Budgeting and Commissioning	5,728,572	5,728,572
	Residential Placements	6,975,000	6,975,000
ICB Discharge Funding	Urgent Community Response	1,711,000	2,774,000
Local Authority Discharge Funding	Home Care or Domiciliary Care	726,000	74,390
	Workforce recruitment and retention	1,560,690	1,560,690
Minimum NHS Contribution	Assistive Technologies and Equipment	1,021,000	1,074,000
	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	7,060,000	7,477,000
	Carers Services	1,093,000	1,150,000
	Community Based Schemes	1,268,000	1,331,000
	Enablers for Integration	109,000	115,000
	High Impact Change Model for Managing Transfer of Care	2,163,000	2,290,000
	Home-based intermediate care services	2,645,000	2,836,000
	Housing Related Schemes	130,000	93,000
	Integrated Care Planning and Navigation	1,236,000	1,306,000
	Personalised Care at Home	1,861,000	1,966,000
	Prevention / Early Intervention	1,679,000	1,769,000
	Urgent Community Response	8,731,056	9,230,233
Total		**53,460,939**	**54,138,834**
Local Authority Discharge Funding	To be allocated subject to review of 2023/24 schemes		2,160,826
Grand Total		**54,112,549**	**56,299,660**

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BCF Introduction

- The Better Care Fund is a collaboration between NHS England, the Department of Health and Social Care, Department of Levelling Up, Housing and Communities and the Local Government Association.
- BCF is a pooled budget for health and social care services to work strategically in local areas, based on a plan agreed between the representative NHS and Local Authority which is then signed off by the areas Health and Wellbeing Board.
- BCF makes the most efficient and effective use of health and social care resources by breaking down organisational barriers. In doing so it assists people to live independently in their communities for as long as possible and to deliver the right care, in the right place, at the right time.

NHS South Yorkshire Integrated Care Board

City of Doncaster Council

Team Doncaster

BCF Budget Headings

Minimum NHS Contribution		Improved BCF		Disabled Facilities Grants		Adult Social Care Discharge Fund	
23/24	24/25	23/24	24/25	23/24	24/25	23/24	24/25
28,996,056	30,637,233	16,310,384	16,310,384	2,782,137	2,782,137	2,286,690 (LA) 1,711,000 (ICB)	3,795,906 (LA) 2,774,000 (ICB)

Total Better Care Fund Budget 2023/24: £54,112,550

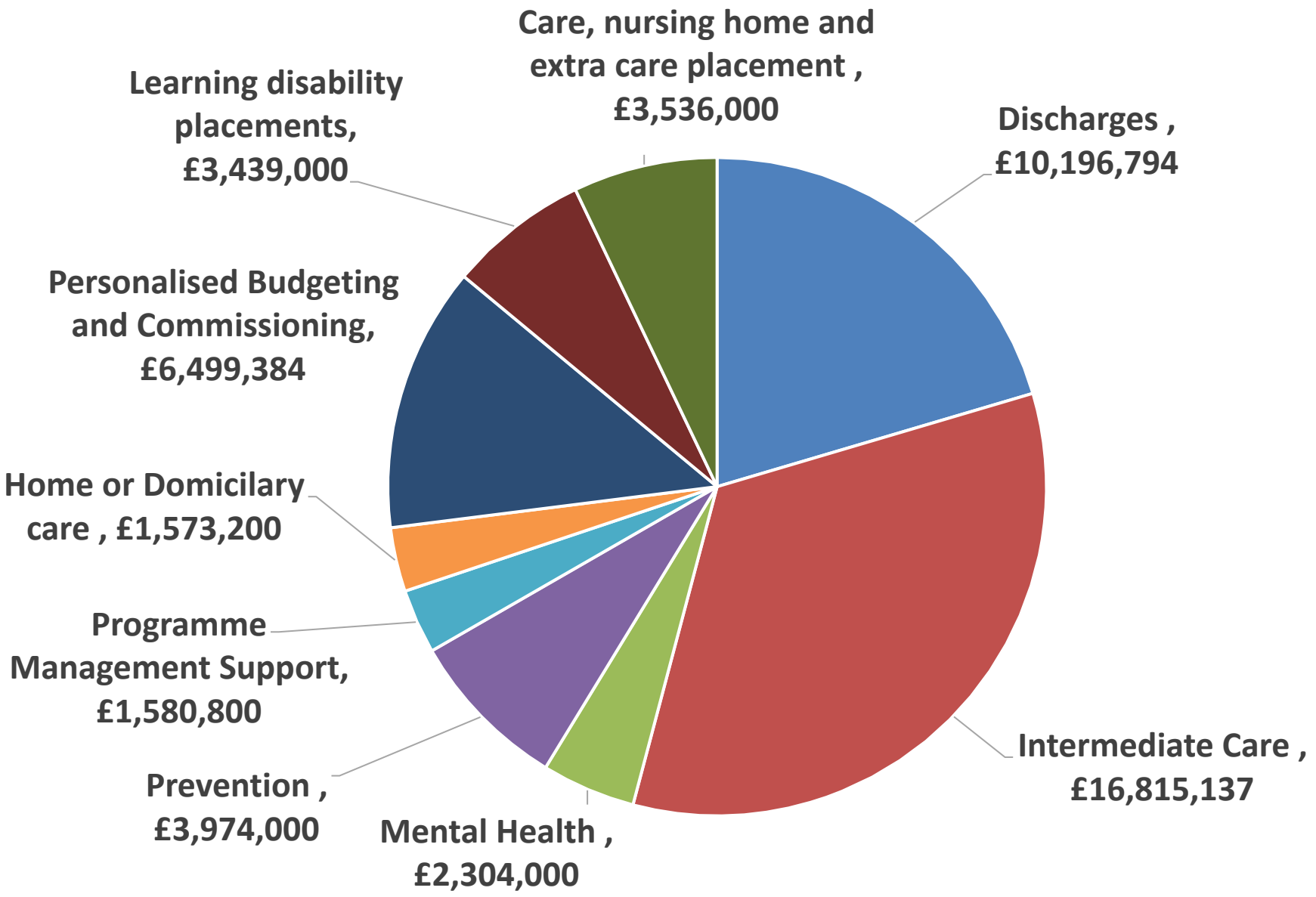
Total Better Care Fund Budget 2024/25: £56,299,660

