Doncaster Health & Well Being Board

Performance Report

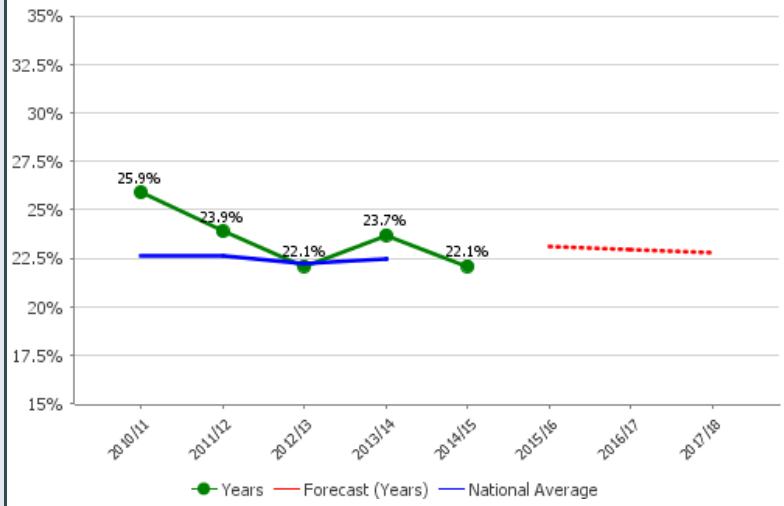
Q1 2015-16

Appendix A

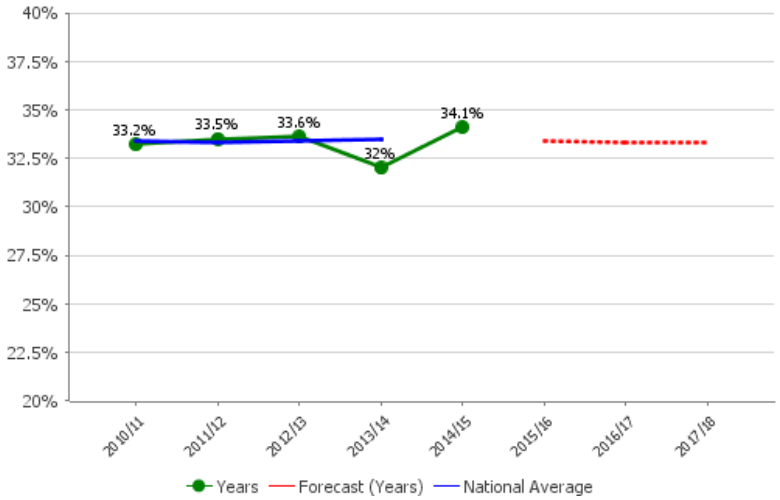
Values below 5 have been rounded to 0 or 5

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

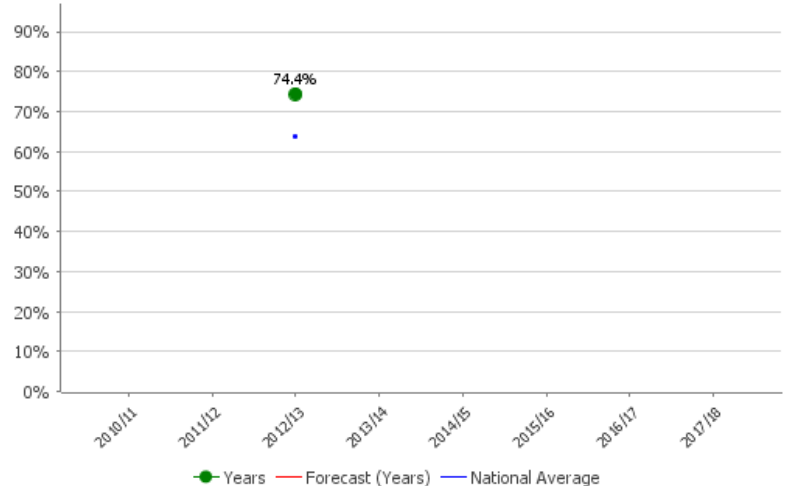
a) % of Children that are classified as overweight or Obese (Aged 4/5)



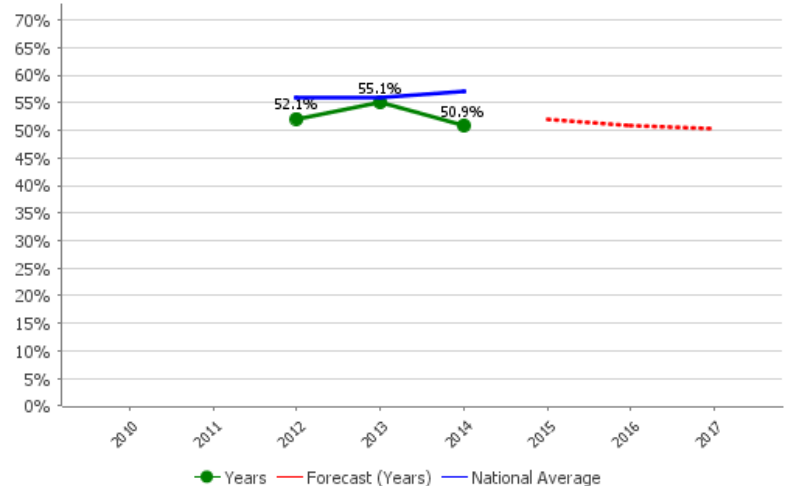
b) % of Children that are classified as overweight or Obese (Aged 10/11)



c) % of Adults Overweight or Obese



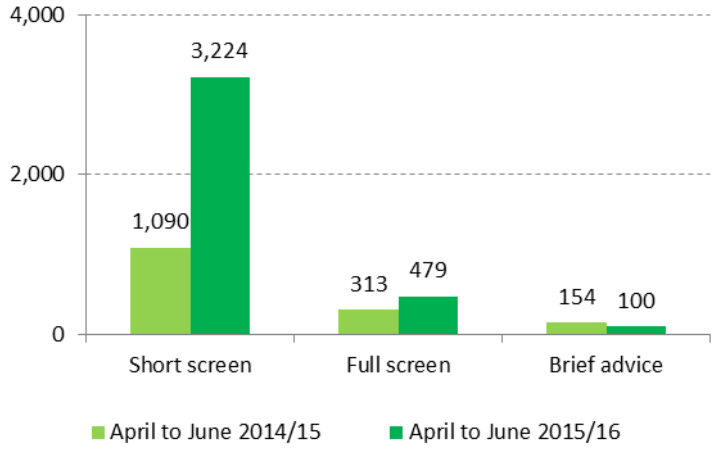
d) % of adults achieving at least 150 minutes of physical activity per week



