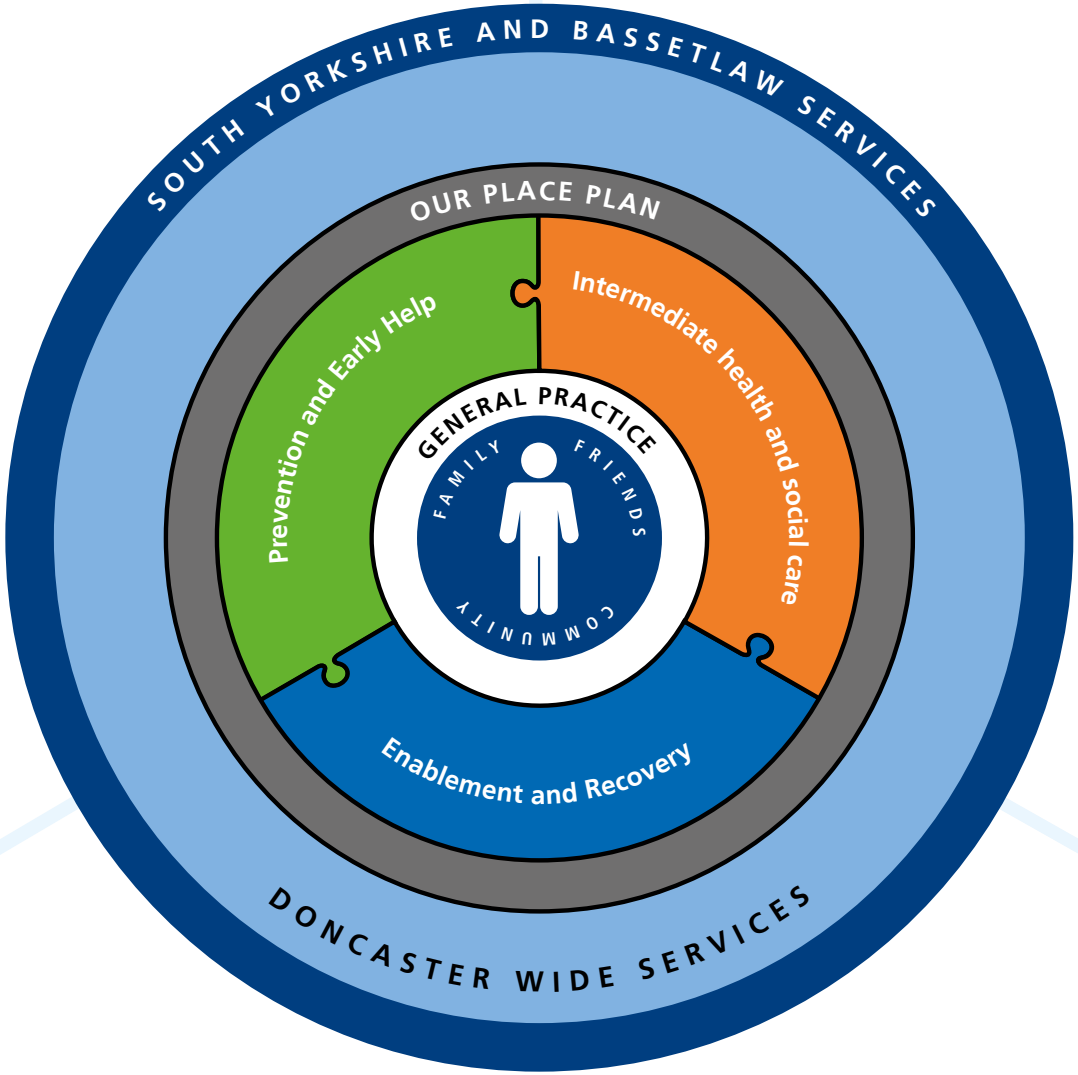
Doncaster Place Plan

2016- 2021



Produced by:
Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Doncaster Children's Services Trust
Doncaster Local Medical Committee
Doncaster Metropolitan Borough Council
Emerging GP Federations
Fylde Coast Medical Services
NHS Doncaster Clinical Commissioning Group
Rotherham Doncaster and South Humber NHS Foundation Trust
October 2016

The Doncaster Health and Social Care community has a long history of working together in partnership to achieve positive change for local people. Each of the health and social care organisations within Doncaster already has plans for the future and these have often been developed in partnership. In some cases, such as the Better Care Fund Plan, the plans are jointly owned.

However there is a strong view that in order to transform our services to the degree required to achieve excellent and sustainable services in the future, we need to have one vision and one Plan for the whole of Doncaster. For this reason, key leaders from across health and social care in Doncaster have come together to develop the Doncaster Place Plan (the Place Plan).

This is the first time in Doncaster that we have articulated a shared vision across health and social care and there has been significant contribution across a wide set of local organisations:

- **Doncaster & Bassetlaw Hospitals NHS Foundation Trust (DBH)**
- **Doncaster Childrens Trust (DCT)**
- **Doncaster Local Medical Committee (LMC)**
- **Doncaster Metropolitan Borough Council (DMBC)**
- **Fylde Coast Medical Services (FCMS)**
- **NHS Doncaster Clinical Commissioning Group (NHS Doncaster CCG)**
- **Rotherham, Doncaster & South Humber NHS Foundation Trust (RDASH)**
- **Emerging GP Federations**

This Place Plan describes our joint focus over the next five years, building upon the existing body of work and local plans already in place. In line with the ***Five Year Forward View***, our aim is to further develop out of hospital services and to foster community resilience, so that we can better support people and families, provide services closer to home and reduce demand for hospital services.

We will monitor our progress on an on-going basis and adjust our focus as required.

The vision is based around a description of a future landscape for health and social care services in Doncaster.

Our joint vision is:

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.

Purpose and positioning of this document

In developing a joint vision and plan, we intend to maximise the value of our collective action and, through our joined up efforts, accelerate our ability to transform the way we deliver services. This Place Plan does not 'start from scratch' or replace individual partners' plans, but rather builds upon them, by taking a common lens and identifying key areas of collaboration.

Each of the partners will also continue implementing existing plans (see diagram below for illustration of local plans).

This Place Plan does not describe all work that is happening in Doncaster - it details our joined up approach to delivering a number of transformational work-streams that will help us achieve our vision as health and social care partners.

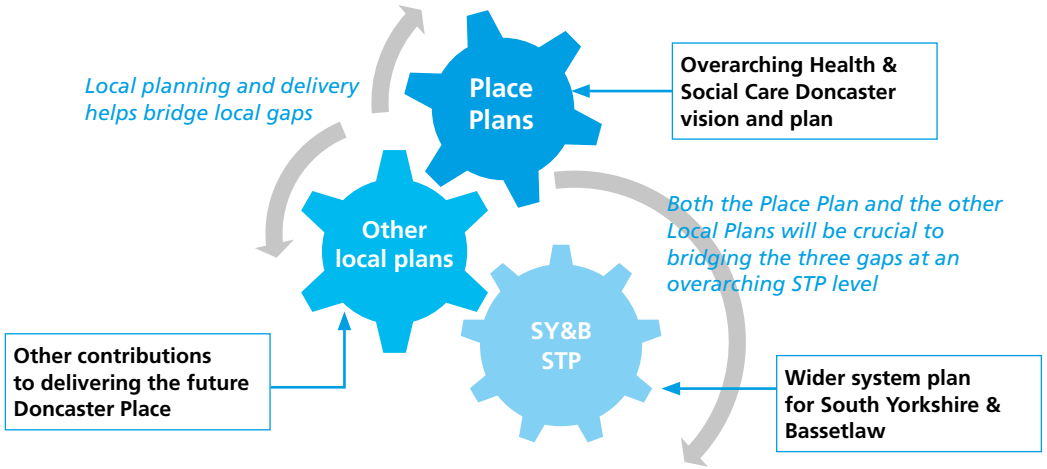
The links between poverty and ill health are well established. Creating jobs, ensuring availability of affordable, good quality housing and targeting resources towards areas of greatest need are all important to reduce poverty and improve our health and wellbeing. Accordingly, Team Doncaster is increasingly focussed on prevention, integration and crucially, co-production with citizens and communities. Team Doncaster's priorities in addressing the wider determinants of health are:

- **Business and job opportunities**
- **Adult Health & Social Care enabling independence**
- **Raising levels of Education and Skills**
- **Safe, Clean and Green Environment**
- **Life Chances for All**

This Place Plan is inextricably linked to Team Doncaster's work.