Total approved and pending earmarked reserve: £3,796,000

Balance of uncommitted earmarked reserve: £627,000

Team Doncaster

BCF Expenditure Against Main Funding Themes

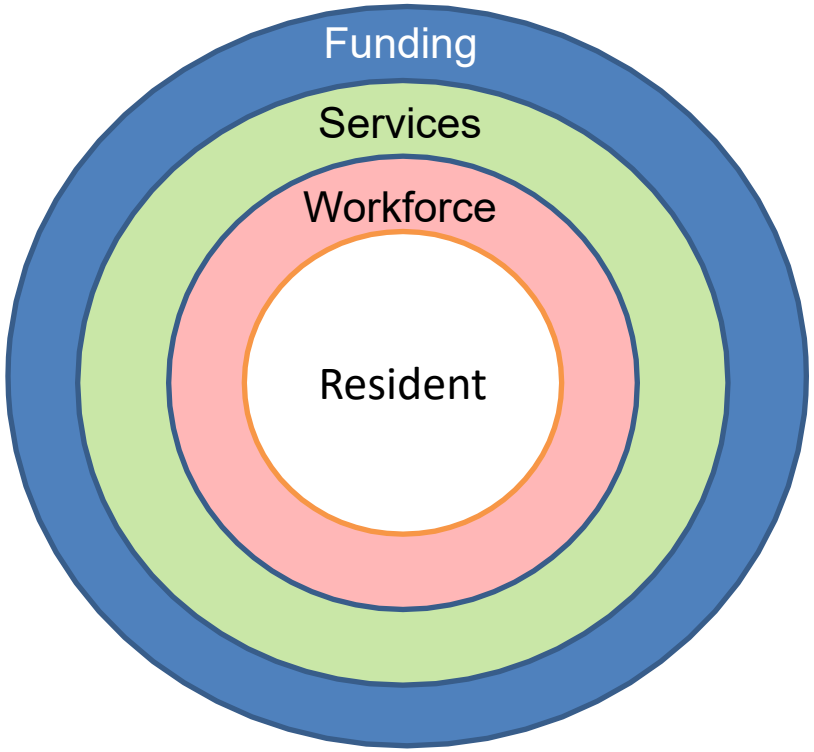


BCF Performance Targets

- Avoidable admissions: The ambition is to have a phased improvement of 7% by end of 2023/24.
- Falls: The system wide frailty network is planned to deliver a 5% reduction in the standardised rate in 2023-24.
- Discharge to usual place of residence: Improvement is expected from baseline of 92.77% to 95% by the end of year 2023/24.
- Residential admissions: Implementation of discharge to assess across all pathways during 2023/24.
- Reablement: Recognising data quality has been an issue in previous years, plans and actions are in place to improve reporting on reablement outcomes for people across all partners and commissioned services.