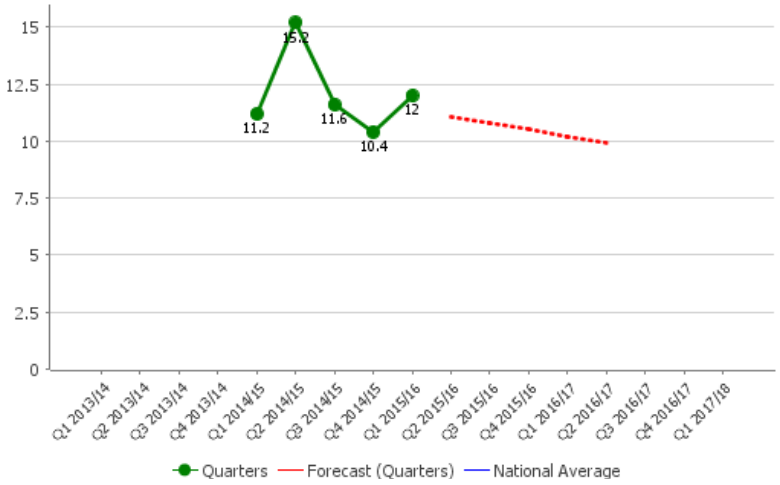
STORY BEHIND THE BASELINE	In order to effectively monitor progress towards the OBA a monitoring database has been set up, team members are undergoing training and will then populate the database with the work they have completed so far. A small number of local organisations have been engaged with in order to improve access to healthier food, and one of these has already implemented changes to menus. The Doncaster Food plan is currently undergoing consultation with stakeholders and will be disseminated in September 15. Work is now taking place with schools to encourage them to incorporate healthy food and cooking into the curriculum, a number of training sessions and workshops in schools will be taking place in the next quarter. The "Decent helpings" work with academic partners has been approved and will now progress. Public Health webpages are now live on the DMBC website. Professionals can access online public health training and through these pages and find out about upcoming national and local public health campaigns and events. Public Health Facebook and twitter pages have been created and frequently used to promote key public health messages and services in Doncaster. We are developing and E-Learning module on Making Every Contact Count (MECC). This module will help people understand when and how to deliver appropriate lifestyle information on five key public health areas; stopping smoking, diet, physical activity, alcohol and mental wellbeing. A consultation with key partners including RDaSH, DBH, South Yorkshire Fire and Rescue is currently underway. Change 4 Life, Disney 10 minute shake up campaign, is running from July to September 2015. It is targeted at children aged 5 to 11 years and their families to be more active. Supporting resources are available and have been distributed to schools and community organisations. Events are planned throughout the borough during the summer to support the campaign.	
ACTION PLAN	**What we will achieve in 2015-16**	**What we will do next period**
	1. The development of a plan to address access to healthier food (to incorporate Doncaster food plan, food procurement, school meals, workplace health award environmental health plan). 2. Work with academic partners to explore the feasibility of a toolkit to improve the food environment in Doncaster communities 3. Active promotion of physical activity opportunities (promotion of discount cards). 4. Development and rollout of a Making Every Contact Count (MECC) training package. 5. Continued work with planning teams to ensure access to healthier food and physical activity opportunities are incorporated into the Local Development Plan.	1. Collection and collation of indicator data for the OBA, work with organisations so that resulting changes can be monitored and evaluated 2. Dissemination of the completed Doncaster Food Plan 3. Commence the Decent Helpings research 4. Deliver training session to improve school food and get cooking on the curriculum 5. Continue to use social media to promote public health messages and services in Doncaster 6. Use social media to target specific communities/groups i.e. age, area, interests 7. Complete consultation of e-learning tool and implement recommendations. 8. Work with developers to create MECC module 9. Develop a Communications plan to launch MECC 10. Evaluate the C4L campaign for the development of future interventions

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

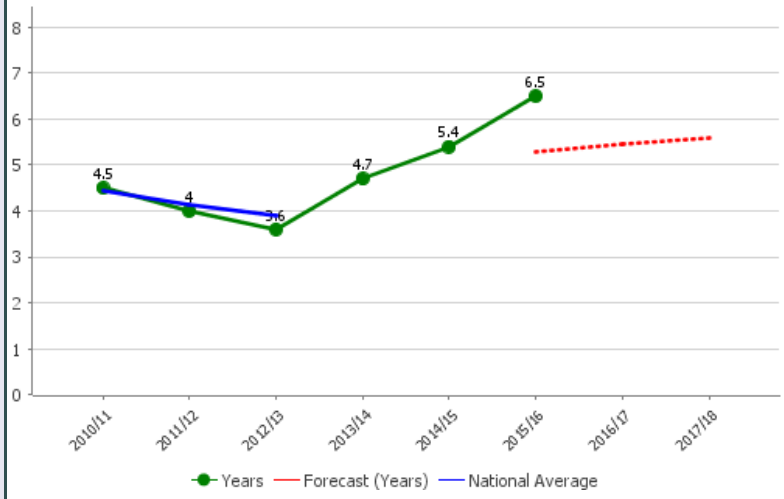
a)Numbers of people being screened for alcohol use and, where appropriate, receiving brief advice



