Public Document Pack

Doncaster
Metropolitan Borough Council

To all Members of the

HEALTH AND WELLBEING BOARD

AGENDA

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

VENUE: The Boardroom, Montagu Hospital, Mexborough, S64 0AZ
DATE: Thursday, 1st September, 2016
TIME: 9.30 a.m.

PLEASE NOTE VENUE FOR THIS MEETING

Items		**Lead**
1.	Welcome, introductions and apologies for absence.	(Chair)
2.	Chair's Announcements.	(Chair)
3.	To consider the extent, if any, to which the public and press are to be excluded from the meeting.	(Chair)
4.	Public questions. **(A period not exceeding 15 minutes for questions from members of the public.)**	(Chair)
5.	Declarations of Interest, if any.	(Chair)
6.	Minutes of the Meeting of the Health and Wellbeing Board held on 9th June 2016. (Attached)	(Chair)

Jo Miller
Chief Executive

Issued on: 23rd August 2016

Governance Officer for this meeting: Jonathan Goodrum
01302 736709

7.	Quarter 1 Performance Update and Focus on Dementia. *(Paper attached/Presentation)*	(Allan Wiltshire/ Wayne Goddard)
8.	Hidden Harm Strategy. *(Paper attached/Presentation)*	(Andrew Maddison/ Kirsty Thorley)
9.	Health and Social Care Transformation Update (Prevention). *(Paper attached/Presentation)*	(Dr Rupert Suckling)
10.	Doncaster's Local Plan and Health and Wellbeing. *(Presentation)*	(Clare Henry/ Teresa Hubery)
11.	Local Digital Roadmap. *(Paper attached/Presentation)*	(Andy Clayton)
12.	Report from HWB Steering Group and Forward Plan. *(Paper attached)*	(Dr Rupert Suckling)

Date/time of next meeting: Thursday, 3 November 2016 at 9.30 a.m. in Rooms 007a and b - Civic Office, Waterdale, Doncaster.

Members of the Health and Wellbeing Board

Chair – Cllr Pat Knight	Portfolio Holder for Public Health and Wellbeing
Vice-Chair – Susan Jordan	Chief Executive, St Leger Homes
Damian Allen	Director of Learning Opportunities and Skills, DMBC
Dr David Crichton	Chair, Doncaster Clinical Commissioning Group
Karen Curran	Head of Co-Commissioning, NHS England (Yorkshire and Humber)
Kim Curry	Director of Adults, Health and Wellbeing, DMBC
Peter Dale	Director of Regeneration and Environment, DMBC
Councillor Nuala Fennelly	Portfolio Holder for Children, Young People and Schools
Steve Helps	Head of Prevention and Protection, South Yorkshire Fire and Rescue
Councillor Glyn Jones	Deputy Mayor and Portfolio Holder for Adult Social Care and Equalities
Acting Chief Superintendent Colin McFarlane	Acting District Commander for Doncaster, South Yorkshire Police
Paul Moffat	Chief Executive, Doncaster Children's Services Trust
Jackie Pederson	Chief Officer, Doncaster Clinical Commissioning Group
Mike Pinkerton	Chief Executive of Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Councillor Cynthia Ransome	Conservative Group Representative
Steve Shore	Chair of Healthwatch Doncaster
Kathryn Singh	Chief Executive of Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
Dr Rupert Suckling	Director of Public Health, DMBC
Norma Wardman	Chief Executive, Doncaster CVS
Vacant	New Horizons

This page is intentionally left blank

DONCASTER METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY, 9TH JUNE, 2016

A MEETING of the HEALTH AND WELLBEING BOARD was held in Room 007A AND B - CIVIC OFFICE on THURSDAY, 9TH JUNE, 2016, at 9.30 am.

PRESENT:

Chair - Councillor Pat Knight, Portfolio Holder for Public Health and Wellbeing

Councillor Glyn Jones	Portfolio Holder for Adult Social Care and Equalities
Councillor Nuala Fennelly	Portfolio Holder for Children, Young People and Schools
Councillor Cynthia Ransome	Conservative Group Representative
Dr Rupert Suckling	Director of Public Health (DMBC)
Damian Allen	Director of Learning, Opportunities and Skills (DMBC)
Peter Dale	Director of Regeneration and Environment (DMBC)
Dr David Crichton	Chair, Doncaster Clinical Commissioning Group
Jackie Pederson	Chief Officer, Doncaster Clinical Commissioning Group
Karen Curran	Head of Co-Commissioning, NHS England (Yorkshire and Humber)
Chief Superintendent Richard Tweed	District Commander for Doncaster, South Yorkshire Police
Kathryn Singh	Chief Executive of Rotherham, Doncaster and South Humber NHS Foundation
Steve Helps	Head of Prevention and Protection South Yorkshire Fire and Rescue

