DONCASTER PLACE PLAN
REFRESH
2019 – 2022

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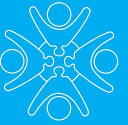
Part 1
Introduction

Introduction



In 2016 the Doncaster health and social care community published its first Place Plan, setting out the ambitions of the partnership over the next 5 years to 2022. It was the beginning of the journey and much has happened since then. Of course plans need to flex and change as we learn more together and understand the challenges we face as a place and the opportunities that brings.

This refresh of the Place Plan therefore builds on the original and takes forward the original ambitions.

The purpose of the Place Plan refresh is to provide clarity about what we intend to prioritise, develop and deliver together as an Integrated Care Partnership over the next 2 years.

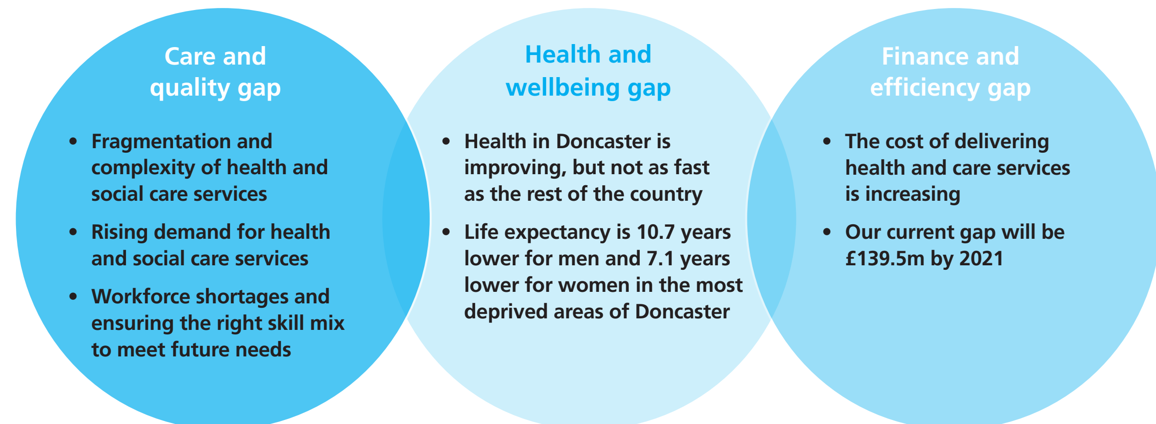
The vision remains the same:

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.

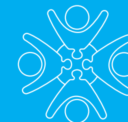
The Doncaster Integrated Care Partnership remains the same:

- Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH)
- Doncaster Children's Services Trust (DCST)
- Doncaster Council (DMBC)
- Fylde Coast Medical Services (FCMS)
- NHS Doncaster Clinical Commissioning Group (NHS Doncaster CCG)
- Primary Care Doncaster
- Rotherham, Doncaster & South Humber NHS Foundation Trust (RDASH)
- St Leger Homes Doncaster

The three major challenges remain the same:



A snapshot of our population



Doncaster's **population** is forecast to **grow to 308,600** by 2021. Over the next 10 years the number of people aged **over 65** in Doncaster will be **more than people aged under 18**

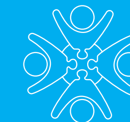
The health of people in Doncaster is generally worse than the England average. Whilst there have been improvements in health including increasing healthy life expectancy and **reduced rates of teenage pregnancy** too many people still experience poor health with **too many people dying prematurely** (i.e. before the age of 75) from preventable conditions. In fact, Doncaster is ranked 124 out of 150 for premature deaths overall.

This is reflected by **lower life expectancy** for both men and women than the England average by 2 years for men and 1.6 years for women.

There are also stark differences within Doncaster as life expectancy varies depending on where people live: **10.7 years lower for men and 7.1 years lower for women**.

Health however, is created by more than health services. The places people live, their education, housing, work, exposure to crime and their environments all contribute to creating health and wellbeing. **Doncaster is one of the 20% most deprived districts**/unitary authorities in England and about 24% (13,300) of children live in low income families and this has a significant impact on health.

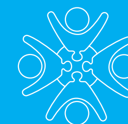
Risk factors and disease in Doncaster



Behaviours	
In general, Doncaster has less healthy lifestyles than the rest of the country. This is true for children as well as adults:	**22.7% of people over 16 are smokers**
	74.4% of adults are overweight or obese
	33.6% are physically inactive
	Doncaster is ranked 120/152 areas for Alcohol-Related Hospital Admissions

Diseases	
Diseases such as cancer, cardiovascular disease, liver disease and respiratory diseases account for between 80-90% of all preventable deaths, although local work to increase awareness of cancer symptoms, early identification and treatment over the past 2 years have resulted in some improvement	**2.2% of people are living with a diagnosis of cancer**
	3.8% of people are living with a diagnosis of Coronary Heart Disease
	2.6 of people are living with a diagnosis of COPD
	7.7% of adults are living with a diagnosis of diabetes

Older people
There are increasing numbers of older people in the Borough, many live alone and require help and support to maintain their independence. The more the population grows and ages the more people will develop dementia.



Why refresh?

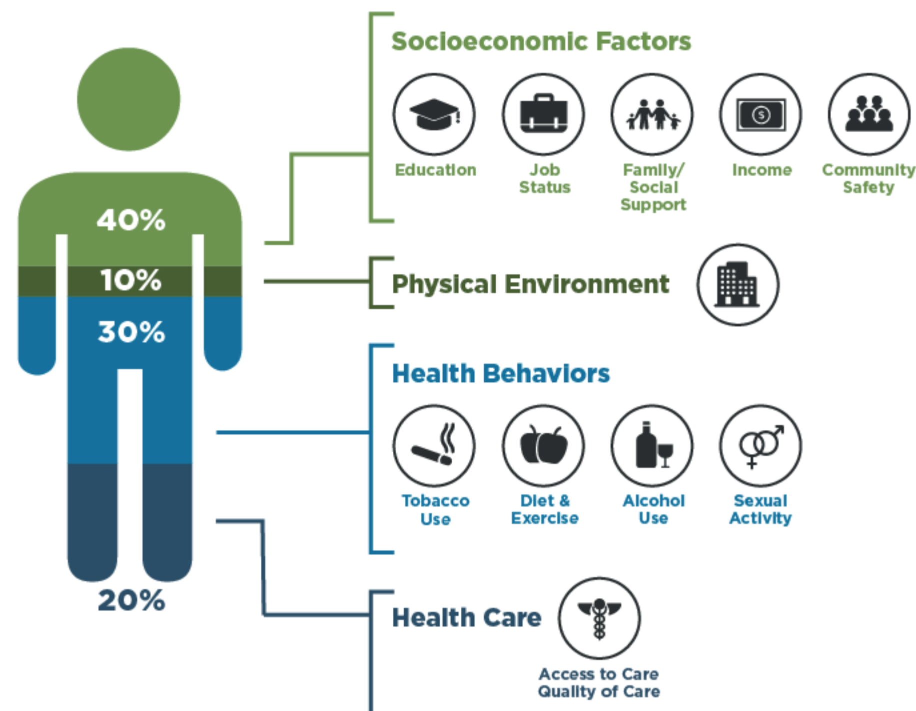
As we refresh our approach to enabling the health and wellbeing of local residents in the Borough, our understanding and thinking has begun to change. Whilst we know that the borough has many real challenges, some caused and reinforced by enduring deprivation, we also know that the towns and villages throughout the borough have a great many strengths that are the basis for thriving communities.

We know that about 20% of a population's health is created by health care. Much more is determined by where and how you live. Socioeconomic factors in particular play a powerful role in determining people's health, wellbeing and life chances and this is why the Place Plan sits within the wider Borough Strategy – Doncaster Growing Together which binds together action and reform across the four major themes of Living, Working , Caring (the Place Plan) and Learning.

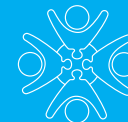
For that reason the refresh recognises the importance of communities and their inherent assets and strengths at the centre of our plans.

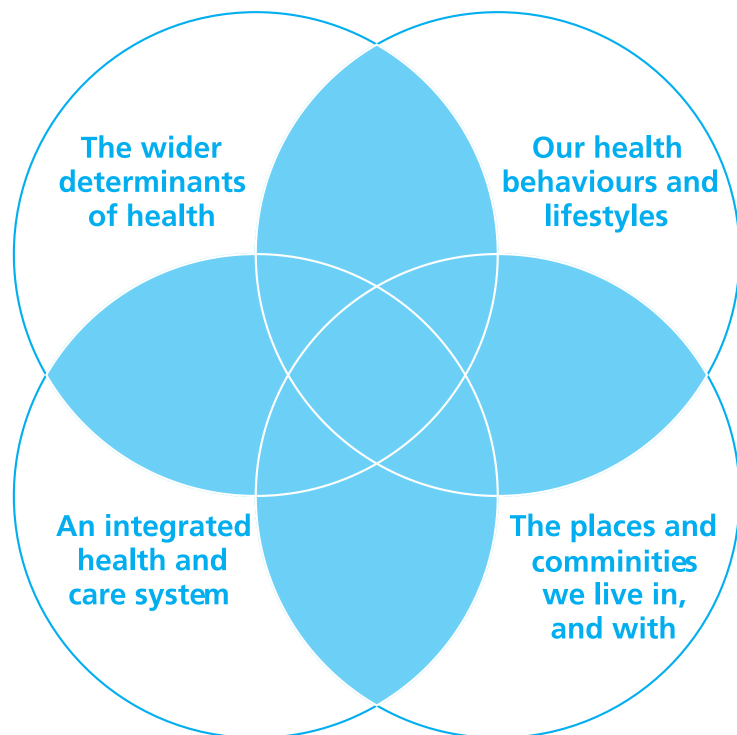
To help frame our thinking, the refresh is based on three intertwined models that have emerged and developed since the first Place Plan was published:

1. Population health
2. Prevention and early intervention
3. Doncaster Integrated Care Partnership's local four-layer framework around which we have built our refreshed plans, underpinned and enabled by Doncaster Clinical Commissioning Group and Doncaster Council's joint commissioning strategy and delivery plans



Population Health





The King's Fund describes population health as:

'An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies.'

As Doncaster's Integrated Care Partnership, we have also started to think about how we understand our populations better, both geographically in terms of the strengths and needs of local neighbourhoods and also segments of the population who have similar needs in terms of their health and wellbeing.

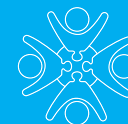
This approach has helped us to start to think about how we can have a greater impact as an Integrated Care Partnership, rather than considering problems and solutions through the lens of individual organisations.

Our starting point was to think about life stages and the very broad groupings of ***starting well*** (children and young people and their families), ***living well*** (working age adults) and ***ageing well*** (older people). The joint health and social care commissioning strategy and delivery plans are organised around these life stages.

However, within those broad life stages, there is a multiplicity of different need and to have a real impact we need to understand what lies within. Population segmentation is a way of understanding the population in more depth and then planning and responding to the needs of that segment with greater impact.

The model is still in development; however we have reached a broad position upon which we can commence the next stage.

Population segmentation and neighbourhood working

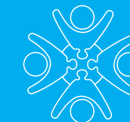


We have already said that where and how we live have a big impact on health and wellbeing, so simply understanding need through segmenting the population into groups of people experiencing broadly the same condition or at the same stage in life is a useful but blunt tool. We also need to think about where people live and the assets available to enable people to keep well and independent or regain their health and wellbeing and independence should they become unwell.

A major part of the refresh is therefore how we work with people and the neighbourhoods they live in to build opportunities and create health and wellbeing.

Population segmentation current thinking

Phase 1: Life stages	**Phase 2: Population segments** (first version, using the Bridges to Health approach)		
Starting well **Living well** **Ageing well**	**Starting well** (children and young people)	**Living well** (young people transitioning into adulthood, working age adults and older people)	**Ageing well** (older people)
This was our starting point to help us think about broad population groups, through the lens of life stages. The joint commissioning strategy has been based around these. We have always recognised that these need to be refined into more defined population segments	• Child and maternal health and wellbeing • Children with long-term conditions • Children with mental health needs • Vulnerable adolescents • Young carers	• Long-term conditions, including multi-morbidity, long-term neuro conditions, chronic disease, chronic mental health and chronic physical and sensory impairments, • Learning disability and autism • Complex lives including drug and alcohol dependence, chronic mental health, consequences of trauma • Carers	• People living with frailty • People at the end of life including organ failure, • Functional and organic mental health problems • Carers
	All age People who are mostly healthy, but need to access services for acute illness (physical and mental health) through general practice, dentists, Emergency Department, self-care etc.)		