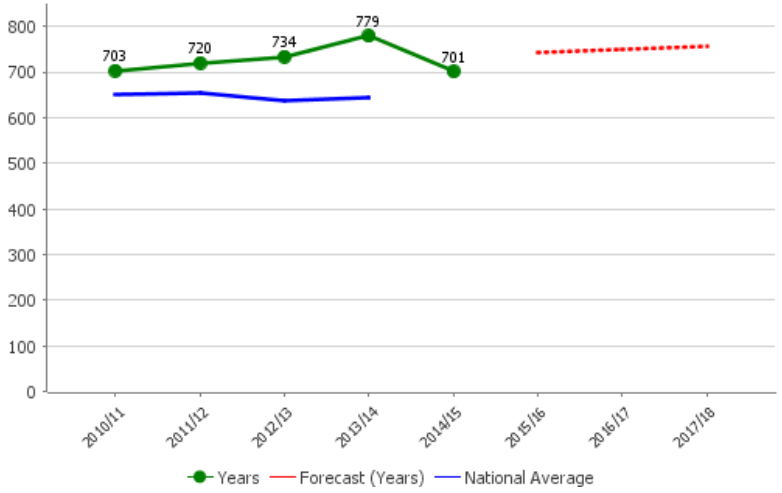
b) Alcohol-related attendance at A&E (per 1000 pop)



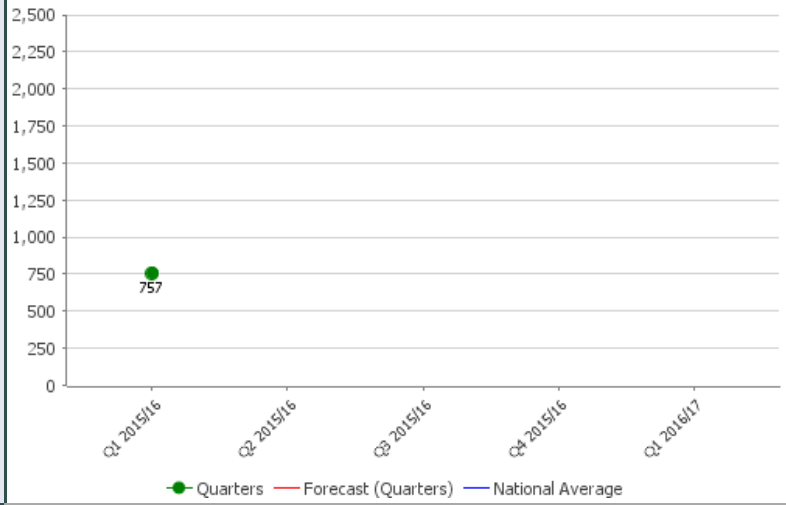
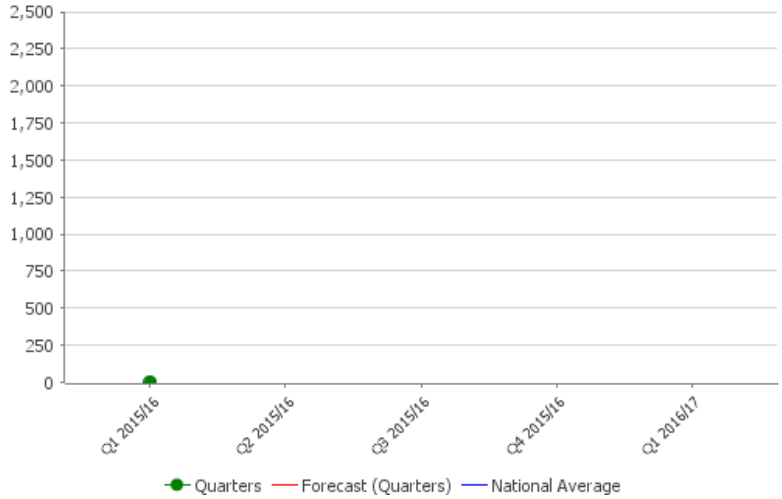
c) Alcohol-related violent crime per 1000 pop (2015/16 YTD Only)