How does our Place Plan fit in with the wider Sustainability and Transformation Plan (STP)?

The diagram below illustrates how the Place Plan and other local plans at a Doncaster level, and the STP, at a wider footprint level will jointly address the challenges that we face.



A couple of clarifications up front

As you read through the plan, you will notice that we talk about 'neighbourhoods' and 'cohorts'. This is because underpinning our vision is the development of four neighbourhoods across Doncaster, which will enable services to be locally focussed and tailored. See page 11

We have grouped our proposed transformation work-streams into the following 'cohorts' of activity:

Cohort A – Early Help and Intervention

Cohort B – Integrated Intermediate Health and Social Care

Cohort C – Enablement and Recovery Services

The cohorts of activity will not run in a linear or phased fashion, they represent tranches of transformation that will take place in parallel.
These are described in detail. See page 12

Our Plan on a Page

The diagram below summarises our Place Plan - how our joint 'cohorts' will help us address our challenges and achieve our vision.

Our Gaps	Health and wellbeing gap	Care and quality gap	Finance and efficiency gap
Our Challenges	• Health in Doncaster is improving, but not as fast as the rest of the country • Life expectancy is 10.7 years lower for men and 7.1 years lower for women in most deprived areas of Doncaster	• Fragmentation and complexity of health and social care services • Rising demand for health and social care services • Workforce shortages and need to ensure right skill mix to meet future needs	• The cost of delivering health and care services is increasing and our gap will be £139.5m by 2021

Our Vision

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.

Our offer: Cohorts

Cohort A - Prevention and Early Help

This cohort is focused on developing community assets and resilience, bringing together our response to the wider determinants of health and social care. It recognises the prevention step needed before all others, but also extends to early help and intervention to support children and families. This will include services such as:

- Children's services
- Primary care
- Population wide prevention interventions
- Social prescribing
- Integrated Team Doncaster approach to individuals and families with the most complex needs

Cohort B - Integrated Intermediate Health and Social Care

Support independence in peoples own homes, test and push forward integrated commissioning and provision, and avoid hospital admissions. The focus of this cohort is on managing the existing demand better. The offer will be focussed around the development of 4 types of response for intermediate care:

- Rapid response
- Short term response
- Medium term response
- Health and social care bed base for Doncaster

Cohort C - Enablement and Recovery Services

The focus is on shifting services out of hospital and into the community where appropriate, delivering care closer to home, through delivery of redesigned services, such as:

- Community led support services
- Therapies
- Outpatients
- Diagnostics
- District nursing
- Mental health and learning disability services.

Benefits

- Prevention and the provision of early help is at the heart of everything we do
- Individuals, families and communities are supported to build resilience and there is a network of resilient communities
- Individuals and families are supported to lead independent lives in strong and sustainable communities

- Services support Doncaster residents to maintain their independence, live at home and in the community as long as possible
- Intermediate health and social care is integrated, and responsive
- Investment in out of hospital services is prioritised to build sustainable future services
- Inpatient beds are used efficiently and only accessed when appropriate

- Respite and residential services are high quality and based on individual need and choice
- All care and hospital based services integrate mental and physical health approaches
- Individuals and families are empowered to optimise their health and wellbeing and feel supported to manage their long term conditions

- All agencies are involved in joint planning processes
- Wherever appropriate services are local to Doncaster neighbourhoods and community assets are accessible
- Health and care services are co-produced with the Doncaster population
- Care pathways across agencies are timely, simple and seamless, supported by smooth information flows
- Market developments to supply alternative models of provision
- Sustainable urgent and elective care services are in place and on a 24/7 basis where appropriate

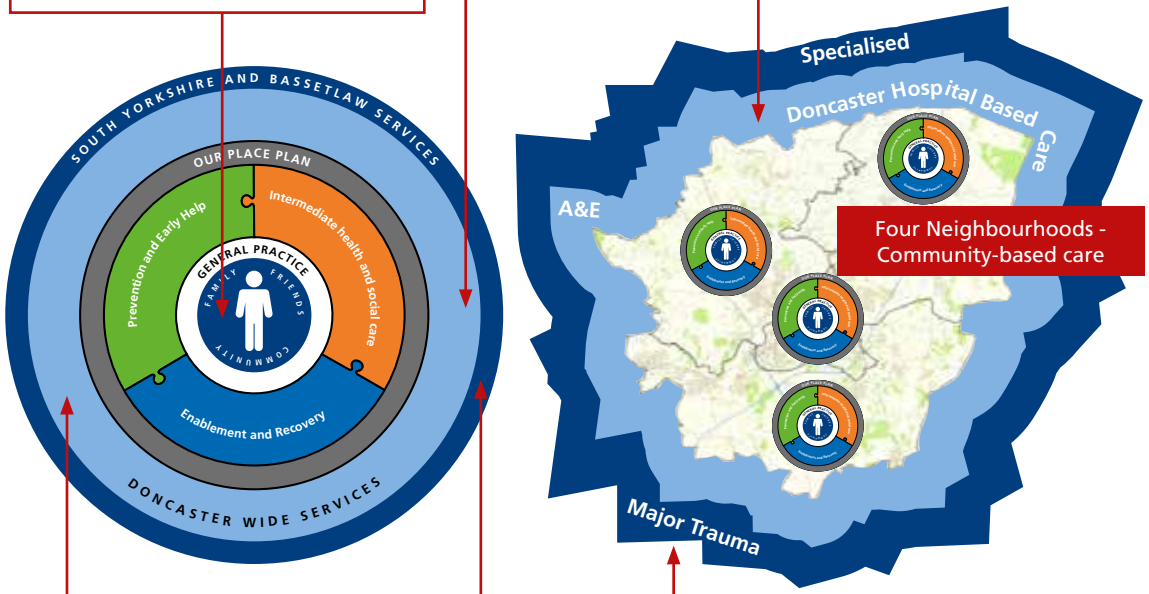
Based on logic model locally developed

Our neighbourhood approach

Focus on the individual, their family and friends, communities and infrastructure.

Primary care is at the heart of health care delivery and closely linked to neighbourhood services

Critical links between neighbourhood services and wider Doncaster footprint, e.g. A&E



High quality emergency and elective hospital based care when patients need it

Some services, e.g. planned care procedures will have more local follow up where appropriate

Specialised services continue to be delivered in tertiary centres across South Yorkshire

How will we measure success?

Measurement is a critical part of testing and implementing changes; measures tell us whether the changes we are making actually lead to improvement. We have identified a balanced set of measures in order to monitor whether we are successfully addressing our key challenges. These are:

Measure	It tells us whether…	…which will help us understand how we are tracking against our challenges…
Healthy life expectancy in Doncaster vs England average	People are living longer, healthier lives in Doncaster and compared to the rest of England	Health in Doncaster is improving, but not as fast as the rest of the country
Life expectancy in Doncaster, by area and vs England average	Inequities in life expectancy between different Doncaster areas have been reduced or not	Life expectancy is 10.7 years lower for men and 7.1 years lower for women in most deprived areas of Doncaster
Delayed transfers of care (days)	All key players involved in caring and supporting people transitioning in and out of hospital are working as a team to provide a seamless service	Fragmentation and complexity of health and social care services
Emergency admissions per 1000 residents aged 75+ by neighbourhood (0 LoS)	Emergency admissions are increasing or decreasing	Rising demand for health and social care services
High level measure on the development of local workforce with health and social care skills to be confirmed	We are well-equipped for future models of care or not	Workforce shortages and need to ensure right skill mix to meet future needs
The size of our financial gap	We are managing to close our financial gap or not	The cost of delivering health and care services is increasing and our current gap is: £139.5m

A snapshot of our population

Doncaster has a population of 304,000 (mid-year 2013 estimate). This is forecast to grow to 308,600 by 2021.