Top Priorities for 2023/24

- Review the recurrent BCF funded schemes through S76 and S75 agreements and determine what we could commission differently and what services we should stop commissioning through exit planning initiatives.
- Effectively engage and invite new business cases especially from the voluntary community and faith sector organisations to meet specific needs faced by our population.
- Align system planning more closely to performance and be more reflective and responsive to what data and local intelligence is telling us.
- Track the flow of funding to determine value for money of services, efficiencies within the workforce to deliver shared outcomes for health & social care.



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City of Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 31 August 2023

Subject: Health Protection Update – Minutes of Doncaster Health Protection Assurance Group Meeting held on Wednesday 19th July 2023.

Presented by: Dr Victor Joseph, Consultant in Public Health, and Chair of Doncaster Health Protection Assurance Group

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

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

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

Doncaster Council assumed the statutory responsibility for health protection when Public Health transferred from the NHS to Local authority in April 2013. Since then, there has been in place Health Protection Assurance Group to provide assurance on health protection in the borough, bringing together the relevant partners.

This Health Protection update provides Doncaster Health and Wellbeing Board with assurance that the duties of protecting the health of the people of Doncaster are effectively being undertaken. The update covers the following:

- COVID-19;

- Measures to prevent and control infections in hospitals (DBTH and RDASH) and care homes;
- Infectious disease surveillance report;
- Health Protection gap analysis carried out by UKHSA for Local Authority consultation;
- Screening, Vaccination & Immunisation programmes
- Tuberculosis

Recommendations

The Board is asked to:-

- Note the update on health protection measures being taken to protect the health the people of City of Doncaster Council.

City of Doncaster Council

Meeting Minutes

Meeting: **Health Protection Assurance Group**
Date/Time: Wednesday 19th July 2023
Venue: Microsoft Teams Virtual Meeting
Attendees: Dr Victor Joseph, City of Doncaster Council (Chair)
Christine Tomes, RDaSH
Sally Spridgeon-Davison, NHS Nottingham and Nottinghamshire ICB
Sarah Gill, NHS England & NHS Improvement | North East & Yorkshire
Dr Ken Agwuh, DBTH
Emma Gordon, City of Doncaster Council
June Chambers, UK Health Security Agency
Sally Gardiner, City of Doncaster Council (Note Taker)

Items for Discussion		Lead
1	**Welcome and Apologies**	
	Apologies received from Andrea Ibbeson, Nick Wellington, Sarah Atkinson, Helen Conroy and Mim Boyack. The group were welcomed and introductions took place.	
2	**Declaration of Interest**	
	None were declared.	
3	**COVID**	
	Incident Rates and Log Victor updated in absence of Policy and Insight Change (PIC) team member. Still receive Care Home Situation report, currently only 1 or 2 cases, so seems quiet. Wider system again nothing significant to pick up. Nationally the rate is low, single figures so good news. Christine updated that it's quiet, 1 patient only at RDASH. Not actively looking now for COVID, especially on physical health wards, but prompt actions of colleagues, doing the surveillance and isolation helps minimise risks to other patients. Victor explained that deaths from covid seem to be high this year compared to last year, although not picked up covid as an issue at moment locally which is being looked at by health protection taskforce. June confirmed correct that covid is being put on death certificates although this may not have been the contributing factor in some cases. Ken advised not actively reporting; and not updating data as used to, so he was surprised of this 1 case in Intensive Care Unit (ICU) today.	

4	**Minutes of Last Meeting and Matters Arising**	
	No outstanding actions from the last meeting. Sexual health action was noted. Minutes were agreed as a true and accurate record. Victor clarified with Christine about receiving the RDaSH monitoring report. She confirmed that this meeting coincides with their assurance meetings which approve the reports for sharing. She confirmed that their annual report is being approved today and can be shared with the group as a post meeting action. **Action: Christine to send annual report to Sally**. Victor suggested where reports are not available for the meetings that a bulleted update could be provide where there are any current issues that need to be shared, or lessons learnt. **Action: Christine will report this back to her line manager to check ok.**	
5	**Health Protection Assurance and Monitoring Reports**	
	Infection, Prevention and Control **Care Homes** Report noted. **DBTH** Ken updated on their report. Noted standard key objectives, specifically mentioned MRSA Bacteraemia cases are on track To minimise cases of Clostridium Difficile (CDI). To keep within trajectory of 42 cases. This is not going right way but got time to get back on track, 22 cases currently, just had 5 cases in dialysis unit 2 weeks ago; called and held outbreak control meeting. Increase screening for Carbapenemase Producing Enterobacteriaceae (CPE) based on new national guidelines; this has led to picking up more cases, particularly overseas visits to Greece and Egypt. Prevent/reduce Nosocomial COVID-19 cases - 1 mentioned earlier, we will be looking more into data now. Continue COVID reactive work in response to changing context – post covid work – postponement of surgery in low-risk patients Respond to any emerging infections – links to bed linens, E-coli blood stream infections recently published keeping close eye. Working collaboratively with partners to try and address the MRSA cases within the intravenous drug users (IVDU) population. No new cases so far this year; pleased to say – last year 9 cases – June said also down to aspire work helping as well Ventilation work is ongoing and Recruitment to the team was noted. Victor suggested improvements in rates of other infections could be down to covid related measure around cleaning etc.	