1. Primary Care Networks

Since the publication of Doncaster's Place Plan, changes have emerged relating to general practice.

Primary care networks (PCNs) form a key building block of the **NHS Long Term Plan**. Bringing general practices together to work at scale has been a policy priority for some years for a range of reasons, including improving the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system.

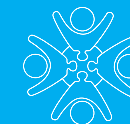
In Doncaster, there are 5 Primary Care Networks, formed around population sizes of between 50,000 and 75,000 patients, and each led by a Clinical Director. Central neighbourhood comprises two PCNs, with the East, South and North neighbourhoods each being largely co-terminus with one PCN each. These will be the footprints around which integrated community-based teams will develop, and deliver services to people with more complex needs, providing proactive and anticipatory care.

To do this they will be expected to provide a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices, for example, social prescribing link workers, first contact physiotherapists and paramedics. Many of these services will be based on a number of national specifications that PCNs will be expected to provide as they are developed and implemented over the next few years; whilst the detail of the specifications is awaited these services are:

- Structured medicines review and optimisation
- Enhanced health in care homes
- Anticipatory care
- Personalised care
- Early cancer diagnosis
- Cardiovascular disease prevention and diagnosis
- Tackling health inequalities

National funding for the additional workforce required to deliver these services will be staged over the next 3 years. Alongside this, existing services that are locally commissioned from individual practices will increasingly be commissioned through the PCNs in order to provide a more consistent high quality primary care offer across Doncaster. The approach to commissioning primary care networks will support the development and delivery of integrated neighbourhood services.

Further information about PCNs in Doncaster can be found at:
www.doncasterccg.nhs.uk/your-health/primary-care



2. NHS Long Term Plan

Published in January 2019, the NHS Long-term plan sets out the ambitions for the service over the next 10 years. It sets out commitments to tackle the pressures our staff face, how the additional funding will be targeted to achieve greatest impact and how to accelerate the redesign of patient care to future-proof the NHS for the decade ahead.

The ambitions of Doncaster's Place Plan are supported by NHS long-term plan, in particular its attention to prevention, integrated care, workforce, digital enablers and improving care quality and outcomes. More details can be found on the NHS England website at:

https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Chapter One sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.

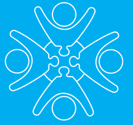
Chapter Two sets out new, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities.

Chapter Three sets the NHS's priorities for care quality and outcomes improvement for the decade ahead.

Chapter Four sets out how current workforce pressures will be tackled, and staff supported.

Chapter Five sets out a wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS.

Chapter Six sets out how the 3.4% five year NHS funding settlement will help put the NHS back onto a sustainable financial path.

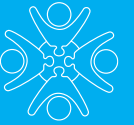


3. Prevention Green Paper

In July 2019 the national prevention green paper ‘Advancing our health: prevention in the 2020s’ was published.

This document identifies a number of opportunities for action including intelligent public health, predictive prevention, focused support and advice together with precision medicine which could be brought to bear on four key challenges being smoke free, maintaining a healthy weight, staying active and taking care of our mental health. It focuses on the role of the NHS. The consultation closes at the end of October 2019 and future outputs from this policy will need to be aligned with the place plan.

Bringing it all together: Doncaster's four-layer model



This refresh supports the Integrated Care Partnership to strengthen its approach to prevention and early intervention by harnessing the resources and support already available in local neighbourhoods.

The four-layer model developed by the Partnership gives equal weight and attention to this for the first time. It recognises that improving the health and wellbeing of the local population will not be achieved by strengthening hospital care and general practice in isolation or that schools or social care can address challenges to children and families alone.

Delivered in neighbourhoods

Thriving communities helping each other to keep well

Support communities themselves and the Voluntary, Community and Faith sector to develop and create local solutions for residents.

Front door system – no wrong door

Getting people to the right place first time

Joined up care and support at home

Tailored to population groups, e.g. people living with frailty

When people need care and support it is joined up. More can be accessed at home. NHS, council, housing VCF agencies and family carers work as one.

Specialist services

Planned and unplanned hospital care

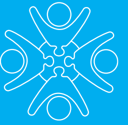
- Access when needed
- Care in an emergency

Specialist children's resources and services

- Child protection
- In-patient child and adolescent mental health

Specialist services such as hospital care are used more appropriately.

Bringing it all together: Doncaster's four-layer model



The refresh of the Place Plan puts a strong emphasis on planning, commissioning and delivering across the four layers.

Layer 1: **Local solutions created by thriving communities**

Communities already have a huge amount to offer their residents and by supporting this, they can achieve even more. There are many local solutions already in communities, including universal services (libraries, leisure centres, family hubs), carer support, voluntary, community and faith organisations as well as groups, clubs and places where people meet together without any external support or facilitation.

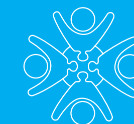
We are testing how we develop this through the Local Solutions prototypes in Denaby and in Hexthorpe with children and families. The prototype will enable us to develop the approach through testing, learning and iteration, then spreading it geographically and to other population groups.

By supporting local solutions, demand may be reduced on statutory services and enable people to take increased responsibility for their health and wellbeing.

This layer challenges the Partnership to think about solutions to and enablers of health and wellbeing from non-NHS or social care services. The arts is one such example, with the arts helping to keep us well, aid recovery and support longer lives better lived. The Council, NHS organisations, Cast, darts and Heritage Doncaster are testing arts programmes to support mental health, dementia, physical activity and loneliness through dance, music and theatre.

A further example is the strengthening connections being made between the Council's Community Service and community health and care services, including General Practice. Their approach focusing on early intervention and prevention around key priorities including supporting families, community development, tackling anti-social behaviour and low level crime by harnessing the strengths within communities helps to improve quality of life and make neighbourhoods safer and more supportive. The Wellbeing teams operating in communities with people needing support but not from social care or NHS services divert demand and keep people connected and independent.

Bringing it all together: Doncaster's four-layer model



Layer 2: **No wrong door**

Wherever people come into contact with our services, they should be directed to the right part of the system first time. Services that need to operate closely together should have their access points integrated into a single access point. This is already developing through the Community Single Point of Access providing access to mental health, carer support, planned and unplanned community nursing services and intermediate care. Plans are developing to incorporate more allied services.

Layer 3: **Joined up care and support at home**

When people (of all ages) and their families and carers need support and care because of a long-term physical or mental health condition or other vulnerability, as much as possible should be delivered at home or close to home. That care should be joined up and organised around the needs of the person and not around the organisations involved. The care and support should be capable of being:

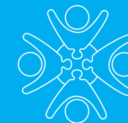
- **Preventative** – enabling people to connect to local solutions in their communities
- **Proactive** – anticipating what could happen and putting in place arrangements to avoid, delay or better manage a crisis;
- **Reactive** – able to respond swiftly if a crisis occurs
- **Strength-based** – built around what matters to the person

We are testing this through the work to prototype and new care model for people living with frailty in Thorne.

Layer 4: **Specialist services**

Secondary and tertiary hospital care will be accessible when needed to respond to both planned and emergency healthcare needs. Specialist services for children and families such as Tier 4 child and adolescent mental health services, or safeguarding will be available when needed. Specialist services need to be connected to joined up care and support at home and in turn to local solutions in communities.

Bringing it all together: Doncaster's four-layer model



In Doncaster, the Partnership understands that to start well, age well or indeed for all of us to live well, all of these layers need to be connected and operate together; with as much as possible delivered in local neighbourhoods:

Starting well – joint commissioning

Living well – joint commissioning

Ageing well – joint commissioning

Commissioning for populations rather than services

Prevention embedded throughout

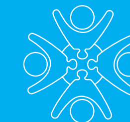
Wider determinants of health and wellbeing
e.g. housing, deprivation, education, connectedness

Primary prevention:
reducing risk factors that cause disease, e.g. smoking

Secondary prevention:
Early detection, e.g. screening programmes

Tertiary Prevention:
living with chronic conditions, preventing further disease

New ways of thinking and working



The learning emerging from the development of the Place Plan's Areas of Opportunity has led to a growing consensus on practice. There is still further work to understand how these inform and enhance the Partnership's emerging new care models, however they provide a strong foundation for more integrated, person-centred delivery of health and wellbeing services.

Whole family working and strength-based practice

There is commitment across the partnership to a coordinated whole-family approach. It takes into account the wellbeing of all the family and the impact of any services and support on other family members, including family carers. It considers both the strengths the family can contribute and also the potential harm and risk members of the family or close individuals can create.

Health and social care services have also historically focused in on the problem to be solved and the individual in isolation. We have generally paid less attention given to the inherent strengths and assets of the person, their family and the community they live in. This approach looks to build on strengths within the family:

- Step one: think family.
- Step two: get the whole picture.
- Step three: make a plan that works for everyone.
- Step four: check it's working for the whole family.

New approach to assessment

Assessment has tended to be organisation-specific and within organisations, profession-specific. For people with more than one problem and more than one agency involved, this can mean multiple assessments and no coherent plan centred on the person, their carers and their wider family.

A new approach is starting to emerge where assessment is proportionate, coordinated and focused on the whole person and their priorities.

Doncaster's approach to engagement and co-production with local people

Doncaster is its people and services can only be truly successful if local people are involved in their development and design. This is what we mean by co-production and we are committed to it being the default approach to developing, designing and reviewing local services across health and social care. We believe that co-production is about developing more equal partnerships, based on equity and respect, between people, carers and professionals.

We will be held to account for the changes and improvements that are made and we expect local people to take an active role in shaping services so that they are fit for purpose for future generations. We will develop and strengthen this approach as the way to deliver this refresh of Doncaster's Place Plan.

In Doncaster our commitment to co-production will be centred around four core principles - ***Engage, Inform, Influence, Empower.***

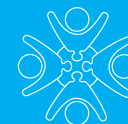
*We will **engage** people in conversations about their experiences of local health and care services. We will listen to those local voices and use what we hear to develop our offer of care and support to improve outcomes.*

*Local people will **inform** us about changes and improvements they want to see in Doncaster. We will respond to local people and tell them what we have heard.*

*Local people's voices, experiences and opinions will **influence** change and improvement in the quality of health and care services in Doncaster*

*Local people's active engagement and involvement will **empower** them to start making changes and to continue to challenge the services that are developed so that quality improves and people take control of shaping the future.*

New ways of thinking and working



Engaging with local people, being informed by them about care and support, listening to their voices to influence improvement and empowering them to get involved will be at the heart of all the work that is done in Doncaster across the Voluntary, Community and Faith Sector, the local NHS and the Local Authority.

What have we done already?

Doncaster Innovates has incorporated co-production into the new approach. Focus groups, ethnographic interviews, and experience-based evaluation forms are some methods which have been utilised to incorporate resident and professional input at each stage of the process, aimed at ensuring the service delivered is fit for purpose. This fits with strengths-based working, and doing with residents, rather than to.

We have developed a community development toolkit to support staff to work better with communities to build on and harness their strengths. This has emerged from the experience of working with the Well North project in Denaby.

Over the last 12 months a significant amount of work has been undertaken with patients and members of the public to inform and influence local health and care services.

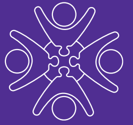
Two key pieces of engagement across Doncaster and the wider South Yorkshire and Bassetlaw Integrated Care System have taken place since publication of the NHS Long Term Plan. They have used the Engage, Inform, Influence approach to co-production and align with key priorities outlined in Doncaster's Place Plan:

- **The Joint Health and Social Care Commissioning Strategy** – the first joint commissioning strategy across NHS Doncaster CCG and Doncaster Council was developed by talking to local people. In Spring 2019, almost 800 people in Doncaster provided their views which informed the final strategy published in April 2019.
- **The NHS Long Term Plan** – What would you do to improve the NHS? – Healthwatch Doncaster led conversations with local people about the NHS Long Term Plan, including with people whose voices are not often heard or listened to. This included prisoners, young people, older people and community groups who offer friendship and emotional support. These conversations will help the local system to develop their plans in response to what local people have told them about the NHS Long Term Plan.
- **Doncaster Talks** – shaping the future of Doncaster as a place – a Doncaster- wide series of engagement activities are taking place to give local people the chance to have their say on what they would like to see happen and change in Doncaster over the next 10 years. The feedback from this will be used to develop the Doncaster Growing Together strategy (the umbrella strategy for the Caring Theme and Place Plan Refresh) and the joint commissioning strategy. This feedback relates to everything from town centres, working, living and playing in Doncaster.