The health of people in Doncaster is generally worse than the England average. Doncaster is one of the 20% most deprived districts/unitary authorities in England and about 24% (13,300) of children live in low income families.

Overall health and wellbeing is improving in Doncaster for both men and women. However, too many people still experience poor health with too many dying prematurely (i.e. before the age of 75). In fact, Doncaster is ranked 124 out of 150 for premature deaths overall. Life expectancy for both men and women is lower than the England average by 2 years for men and 1.6 years for women.However, the inequality in life expectancy is more stark when comparing the most and least deprived areas of Doncaster, whereby it is 10.7 years lower for men and 7.1 years lower for women. Where people live, as well as education, housing, work, crime and the environment all contribute to health and wellbeing.

Risk factors and disease in Doncaster	
Lifestyle	
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.	

How this place plan was developed

Doncaster's health and social care organisations have come together through this journey of developing our vision and joint Place Plan. Whilst the most recent focus has been on the development of the Plan, the partners will continue working closely together to ensure that the Cohorts of transformational work-streams in this Plan are implemented.

The Place Plan and its implementation will be further refined over time, and it is envisaged that it may eventually include other services such as Police, Fire and Rescue Service and Ambulance Service.

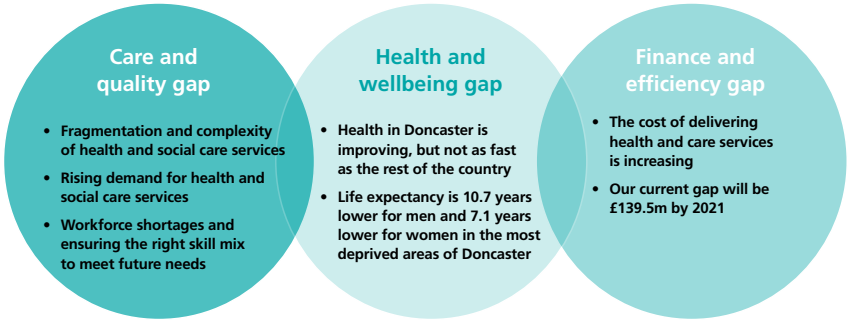
We have made substantial progress to date

It is important to take into account the significant work that has already been undertaken in Doncaster to:

- Redesign urgent care services, leading to the transformation and delivery of a streaming service at the front door of A&E which directs people away from A&E where it is not needed, into other pathways such as to the integrated urgent care centre
- Review mental health services which resulted in redesigned crisis support 24/7, accessed via one phone call
- Re-shape end of life care resulting in 24/7 access to palliative care and hospice services and the development of hospice at home
- Refocus on appropriate residential care, reducing the Doncaster average number of people in long term care and length of stay
- Implement the redesigned community nursing service to provide holistic case management through planned / unplanned teams
- Secure 24/7 equipment delivery direct to patients, significantly reducing waits for equipment
- Implement Woodfield 24, a responsive domiciliary care service for end of life patients that enables more patients to stay at home
- Procure wider domiciliary care to support people to live at home independently for longer
- Implement the Admiral Nursing Service for dementia, providing support for both people with dementia and their carers
- Extend the integrated health and social care discharge team to 7 days, enabling discharges to happen throughout the week
- Deliver social prescribing across the full Doncaster geography

Our key challenges

We have mapped our key challenges to the ***Five Year Forward View's*** three aims/gaps.



Work on our cohorts will allow us to address our challenges. For example, through developing a new integrated model for intermediate health and social care (Cohort B), we anticipate both:

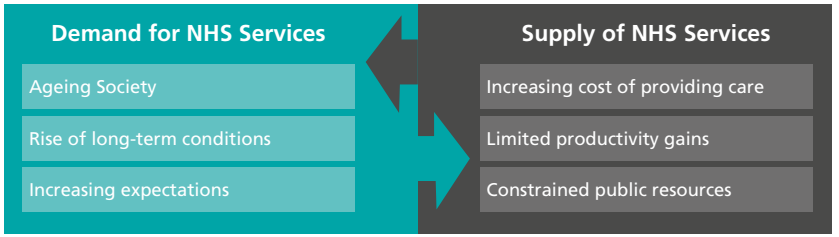
- reducing fragmentation in health and social care services and also
- avoiding unnecessary emergency admissions and thereby mitigating the rise in demand for hospital services.

Through focusing on prevention, developing community assets and tackling our wider determinants of health (Cohort A), we anticipate improving the health and wellbeing of our population and, over time, it will also help us close our financial gap, through reducing the need for more complex and costly hospital based services.

If we did nothing…

Whilst our Place Based Plan is aimed at improving the health and wellbeing, and the quality of care for our Doncaster residents, there is an ever increasing pressure to do this within the financial resources available to our Organisations.

The financial situation within Doncaster mirrors the national pressures upon health and social care services. The cost of providing care is getting more expensive. New drugs , technologies and therapies have made a major contribution to curing diseases and extending the length and quality of people's lives within the region. This is clearly a good thing, but it needs to be considered in the context of much tighter public finances.

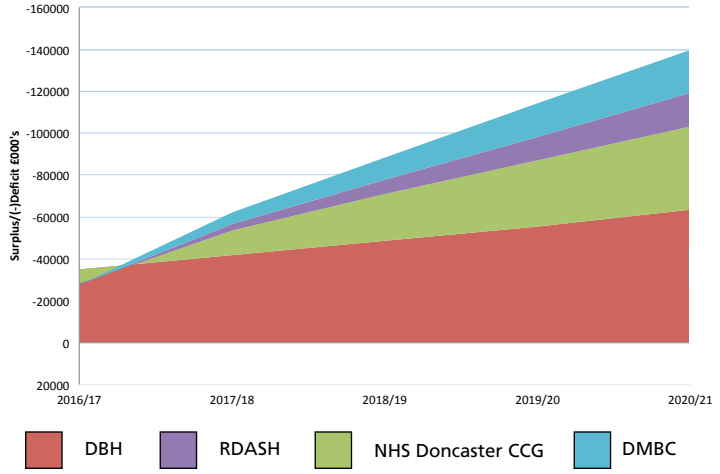


Our NHS Organisations can broadly expect their budgets to remain flat in real terms, (assuming a minimum 2% efficiency) over the next 5 years , whilst our Local Authority (like all Councils) may need to reduce spend in social care to remain in line with their financial budgets. Doncaster therefore needs to consider how the health and social care spending is best allocated in the round rather than separately in order to provide integrated services.

Locally the "do nothing" scenario is demonstrated on the next page.

The total financial gap is made up of a combination of potential provider deficits, and the individual financial income and expenditure gaps of the CCG and the Local Authority commissioning budgets. It is clear that the place plan must be aimed at spending the "Doncaster pound" more effectively.

Summary of Doncaster financial position - Do Nothing



Note: Does not include Doncaster Children's Trust

We know that by working together, we can transform the way we work and improve the health and wellbeing of our population further and faster. In order to do this health and social care will need to come together to commission and provide services.