	GRE (Glycopeptide Resistant Enterococcus)[1] outbreak in Orthopaedics – 14 patients affected – samples sent, Ken asked June about sending samples– can we get a reference lab number. June said yes can get this. June to action outside of this meeting. Work is still required to increase CPE screening. Blood culture contamination rates 5.2% - analysis of cases over past year demonstrate nursing staff as having higher number of contaminants. Animation video in progress. Training department reviewing whether individuals have been assessed. Superficial infections identified in Breast surgery – improvement work under way. **RDaSH** Christine said they're looking at their resilience plans; interesting to hear updates particularly on measles from others. **Surveillance Report** June updated, noted:- 1 covid case in May. IGAS and IGAS Septicaemia rates finally coming down which is really good and now down to level expected. Influenza A Avian had 1 case, had 3 positive farm workers, none in Doncaster. Measles this one is not a positive confirmed case, notified by GP but no testing; although there has been 1 case this weekend but not in Doncaster. If they receive a report of a case they have to record it. Expect cases across to be calmer as schools close for summer holidays, then from October expect to see the usual food poisoning, emphysema, scarlet fever cases to go up again. Ken asked June about covid reporting, how are you notified now? He explained that on his inspection today they have 1 covid case in intensive care unit, the person had only had one vaccination. June advised there is no need to notify now but we will record if notified. June mentioned covid cases in Bradford and Leeds, the cases came from 1 person in Bradford, 2 linked cases in Leeds but don't know where first case from; first case was travel related in Spain, 1 case this weekend. Emma advised nothing to add except numbers are what's expected this time of year, regarding the salmonella cases there had been no common factors in cases reported. **Gap analysis paper** June explained that her colleague Andy Irvin did this as a kind of a project to see what's missing as part of a collaboration. This came out of the covid emergency.	

[1] Enterococcus is a bacterium which is carried harmlessly in the gut. GRE are types of Enterococcus which are resistant to the Glycopeptide type of antibiotics (vancomycin, teicoplanin)

	Basically what's out there and what missing. **Action: All members to review document and provide any comments, eg what their organisation does if not on the plan; missing points; good ideas or not, omissions.** Victor said there are some gaps which have been addressed through services like swabbing. Also TB not had to do large scale testing or screening but we were tested before covid on TB in schools and hospitals; screening lessons learned was to do something in house as tests ended up in northern Ireland; not been able to test this yet if we had a case. **Action: Sarah confirmed she'd look at it regarding vaccinations and feedback.** June talked about the hotels housing asylum seekers where there've been outbreaks of diphtheria, issues around administering antibiotics/testing/vaccinations, although not had any in South Yorkshire; due to the nature of disbursement of them they likely will get missed, noted children assessed but not adults and most diphtheria has been adults – so can be easily missed; found out though antibiotic uptake was good but vaccination rates were poor, could have been down to confusion of purpose of it and covid vaccination was been done at same time; need to bear in mind these people aren't used to having vaccinations, this will be the case for the influenza vaccination going forward. Victor mentioned the Scabies outbreak in hotels, treatment logistics were an issue, around finding clothes, it also highlighted a funding issue; there was some prior arrangement before covid in that the LA/NHSE/CCG would split costs if huge but lead commissioner would manage it if not, so maybe future thing to test us not as big as covid was going forward. Noted NHSE and ICB will be one and then the LA so 2 not 3 organisations, how do we manage if we do have a major emergency to pool resources. June said if MRSA had been bigger that would have been an issue, so trial runs to see how would step those up. Victor mentioned antivirals for avian flu, formalise pathway if need antivirals, currently 1 local pharmacy is going to work this out and there are S Yorkshire discussions so for example if Doncaster had a case we would know who to signpost patient to. June mentioned they are looking at getting 3 or 4 pharmacies in South Yorkshire so the onus doesn't fall on just one; this has been a nightmare for North Yorkshire. **Screening, Vaccination & Immunisation** Sarah updated – PowerPoint attached refers. HP Board Powerpoint.pptx **Bowel screening** Age extension continues to 56-58 year olds No concerns - **Breast screening** Uptake has dropped, not brilliant, need support to increase uptake, noted reward offer in October. **Cervical screening** Offered to staff at Trust Survey just been sent out; feedback from the Flying Scotsman received already, suggests	**ALL** **SG**