Part 2

Refresh

How the Refresh is structured



1.	**Progress on the original seven areas of opportunity**
2.	**Delivery of neighbourhood-based integrated new care model**
3.	**New areas of opportunity**
	Children living with long-term conditions, including disabilities
	Mental health wellbeing and dual diagnosis with substance misuse
	Healthier Doncaster
4.	**Strategic enablers**
	Workforce education, training and development
	Digital Doncaster
	Finance, contracts and payments
	Estates
5.	**Governance and decision-making**

1. Progress on the original seven areas of opportunity

The original seven areas of opportunity were chosen because firstly they represented areas of service or need that needed to be improved and secondly could only be tackled through a partnership approach.

The purpose was to create new ways of working that would achieve better outcomes and experience for users of the services, carers and for staff, whilst making the Doncaster pound go further – a pressing need in a challenging economic environment.

New ways of working have been tested, with some more progressed and mature than others. It is important that as we refresh our plans that those areas are not lost or left behind, but are brought to maturity, stop being projects and are embedded in day-to-day service delivery.

The following sets out the high-level plans for each area to achieve this. Detailed plans can be found in the appendix, however the following sets out progress already made and the impact for Doncaster residents.

Complex lives

The Complex lives programme was established in response to a major homelessness challenge in Doncaster. The programme is whole system addressing the immediate needs of people who are homeless (healthcare, psychological, mental health, financial, housing) as well as addressing the availability of long-term sustainable housing and employment opportunities. This is ***'William's'*** story:

William's younger life was unstable and he had little guidance. His mum was a heavy drinker, and he was abused sexually by a male that visited the property. After leaving home at 18, he lived on the streets; began experimenting with drugs, and becoming involved in criminal activity. Over the last year William was a victim of domestic violence while in a volatile relationship and because of their behaviour were evicted from all housing providers, and options for them had run out.

The Complex Lives Team has supported William since February 2017, when he was 21 years old and street homeless. His volatile relationship has ended and he is now being supported to manage his own tenancy. He is drug free, is engaging with all services, and has been doing some agency work. William has said that we have helped him turn his life around; he has now started to build relationships with his father and other family members He is making amazing progress towards a more positive future.

Intermediate care

Intermediate care is an important part of the health and care system ensuring that (mostly older) people have access to support to address their medical, nursing, therapy, reablement and care needs in a crisis or after an admission to hospital. The overarching aim is to enable people to regain and maintain their health, wellbeing and independence.
Here is ***Mrs Lucy's*** story:

Mrs Lucy is 92 and lives in a residential home. The Care Home Frailty Team got involved after her GP raised concerns about her pain, low mood and hallucinations. Her mobility is poor and she was not motivated to move around the care home. She doesn't have a diagnosis of dementia but is known to the Older Peoples Mental Health team due to previous episodes of low mood.

Mrs Lucy had a number of inter-related problems that needed to be addressed with her as a whole and so the team undertook a holistic frailty assessment to look at her mental health, mobility, frailty and pain. There were also concerns about the care home's ability to manage the complexity of her care.

The team found that her low mood affected her motivation to mobilise which contributed to pain in her muscle and joints. Despite being prescribed paracetamol Mrs Lucy declined it and staff felt unable to explore the issue of her pain further.

The Advanced Nurse Practitioner prescribed an antidepressant and pain relief as agreed that pain was also impacting on her mood and her pain relief was prescribed on a regular basis. The physiotherapist has completed intensive work with her providing exercise and encouragement and acting as a role model to the care home staff to assist and motivate Mrs Lucy to mobilise.

As her pain and mood were managed, Mrs Lucy's motivation to move around increased and she regained some of her independence. All the staff involved completed a joint learning package with care home staff to provide education to the staff.

Her mood is now much improved and her pain managed without sedation. She is eating and drinking better and mobility has improved reducing the risk of falls.

Urgent and emergency care programme

Closely linked to intermediate care, the Urgent and Emergency Care (UEC) programme has set out to develop a whole system response, with common purpose, vision and system goals. The work to date has focused on defining and agreeing the future state. The focus now is on delivery to improve and enhance the existing service from September 2020.

The priorities are:

- For provider organisations work collaboratively at both an operational and executive level
- To support people to self-care and look after themselves and their families
- To raise awareness of UEC services so that people can access the right support at the right time
- To provide out of hospital care where possible keeping care close to home, hence close links with intermediate care and integrated neighbourhood-based care

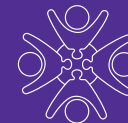
We have worked with the public to better understand local culture, behaviour and awareness of UEC services. It is evident that a significant number of people who come to the Emergency Department (ED) could have their needs met in other parts of the Doncaster urgent care system.

Doncaster's future UEC system will:

- provide better support for people and their families to self-care or care for their dependants
- help people who need urgent care to get the right advice in the right place, first time
- provide responsive, urgent physical and mental health services outside of hospital
- ensure that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities
- connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts

In reality, for people this will mean:

- A single point of contact to help people get to right service easily
- Joined up, coordinated and consistent care
- Advice and support to self-care



Introduction

The health and care system in Doncaster is a highly complex one evolved over many years in response to local need, and shifting local and national policy and economic conditions. It has changed as we understand more about what keeps people well. Our concern for the experience of the person has grown too, and the importance of putting the person and their family and carers at the very centre of the way we delivery care and support has become more than rhetoric.

There is increasing recognition too that whilst we have hospital services we can be proud of, home is often best and many treatments can now be delivered closer to home. Our children's services have improved and alongside keeping children safe, we value ensuring that families have access to information, advice and guidance to be the best parents they can be.

There was a clear commitment in the Place Plan to develop neighbourhood-based integrated care teams: the model requires new ways of working, focused on services working together, wrapped around the person and delivered in neighbourhoods.

This Refresh focuses in on how NHS, social care and other key partners such as education, housing and Wellbeing Services can join forces and dissolve boundaries to deliver care and support closer to home. We do however recognise that the health and wellbeing of the population is not the sole preserve of NHS and social care services: the ability for people and communities to thrive is as much founded in the places people live and the economic, educational and environmental context.

As Team Doncaster develops its approach to integrated neighbourhood delivery across the whole spectrum of public sector services and their partners, the Place Plan integrated neighbourhood delivery model for NHS and social care services will sit within that providing a specific focus on creating a local integrated care system delivering health and social care.

The purpose of developing integrated neighbourhood working

The overarching aim is to archives the best outcomes for Doncaster's residents from the investment we make in NHS and social care services.

For people: (children, young people and adults):

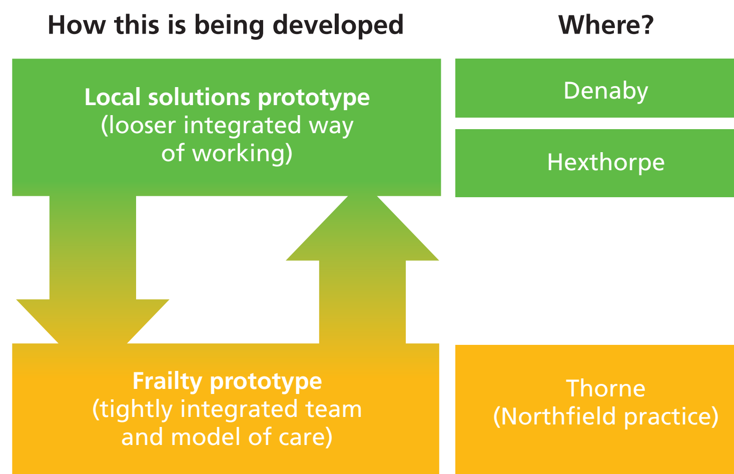
- Provide information, advice and guidance for families to be self-sufficient or respond to additional needs as they arise to promote better outcomes.
- Create a better experience of care and support for people who use services and their carers to achieve better outcomes
- For people with complex needs - coordinated, joined up care and support: one person up the garden path where possible
- Better access to information and advice to support self-care and community-connectedness
- An approach that values carers and focuses on recovery and rehabilitation enabling people to achieve health and wellbeing and reduces dependency on statutory services

For services:

- Enable GPs to work at scale in networks to achieve economies of scale, increased resilience
- More efficient and targeted use of the community-based health and care workforce and resources generally
- Manage more care at home, and reduce demand/improve flow in hospital services
- Shift from reactive care to more proactively managing the health of local populations/natural communities
- Shift from a crisis response model to a more planned approach by case-finding, planning and optimising care and support including carers as experts by experience (reduce unplanned demand on GP, ED, non-electives and social care)
- Improved collaboration between agencies (cross adult / child sector and cross discipline) and carers which target resources more effectively to family needs

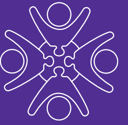
What we mean by integrated care in Doncaster

Doncaster's four-layer model recognises that to start, live and age well, most of our service delivery and work with communities should be taking place in local neighbourhoods, where people live and where they can access, or be supported to access local solutions, enhanced by more formal, integrated support when this is needed.



The Doncaster Innovates programme has been exploring and prototyping aspects of integrated working in different neighbourhoods, with different life stages and with testing different degrees of integration. The process has also started to describe a common methodology, for developing and implementing integrated care, regardless of the setting or location.

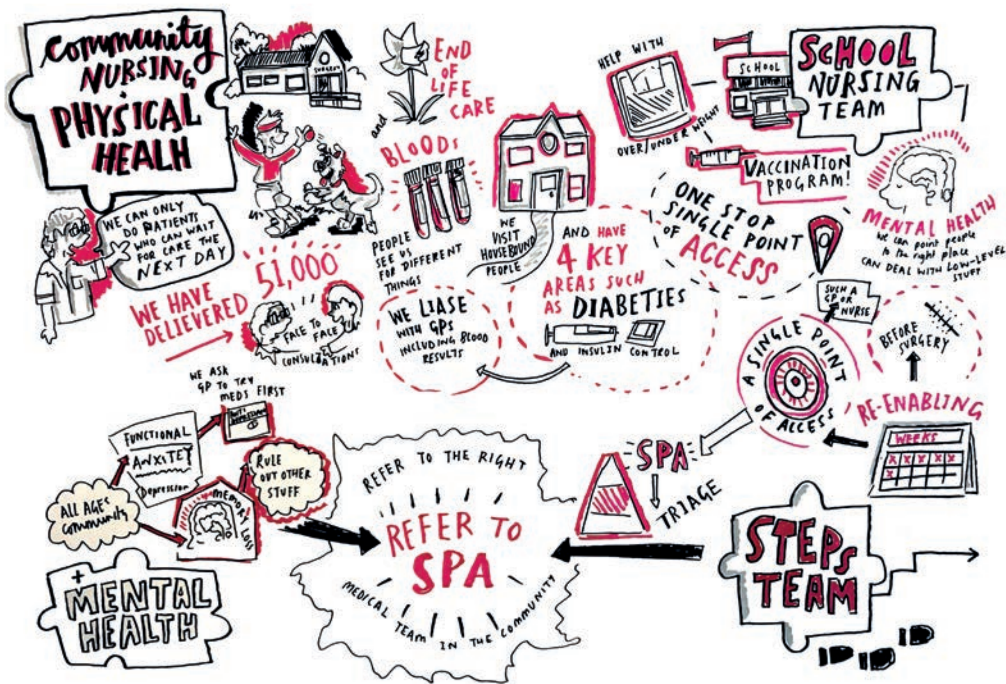
Although the prototypes relate to distinct areas of practice or cohorts, once defined and tested, the methodology and approach can be translated and applied to other cohorts needing a similar approach.

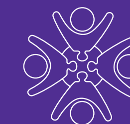


The foundations for integrated care in neighbourhoods

The complex nature of the health and wellbeing system in Doncaster means that often individuals, teams and services simply don't know what else is in the neighbourhood they are working in: what assets the neighbourhood already has to connect local people too and which services can work more closely to achieve better results for people.

Primary Care Doncaster has employed Neighbourhood Project Coordinators to help link services and communities as the foundation for more joined up ways of working. Simply by spending time together, teams and professionals are already making important connections and building their networks.





Local solutions prototype

THE PROTOTYPES

Children, young people and families.
Denaby and Hexthorpe

Why?

Families sometimes enter the social care system unnecessarily, when there are good alternatives to be found as part of local resources and services. This places significant demand on the service and families experience being 'over –processed' and assessed for relatively low-level issues.

This prototype aims to promote meaningful connections between professionals within a community and the community themselves, developing their resilience and the opportunity for local people to tackle their problems closer to home. This will help families achieve their goals and develop their strength.

From an organisational perspective, this aims to reduce demand for statutory services as families are connected with alternative, neighbourhood-based resources.