A neighbourhood approach

For the first time, Doncaster health and social care partners have defined four co-terminus neighbourhoods with the intention of further enabling services to be locally focussed and tailored and to deliver care and support locally whenever appropriate. The neighbourhoods follow the natural geographic pattern of Doncaster and are already the basis of service provision for much of Doncaster social care and community services Where this is not currently the case, neighbourhood services will be commissioned on this basis. The importance of the neighbourhood structure is that it:

- Provides the structural linkage between the very local provision at primary care level through to wider pan Doncaster services
- Facilitates targeted interventions based on needs and strengths of the population
- Enables services to be delivered locally around community hubs
- Provides a footprint for service structure that can be up/down scaled to suit population and service needs

However it is also important to note that whilst services will be structured around the four coterminous neighbourhoods that have been agreed, this does not mean that there will be rigid geographical boundaries that create barriers. It is envisaged that services will flex across to ensure that patients' needs can be met and that the neighbourhood focus does not become a barrier, with some services being delivered on a pan Doncaster or even wider footprint.

It is envisaged that the offer will build on existing strengths, with the focus on the individual, their family and friends, existing communities and their infrastructure.

Primary care will be at the heart of health care delivery, closely linked to other neighbourhood level services in health and social care, such as community nursing, therapies, Start Well (first 1001 days), community mental health services and community led support for adult social care.

More specialised services will continue to be delivered at a wider South Yorkshire & Bassetlaw level at tertiary centres. There will be critical links between neighbourhood services and those that are provided on a whole Doncaster footprint, such as A&E.

Some services, such as planned care procedures, may be provided across the South Yorkshire footprint, but with more local follow up where appropriate.

Our principles

The following principles have been developed and agreed by all partners during the journey to develop the Place Plan. They have been used to guide the development of the plan to date and will be used across partners to drive future planning.

Decisions will be focused on the interests and outcomes of patients and people in Doncaster, and organisations will collaborate to prioritise those interests
Doncaster commissioners, providers, patients, carers and partners will shape the future of Doncaster services together
We will work in an open, honest and constructive way
All partners will actively promote a picture of 'One Doncaster' and speak with a single voice for the greater good
The default position will be that organisations share information to support the provision of good care
As a Doncaster partnership , we will be prepared to take calculated risks
Each organisation will actively promote a culture that facilitates integrated working and empowers staff
We will develop services that respond to the needs and personal goals of the person and their family/ carers
Services will be developed to meet physical, mental health and social care needs
Patients will access excellent hospital based services when needed but there will be a focus on out of hospital care, enablement, maximising independence, promoting self-care and maintaining social networks

Our 'Cohorts'

Our focus in Doncaster is on a set of Cohorts that will maximise the value of our collective action and transform our health and care system further than we already have, so that we can ensure services are delivered in the best place, reduce demand for acute services and achieve clinical and financial sustainability. We note that even though the Cohorts are presented as separate initiatives, they are all very closely interlinked and will often occur concurrently, not in a linear fashion.

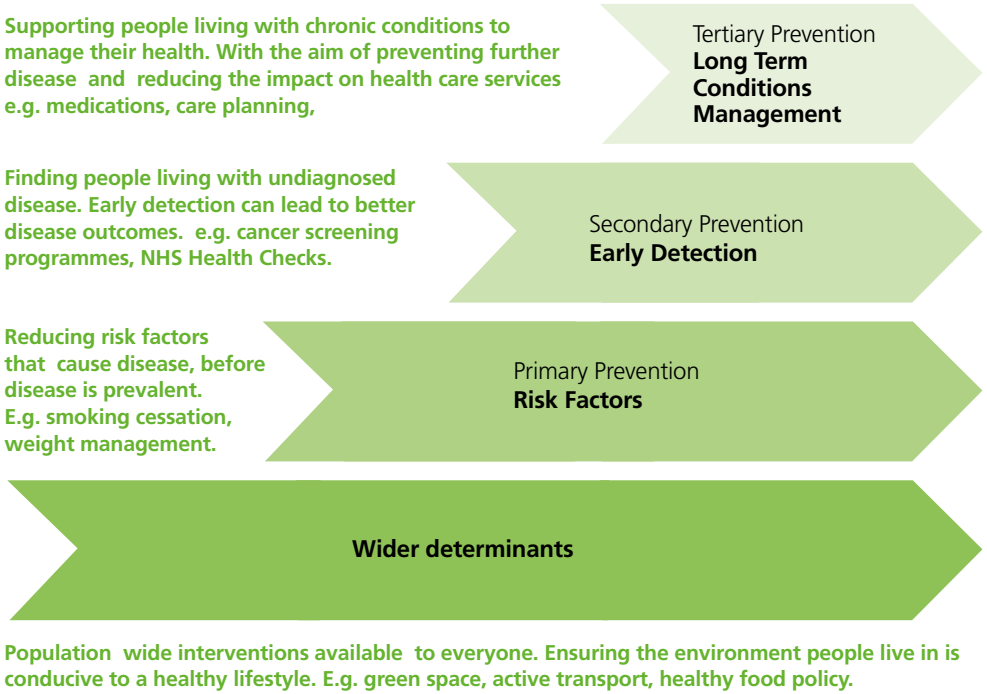
In line with the ***Five Year Forward View***, we aim to further develop out of hospital services, create community resilience and maximise the strengths already in communities. It is recognised in Doncaster that delivery of the offer for out of hospital services will drive a clearer focus on activity only taking place in hospital when absolutely needed and will create hospital based capacity by doing so. This shift in focus for acute care will facilitate some of the changes that are being driven across the South Yorkshire & Bassetlaw Sustainability and Transformation Plan (STP) footprint. The STP changes are focussed on the development of an offer across a wider footprint for services that can only be effectively delivered on a larger scale.

The Cohorts are summarised in the diagram below and described in more detail in this section. Work is still ongoing to define the full programme of work within each Cohort.

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

Prevention at the heart of all we do

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



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

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

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

What this will mean in real life to 55 year old Samson

Samson is 55 years old and has recently had an NHS Health Check in the community which identified he might be at risk of heart disease. The check found that Samson is overweight, has high blood pressure and high cholesterol. Under the current system as Samson is a smoker he is offered a referral to the stop smoking service and he is asked to make a follow up appointment with his GP.

Following transformation the community that Samson lives in is a healthier one. His local takeaway has done work to reduce the salt and fat content of the dishes he eats and he has joined a local walking group that he found out about when he visited his GP. He also has access to a local wellbeing service in his community which is helping him keep his health on track including giving him advice on how to manage his weight, reduce his stress levels and keep smoke free.

Primary Care at the heart of communities

Primary care services across Doncaster have always been a focus for local provision of what for many people is their main contact with health services. The vision for primary care in Doncaster is that it will not only continue in this vital role, but that it will be at the heart of system transformation, through enhancing the offer across four pillars.

See page 19

These pillars of care represent the enhanced services that will be commissioned from general practice, as the fulcrum of primary care. In order to achieve this vision general practice will need to operate without borders and in partnership with other primary care providers, particularly pharmacy, and also the wider health and care system. A phased approach will be taken to implementation to ensure that consistent services will be offered to patients across Doncaster.