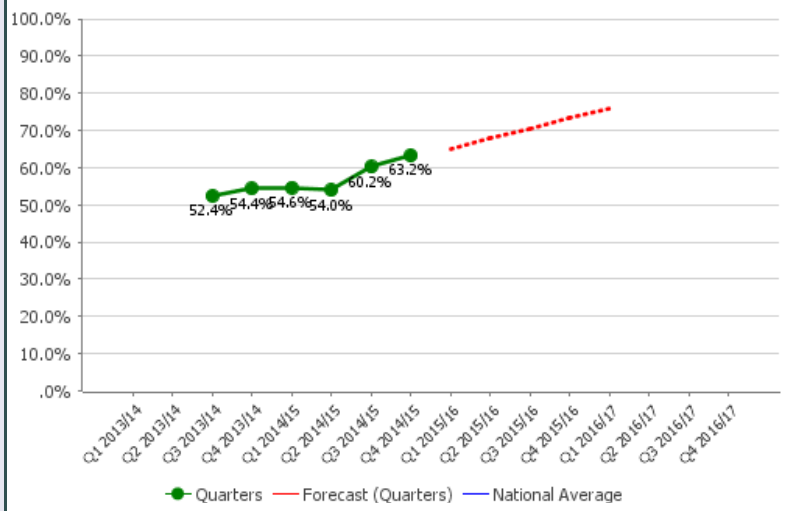
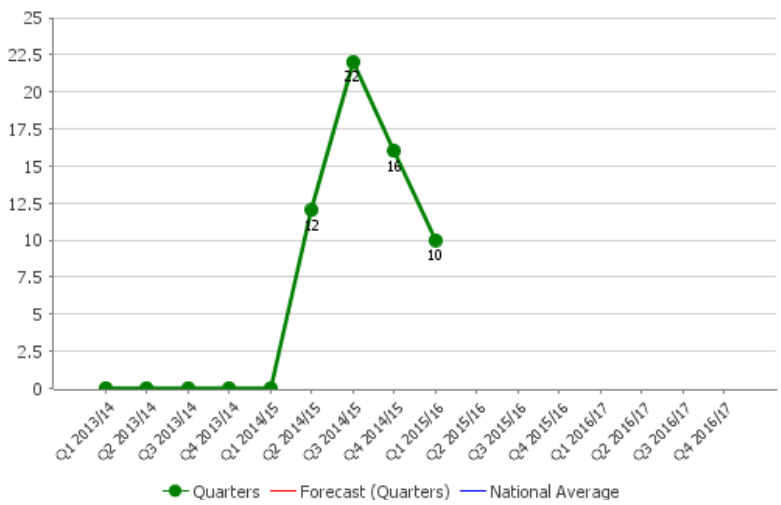
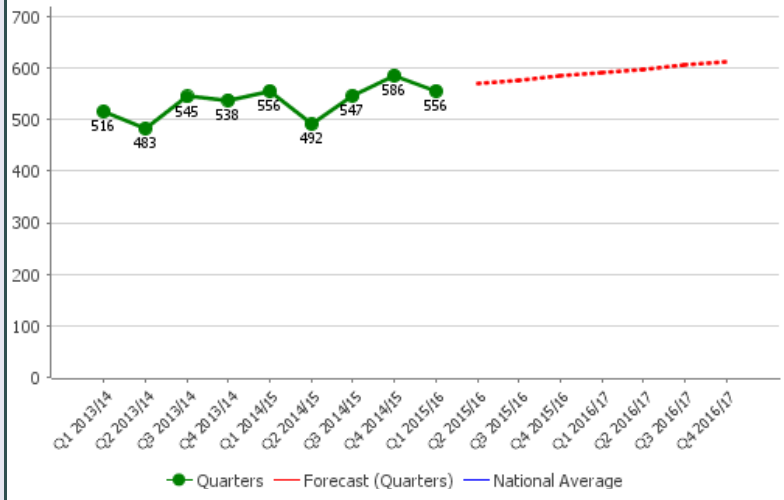
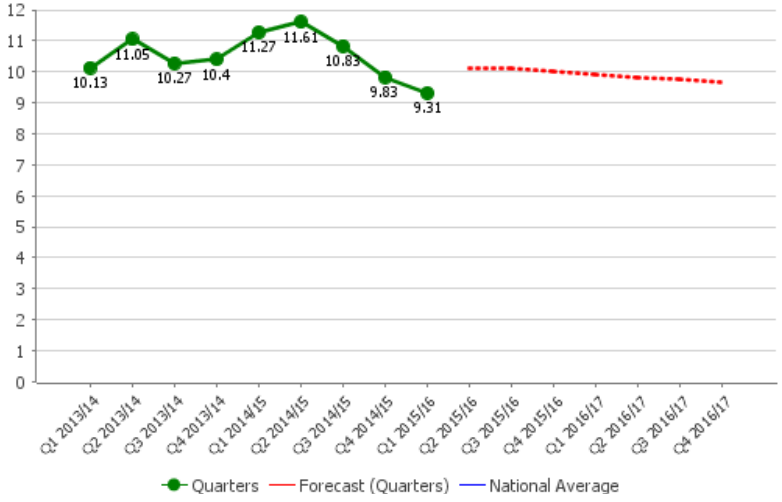
d) Alcohol related admissions to hospital (14/15 data provisional)



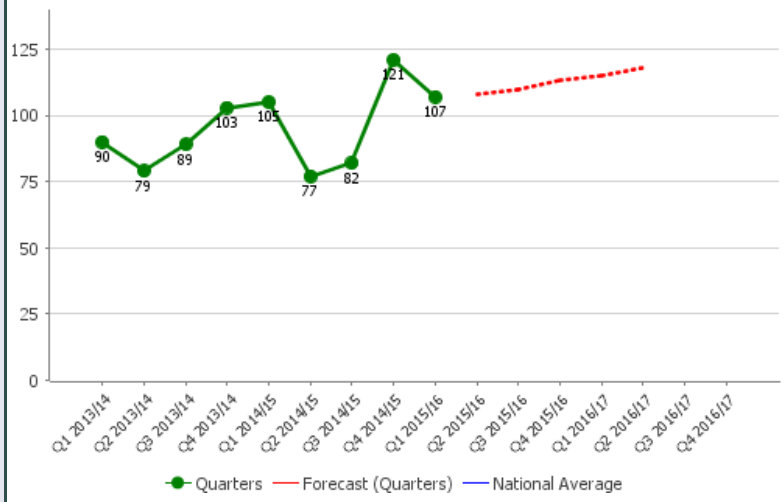
STORY BEHIND THE BASELINE	The short form of alcohol screening has trebled from last year to this and the ratios then receiving a full screen and brief advice mirror the evidence base (i.e. 5:1 at each stage). This suggests screening and advice is being targeted at suitable patient groups. Alcohol-related admissions increased up to 2013/14 and were consistently above England. The rate for 2014/15 appears to decrease sharply though this requires further investigation. These admissions are primarily linked to cancer, unintentional injuries and mental/behavioural disorders. These admissions are primarily linked to cancer, unintentional injuries and mental and behavioural disorders linked to alcohol. Alcohol-related A&E attendances fluctuate over time but there are no significant trends. Attendance peaks sharply between 21-25 years but over half of attendances occur in people aged 26 to 60, cutting across age groups. Reviewing the presenting condition, it appears three quarters of attendances are linked to minor injuries and accidents rather than assaults. Alcohol-related crime has increased significantly from a low in 2012/13. The Joint Strategic Intelligence Assessment notes this increase citing increases in Town Centre violence and recorded domestic abuse, but also changes in the recording process.	
ACTION PLAN	**What we will achieve in 2015-16**	**What we will do next period**
	1. Work with GP practices to expand and improve screening and interventions from this year to next. There is also scope to deliver screening and very brief interventions in non-primary care settings such as pharmacies, hospitals, criminal justice, housing providers and social care (the evidence base outside primary care is mixed so investment would be carefully considered). 2. Evaluate the Community Alcohol Partnership (CAP) in Askern, Campsall and Norton and expand the model to other areas if appropriate. The CAP was launched in November 2014 and is a partnership approach to address underage sales and antisocial behaviour. This is a collaboration between the community, schools, retailers, the Local Authority, Police and St Leger Homes. Utilising communities and addressing underage consumption will be key in the future. 3. Make greater use of campaigns to raise public awareness and influence attitudes to alcohol in the population. Fixed national dates include Alcohol Awareness Week and Dry January while local campaigns will likely include topics such as alcohol in pregnancy, alcohol and older people and the link between alcohol and house fires. Public Health will work on campaigns aimed specifically at businesses to help foster an ethos of responsible retailers, for instance working with Pub Watch organisations and delivering a 'Reduce the Strength' campaign to limit the availability of very strong alcohol. 4. Improve the referral pathway between hospitals and the treatment system and enhance the identification and support to people repeatedly attending A&E or admitted to wards. Alcohol Concern defines these as 'Blue Light' clients - people who become vulnerable and isolated so that emergency services are their only source of support. Similarly there are vulnerable people, including alcohol misusers, who revolve through the Criminal Justice System. The Criminal Justice Liaison and Diversion Scheme launched in April 2015 and Public Health will work with partners to embed substance misuse within the model.	1. Awarding and mobilising the new recovery system around the lead provider 2. Continuing to monitor and screening and brief interventions through GP practices 3. Delivering public awareness campaigns, e.g. alcohol in pregnancy (Sept 2015), alcohol awareness week (Nov 2015). 4. Engaging magistrates to raise awareness of custody testing and the role of Alcohol Treatment Requirements (ATRs). 5. Promote custody testing and ATRs within the Liaison and Diversion Scheme. 6. Monthly monitoring of exits and representations.