Also in attendance

Patrick Birch, Programme Manager, DMBC
Grant Lockett, Head of Access to Homes, St Leger Homes
Peter Featherstone, Interim Business Manager, Doncaster Children's Trust
Debbie Hilditch, Healthwatch Doncaster
Allan Wiltshire, Head of Performance and Data, DMBC
Helen Conroy, Public Health, DMBC
Jenny Jenkinson, Meeting New Horizons
Jon Tomlinson, Interim Assistant Director Commissioning, DMBC (observer)

62 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed the new Members of the Board, Dr David Crichton, Chair of Doncaster Clinical Commissioning Group, Jackie Pederson, Chief Officer at the Doncaster Clinical Commissioning Group, Peter Dale, Director of Regeneration and

Environment who had been formally appointed at the Council's Annual Meeting on 13th May along with Paul Moffat from the Doncaster Children's Services Trust.

The Chair also welcomed Jenny Jenkinson who was representing New Horizons and Jon Tomlinson the new Interim Assistant Director of Commissioning in Adults, Health and Wellbeing who was an observer at the meeting.

Apologies were received from Kim Curry (Patrick Birch deputised), Paul Moffat (Peter Featherstone deputised), Susan Jordan (Grant Lockett deputised), Steve Shore (Debbie Hilditch deputised) and Mike Pinkerton.

63 APPOINTMENT OF VICE-CHAIR

The Chair announced that the Board had received 2 expressions of interest for the role of Vice-Chair and in accordance with Council Procedure Rule 21.6 the Chair invited nominations.

It was proposed by Damian Allen and seconded by Chief Superintendent Richard Tweed that Susan Jordan be appointed as Vice-Chair of the Board

It was proposed by Rupert Suckling and seconded by Kathryn Singh that Steve Shore be appointed as Vice-Chair of the Board

On being put the vote, it was declared as follows

Susan Jordan	8
Steve Shore	2

RESOLVED that Susan Jordan be appointed as Vice-Chair of the Board for the 2016/17 Municipal Year.

64 CHAIR'S ANNOUNCEMENTS

The Chair announced that Chief Superintendent Richard Tweed was due to retire in July and this would be his last meeting as a Member of the Health and Wellbeing Board. On behalf of the Board she expressed her sincere thanks to Richard for the significant contribution he had made to the work of the Board and wished him all the very best for the future

The Chair also reported that she had been informed that Trevor Smith had left New Horizons and an interim replacement on the Board would be confirmed in due course. On behalf of the Board, she expressed her thanks to Trevor for the contribution he made during his time on the Board.

65 PUBLIC QUESTIONS

Mr Tim Brown expressed his concern that the Black and Minority Ethnic (BME) Health Needs Assessment was over 12 years old. He added that he was not aware of any of the recommendations from the previous Assessment ever being implemented and no feedback had been given. Mr Brown praised Professor Fenton and suggested that the Council liaise with him with regard to best practice. He welcomed the paper attached at Item 11 of the agenda but felt that the report lacked significant evidence of where

BME health needs had been met. In addition, Mr Brown sought assurances that there would be sufficient resources put in place to support all citizens of Doncaster.

The Chair highlighted that discussion would take place at Agenda Item 11 but invited Members to make comments.

Kathryn Singh stated that she had met with Mr Brown and felt that he was fundamental in what he was saying regarding collective information being key. She reported that overall internally against the Race Equality Scheme there was an over representation of employees for BME. She pointed out that this issue was very challenging and through talking with Dr Rupert Suckling there was a need to look at all demographics. She thanked Mr Brown for his comments.

Rupert Suckling welcomed the suggestion of working with Professor Fenton and would seek to take up that offer of support.

Dr David Crichton also reported that the proposals for Joint Health and Social Care would be supported by the Clinical Commissioning Group and would offer their support through working alongside Public Health.

Mr Brown was thanked for his question and comments.

66 DECLARATIONS OF INTEREST, IF ANY

There were no declarations of interest made at the meeting.

67 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 3RD MARCH 2016

RESOLVED that the minutes of the Health and Wellbeing Board held on 3rd March, 2016 be approved as a correct record and signed by the Chair.

68 QUARTER 4 PERFORMANCE UPDATE AND FOCUS ON SUBSTANCE MISUSE

The Board considered a report which provided the latest performance figures for the Quarter 4 period. The paper set out the current performance against the agreed priorities in the Health and Wellbeing Strategy.