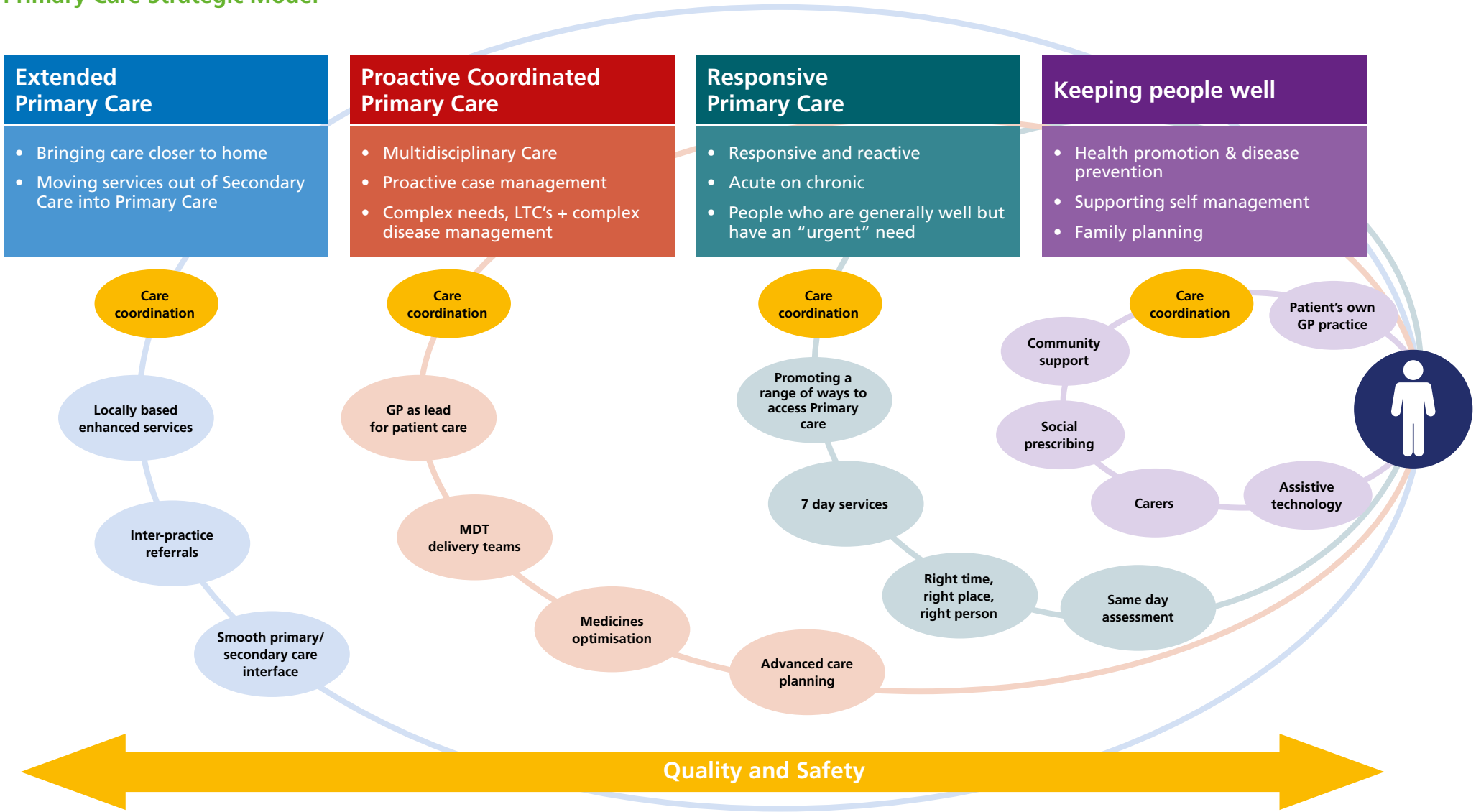
The Proactive Co-ordinated Primary Care Pillar has very recently been commissioned. This will see the most complex and/or frail patients in Doncaster being identified and offered a targeted, multi-disciplinary, proactive approach to care planning and review within their local practice, with the aim of improving health outcomes alongside patient experience.

Delivery of the remaining pillars will ensure that over time there will be:

- A consistent point of **Contact**, as close to home as possible
- **Continuity** to follow patients over time
- **Comprehensive** services that are proactive and focussed on early diagnosis and interventions and support independence
- **Coordination** with other experts / professionals.
- Access to high quality, clinical care in a **responsive** and timely manner

To pave the way for the model above to be successfully implemented, a focused transformation programme for general practice will be required; this represents a significant change. Particular emphasis will be on redesigning workforce, improving infrastructure, managing demand more smartly, and delivering "at scale" primary care, all of which will allow general practice to fit and function within the emerging neighbourhood model most effectively.

Primary Care Strategic Model



Early Help

Across Doncaster there is recognition that Early Help and prevention is key to child and family development:

Early Help is the term used to describe arrangements and services that respond to the needs of children, young people and their families as soon as problems start to emerge at any point in their lives, or when there is a strong likelihood that problems will emerge in the future. Critical features of an effective Early Help system are:

- A multi-disciplinary approach that brings a range of professional skills and expertise to bear through a 'Team Around the Child, Young Person/Family'
- A relationship with a trusted lead professional who can engage with the child / young person and their family, and coordinate the support needed from other agencies.
- Practice that empowers families and helps them to develop the capacity to resolve their own problems.
- A holistic approach that addresses a child / young person's needs in a wider context
- Simple, streamlined enquiry and assessment process

This workstream aims to act early to prevent harm through universal services, support to families and those who care for children. Encouraging self-care and building resilience through to adulthood are key. The offer for children will ensure that children and young people have early access to the right support at the right time in the right place. This will build on community assets, connecting to core services and specialist services when necessary, so that services can be provided when they are needed and in a way that feels safe for children.

In Doncaster we have developed a supporting infrastructure with three core elements, which all staff from agencies and services across Doncaster will use to support them when they are working as a multi-disciplinary team around the family:

- Early Help Hub
- Locality Support – Early Help Coordinators
- Lead Practitioner (who can be from any service or agency, and ideally who has the closest relationship with the family) - Team Around the Child, Young Person / Family

We are also working to secure sustainable improvements in children and young people's mental health and emotional wellbeing outcomes. This will be delivered through a number of transformation work-streams including:

1. Resilience, Prevention and Early Intervention for the Mental Well-Being of Children and Young People
2. Improving Access to Effective Support
3. Caring for the most Vulnerable
4. To be Accountable and Transparent
5. Developing the Workforce

Underlying all this work there is a critical role for safeguarding children and protecting them from harm. In Doncaster safeguarding is recognised as everyone's responsibility, with all agencies that come into contact with children and families having a role to play.

What this will mean in real life to 10 year old Charlie

Charlie has an issue which is manifesting itself in problematic behaviour at school. School are trying their best to meet Charlie's need but are unable to do so effectively. Under current arrangements the School refers to Charlie's GP at this point. The GP refers Charlie into CAMHs and the referral doesn't meet the threshold so Charlie isn't accept into CAMHs. This leads to frustration from every-one involved and Charlie's family isn't sure where to go next.

Following transformation this will no longer happen. There will be new locality emotional health and wellbeing workers based in the community who will provide guidance and support. Access to support around emotional wellbeing and mental health will be via discussion and joint working to ensure a more systemic approach. As a result Charlie will be seen quicker, and will be able to access the right support earlier.

A range of integrated services to promote **faster recovery from illness, prevent unnecessary acute hospital admission** and **premature admission to long-term residential care, support timely discharge from hospital** and **maximise independent living**.

Intermediate care services are usually time limited, normally no longer than six weeks and frequently as little as one or two weeks. Intermediate care should be available to adults age 18 or over.

National audit of Intermediate Care 2015
NHS Benchmarking (Plain English approved definition)

We undertook a significant review of intermediate care in 2015, including:

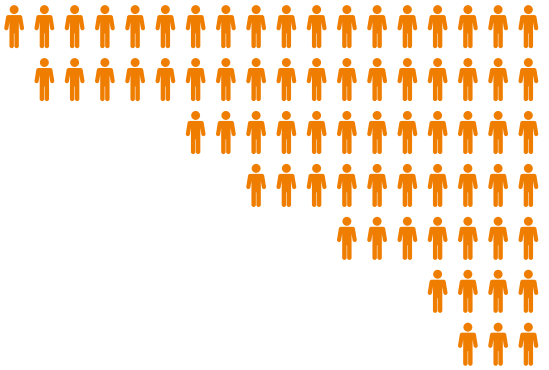
- In depth study of the needs of people referred to intermediate care in 2014 (see below).
- Interviews with 58 people using intermediate care services about their experiences.
- Findings from the hospital discharge pathway study. Qualitative study led by Sheffield Hallam University following people and their carers from discharge, through intermediate care and home for 12 months.