OUTCOME	**Families who are identified as meeting the eligibility criteria in the expanded Stronger families programme see significant and sustained improvement across all identified issues.**
INDICATORS	**a) Number of Families Identified as part of the Phase 2 Stronger Families Programme**  **b) Number of families achieving positive outcomes through the Stronger Families Programme** 
STORY BEHIND THE BASELINE	Following the success of delivering 100% of the first Stronger Families Programme, Doncaster was eligible to participate in the Expanded Troubled Families programme. (Stronger Families locally). This programme commences in April 2015 and runs initially to March 2016 but is planned to run until March 2020. A formal announcement is awaited from the Department of Communities and Local Government (DCLG) who lead the programme nationally. The Expanded programme has 6 headline 'family problems' that we must use to determine whether families are eligible for the programme or not. These are used by us to build a local Stronger Families Outcomes Plan (SFOP) that we agree with audit as the basis of our claims for Payment by Results PbR). The aim of the programme is to transform service for families and reduce costs to the public purse by more coordinated whole family approaches and intervening earlier. We agree a number of families we will 'turn around' with DCLG via the Council CEO. For Doncaster this is 491 this financial year (2015/16) and around 3000 across the five years from April 2015 to march 2020. To achieve this we will need to work with well over this number. Doncaster has taken an approach to change the way services work with families rather than build a new team or service, so this means that delivering Stronger families is everyone's business. The base line for SF is 491 and the indicators we have set are No of families identified as eligible and No of families claimed for via the PbR process. The indicative figure for families identified as part of phase 2 of the Stronger Families Programme is 757. This figure includes Phase 1 rollover families (any not claimed for in Phase 1), Phase 2 identification process (any that were eligible from phase 2 criteria and household composition could be confirmed) and Phase 2 referrals from any new families referred in from various services.

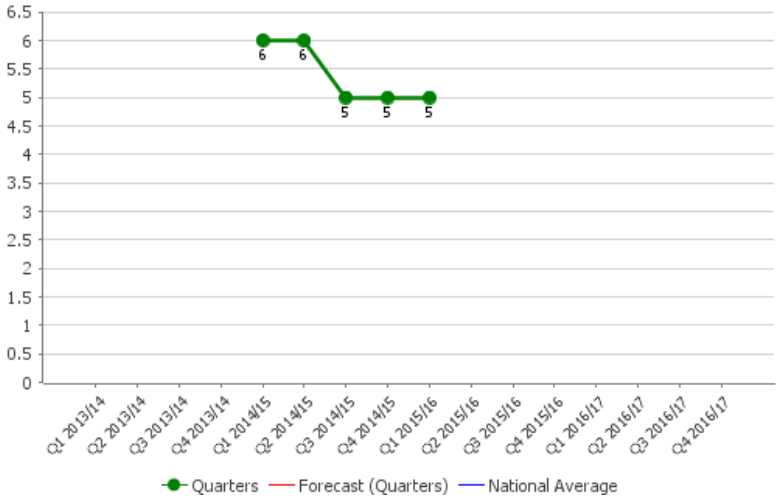
ACTION PLAN	**What we will achieve in 2015-16**	**What we will do next period**
	1. To identify as many families who meet the criteria as we can 2. Implement the case management system to allow for easier case management , tracking and progress reporting 3. Commission services needed by families following evaluation of the first SF programme. 4. Train multi-agency staff in working with families, 'early help' assessment and case management system inputting.	1. Work on the Cost Savings Calculator processes 2. Work on the Family Progress data (FPD) requirements 3. Implement the Case management system (EHM) 4. Upload families onto the EHM system.

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

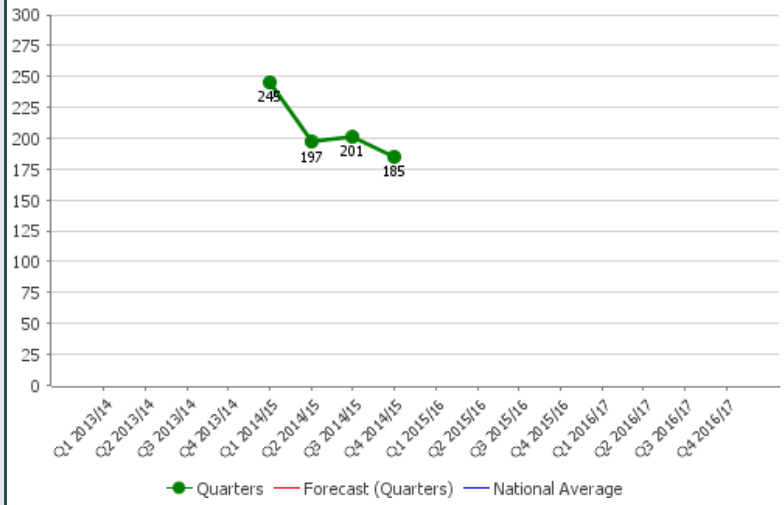
e) Hospital re-admissions within 30 days (DRI) for people with Dementia