It was reported that a refreshed 'outcomes based accountability' (OBA) exercise was completed parallel to the refresh of the Health and Wellbeing Strategy. The five outcome areas remain and specific indicators had been identified which would measure progress towards these outcomes in 2015-16. Further information and narrative around the performance was available in Appendix A to the report. The OBA methodology moved away from targets for the whole population indicators and this was reflected in the report. Instead, the trend and direction of travel was the key success criteria.

Members were advised of the additional OBA exercise that had taken place for drugs misuse on individuals, families and communities. This along with alcohol would provide information for a combined area of focus for substance misuse for 2016/17. Additional measures proposed to be included were as follows:-

- Increase the proportion of all in treatment, who successfully complete treatment and do not re-present within 6 months
- Reduce drug related offending (reoffending of DDR clients)
- Increase the number of clients in treatment who live with children
- Increase Numbers in Treatment
- Drug related crime (TBC)

In a response to the Chair's query regarding Outcomes 4&5 being harder to measure, it was stated that as there was more in-depth work to be carried out, the short term performance figures were harder to achieve. It was noted that some outcomes take longer to turn around and become engaged in the programme. Jackie Pederson stated this was something the Clinical Commissioning Group would need to take away and grasp an understanding of the issues but was keen to engage in the process.

Councillor Glyn Jones stated that whilst the information provided a good snap shot, he asked whether there was any possibility of breaking the figures down to give a more accurate picture on the differing levels of intervention to identify any trends. It was noted that this could be accommodated.

Further discussion took place with regard to Outcome 4 and the various elements associated with Dementia. The report was welcomed by the Board but Members felt that the subject warranted a more in-depth discussion at the Board's next meeting in September and requested that it be added to the Forward Plan along with Prevention. It was noted that if any Member of the Board wished to make comments on the matter prior to the meeting they should forward these to Dr Rupert Suckling.

The Board received a presentation by Helen Conroy on Substance Misuse which included the following key areas:-

- Size of the problem: prevalence
- Headline treatment figures for drug treatment
- Emerging issues
- Drugs and Alcohol as a priority
- Successes; and
- Challenges

Following the presentation, it was agreed that further discussion was needed around the subject of prevention. It was also noted that some discussion was required with regard to licensing of premises such as off-licences within the Borough. It was suggested that there was clustering of these premises within the town and a more strategic approach was required.

RESOLVED that:-

(1) the performance against the key outcomes be noted;

(2) the presentation on the Alcohol area of focus be noted;

(3) the Board receive a detailed report on Dementia at its next meeting in September 2016; and

(4) performance reports will contain drug performance information from Q1 2016-17 onwards.

69 JSNA UPDATE

The Board received an update report which outlined some of the potential challenges facing adult social care over the next 15 years. The report showed that Doncaster had an ageing population but also had a population that had lower disability free life expectancy. Doncaster men and women were living longer with disability than many similar areas and with greater disability would come greater demand on social care services. Additionally the report presented the potential increases in demand for social care that could result from an increasing ageing population.

It was noted that the trajectories described in the report should be regarded as predicting demand if no changes were made in the commissioning and delivery of social care services.

Discussion took place of the following key points within the report:-

- Life expectancy – the report identified evidence of levelling out, which was a national trend.
- Disability Life Expectancy – In relation to the further analysis undertook at page 56 of the report, clarity was sought as to why the data revealed Doncaster had a higher demand on social care. It was stated that although causes had not been looked into, it was envisaged that it would be disease related such as Cancer, heart disease and respiratory disease. It was also noted that smoking was the biggest contributor for disability.

It was acknowledged that there was a number of new members on the Board and it was advised that the Board had agreed to commissioning a Joint Strategic Needs Assessment for the 2015/16 municipal year and it was envisaged that for 2016/17 the Board would be focussing on Children's Services.

RESOLVED that the report be noted.

70 HEALTH AND SOCIAL CARE TRANSFORMATION UPDATE

The Board received a presentation by Jackie Pederson, Chief Officer, Doncaster Clinical Commissioning Group on the Health and Social Care Transformation Update. Jackie summarised the salient point within the presentation which included the following areas:-

- The Doncaster CCG system vision
- Progress so far
- Next steps
- Changing landscape
- What might the future Doncaster service model look like.

Following the presentation, Members were afforded the opportunity to make comments and ask questions. Councillor Nuala Fennelly made reference to the pilot nursing scheme which had been a success. It was explained that over the years the model of service had become very complex and under the new proposals the service

would become much easier to use and understand. It was reported that the presentation had been very helpful and created a desire to provide the right service.