How it works

A multi-disciplinary team of practitioners and clinicians meet to triage the needs of a family who have come to the attention of any member of the team or through wider connections. The focus is on low level need that is not at the point of crisis.
The team will then connect the family with local solutions to meet their needs.

Application to other cohorts

This approach can be applied to any cohort, as a means of connecting people with resources, support, activities and social opportunities within a neighbourhood, for example people living with low to moderate frailty.

Local solutions: **wrapping services around people**

What happened when the Jones couple needed support?

The Jones couple dropped into Doncaster Council's offices asking for support and advice. They had no food or money following a move into the Doncaster area. The couple were expecting their first baby in four months' time. Their flat had no furniture and didn't know where to turn.

The Jones couple were one of the first families to experience our new approach to finding Local Solutions…

First things first, the Communities Coordinator, Neil, visited them to provide a food parcel. He then welcomed the Jones couple to the community.

Neil started to get to know them and found out that the couple had fled their home and moved into a flat above a shop. The flat was unfurnished and they had no belongings at all to bring with them. They were moving a light bulb around from room to room. Their benefits were being reviewed which had left them with nothing.

The Local Solutions approach brought together all the agencies who needed to contribute towards supporting the couple and with them, they worked out what was needed in the short-term: a bed, cooker, washer, crockery, pans, cutlery, bedding, towels and curtains.

There were no worries from a midwifery perspective as Mrs Jones was registered and seeing the midwife regularly.

The Communities Coordinator visited the flat the following day to discuss how we could support them and the couple were overwhelmed with the response. Just two days after the initial visit, everything the couple needed were provided and a full benefits check had been completed.

It was agreed that the local team would keep in touch with the couple through the Communities Coordinator, acting as a trusted professional, keeping a watching eye on them to ensure the situation continued to improve.

With their correct benefits now in place, the Jones couple were managing well. They built up a good relationship with their trusted professional and Mrs Jones was accessing groups at the family hub; all midwifery appointments were attended and Mr Jones started to think about getting work ready.

How was the Local Solutions approach better?

The previous approach would have taken much longer and support wouldn't have been joined up. There would have been a three day wait for screening and allocation, followed by a further 45 days for the assessment to be completed before the intervention could start.

Our new way meant that it took just three days from the first conversation to support being provided.

Frailty prototype

Older people living with frailty in Thorne

Why?

People living with frailty and their family carers often experience deteriorating physical and mental health, often with one or more long-term conditions, sometimes including dementia. The person is likely to be coming towards or is in the last stage of their life. People living with frailty often experience crises in the physical and mental health, resulting in frequent attendance at the Emergency Department or in unplanned, emergency admissions to hospital. Recovery after a crisis is often poor and leads to a deterioration in the health and independence, leading to further crises.

There is frequently a wide range of professionals, family carers and services involved in their care and support. People tell us that this isn't always well coordinated. People and their carers struggle to maintain important social connections, activities and friendships as their health deteriorates.

How it works

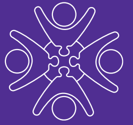
This is developing a model of tight, one-team integrated working, focused around the needs of a particular cohort or population segment that need targeted intervention to prevent or respond to a predicted crisis in their independence, health and wellbeing.

The team proactively identify people living with frailty: through tools such as the e-Frailty Index, information on hospital admissions or discharges or through clinical/ practitioner insight.

The team coordinate a single, holistic assessment based on what is important to the person and their strengths. The lead practitioner, supported by the multi-disciplinary skills within the team, the person, and their support network, jointly create a plan which incorporates the components of the comprehensive geriatric assessment.

This proactively identifies and addresses potential issues that can be anticipated, e.g. polypharmacy or environmental factors increasing the risk of falling, mobility, pain control, problems with activities of daily living, managing anxiety, depression, delirium etc. It also contains core details of the individual's future care wishes should a crisis situation arise.

2. Delivery of neighbourhood-based integrated new care models



There is a strength-based, single assessment and care plan, supported by the integrated digital care record. We are developing a strength-based conversation starter tool with residents, based on the image below.

Conversation starter:

Can you tell me about your home—what works well?

Who and what are the things that matter to you?

What are your hopes for the future?

It has been well received and the evaluation shows residents feel more listened to, whilst some professionals find it helpful to be less 'task focussed'.

"I liked that somebody was interested in my needs and was helpful."

Resident of Thorne

"It is useful if you do not already know the resident. It allows for more free flowing conversation led by the service user."

Member of staff

The team also help connect the person to local solutions, using the methodology developed by the Local Solutions prototype, described above, to ensure that the person retains or re-establishes neighbourhood connections, activities and friendships that are important to them.

Brenda, 82

Widowed with no children – has neighbour Jean who is close friend. Used to enjoy travelling and fishing with her husband.

Has carers 3 times a day for help with medication prompts, meal preparation and personal cares. District nurses visit daily to attend to her leg dressings.

Brenda has diabetes, high blood pressure, sight loss due to glaucoma and experienced a stroke 2 years ago affecting her mobility such that she uses tri-wheeler.

Current state:

- Brenda falls at home and is found on the floor by carers in the morning ➲ 999
- After 4 hours in the Emergency Department is transferred to CDU
- When no fractures are confirmed she is seen by RAPID and discharged after 14 hours in hospital with her usual package of care to return to falls clinic within 2 weeks

Future approach

- Brenda goes to a local Pilates class ➲ feels her balance is much better and is more confident getting out of the house
- If she were to fall the RAPT team in the Emergency Department will assess early, advise fit to sit and aim home first and home now. No further hospital appointment because RAPT contact the neighbourhood frailty team to complete comprehensive geriatric assessment in the community and co-create with Brenda and Jean an emergency plan for if Brenda has a health crisis (e.g. fall/UTI/chest infection) ➲ Documented on a single digital care record
- Ensure Brenda and Jean know who to contact if any new needs arise, and when to do this

Bert, 82

Bert experiences advanced Parkinson's disease and Lewy body dementia and lives with wife Eva. Bert now has a bedroom downstairs and receives carers 4 times per day to help with personal cares. Eva provides the overnight support. Bert is a retired headmaster and enjoyed playing golf and singing in the church choir.

Current state:

- Experience polypharmacy ➲ at higher risk for adverse events such as fall/delirium
- Parkinson's specialist nurse notes Bert's condition is progressing, however she is struggling to coordinate increasing his package of care and organising advance care planning discussions
- Eva is concerned about Bert's swallow, community Speech and Language Therapist is unable to visit for 4 weeks ➲ Bert ends up in hospital with another chest infection before this community visit takes place ➲ his admission is 5 weeks long and he is discharged to a nursing home ➲ his condition deteriorates rapidly and he dies within 2 months of admission to the nursing home

Future approach

- Before his disease became advanced, Bert was videoed saying who and what were important to him, and his wishes for the future including his preferred place of care
- If Bert is admitted to hospital, the front line team have access to his ongoing care record so they are fully informed about his most up-to-date care plans including the course of action for expected and unexpected medical emergencies ➲ they know who to contact in the community and trust the necessary actions will be taken to get Bert home as quickly as possible, as per his wishes for end of life care in the community and dying in his own home

Application to other groups of people with different needs

This way of working is applicable to any cohort of people needing intense support from a cross-section of professionals and agencies.

The tightly integrated care team: tailored to population segments

The Integrated Care Partnership has agreed that the function of the service will determine its form and that organisational structures should not get in the way of delivering truly joined up care centred on the needs of the person and their carers and wider family.

In practice, this means the following for day-to-day working:

The team shares

- a single process for access, triage and prioritisation
- a common caseload and approach to case finding
- a common way of day-to-day working, with common standard operating procedures
- information, advice and guidance
- a team room
- a leader

The team is supported by

- Whole system workforce planning, education and training
- Practice/clinical leadership and governance
- Shared business intelligence, performance information, finance reporting
- A leadership team from the partnership
- Single assessment and care plan (person not profession-oriented) with key worker/case management approach that involves carers
- The right skill mix
- Access to specialists
- Access to information on local assets

The team feels

- there is a common purpose or endeavour
- there are the right skills in the team to provide holistic assessment and interventions encompassing physical and mental health, psychological, social and safety needs
- the team is more important than the organisations the members are employed by
- skills can be shared and roles blurred
- that one person's assessment is trusted by another
- that the person has a better experience, that their care is coordinated and based on what matters to them
- it is continually learning, changing and improving

Outline timeline for implementation of integrated neighbourhood teams across the Borough (adults)

Now | Xmas '19 | April '20 | July '20 | Sept '20 | Xmas '20 | April '21

East neighbourhood

Prototyping and mobilising frailty model

Thorne neighbourhood integrated frailty team operational

test, iterate, learn. Prep for next phase

Embed new care model
Widen cohort to include multi-morbidity, dementia, long-term conditions
Widen to other practices in neighbourhood

Fully embedded Integrated care model in **Thorne** neighbourhood

Northfield practice

All Thorne neighbourhood practices

Id. metrics and collect baseline

Impact @ 3 mths

Impact @ 6 mths

Impact @ 9 mths

Impact @ 12 mths

Design prototyping and mobilise new care model in remaining EAST neighbourhoods

EAST locality neighbourhoods
Integrated care model operational
including frailty, multi-morbidity, dementia, long-term conditions etc.

Fully embedded Integrated care model in **EAST**

Central

Design prototyping and mobilise new care model Central neighbourhoods: build on existing good practice

CENTRAL locality neighbourhoods
Integrated care model operational
including frailty, multi-morbidity, dementia, long-term conditions etc.

South

Design prototyping and mobilise new care model in South neighbourhoods: build on existing good practice

SOUTH locality neighbourhoods
Integrated care model operational
including frailty, multi-morbidity, dementia, long-term conditions etc.

North

Design prototyping and mobilise new care model in NORTH neighbourhoods: build on existing good practice

A note on roll-out:

The first prototype is based around the neighbourhood of Thorne and the Northfield Practice, followed by a roll-out across the East locality and practices.

The next phase in terms of practices and neighbourhoods is not fixed and is flexible: some will be ready to go before others.

There are lots of examples of good practice already happening across Doncaster, for example the Proactive Care service at the Scott Practice.

The emerging, neighbourhood-based integrated care models will build on these, benefiting from the experience they bring.

Our approach to prototyping

ROOTED IN PLACE & STRENGTHS
PERSON CENTERED & ACTION FOCUSED
EARLY IDENTIFICATION & ANTICIPATORY PLANNING
MULTI AGENCY TEAM
INCLUDE WHOLE FAMILY & WIDER SUPPORT NETWORK

Frailty Progress Sep 2019

Locality solutions Progress Sep 2019

0 SELECT (2 weeks)	1 UNDERSTAND (2 weeks)		2 PROTOTYPE (2 weeks)		3 EXPERIMENT (2 weeks)		4 GO LIVE (Ongoing)
Based on evidence, prioritise a population group and location to work in	Understand the area through research with residents	Build a multi-agency team and select a lead	Engage relevant partners	Identify what we are measuring so we know if it's working	Test new solutions with residents	Develop higher fidelity prototypes	OnGoing impact measurement
	Agree outcomes that we are measuring for	Start ongoing mapping of local assets and potential local assets with staff and residents	Share learning locally and across the partnership		Ongoing testing, iterating and learning		
	Share learning locally and across the partnership		Teams coproduce prototypes with local staff and some residents	Team test prototypes with local staff and some residents	Ongoing impact measurement		Start process again in next locality
	Share learning locally and across the partnership	Ongoing team relationship building			Reflect on impact and share learning locally and across the Partnership	Identify and develop team skills needed to 'go live'	
	Establish team rhythms and rituals		Identify and develop team skills needed to move to 'experiment'				

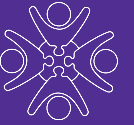
BUILDING BLOCKS

- FINANCE, COMMISSIONING AND CONTRACTING
- ESTATES
- DATA
- LEADERSHIP
- DIGITAL SOLUTIONS
- COMMUNITY DEVELOPMENT
- WORKFORCE DEVELOPMENT

A note on Doncaster Innovates and prototyping new models of care:

Partners in Doncaster have been working with the Innovation Unit and Future Gov to develop our innovation skills including co-producing designs with local people and prototyping new ways of working including innovative approaches to assessment.

The approach can be applied to all aspects of service development, innovation and improvement and we will continue to develop and hone our innovation skills through the delivery of this refresh.