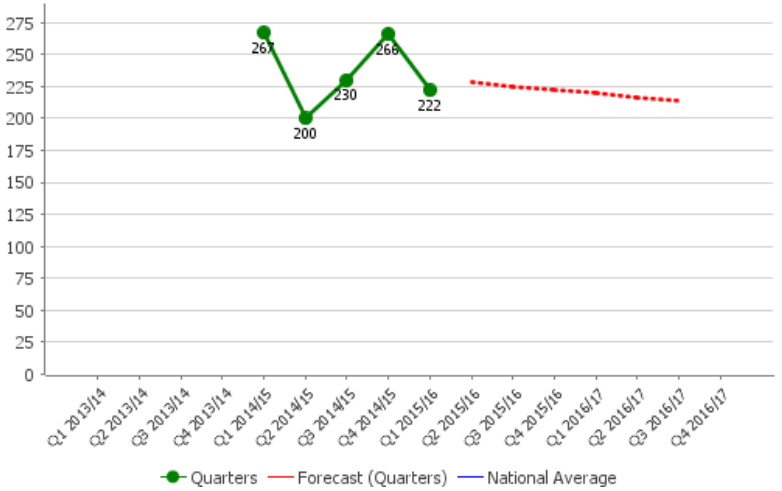
f) Number of patients having any delayed discharges encountered at RDaSH



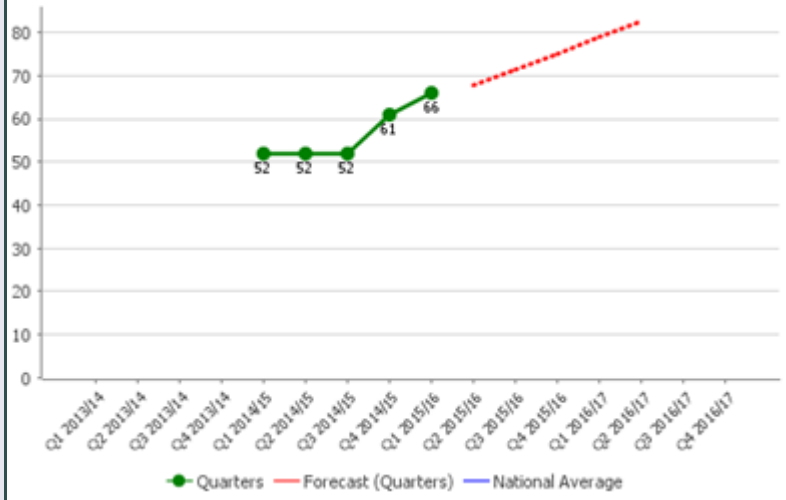
g) Attendances at A&E for people with dementia



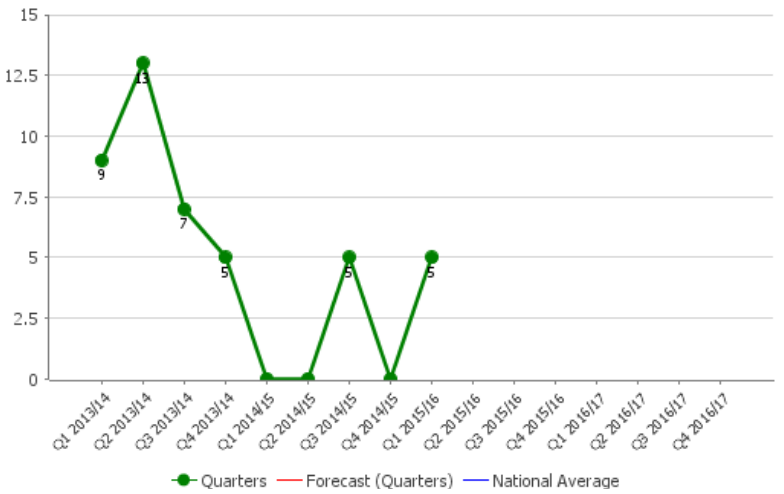
h) Number of people with dementia being admitted from care homes to DRI



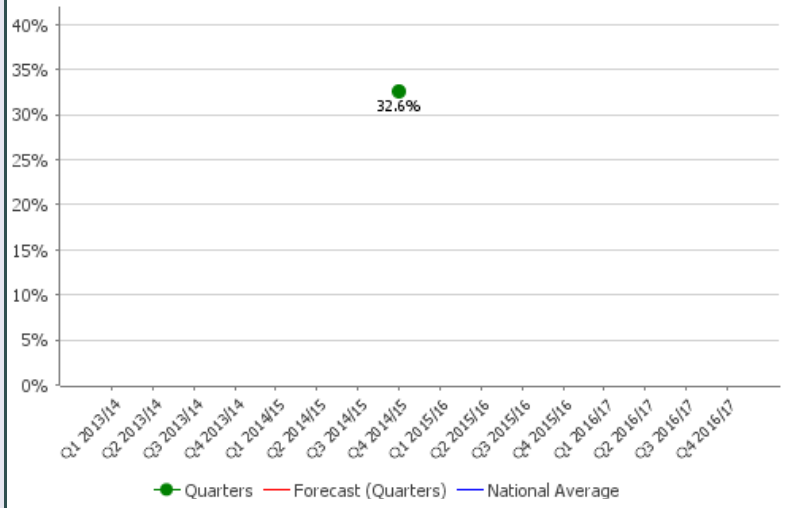
i) Number of Hospital deaths for patients with dementia