The in depth study is summarised below:

1027 records (a statistically significant sample) reviewed from a number of touch points along the intermediate pathway to capture a picture of people's needs when they were referred to the following services.

A&E	Social Care Services	Neurology Rehab beds	Community Hospital beds	Community Social Care beds
Rapid Assessment & Prevention Team	Community Nursing	Care Home beds	Rehab Centre	Older People's Mental Health beds

This was followed by 78 multidisciplinary, multiagency panels held over 10 months to review the needs captured and identify future optimal care packages. 71 health and social care staff involved in the panels including:



Nurses
Mental Health representatives
Social care staff
Therapy staff
Community & Voluntary Sector staff
Geriatricians
GPs

The key findings from the review were:

- Services are too complicated, difficult to navigate and not as efficient as they could be
- There are not enough home based services in Doncaster to respond quickly at times of crisis and help people maintain their independence in their own environment.
- Approximately 50% of over 75 year olds admitted to hospital could potentially be supported at home with different intermediate care services
- Over a quarter of people reviewed had medium to very high needs related to cognitive impairment and the majority of current intermediate care services don't work with people with this level of need
- The social care needs for this group were complex

Doncaster is now at the point that the future model for intermediate health and social care has been designed and implementation of early testing, whilst the model is refined, is expected to commence over winter 2016. Our offer will be focussed around the development of four types of intermediate care responses:

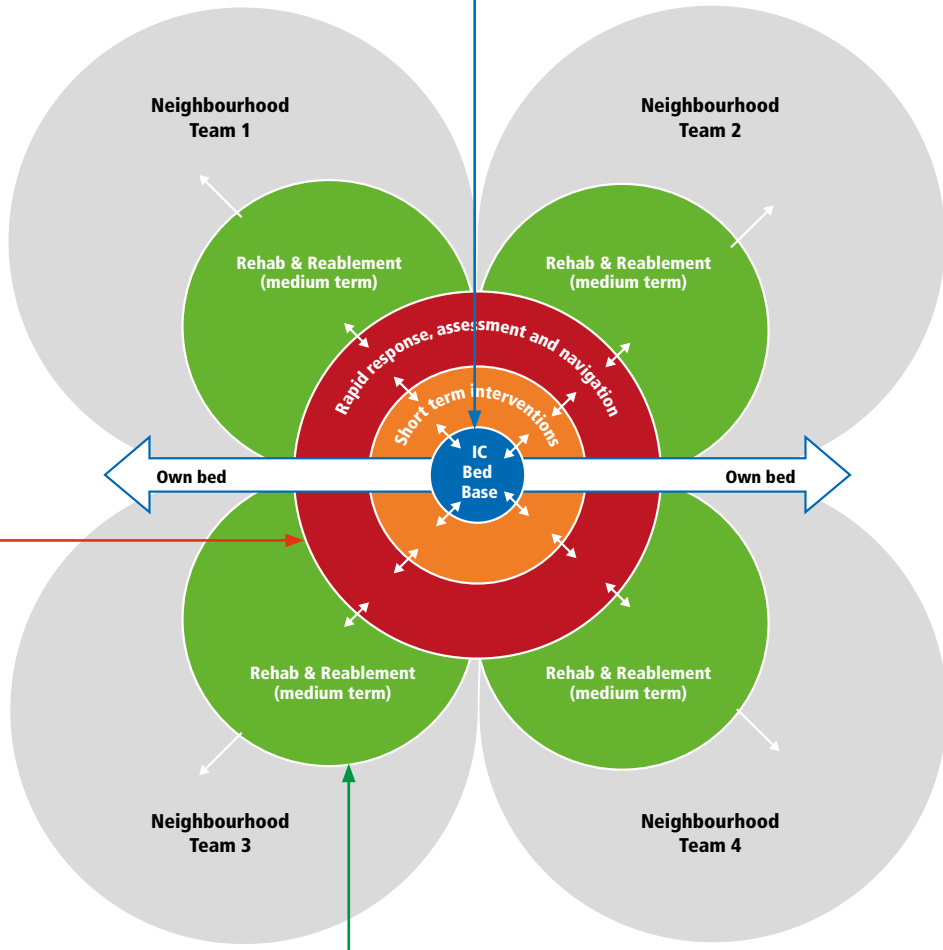
Central assessment and navigation service, providing…

1. **Single point of contact and assessment** (discharge and prevention)
2. **Rapid response** (see and treat or see and solve)
3. **Short term/ intensive response** (see and keep in 'own bed')
4. **Co ordination of reablement/rehab plans** (delivered in localities/ neighbourhood teams).

Overview of intermediate care caseload and closely linked into acute capacity management processes.

Community based with a presence in A&E and on the wards to pick up face to face referrals.

Single health and social care bed base - central location.
Linked very closely or staffed by the same team as deliver the **short term/ intensive response** as would be offering similar interventions but in a 'borrowed bed'



Locality/neighbourhood based reablement/rehab.
Providing the **medium term response**.

What this will mean in real life to 78 year old Maurice

Maurice, is 78 years old and has had an elective total knee replacement surgery in hospital. He was very independent prior to his operation, living in his own bungalow, seeing family and friends and driving his car. Maurice has asthma and angina which he manages well. Two days after surgery he is assessed by the Integrated Discharge Team (IDT) as needing some rehabilitation to restore his confidence and improve mobility. He was transferred to an intermediate care bed based unit to receive his rehabilitation and after 18 days he was discharged home with no follow up as he was fully independent again.

In the future Maurice would receive his rehabilitation from a community based team of therapists, nurses and support workers who could will help him settle back in at home for a few days after his surgery and maintain his links with his local community.

What this will mean in real life to 89 year old Florence

Florence is 89 years, she had a stroke 9 years ago and has been using a zimmer frame to walk since then. She lives in a bungalow and can make her own meals but homecare call every morning to help her with her personal care. Florence's family take her shopping. She was using the dial a ride service to get out in the community but her outings have reduced recently.

One morning her carers arrive and find that she has fallen. She has been able to get up from the floor but has a small cut on her arm. They call an ambulance to get her checked out, who transport her to A&E to be seen by a Doctor. After several hours all her tests are clear and it is confirmed that no treatment is required so she is referred to the Rapid assessment and prevention team (RAPT) to assess if she is ok to go home. They arrange for her to have an assessment for some extra homecare the following day and she is taken home by her family that evening with some new equipment. She is also referred for follow up in the falls service in a few weeks time. While she is waiting for an appointment she falls again and is admitted via A&E to the frailty unit at the hospital for further assessment.

In the future her carers will be able to request a rapid response by an appropriately trained clinician who will assess her at home, arrange relevant tests and co-ordinate any short term health and social care needed at home, including a full falls assessment and any appropriate falls programme. This will allow Florence to stay in her own home, prevent an A&E attendance, reduce the number of assessments completed and ensure more timely access to falls assessment, potentially preventing further falls and an admission. Her assessment will also identify ways to ensure that in the future Florence is able to access other support services delivered within and by her local community.

The focus of Cohort C is on redesigning and shifting services out of hospital and into the community where appropriate, through e.g. community led support, therapies, outpatients, diagnostics, district nursing, mental health and learning disability services.

Neighbourhoods are at the heart of this cohort, focussed around holistic approaches to peoples' needs, and what can be delivered within that neighbourhood setting. Below we present some examples of transformation work streams that will be delivered within neighbourhoods.