	women can't get through to get appointments and appointment times wanted; hopefully use this information to improve attendance. **Diabetic eye screening** Good uptake; patients at low risk of developing diabetic retinopathy are to be offered screening at 24-month intervals, rather than 12 month as recommended by UKNSC this will start in October. **AAA** Little low on uptake, working to promote service. **Vaccinations** Influenza - South Yorkshire Winter Vaccination Operational Delivery Group underway meet on a monthly basis to improve uptake; pregnant women network –looking at putting messages in weight management service and lung health checks and family hubs. 2/3 year olds – school service asked them to offer to 2/3s. **Adult vaccinations** From September 2023 a significant change to the shingles programme is being implemented to move from the current 1 dose offer of Zostavax to 2 dose Shingrix vaccine as recommended by JCVI **Childhood Immunisations** Work with system 1 to improve offer; targeted offer; work with gypsy traveller community. Thinking about offering vaccinations via the Health bus. **Measles** Family Hub Start for life programme action plan- is this including vaccinations? Sarah asked if this is happening in Doncaster. June said we have used health bus in past for gypsy/travellers, consecutive outbreaks of measles and one co-infected with mumps at same time, had school nurses and was quite successful. Sarah confirmed working on a video and want to know who is available. **Action Sarah needs to speak to Saima Nazir/Carrie Wardle in Public Health, Sally will send Sarah their details.** June said the gypsy/travellers will be travelling over summer particularly to Spain where there have been cases and so could bring back measles. Victor asked `should we wait for cases to pop up in all areas or start doing something now?' Sarah said better to have plans in place and be prepared if an outbreak. She said there is a S Yorks group for measles, we can then have a Doncaster focus workplan. Victor asked if it is possible to get uptake of screening by ethnicity data, this was raised at Minorities Partnership Group. Sarah difficult to do for all screenings, cervical can, breast only if information is shared from GPs. Victor asked about childhood immunisation, Sarah said she'd tried to speak to child health.	**SG**

	Action: Victor to provide Sarah with what information he needs. Noted South East area is doing it, so can be done, just need to find out who and how. Sarah said North PCN looking at what ethnicity information is captured, not all information is captured. Victor asked her to check with Cathy Wakefield/Phil Kirby. **Action: Sarah to check.** Victor explained to target the gypsy/travellers community it would be helpful to have the ethnicity data to know what it looks like. Victor asked about flu vaccination take up for home schooled children, how are they addressed. Sarah explained they offered it at community clinics or through health bus, noted every half term she gets an update on the uptake of all children. Victor asked about the community pharmacy role, he said they'd offered to do mop up of those missed children; Sarah said this had been discussed at the flu vaccinations meetings, but wasn't routinely offered to children by pharmacies; she said if there is an appetite for it to happen then she can take that to the next flu group meeting. **Action: Victor will liaise with pharmacy/primary care grp.** June said they'd found a lot say they are British even though they're not, based on the fact they are living here so say they're British. June asked about Screening in prisons, noted AAA and diabetic are all ok, also just had data for bowel screening in prisons. 3 out of 5 have good uptake. Visits are planned for September. Noted high turnover of prisoners in Doncaster prison as many just on remand. Group discussed university activity on vaccinations and take up.	**VJ** **SG** **VJ**
6	**Standing Agenda Items**	
	No update.	
7	**Key Updates from Meetings**	
	TB Steering Group Met about paediatric pathways issue, very useful meeting to clarify issues and ensure appointments are offered timely; discussed what happens if need to see a consultant as there is only 1 and they're not available, noted can refer to Sheffield children hospital now. **TB Cluster meeting** Some ongoing work being done outside of meeting, workplace settings, comms to groups awareness on TB. **TB Strategic Group** There is a separate cohort review meeting; June said the chair had been on long term sick but back and so actions will now get picked up.	
8	**Any Other Business**	
	Sarah advised BCG vaccinations to babies before 24 days old, target is to vaccinate 80% by 2018, in last 2 months hit over 80% so achieved the target.	

10	**Dates and Times of Next Meeting**	
	Wednesday 18th October, 2:00-3:30pm	

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