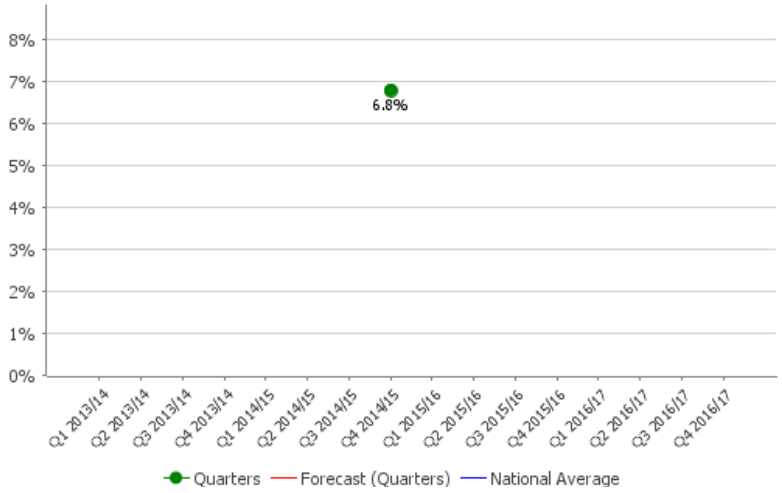
j) Unplanned episodes of Respite for people with Dementia



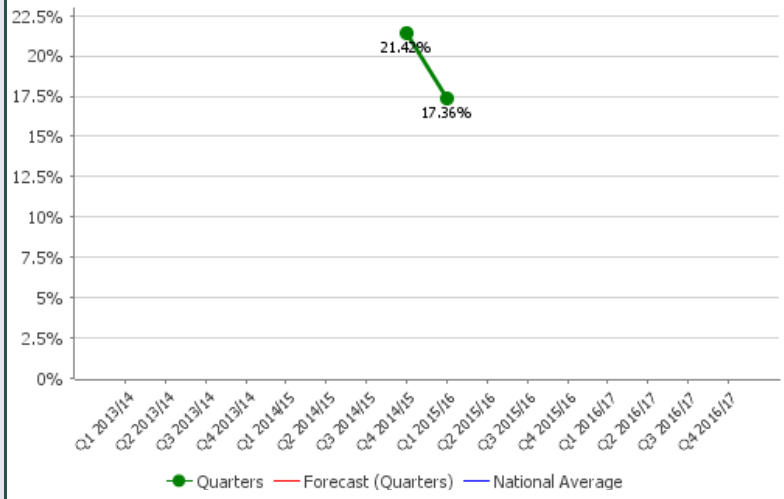
k)Proportion of People with dementia (receiving Social Care) living in the community



l) % of People with dementia accessing social care in the community with a direct payment



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



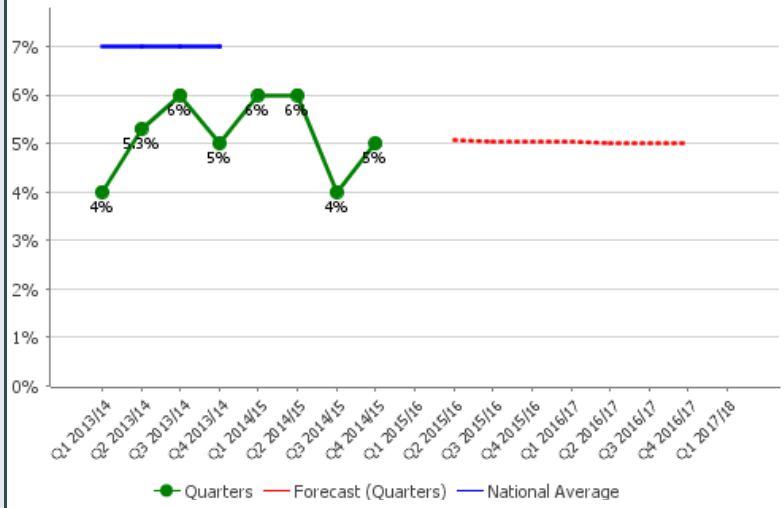
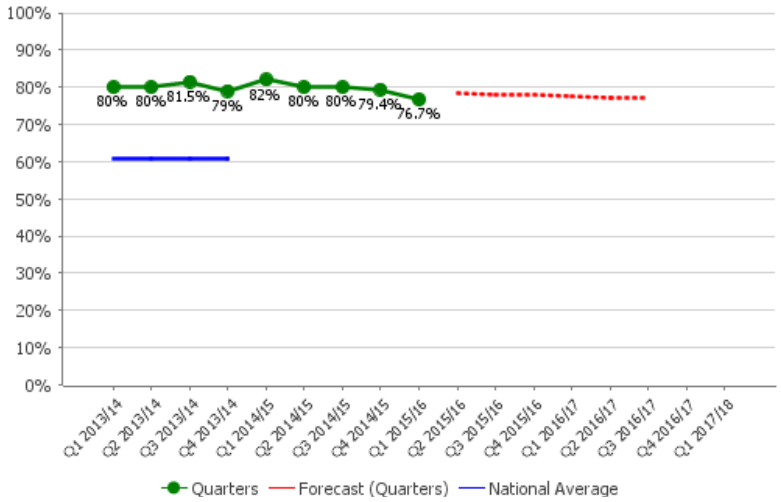
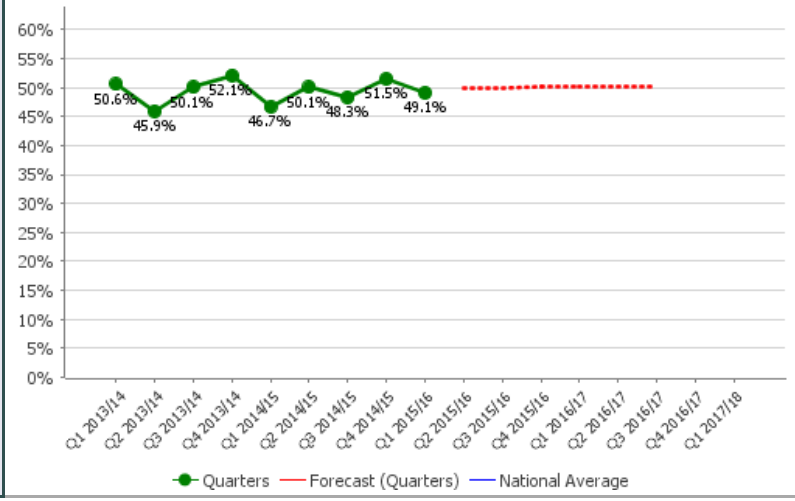
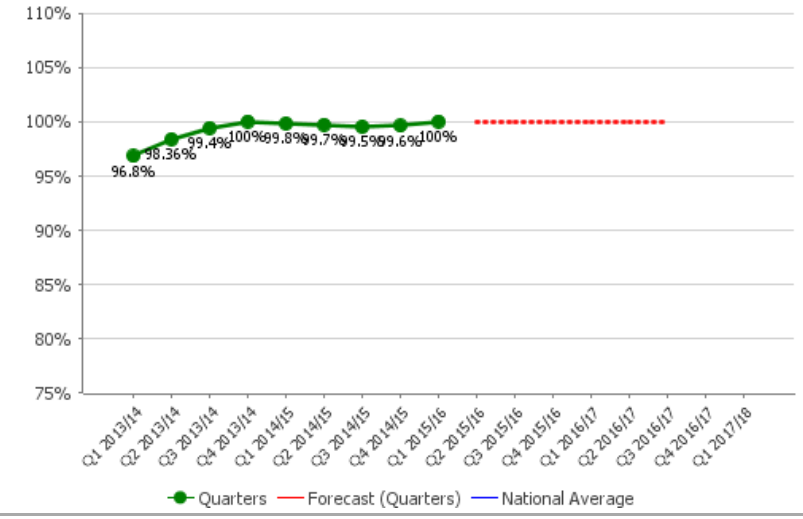
STORY BEHIND THE BASELINE