What this will mean in real life to Brian

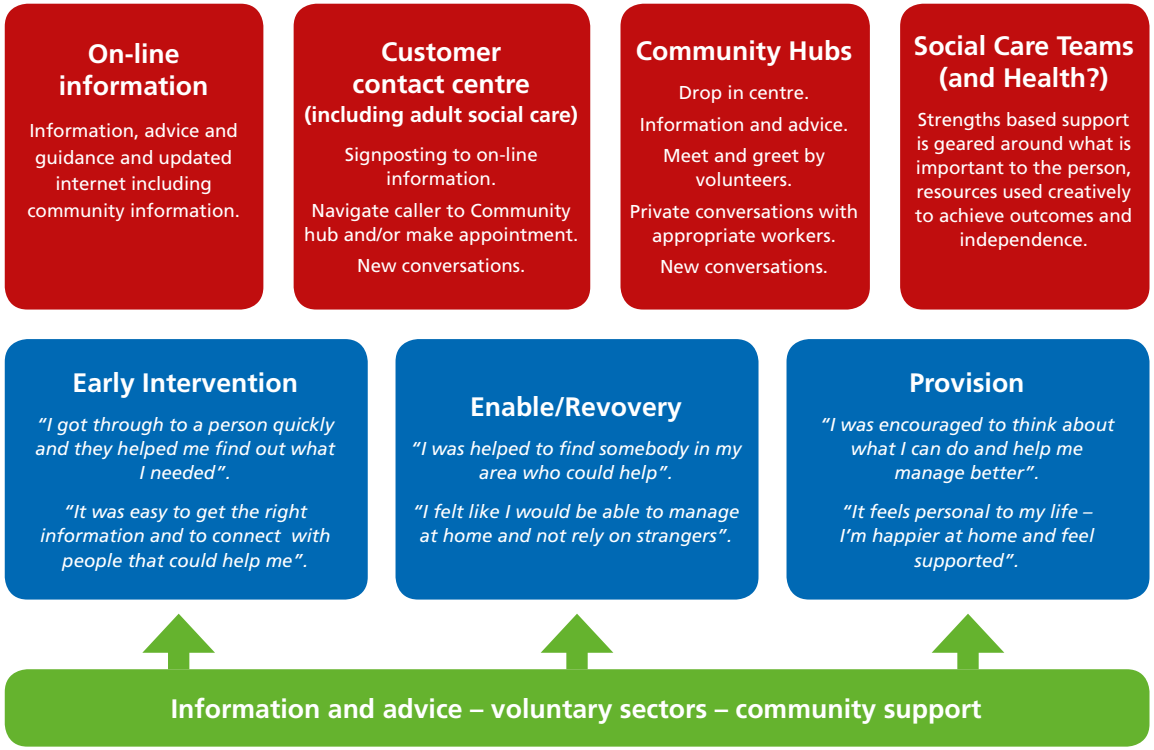
Brian currently receives a face to face call twice a day which includes ensuring he has taken his medication. Following transformation this prompting will be achieved through the use of technology, which means that there will be more time to devote to achieving improved outcomes for him.

Delivering Community Led Support

One of the key work-streams within this cohort will be the delivery of Community Led Support. The future model for adult social care is based on recognising that there are 3 "conversations" with people, which focus on individuals' own strengths and the support that is already within the community. Enablement and re-ablement are at the core:

- Conversation 1: **giving advice** or connecting the person to others who can help them get on with life
- Conversation 2: a **more in-depth discussion** about what matters to the person, helping them identify what they need to do in order to make the most of their options
- Conversation 3: **what else does this person need** in order to build on their strengths and connections? Can others help? Do they also need help to make a support plan? How do we continue to support them

Future Community Led Support Model for Doncaster People



See and Solve Team

A temporary team to respond more quickly to Requests for Support, whilst the Community Led model is being developed.

Transforming Learning Disability and Mental Health Services

Also within Cohort C, Learning Disability services will be ensuring that more patients can be treated locally, without the need to receive support from out of the Doncaster area. This will be delivered through:

- Early intervention and crisis prevention through comprehensive case management
- Acute and primary care liaison
- Dynamic Case Management for more complex patients to prepare for step-down from secure settings out of the Doncaster area, safely back into the local community

With regards to mental health, building on recent transformation the next steps will be to deliver:

- A community based perinatal-mental health service
- Enhanced psychological therapy pathway in primary care to support people with long term conditions
- Psychiatric Liaison Service 24/7 at the Acute Hospital
- Locally delivered, robust annual health reviews for people who are severely mentally ill
- Maintenance of individuals in local services and provision of care as close to home as possible, not outside the South Yorkshire and Bassetlaw footprint

This work will be in tandem with the transformation of Children's mental health services and where appropriate, ageless care pathways will be put in place.

The list for Cohort C is not intended to be exhaustive, at this point it is illustrative of the breadth and depth of the transformation that will make up Cohort C. Cohort C will include other services with an enablement and recovery focus; this will be developed over time and co-produced with local people to ensure that we get this right for Doncaster.

What this will mean in real life to David

David was in a long term placement outside the Doncaster area. His brother has now moved into an adapted bungalow so that David can move back into the community. David has challenging behaviour and requires 2:1 support. A transition plan was put in place for home care staff to learn David's routine. The new package at home is a combination of commissioned care and a personal budget. David is now living at home with his brother and accessing his local community

Health and Wellbeing and Care and Quality benefits

Cohort	Benefits
Cohort A Prevention and Early Help	Prevention and the provision of early help is at the heart of everything we do
	Individuals, families and communities are supported to build resilience and there is a network of resilient communities
	Individuals and families are supported to lead independent lives in strong and sustainable communities
Cohort B Intermediate health and social care	Services support Doncaster residents to maintain their independence, live at home and in the community as long as possible
	Intermediate health and social care is integrated, and responsive
	Investment in out of hospital services is prioritised to build sustainable future services
Cohort C Enablement and Recovery	Inpatient beds are used efficiently and only accessed when appropriate
	Respite and residential services are high quality and based on individual need and choice
	All care and hospital based services integrate mental and physical health approaches
	Individuals and families are empowered to optimise their health and wellbeing and feel supported to manage their long term conditions
Benefits across all Cohorts	All agencies are involved in joint planning processes
	Wherever appropriate services are local to Doncaster neighbourhoods and community assets are accessible
	Health and care services are co-produced with the Doncaster population
	Care pathways across agencies are timely, simple and seamless, supported by smooth information flows
	Market developments to supply alternative models of provision
	Sustainable urgent and elective care services are in place and on a 24/7 basis where appropriate

Financial benefits and investment required

The Cohorts in our Place Plan will contribute to closing the total gap of £139.5m by 2021, identified through the South Yorkshire and Bassetlaw STP process.

The diagram below is conceptual. In the next stage of work, more detailed financial analysis will be carried out.

In order to develop our new models of delivery it is clear that this will need some investment to resource the transformation. The work in cohort B, for example, will require some non-recurrent investment to implement the changes within neighbourhood services that over time will reduce the need for hospital attendance and admission. Ultimately the finance and efficiency gap will be met by ensuring that the new models of care make the most effective use of the "Doncaster pound".

Joint Commissioning and Provision

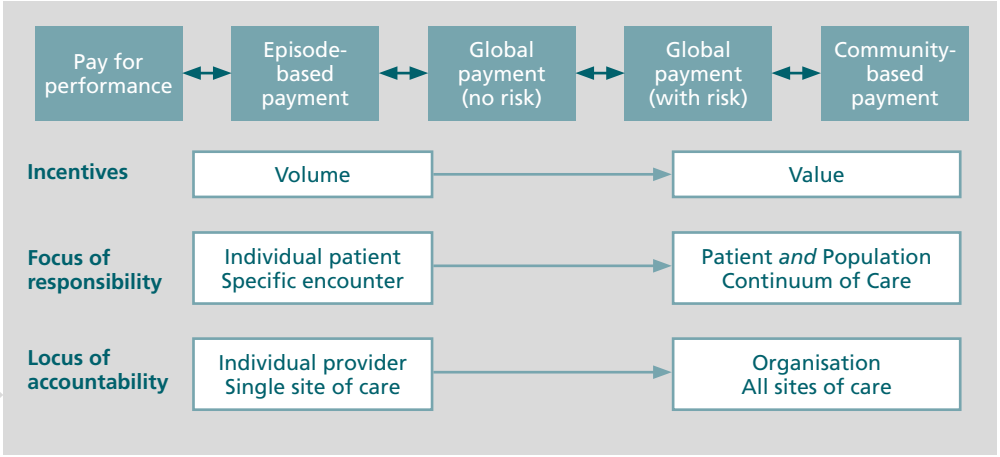
In order to commission and provide services to meet the vision and offers set out above, it is envisaged that the commissioner and provider landscape will change.