Theory into practice:

Doncaster Innovates supporting us to test and deliver integrated care teams

2. Delivery of neighbourhood-based integrated new care models

The Refresh commits the Doncaster Integrated Care Partnership to:

1. Continue to build networks across the partnership, creating connections and building foundations across the partners.
2. Support the evaluation and roll-out of the Local Solutions prototype across the District
3. Support the implementation, evaluation and roll-out of the frailty prototype
4. Expand and extend the prototypes to establish neighbourhood-based integrated care based on a common model, tailored to population segments and local need
5. Extend the 'local solutions' integrated way of working approach into adult services
6. Extend the integrated care team model into children and families services, including extending the skill mix to include specialist support to adults with needs within the family group
7. Establish multi-agency and multi-disciplinary integrated care teams drawn from existing uni-professional and single organisation teams and services
8. Establish a leadership model operating across the partnership
9. Establish common caseloads across organisations
10. Implement mechanisms to support case finding and early triage to enable proactive/anticipatory care and direction to local solutions
11. To shift the delivery model to include anticipatory and preventative interventions
12. Extend the integrated digital care record to enable a single assessment and care record approach
13. Develop communities to enable people to access support, information, advice and guidance through local solutions
14. Develop strength and asset-based approaches to practice, including whole family working where relevant and particularly for children and young people
15. To embed carers in all works steams to ensure carers are identified, treated as experts in care, are valued and included by all professionals in line with NHS Long Term Plan, Children and The Children & Families Act 2014 and the Care Act 2014

Children with long-term conditions including disabilities

So far, the Place Plan has focused on two specific cohorts of children who would benefit from a whole system, joined up approach to their care and support:

- **First 1001 days** – integration of the support provided from conception to the child's 2nd birthday, bringing together midwifery, health visiting and developing a new First 1001 days worker to provide continuity of support for the family
- **Vulnerable adolescents** – development of a whole family approach to avoiding harm to young people brought about by adult behaviour, including substance misuse, mental health problems and domestic violence; also creating the conditions to bring vulnerable young people in specialist out of area placements back into Doncaster, taking a whole system – education, health and care – approach to meeting their needs

Through the development of integrated neighbourhood delivery, prototypes have focused on children and families needing additional support and connecting them with local solutions where these provide a good alternative to statutory support services.

The Refresh will introduce a new area of opportunity, aimed at improving the experience and outcomes of children and young people living with disabilities and/or with long-term conditions, including mental health needs or who are young carers. These may include asthma, cystic fibrosis, inflammatory bowel disease etc.

The current system is highly complex, involving primary, secondary and community and specialist tertiary NHS care and treatment; education, social care and housing, mental health and physical health support, amongst others. The needs of parents (frequently balancing work, family and caring responsibilities), family networks, carers, siblings and friends add further layers of complexity.

The Integrated Care Partnership will

Develop an area of opportunity to create an integrated service for children with long-term conditions, including disabilities:

- Explore and co-produce with parents, parent carers and children the blueprint for the service
- Develop a multi-disciplinary and multi-agency integrated approach capable of working with children and families to meet the educational, medical, community nursing, social, therapeutic, mental health and psychological needs of the child, siblings and family, including:
  - Integrated children's therapy services across NHS providers and the Council
  - Integrated housing adaptations and equipment services within the offer
  - Bring together physical, mental health, educational and psychological support
- Address carers support including short breaks

Mental health

Mental health flows through all of the existing areas of opportunity, with some having a greater emphasis on it than others, for example Complex Lives or Vulnerable Adolescents. The development and introduction of ***integrated neighbourhood working*** will bring together the skills and agencies to create an integrated, whole person, holistic response to people's physical, social, psychological and mental health needs.

This is being testing across the whole continuum of support from connecting people to local solutions, as in the Denaby and Hexthorpe prototypes) through to fully integrated care teams being developed to work with people living with frailty.

However, there are additional specialist areas of mental health provision that could benefit from targeted attention as an area of opportunity within the Place Plan Refresh to improve the experience and outcomes for people with mental health needs and their carers. The first fits within the green layer of the Doncaster four-layer model: ***thriving communities creating local solutions*** and the second is part of the orange layer, *joined up care and support at home.*

The Integrated Care Partnership will

1. Develop the mental health community and wellbeing offer, co-produced with people with mental health needs. It will:

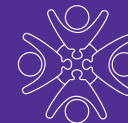
- Focus on harnessing local solutions and building on the approach exemplified by the People Focused Group, Open Minds and MIND.
- Strengthen the approach to prevention, early intervention and mental health first aid
- Build on the Safe Space trials, develop peer-led community and wellbeing solutions that can engage with a person in need, providing immediate empathy and understanding and also connection to tailored support
- Develop integrated mentoring – expansion of limited current delivery working with vulnerable groups to better understand behaviour triggers and routes to better outcomes for the individual that includes family carers

2. Development of a neighbourhood-based integrated delivery model, co-produced with people with mental health and dual diagnosis (co-existing mental health and alcohol and drug misuse problems) and their carers, spanning:

a. Integrated assessment and care management

b. Housing solutions

c. Acute liaison



Healthier Doncaster

Prevention and early intervention are at the heart of the place plan. Almost 28,000 local people already have one long term condition and 12,000 have more than three long term conditions. The refresh needs to ensure that

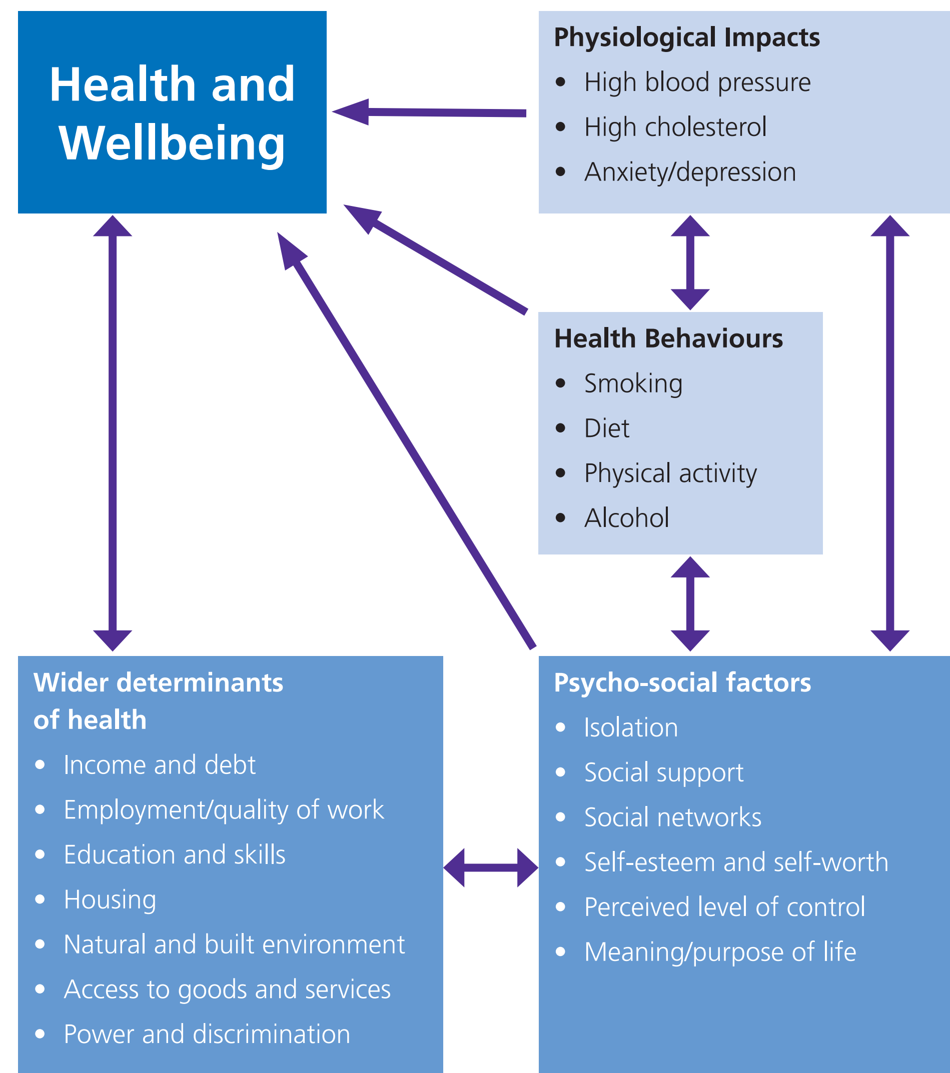
- Seamless care for those already with one or more long term conditions
- Support to prevent developing a long term condition in the first place

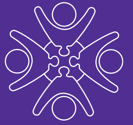
This new area of opportunity will need to use a population health approach to address the key causal factors of health and wellbeing including wider determinants of health, psycho-social factors, health behaviours and physiological impacts to realise a smoke free Doncaster, a more physically activity Doncaster, a more connected and less lonely Doncaster.

The Integrated Care Partnership will

Develop with local people an area of opportunity to create and maintain a healthier Doncaster and reduce the differences between communities including:

- Building on the assets of local people and places
- Becoming Age-Friendly
- Building on dementia friends and cancer champions to create people-led public health encouraging self-care and self-management
- Identifying and supporting Community Wellbeing Hubs addressing social, financial as well as physical and emotional health challenges
- Improving the coordination of health behaviour services and developing the workforce
- Developing new collaborative commissioning relationships



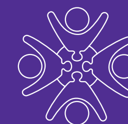


Workforce

As we start to think and act as a whole system to transform the way people experience our health and care services, the support and development of our workforce must continue to take priority. The Partnership has established the Strategic Workforce and Education committee (SWEC) to lead on the planning and development of our collective workforce, ensuring that we have the capacity and capability to deliver more care out of hospital and adopt new care models focused on early help, prevention, anticipatory care and a whole family, strength-based, person-centred approach.

The Strategic Workforce and Education Committee will lead on the following:

1. Commission a whole system (not including hospital) workforce analysis, including social care, primary care/GP, community health and mental health, including:
    - Workforce modelling/simulation tool to predict future requirements/impact of care model changes on the workforce.
    - Whole system model to develop our understanding of our population segments, to build on Public Health's initial work, so we can map future workforce needs across the system against the needs of pop segments
2. Assess the current workforce against our future needs as driven by our emerging new care models (more prevention, early help/intervention, community-based, joined up, anticipatory etc) as emerging from our prototypes and by population changes that includes future upward trajectory of working carers, currently 1 in 7 employees juggle work and caring responsibilities.
3. Assess and plan for workforce development, education and training, including influencing pre-registration training and other home-grown, place-based initiatives
4. Assess and support the workforce impact of the development and implementation of integrated neighbourhood teams and 7 Areas of Opportunity:
    - Deep engagement of the workforce to design the initial model
    - Quality improvement methodology employed to learn quickly and develop the model
    - Co-location of staff
    - Development of new models of leadership
    - Organisational development support
    - Starting to test skill sharing, role blurring and new roles supported by evidence-based approach to manage risk e.g. Calderdale Framework
5. Work with South Yorkshire Regional Excellence Centre to inform future workforce models and training for non-qualified/support staff
6. Inform the SY&B ICS approach to the development of capacity and demand tools across the health and care system to more accurately predict workforce requirements that includes future upward trajectory of working carers, currently 1 in 7 employees juggle work and caring responsibilities.
7. Work with local schools and colleges to increase workforce supply through the development of apprenticeships and similar training opportunities
8. Development of ICP-wide training, education and development opportunities to support staff to acquire new skills required to operate within the new care model for Doncaster, that is increasingly community/home-based, preventative, carer-focused, strength-based and supports self-care. This may include: rotations across hospital and community services, NHS and social care settings; Place-based career pathways; pass-porting of training and qualifications between organisations.



Digital Doncaster

Our Doncaster Place Digital Strategy (2019-22) will support health and social care transformation whilst also fulfilling the national digital requirements for health and social care.

The NHS Long Term Plan (2019) sets out a 10-year blueprint that has informed the development of our digital strategy. Digital Primary Care is a developing ambition nationally and has been championed in the Long Term Plan to ensure that *'by 2023/24 every patient in England will be able to access a digital first primary care offer'*. We will seek to deliver these programmes and will expand delivery beyond primary care into the wider health and care settings.

Our digital vision

'Digital services will empower Doncaster people to maximise their own health and wellbeing and enable our teams to deliver high quality integrated care'

We also consider the digital programmes and developments within the South Yorkshire and Bassetlaw Integrated Care System (ICS) and how can align our local digital developments with those at ICS level to avoid duplication of effort and make the best use of investment.