Much of the work that took place in 2014/15 focused on delivering against the 3 key areas of the National Dementia Strategy 2009 namely Raising Awareness and reducing stigma, Improving Diagnostic Rates and Supporting People to live well with dementia. There were some key successes in all areas; 4500 dementia friends, diagnostic rate improved to 63.2 % and acute data showing less people were being admitted to hospital, staying shorter periods and not being readmitted. This was against the backdrop of increasing disease prevalence and more accurate data capture through various coding mechanisms. 'The dementia prevalence rate methodology changed on 1 April 2015, and is likely to lead to a significant change in future dementia diagnosis rates. The next GP Service extract will be "as at end-August 2015" and is anticipated to be published at the end of September; publications will then continue monthly during 2015-16. An additional publication by October will provide the monthly extract data from April through July 2015.' It is anticipated that the new methodology will mean a further 3%-6% increase in Doncaster's dementia diagnostic rate.

Moreover crisis activity across the system (4hr response, a&e attendances, emergency carer respite etc.) all reduced or similar showing better support and prevention mechanisms. There are currently 2, 212 people in Doncaster who are living at home with a Telecare package, in 2015/16 for Quarter 1 (Apr –Jun) we have received a total of 334 referrals, of which 17.36 % have been for people living with Dementia (inc. Alzheimer's).The main reasons for referral are property exit sensors, bogus caller buttons, medication reminders and gas detectors.

Information is now much more widely available and the content and standard is consistent and reliable through a number of mechanisms such as the dementia roadmap, a dementia page on the Team Doncaster website under the Health and Wellbeing Board tab, a dementia page on the Public Health site and partners presenting links on their communication systems to these resources. Social Care data collections changed significantly in 2014-15 which effected comparability to previous years, other measures relating to social care will be available in the Q2 performance cycle.

	What we will achieve in 2015-16	What we will do next period
ACTION PLAN	For 2015/16 the action plan will address the 5 Key Areas of Focus as presented in Dementia Strategy for Doncaster, Getting There, launched in March 2015. These are Information, • Advice and Signposting, • Assessment and Treatment, • Peri and Post Diagnostic Support, • Care Homes • End of Life. This will ensure we build on the success of 2014/15 but also address identified gaps and areas for improvement. This year the people of Doncaster will be able 1. to access reliable and consistent dementia information and support in a timely manner; 2. there will be reduced variance in assessment and treatment pathways ensuring every referral receives a timely and effective response; 3. there will be a integrated and co-ordinated support pathway/service for people with dementia and their carers/families before and after diagnosis; more people will live at home with dementia and be in control of their life/care delaying the need for possible residential care and people; 4. when people with dementia need residential care they receive high quality care locally 5. people with dementia will die with dignity and in a place of choice through planned empowerment.	1. Q2 will see the commencement of a new dementia screening pilot involving both primary and secondary care involving software. This will not only assist in improving diagnostic rates but also support a possible earlier diagnosis. 2. October will see the launch of a new post diagnostic service involving Admiral Nurses and Dementia Navigators which will ensure every person with dementia and their families and carers will have a point of contact for support through case management. 3. Q2 will also see the start of several new projects aimed at making "Doncaster Friendly" working with communities, businesses, schools, academia, leisure and the arts.

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

STORY BEHIND THE BASELINE	There is a slight downward trend for both the proportion of adults in secondary mental health accessing paid employment and also the proportion living independently, with or without support. However the Paid employment measure is below the national and regional averages and has been so for some time. The proportion of people completing treatment and moving to recovery has decreased this quarter. Each CCG nationally has received a sum of £11,000 which will be used to support CCGs in an IAPT waiting list initiative to achieve fully validated waiting lists and good operational processes in all IAPT services. CCGs have also been invited to apply for further funding of £6 million nationally, due to significant regional variations in services as evidenced by the waiting list clearance times. NHS Doncaster has submitted a bid along with proposals for improvements.	
ACTION PLAN	**What we will achieve in 2015-16**	**What we will do next period**
	1. Continue to implement the recommendations of the Mental Health Review and by doing so, support the delivery of the National Mental Health Agenda: Continue the development and implementation of the Mental Health Development Programme and pathway redesigns – 3 year development programme (currently in year one) a. Crisis and acute care pathway b. Secondary Care & Community Teams i. Personality Disorder ii. Perinatal Mental Health iii. Eating Disorders iv. Attention Deficit Hyperactivity Disorder 2. Collaborate with Public Health to ensure that the Joint Strategic Needs Assessment has a strong focus on mental health and physical wellbeing 3. Implement the local Crisis Care Concordat Action Plan with regular progress reports to the Health & Wellbeing Board	