Commissioners will need to work closely together to develop joint specifications for services, using different types of contracts such as alliance contracts and a "control total" approach across groups of providers. Commissioners will need to make a decision to work differently, together, using opportunities such as pooled budgets to commission services jointly and move towards the development of new care models. Effective, strategic commissioning will continue to be key, to ensure the continued provision of comprehensive local health and social care in Doncaster, within available resources. Joint governance arrangements will be required that facilitate such joint working.

The delivery of joint commissioning and resultant joint specifications will allow providers to respond to a unified requirement, reducing duplication and indeed gaps in service commissioning.

Providers will therefore also need to work together to respond to joint specifications as it is envisaged that they will cover services currently provided by more than one individual organisation. Although the mechanisms to do this are not yet fully developed it is envisaged that the future configuration may be as demonstrated in the diagram below.

This model builds on the work of the current vanguards around new models of care and will provide flexibility for the partnerships to develop over time and in line with the developing cohorts. The model requires new ways of working, focused on services working together, wrapped around the patient and delivered in neighbourhoods. The approach is already in place in some programmes within Doncaster, such as through the Stronger Families Programme, but our vision for the Doncaster place is that this becomes the norm and is widely adopted.



Source: The Dartmouth Institute for Health Policy and Clinical Practice

New Care Model Landscape

Working together as commissioners to jointly commission integrated health & care services

CCG / LA Joint Commissioning

Via a new contracting methodology

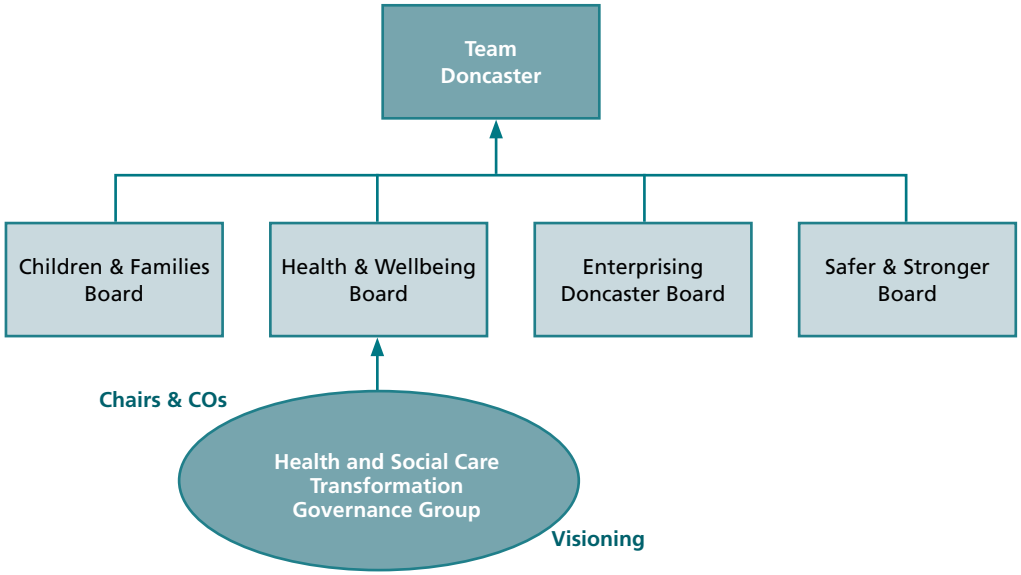
Accountable Care Partnership
(all providers below)

- Primary Care Federations
- Local Authority (DMBC)
- Acute Trust (DBH)
- Mental Health & Community Trust (RDASH)
- Private Sector (FCMS /….)
- Children's Trust (DCT)
- 3rd Sector

Working collectively as providers on an outcome based contract

Governance for our Place Plan

The Place Plan sits in a wider local context, under the Team Doncaster structure and contributes to the locally emerging common objectives. It is envisaged that this will become the wider umbrella for the Place plan and existing Doncaster forums will be used to oversee delivery, which are structured as follows:



It is recognised that it is important to maintain the momentum in the delivery of our vision and transformation work-streams and in order to do so we will ensure that there is appropriate governance in place to support the implementation and changes to ways of working across commissioners and providers.

It is expected that over the next short period the role of the Health & Social Care Transformation Governance Group, in particular, will be reviewed as this forum provides the opportunity to oversee progress against both joint commissioning and joint provision. Governance arrangements will be put in place to support that changed role.

Workforce, Estates and Integrated IT

Work is already underway to develop Doncaster wide approaches to workforce, estates and IT, led by the work on intermediate care in the first instance. This complements the enabling workstreams for the wider STP and will work in partnership to secure the best improvements for Doncaster.

Our vision for Doncaster will see changes in how and where services are delivered. They will be based more locally, within neighbourhoods and be more tailored to individuals' and families' needs. The corner stone will be the development of existing community assets and helping Doncaster people to build their own resilience within their community. This represents quite a shift for Doncaster but will lay the groundwork for services to be more accessible and needs based for the different groups of people within Doncaster.

It is therefore vital that we begin to engage around this, both with staff and the public and ensure that there is a single, agreed approach with a clear message. In order to do so there will be a Doncaster system-wide approach to developing key messages and communicating them effectively and consistently through the various channels that health and social care partners in Doncaster have at their disposal. This will be led by partner communication and engagement teams and facilitated through a Doncaster-based forum. It is envisaged that timely, relevant communication and engagement systems will underpin the delivery of the place plan, continuing over a period of time, and not just be focused on an initial "burst" of activity.

Whilst the engagement planned at this stage will be around the vision for Doncaster as a whole, it is recognised that there will need to be specific consultation around each transformation work-stream within each cohort. This will take place as each cohort, and the transformations within them, are developed. A similar approach will also be taken with regards to engaging around each work-stream of the STP as plans are developed. It is also expected that each transformation work-stream will give due regard to the effect on different groups, whilst sitting in the wider context of the Place Plan which enhances access to services through the development of neighbourhoods and strengthening of community assets.

The success of the transformation programme will also depend on the degree of understanding and buy-in from a wider set of stakeholders from across Doncaster, not just health and social care, so effective, inclusive engagement, across Doncaster is vital. Early conversations have commenced at this Team Doncaster level, and stakeholders are beginning to consider the opportunities from coming together on this broader scale, including Police, Fire and Rescue, Housing, Doncaster Chamber, Voluntary Services and Doncaster College.

Next steps

Whilst we have agreed our three transformation cohorts, and have detailed plans for some of the transformation workstreams, the full timeline is still in development.
Below we present high level timeframes for our short term milestones (over the next three years).Further refinement will be required as we move into delivery of the Place Plan:

Place Plan key milestones and timeframes		2016-17	2017-18	2018-19
Governance	Confirm governance arrangements to support delivery			
	External support for implementation			
Coterminosity	Agree boundaries			
	Delivery across 4 neighbourhoods			
Joint Commissioning	Develop Memorandum of Understanding			
	Test on Intermediate Care			
	Develop joint specifications			
	Develop new contracting approach			
	Move towards integrated working			
New models of Care	Testing for intermediate care and Prevention and Early Help			
	Emerging provider partnerships and primary care federations			
	Respond to joint specifications			
	Respond to new contracting approach			
Engagement	Place Plan partners develop comms and engagement plan			
	Public engagement on vision and Plan			
	Specific work-stream consultation			
	Ongoing engagement			