Digital Integrated Care – Ensure our digital services are an effective enabler for service transformation and integrated care delivery

Collaboration – Use digital services to enhance our collaborative programmes and transform existing ways of working

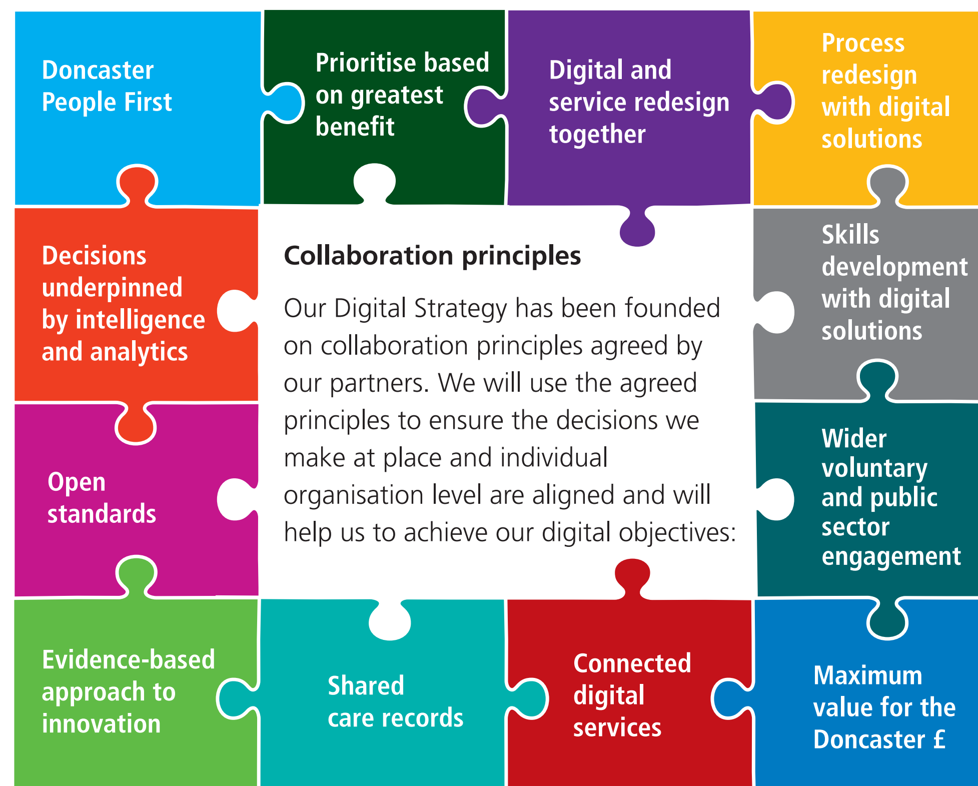
Connected Digital Services – Deliver connected digital services to provide seamless and reliable access for our staff and people

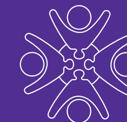
Seamless information flow – Deliver fast, relevant and secure information sharing for all who require it

Access & Engagement – Provide unified and easy digital access for Doncaster people to support their interaction with our services and active contribution to their own records

Intelligence – Leverage the power of our information to improve services for people

Workforce – Minimise duplication of effort and maximise the value of our workforce



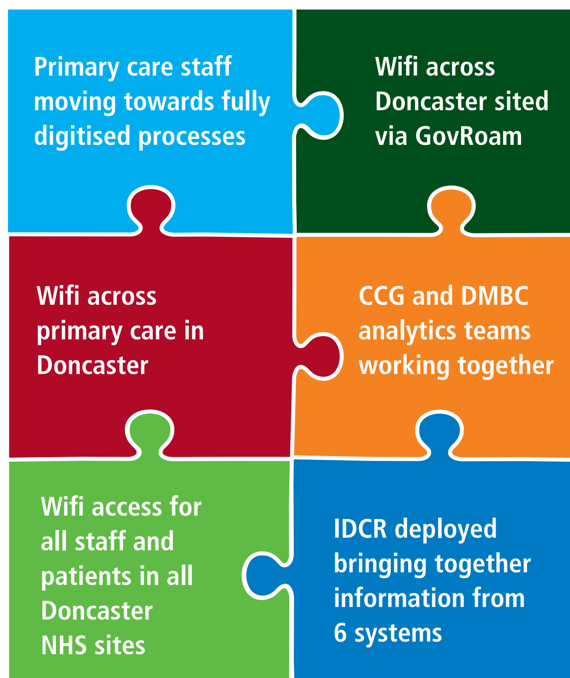


Using the Digital Work stream to address our system challenges

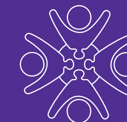
A key requirement of the digital work stream and place wide strategy is to help address the Care & Quality Gap, Health & Wellbeing Gap and Finance & Efficiency Gap articulated in this plan.

We have identified the digital challenges we need to overcome to address these system challenges and support high quality integrated care.

Wifi across primary care in Doncaster

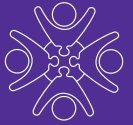


Place Challenge	Associated Digital Challenge
Local Strategy	• Prioritising programmes when there is a lot happening at local, place, regional and national level. • Managing multiple digital priorities across the health and care organisations. • Managing significant culture change to move away from traditional paper based processes and towards fully digitised processes. • Aligning our partner organisations' digital strategies and programmes of work will take time. • Achieving the mandatory target milestones whilst some of our existing IT systems are not fully compliant with the recently published technical and interoperability standards.
Closing the Care and Quality Gap	• Ensuring we have the robust, secure and modern connected digital services required for our teams to work across organisation boundaries in an integrated manner. • Delivering seamless flow of information across organisation boundaries with patients able to access and contribute to their own care record. • Using new and existing digital channels to enable patients to access services and to support self-care. • Ensuring digital developments reduce the overall burden for staff and help make our organisations the best place to work. • Making the digital services we provide an inclusive and positive experience for Doncaster people.
Closing the Health and Wellbeing Gap	• Developing our intelligence capabilities to enable us to better manage the health of Doncaster people and further target services where they will improve health and wellbeing for those who need it most. • Achieving data driven, evidence-based decision-making in care delivery, care planning, commissioning and performance management.
Closing the Finance and Efficiency Gap	• Ensuring we get the best possible value from all investment in digital services. • Ensuring that we avoid duplication of cost and effort between organisation, place, ICS and national digital programmes.



Digital programmes - our digital strategy focuses on the delivery of four programmes of work:

Connected Digital Services: infrastructure, information, data, tools and IT solutions that will help health and care professionals, commissioners and managers get the best outcomes for Doncaster people	**Sharing records:** patient and clinical information to be made available to the right health and care professional at the right time to achieve the best outcomes for Doncaster people	**Access & engagement:** how Doncaster people access and engage with our services is key to the delivery of our plan objectives and will be an extremely important element of our neighbourhood working approach	**Intelligence & Analytics:** leverage the power of our information to improve services for Doncaster people.
• Develop our connected digital services to enable our teams to work in an agile and integrated manner • Enable staff to work flexibly and seamlessly across organisations and from any physical location. • Fulfil the national requirement for compliance with mandatory cyber security standards • Help doncaster people interact and correspond with our health and care services; • 24/7 system availability and access to it systems from any location; • Improve real time access to data and reporting capabilities.	• All health and care services in Doncaster to be using compliant IT systems, • Optimise existing solutions and achieve rich information flow across Doncaster • Roll out and develop the idcr as the place-wide shared care record solution to support better information sharing for our integrated care teams. • Explore the idcr to support electronic shared care assessment and planning for integrated care teams. • Use existing solutions and direct integrations where this is technically possible and cost effective. • Digitisation of maternity notes for all women in Doncaster and a digital "Red Book" to enable parents to record and use information about their child	• Adapt the way we deliver of our services to enable Doncaster people to interact with us digitally, giving easy access to their health and care records including medication, care plans and appointments • Implement and promote effective digital solutions that will support the integrated care delivery • We will ensure the Digital and Communications & Engagement work streams are closely aligned to help to improve how we currently inform the public about our digital programmes • Our digital communications including interaction with the public via social media will continue to be led by Team Doncaster to ensure consistency • Roll out the primary care online consultation tool by March 2020. • We will seek to use the same "digital front door" for all of our health and care services.	• Information Sharing Agreements to ensure that data is able to be shared on a sound legal footing; • Implement the national interoperability standards • Increase the quality and depth of our health and social care data sets, potentially through the idcr; • Participate in ICS initiatives and the LHCRE Programme to facilitate alignment of these activities with our Population Health Management aims; • Incorporate interpretive skills in our skills development programme to support evidence-based decision-making.



Finance, payments and contracting

Doncaster's Integrated Care Partnership recognises that we need to find different approaches to finance, payments and contracting to support its development and to delivery person-centred, whole system new care models.

To develop truly integrated models of care, it is imperative for us to first understand the current landscape of these services: which organisation provides them, how they are commissioned and how they relate to one another. This includes a full understanding of how, where and at what cost these services are currently being delivered.

A strengthened understanding of what services cost to delivery across the whole of Doncaster will have a direct and beneficial impact on care for local people through supporting better strategic decision making, improved contracting and commissioning and ensuring that financial resources are allocated effectively.

We also need to implement a consistent approach to developing and approving business cases as an Integrated Care Partnership rather than as individual organisations. This ensures there is confidence in the financial information to support strategic decision making across the Doncaster system and so we understand the impact of investment or disinvestment in one part of the system on the rest: for example, a decision made by the hospital can have a major implication for costs in the social care system and vice versa.

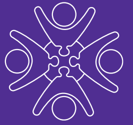
We have developed a robust, easily used and updated costing model that shows the current costs, for all relevant providers, of delivering the services across the Doncaster system.

The total cost to delivery health and care services across all partner organisations is £741m. Of that, we spend £293m is on services to support Long-term Condition Management.

It is important that we continue to develop the model with more up to date financials and consistent activity information to allow meaningful comparison. It is also envisaged that the model is developed to support population health management and an outcomes approach for strategic commissioning and integrated provision.

During the next phase of the Place Plan, the Partnership is committed to develop the following:

- To develop the costing model to further understand the costs of the Doncaster system and utilise the model to support strategic decision making. This will include improving the costing data and developing a consistent costing methodology approach.
- To develop a consistent method of evaluating business cases for proposed service changes; this will ensure that costs across the system are understood along with the implications of any changes.
- Collaborative work will be undertaken with NHS England and Improvement Payments team to consider and develop national guidance how a whole system blended payment approach can support the effective implementation of the five year system plan. This will include:
  - Working with the national team and other test sites across England to understand how blended payments could developed to best support local plan implementation
  - Apply the learning across the Integrated Care Partnership in Doncaster with a clearly phased plan
  - Share our learning with the national team to help inform national policy and help to develop national guidance to support other sites considering using whole system blended payments
- Develop alternative financing and contracting methodologies to support the proposed developments across the system e.g. a pooled budget for Children's Out of Authority placements.



Estates

Team Doncaster has agreed to take a cross-partnership strategic approach to estates/ assets. The aim is to support delivery of the ambitions set out in the Doncaster Growing Together (DGT) transformation plans, for example integrated neighbourhood service delivery, and simultaneously optimise the utilisation of the collective estate across the public sector in Doncaster.

The aim of the SPAcE (Strategic Partnership Assets and Estates) programme is to align estates planning and delivery across the partnership. Oversight and governance of the associated programme will rest with the Caring (Place Plan) theme on behalf of the DGT programmes and be supported by the Strategic Estates Group. A critical part of the process will be aligning the requirements of the transformation programmes with the objectives of the SPAcE programme, ensuring that the emerging new delivery models are enabled by our strategic approach to estates.

The partners will work to a common set of design principles, including:

- working together in an open & transparent way
- sharing information & plan for the future together
- building on the strengths of local assets
- using our assets in the best way we can

Priorities to support the delivery of the Place Plan are:

- Establishment of an estates lead acting on behalf of all partners, who will lead on the delivery of;
- A strategic review of estates across the ICP and development of a partnership estates strategy to enable:
  - Agile use and management of partner owned and occupied assets
  - Optimum utilisation of the local 'LIFT' estate
  - Identification of OPE opportunities
  - Asset rationalisation across the combined public sector asset portfolio.
  - Phased asset delivery plans directly supporting new models for integrated neighbourhood delivery across the Borough
  - Identify and implement a tool to map all partner assets, both owned and leased

Joint Intelligence

We have a well-developed, well-led, collaborative working relationship between our CCG analytics team and the Public Health and analytics teams at the Council. In recent years our analytics teams have produced a joint programme of work covering common areas of interest.

Our Plan for Joint Intelligence

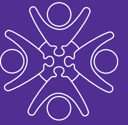
Our Joint Intelligence Working Plan includes:

- Further development of our joint function including relationship building, skills development and resource sharing
- Build strong networks across Doncaster and South Yorkshire and Bassetlaw for intelligence and analytics, to build relationships, knowledge, skills and utilise best practice and opportunities for efficiency
- Optimise a population health management approach to intelligence to drive priority setting, decision making and reduction in inequalities
- Expand analytical capability and insights through linked health and social care datasets; increasing the breadth of data included using stakeholder engagement to drive buy-in and based on robust data sharing agreements
- Further develop outcomes-based monitoring of progress across Doncaster NHS and social care and for new care models arising from the Place Plan Refresh
- Grow the focus on evaluation and testing, using structured approaches to evidencing the impact interventions have on our population
- Create a go-to place for available intelligence for commissioners to access timely and relevant intelligence for the population they are commissioning for

We plan to use the nationally recognised 'Bridges to Health' model for segmentation of our population and are mapping our progress against the Population Health Management Flat Pack Guide (2018).

We have already begun analysing data to start the segmentation process and have already begun a 'heat mapping' process to identify areas within our geography of high health and social care usage. We plan to map this demand against available healthcare resources in these areas and to resource cost. This will serve to inform later segmentation and impact modelling work.

Whilst achievement of our long term Population Health Management ambition is a complex undertaking, we are seeking to start with a simpler approach and will start with developing and defining our analytics capability based on specific areas of focus in line with the joint commissioning teams.



Joint Commissioning

Integrated Care Partnership

Provider Alliance

Strategic direction

Doncaster CCG Governing Body

Doncaster Council Cabinet

Team Doncaster

Health and Wellbeing Board

Provider Organisation Boards

Joint Commissioning Management Board

Sets ICP strategic direction

Advises on joint commissioning response

Doncaster Integrated Care Partnership Board

Sets ICP strategic direction

Advises on alliance provider delivery response

Provider Executive Group

Assurance and tactical

Joint Commissioning Operational Group

Doncaster Integrated Care Delivery Group
(merger of DICOG and Finance Working Group)

Provider Operational Group

Delivery and operations

Starting Well Commissioning Programme Board

Living Well Commissioning Programme Board

Ageing Well Commissioning Programme Board

Children and Young People's Services commissioning governance

BCF Steering Group

Areas of Opportunity: programme boards and task and finish groups

- Intermediate Care Programme Board
- Complex Lives
- Urgent and Emergency Care group
- 1001 Days
- Vulnerable Adolescents
- Dermatology
- Learning disability and autism
- New Areas of Opportunity task and finish groups

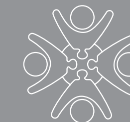
Integrated neighbourhood delivery

- Engine Room
  - Frailty prototype
  - Local Solutions prototype

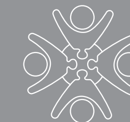
Strategic Enablers

- Strategic Estates Group
- Interoperability Group
- Strategic Workforce and Education Committee
- Business Intelligence
- Communication and Engagement (DGT)

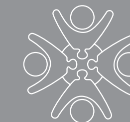
Integrated neighbourhood delivery moving parts



	Moving part	Engine room lead	Key people and delivery support	Prototype	Locality/ neighbourhood
Asset-based community development approach	**1. Local solutions:** Localised process to identify risks early, apply rapid local triage and to delivery multi-agency problem solving, resolving concerns early and preventing demand. Based on the principles of 'no wrong door' and strengths based conversations. Connecting people to resources created within the community and through VCF.	Riana Nelson	Dawn Lawrence Neil Lou Carter Steph Douglas DCST RDASH Health visiting	Early help/demand management for children and families. ***Supported through Doncaster Innovates***	Denaby and Hexthorpe
	2. Community strength-based approach: Engaging and enabling networking and communication between local front line workers, VCF and resident 'community diamonds' who will be supported to play a central role. Developing the ABCD approach, including a Community Development toolkit Link	Dave Ridge	Chris Smith Vanessa Hoyland-Powell Emma Nicholas	Well Denaby/ Well North projects	
	3. Local assets map: A clear accessible picture of community resources, local public services and specific services and interventions available to support delivery of outcomes	Vanessa Hoyland-Powell and Emma Nicholas	Chris Smith	Early help/demand management Frailty Well North	Denaby and Hexthorpe Thorne Denaby



	Moving part	Engine room lead	Key people and delivery support	Prototype	Locality/ neighbourhood
Integrated team operating model	**4. Local integrated teams:** Integrated teams drawn from relevant services/professions/ organisations across team Doncaster working to a common practice and operating model, to deliver specific services and interventions to achieve outcomes for people. Tailored to meet the needs of population segments. Informed by operating principles and practice including whole family working that includes carers. Skill mix, training, skill development, organisational development	Alison Lancaster and Debbie John-Lewis	Jo Forrestall, Debs Crohn, Rachael Webb Strategic Workforce and Education Committee	Frailty. ***Supported through Doncaster Innovates***	Thorne
	5. Whole family working: Family focused assessment and case management incorporating and assets based approach (supported by an integrated digital care record – existing project c/o Interoperability Group). Informs Operating principles and practice.	Andy Hood DCST	Dave Simpson (Adult mental health DMBC), Dawn Lawrence	Vulnerable adolescents	
	6. Operating principles and practice: Common guiding principles to inform practice e.g. whole family working, strength-based, carer focused etc. Tailored to purpose of Local Integrated Team Operating model e.g. daily huddles, approach to triage, assessment and care/support planning, work allocation, key worker etc	Karen Johnson	Griff Jones Plus Nursing Mental health Therapy	Frailty Early help/demand management	

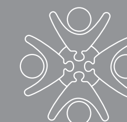


	Enabling systems and infrastructure, supporting delivery of the Place Plan	Place Plan lead	Key people	Link to prototype	Existing/new?
	7. Business intelligence and evaluation: Outcomes and performance management framework to guide and track progress towards agreed goals. Qualitative and quantitative. Locality dashboard development with operational, tactical and strategic level information.	Jon Gleek Amy Coggan		Frailty Early help/demand management Well Denaby	Existing
	8. Integrated digital care record: Information governance and sharing Enabling case finding, joint assessment and care planning		Paul Burton (for intermediate care)	IDCR Digital strategy development (Channel 3)	Existing Interoperability group
	9. Governance and leadership: Leadership at team, neighbourhood and district levels	Cath Doman	Riana Nelson, Jo McDonough, Debbie John-Lewis, Karen Johnson, Laura Sherburn Marie Purdue. PCN Clinical Directors		Existing Caring/Place Plan governance plus emerging arrangements to support operational, tactical and strategic delivery of integrated neighbourhood working.
	10. Estates	Partnership lead tbc	Dave Wilkinson Hayley Tingle		Existing Strategic Estates Group
	11. Joint commissioning, finance and contracting Population health management development	Life stage commissioning leads	Commissioning and finance teams, Public health		Existing: DICOG and JCOG

Appendix 2

Place Plan area of opportunity exit plans

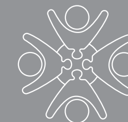
The following plans set out how the areas of opportunity developed over the last 18 months, will transition from projects to new ways of working embedded in day-to-day operational delivery.



Area of Opportunity exit plan and transition to business as usual: **Development of a Learning Disability and Autism Strategy**

This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:	End March 2021
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):	Phil Holmes (LA), Jackie Pederson (CCG)
The Strategic Change Manager is:	Karen Johnson/Ailsa Leighton (Jayne Gilmour on contracted basis)
The Commissioning lead is:	Mark Wakefield/Paul Tarantiuk
The operational delivery lead is:	Annika Leyland

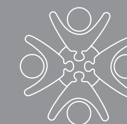
	The following sets out what needs to happen by when to achieve this:	**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	An overarching integrated delivery plan to implement the strategy and critical path will have been developed which is aligned to Joint Commissioning plans and governance arrangements will be in place. Work-stream plans to deliver on the priorities will be in place. Work will continue with current work-streams moving to a position of setting clearer targets.	Cabinet sign off for the strategy and launch. All work-streams in place with clear targets 5 year housing strategy in place	Continuation of work-streams and meeting new targets around: • Housing • Health (including diagnosis) • Employment • Needs of carers • Short Breaks	Continuation of work-streams and meeting new targets around: • Housing • Health (including diagnosis) • Employment • Needs of carers • Short Breaks Identification of new service models/service reconfiguration	Continuation of work-streams and meeting new targets around: • Housing • Health (including diagnosis) • Employment • Needs of carers • Short Breaks Identification of new service models/service reconfiguration
	Anticipated significant decisions or stop-go gateway points	Approval of integrated delivery plan	Cabinet and CCG sign off		Any policy/service changes requiring Cabinet/CCG approval to be identified.	Any policy/service changes requiring Cabinet/CCG approval to be identified.
Commissioning	**Significant enabling commissioning activities and decisions**, including business case development, procurement, funding, identification of key personnel and any other key activities	None	Targets for development/ commissioning of accommodation	Potential changes to commissioning of short breaks	Possible changes to how employment services are commissioned and/or provided.	



Area of Opportunity exit plan and transition to business as usual: **Dermatology**

This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:	June 2020
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):	Laura Sherburn
The Strategic Change Manager is:	Emma Challans
The Commissioning lead is:	Karen Leivers
The operational delivery lead is:	Rebecca Wright

	The following sets out what needs to happen by when to achieve this:	**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	Business case signed off	Community clinic mobilised	GPs commenced on accreditation framework with DBTHFT oversight	Community clinic and GP training underway	Community Clinic and GP training underway, early evaluation in place
	Anticipated significant decisions or stop-go gateway points	Approval of Business Case	Consultant job plans re-designed			
Commissioning	**Significant enabling commissioning activities and decisions**, including business case development, procurement, funding, identification of key personnel and any other key activities	Business case signed off				
	Anticipated significant decisions or stop-go gateway points	Approval of Business Case				



<table>
<tr><th colspan="7">Area of Opportunity exit plan and transition to business as usual: Urgent and emergency care</th></tr>
<tr><td colspan="5">This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:</td><td colspan="2">December 2020</td></tr>
<tr><td colspan="5">The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):</td><td colspan="2">David Purdue</td></tr>
<tr><td colspan="5">The Strategic Change Manager is:</td><td colspan="2">Ruth Bruce</td></tr>
<tr><td colspan="5">The Commissioning lead is:</td><td colspan="2">Ailsa Leighton</td></tr>
<tr><td colspan="5">The operational delivery lead is:</td><td colspan="2"></td></tr>
<tr><td colspan="2">The following sets out what needs to happen by when to achieve this:</td><td>By end of Q3 2019, the following will be in place

Christmas 2019</td><td>By end of Q4 2020 the following will be in place

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June 2020</td><td>By end of Q1 2020 the following will be in place

September 2020</td><td>By end of Q2 2020 the following will be in place

Christmas 2020</td></tr>
<tr><td rowspan="2">Operational delivery</td><td>Significant operational delivery activities (including business case development, procurement, funding, identification of key personnel and any other key activities)</td><td>Business case developed to include individual service costings

Business Case approval by Provider Operational and Executive Groups (Sept 19)

Service Specification and Case for Change developed

Quality Impact Assessment completed

Clear mobilisation plan developed</td><td>Phased mobilisation with partners:

PHASE 1 – initial service change
PHASE 2 – integration to teams

Detailed future state model confirmed and UEC strategy written

Testing in the following areas:

Front door Doncaster

Urgent Treatment Centre Doncaster

Urgent Treatment Centre Mexborough (*may be Dec 19)

Enabling work identified:
• Workforce strategy
• IT – interoperability</td><td>Testing in the following areas:

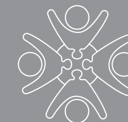
Clinical Assessment Service (Doncaster CAS)

Implementation of Doncaster UTC</td><td>By end of Sept 2020, all new services will have been mobilised

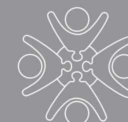
PHASE 2 – further integration of services</td><td>All elements of the new service will have been implemented and embedded

Evaluation of effectiveness – quality and performance

Patient experience</td></tr>
<tr><td>Anticipated significant decisions or stop-go gateway points</td><td>Sept 19 – agreement about the new UEC model and decision to from an alliance</td><td></td><td>Decision to cease local 0300 contact number</td><td></td><td>Further developments within service to be identified – part of 5 year plan</td></tr>
</table>



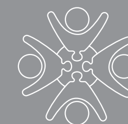
Area of Opportunity exit plan and transition to business as usual: **Urgent and emergency care**						
The following sets out what needs to happen by when to achieve this:		**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Commissioning	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	Commissioning approach – options for an Alliance Contract considered and preferred option agreed Costings reviewed and approved by CCG Case for Change document to be presented at CCG Executive Committee and then Governing Body on 7 November 2019	Alliance Approach established Contract duration determined Review of arrangements – activity v expected			
	Anticipated significant decisions or stop-go gateway points	November 2019 – approval from Governing body to proceed under a Provider Alliance Contract				



Area of Opportunity exit plan and transition to business as usual: **Complex lives**

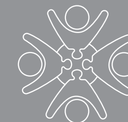
This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:					April 1 2021	
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):					Phil Holmes	
The Strategic Change Manager is:					Chris Marsh	
The Commissioning lead is:					Mark Wakefield, Helen Conroy, Stephen Emerson	
The operational delivery lead is:					Pat Hagan/Debbie McKinney	
The following sets out what needs to happen by when to achieve this:		**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	**Integrated Delivery Team** Financial analysis of whole integrated service costs and partner contributions Design and agreement of new localities operating model incorporating role of Complex Lives Integrated Delivery Team. Delivery partners agreement of future delivery model – loose partnership or tighter collaboration. Partner engagement in deep dive follow up evaluation including cost - benefit analysis. Outline business case prepared.	**Integrated Delivery Team** Delivery partners agree to future basis of operating model and support/governance arrangements Delivery partners collective agreement on basis of sustained, mainstream investment: a) in event of MHCLG funding withdrawal at end March 2020 and b) beyond March 2021	**Integrated Delivery Team** Continued delivery and stocktakes	**Integrated Delivery Team** Continued delivery and stocktakes	**Integrated Delivery Team** Agreement on future operating model and financing of the Integrated delivery team post March 2021.
		Accommodation reform Engagement of key accommodation support providers in planning for future model.	**Accommodation reform** Engagement of key accommodation support providers in planning for future model.	**Accommodation reform** Engagement of key accommodation support providers in planning for future model.	**Accommodation reform** Engagement of key accommodation support providers in planning for future model.	**Accommodation reform** Engagement of key accommodation support providers in planning for future model.
	Anticipated significant decisions or stop-go gateway points	Sign off of programme plans for localities operating model December 2019	Provider partners commitment to future operating and financing model.			DICPB and partners agreement to future operating and financing plans

Appendix 2 Place Plan area of opportunity exit plans



Area of Opportunity exit plan and transition to business as usual: **Complex lives**

	The following sets out what needs to happen by when to achieve this:	**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Commissioning	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	**Integrated Delivery Team** Joint commissioners input in to shaping the basis of locality operating model. Joint commissioners leadership of and engagement in financial analysis and evaluation/cost benefit analysis	**Integrated Delivery Team** Joint commissioners agreement of basis of sustained investment in integrated delivery team a) in event of MHCLG funding withdrawal at end March 2020 and b) beyond March 2021	**Integrated Delivery Team** Continued delivery and stocktakes	**Integrated Delivery Team** Continued delivery and stocktakes	**Integrated Delivery Team** Agreement on future operating model and financing of the Integrated delivery team post March 2021.
		Accommodation reform Joint commissioners leadership of planning for accommodation future model, post Homelessness review. Production of Homelessness Strategy and blueprint for future accommodation model. Jointly agreed specification for recommissioned hostel provision.	**Accommodation reform** Joint commissioners agreement of future accommodation plans Launch commissioning process for hostels according to agreed strategy and blueprint	**Accommodation reform** Mobilisation of future accommodation plans – managing transition Conclude commissioning process for hostels according to agreed strategy and blueprint	**Accommodation reform** Mobilisation of future accommodation plans – managing transition Transition planning for future hostels model	**Accommodation reform** Mobilisation of future accommodation plans – managing transition Commence future hostels operating model
		Overall Define and approve role of Lead commissioner and system commissioning team approach for Complex Lives	**Overall** Establish and appoint role of Lead commissioner and develop system commissioning team approach for Complex Lives	**Overall** Delivery of systems commissioning approach and stocktakes	**Overall** Delivery of systems commissioning approach and stocktakes	**Overall** Delivery of systems commissioning approach and stocktakes
	Anticipated significant decisions or stop-go gateway points	**Integrated Delivery Team** Sign off of programme plans for localities operating model December 2019.	**Integrated Delivery Team** Commissioners commitment to future operating and financing model.			
		Accommodation reform Sign off of Homelessness strategy and future accommodation blueprint, including hostels model		**Accommodation reform** Hostels future operating model contract decision		



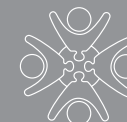
Area of Opportunity exit plan and transition to business as usual: **Complex lives**

The Complex Lives Alliance is a whole system delivery model, comprising a series of operational and enabling features as set out in the system specification, which is still the basis of operation and development of the model. In terms of both the necessary ongoing development and the financial sustainability of the model there are a number of key considerations and development work-streams in play. These are:

1. **The Complex Lives Integrated Delivery Team:** Its future development as an integrated team and its positioning in the context of integrated work in the emerging DGT localities model. This will be accompanied with an increasing focus on prevention and rehabilitation/resettlement of people who are experiencing multiple disadvantage. A key issue to consider is the current reliance on various strands of external and/or short funding, and current uncertainty about likely extension of these (in particular from MHCLG) which is a key factor in sustainability planning.

2. **The Supported Accommodation Pathway:** The development of a reformed scale and range of supported accommodation, including reform of the Hostels offer and an overall emphasis throughout on wrap around care and support. The recommendations of the recently commissioned Homelessness review and subsequent Homelessness strategy will provide the framework for this. Further work will need to define detailed plans accelerate to move key areas of work along to meet timescales, in particular relating to the recommissioning of Hostels for a new contract start date of October 2020.

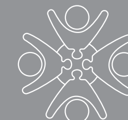
Joint system and service commissioning: The above two key areas of reform and the effective operation of the whole model need to be underpinned by a move to collective strategic commissioning at the level of the whole system of delivery, and for specific interventions to secure wrap around accommodation, care and support by design. This is in the direction of travel of strategic commissioning work in progress but will require acceleration of joint and lead commissioning arrangements to effectively support the above developments.



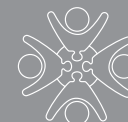
Area of Opportunity exit plan and transition to business as usual: **Vulnerable adolescents**

This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:	
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):	Riana Nelson
The Strategic Change Manager is:	TBC
The Commissioning lead is:	Lee Golze
The operational delivery lead is:	Andy Hood

	The following sets out what needs to happen by when to achieve this:	**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	• Identification of host organisation • Identification of premises • Procurement of IT • Policies and Procedures in place • Referral mechanism established • Project Comms established • Base training in core activity and principles to partner agencies delivered • Governance arrangements agreed	• The staff team to be place, including both seconded and recruited staff • Staff training in relevant therapeutic approaches to be completed • Governance and reporting arrangements a in place • First cohort of families identified to receive intervention	• Operational delivery to 25-30 families will be underway	• Operational delivery to 25-30 families will be underway	• First bi-annual evaluation of programme efficacy • First cohort of families begin to step down following successful intervention • Introduction of new families onto the programme • Crisis referrals are accepted onto the programme
	Anticipated significant decisions or stop-go gateway points	• None	• Agencies ability to second staff in line with programme objectives • Recruitment of appropriately qualified and experienced clinical staff	• None	• None	• None



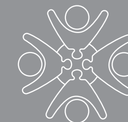
Area of Opportunity exit plan and transition to business as usual: **Vulnerable adolescents**						
The following sets out what needs to happen by when to achieve this:		**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Commissioning	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	• Agreement from the Doncaster Integrated Care Delivery Group (DICDG), including appropriate allocation of funds from the BCF to deliver the Pilot Vulnerable Adolescents Work Stream	• Operational budgets relating to staffing expenditure established within the host agency • Procurement framework relating to specialist training provision (DBT/CBT) models etc. agreed and implemented	• None	• None	• Programme evaluation indicates approach not working in line with objectives. New provision/ approach needs to be commissioned • Internal resource allocated to programme is not sufficient for demand in one area (i.e. Adult LD nurse) requiring additional recruitment/ secondment not in the base budget • Families don't transition within expected timescales causing wider capacity issues within the system, necessitating additional commissioning decisions
	Anticipated significant decisions or stop-go gateway points	• Decision from DICDG to support the pilot	• Operational budgets are insufficient for planned activity due to unanticipated need once the project is operational. DICDG need to consider additional resource allocation	• None	• None	• DICDG need to support additional capacity (backfill) commissioning in partner agencies to support capacity shortfalls



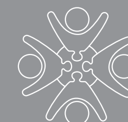
Area of Opportunity exit plan and transition to business as usual: **First 1001 days**

This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:	November 2021 -after the 2 years prototyping in the two areas.
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):	Riana Nelson
The Strategic Change Manager is:	Stephanie Douglas
The Commissioning lead is:	Lee Golze and Carrie Wardle
The operational delivery lead is:	Denise Beevers

	The following sets out what needs to happen by when to achieve this:	**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	**Business case complete Jan 19.** **Funding secured for 2-area pilot Jun 19.** **ODRs agreed& signed off Aug 19.** • Complete letter of intent, memorandum of understanding and agree staffing line management Aug 19 • Working groups to resolve fine details for Operational Services, Quality and Governance reporting frameworks, HR, Finance and communications plans Oct 19 • Recruitment to posts for Transformational Project Manager, 1001 Days Team Manager, Midwife, Health Visitor and 1001 days Support Workers Aug to end Oct 19 • The new First 1001 days team will be in posts and operating on the ground with families 1st Nov 19	• Whole 0 to 1001 days caseloads in pilot areas now delivered by the 1001 days team • Set of KPI's for continual monitoring of performance • Measures to monitor impact on outcomes as well as staff performance • Regular team meetings set with internal review on ways of working including community relationships, whole family focus, equal health, care and educational approach.	• Two year pilot running business as usual with performance monitoring and continual review • Issues improvements identified with team approach to solutions • Significant shift for super local professionals perception of cross partner working relationships and connectivity with local area	• Two year pilot running business as usual with performance monitoring and continual review	• Two year pilot running business as usual with performance monitoring and continual review
	Anticipated significant decisions or stop-go gateway points	• Complete letter of intent, memorandum of understanding and agree staffing line management – imminent • Recruitment to posts for Strategic Change Manager, 1001 Days Team Manager, Midwife, Health Visitor and 1001 days Support Workers by end Oct 19				



Area of Opportunity exit plan and transition to business as usual: **First 1001 days**						
The following sets out what needs to happen by when to achieve this:		**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Commissioning	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	**Business case complete Jan 19.** **Funding secured for 2-area pilot Jun 19.** • Recruitment to posts for Transformational Project Manager, 1001 Days Team Manager, Midwife, Health Visitor and 1001 days Support Workers Aug to end Oct 19				
	Anticipated significant decisions or stop-go gateway points					



Area of Opportunity exit plan and transition to business as usual: **Intermediate care**

This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:	April 2021
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):	Jackie Pederson
The Strategic Change Manager is:	TBC
The Commissioning lead is:	Joanne Forrestall
The operational delivery lead is:	Joanne McDonough

	The following sets out what needs to happen by when to achieve this:	**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	Doncaster Provider Alliance agreement to continue as collaboration. Live case audits evaluated to provide further assurance and identify any gaps within the new care model. Implementation plan and mobilisation Gateway process agreed with clear timelines & agreement of financial risk sharing	A single management structure to promote a multi-disciplinary approach and reduce duplication & improve efficiencies by realigning the provision Fully integrated Home First offer. Completion of first cohort of bed redistribution into community offer. Fully operational Community SPA to manage discharges (in the first instance). Final cohort of bed redistribution identified, agreed and implementation plan developed NHS Standard contract Alliance Agreement signed by all stakeholders.	Provider alliance will fulfil the actions outlined in the Implementation plan	Provider alliance will fulfil the actions outlined in the Implementation plan	Delivery plan in place for the delivery of a full integrated Intermediate Care New Care Model in line with Service specification
	Anticipated significant decisions or stop-go gateway points	Implementation plan and mobilisation Gateway process agreed with clear timelines & agreement of financial risk sharing	Financial envelope to be agreed			
Commissioning	**Significant enabling commissioning activities and decisions**	Outcome based service specification approved by Clinical reference Group Business Case agreed by DCCG Executive Committee. Joint performance framework agreed	NHS Standard contract Alliance Agreement signed by all stakeholders Financial envelope to be agreed (Financial Sustainability)	Potential changes to commissioning of short breaks		Embedded into the Gateway Agreement

DONCASTER PLACE PLAN REFRESH

2019 – 2022