Further comments were made with regard to the following issues:-

- Lack of GPs
- IT Systems
- Patient confusion on which hospitals to go to

Dr David Crichton, Chair of Doncaster Clinical Commissioning Group stated that at present there were not enough GPs to fill the current gap but under the new proposed model of care, patients would have access to a variety of professionals other than their GP. It was also advised that with the development of integrated IT systems, the service would be moving towards full interoperability of all health and social care systems.

Whilst it was recognised that access to patients would always prove to be a challenge, this would be improved with the proposal for a 24/7 single point of access for patients and professionals. It was also advised that further imaginative work was required within the urgent care system.

In addition, the Board received a presentation from Patrick Birch which outlined proposals for the Adults, Health and Well Being Transformation. Patrick summarised the salient points within the presentation which included the following outcomes:-

- People can lead independent lives in strong and sustainable communities
- People will have choice and control
- People are healthy and safe, especially when in urgent need or crisis

Details on the 5 transformation themes were also outlined within the presentation. Following the presentation members of the Board were afforded the opportunity to ask questions and make comments. Dr Rupert Suckling acknowledged that there were clear challenges ahead but it was encouraging that conversations and discussions were taking place. He stated that the next step of the process was to get others involved.

Jackie Pederson stated as far as the Clinical Commissioning Group were concerned she felt that further conversation needed to be had on the stages of the process and what the boundaries were but emphasised the need for all parties to be involved in those discussions.

RESOLVED that the presentations and update on the Health and Social Care Transformation be noted.

71 HEALTH INEQUALITIES - BME HEALTH NEEDS ASSESSMENT PROPOSAL

The Board received a report which outlined proposals for an updated Black and Minority Ethnic (BME) Health Needs Assessment. It was reported that the last needs assessment in Doncaster was in 2004 and since that time, the health needs of BME communities had been identified through the Joint Strategic Needs Assessment. In 2015 Doncaster established a Fairness and Inclusion forum with an independent Chair. It was noted that the make-up of BME communities in Doncaster was changing

and the 2015 Director of Public Health Annual Report recommended an update of the health needs assessment in order to ensure the local understanding of needs was a full as possible.

It was reported that the Board should ensure an updated BME health needs assessment was undertaken and be led by the steering group. The proposals were outlined as follows:-

- Establish baseline demographic details using the most recent national census data, NHS data and other local census data e.g. school census data (June 2016 to July 2016)
- Review the literature and evidence base for effective engagement approaches, common BME health needs and possible solutions (June 2016 to July 2016)
- Conduct a range of focus groups with identified local BME groups using the Team Doncaster partnership 'map' of groups and other local data. (August 2016 to October 2016)
- Assess any differences in access to and outcomes from local health and care services (September 2016 to October 2016)
- Final report and recommendations back to the Health and Wellbeing Board (December 2016).

A short discussion took place on the proposals and the Board agreed that the proposals be endorsed and Dr Rupert Suckling would lead on the process with support from Board Members.

RESOLVED to agree the proposals and support the production of an updated BME Health Needs Assessment.

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

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

Dr Rupert Suckling summarised the salient points in the report, which included updates on:

- Childhood Obesity;
- Loneliness and social isolation;
- Sheffield City Region Health and Employment
- Safe and Well Visits (Joint work with South Yorkshire Fire and Rescue)

Further discussion took place on the Forward Plan and following comments from earlier agenda items Members sought the inclusion of Dementia, Prevention and Licensing to be placed on the forward plan for discussion at future meetings.

RESOLVED that:-

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

(2) the proposed Forward Plan as detailed in Appendix A to the report be agreed subject to the inclusion of:-

- Dementia
- Prevention
- Licensing

Prior to the conclusion of the meeting, Damian Allen, Director of Learning and Opportunities brought to the Board's attention the impending SEND inspection. He stated that the SEND Partnership Board were overseeing the preparation for the inspection but urged partners to be present at the meetings if required to do so.

CHAIR:_____ DATE:_____

Doncaster
Metropolitan Borough Council

Doncaster Health and Wellbeing Board
Date: 01.09.16

Subject: 2016-17 Q1 Performance Report

Presented by: Allan Wiltshire

Purpose of bringing this report to the Board	
Regular performance reports on the priorities set out in the Health and Well-being strategy will provide assurance that progress is being made and the board are made aware of any risks or barriers to improvement in key areas.	
Decision	NA
Recommendation to Full Council	NA
Endorsement	Y
Information	Y

Implications		**Applicable Yes/No**
DHWB Strategy Areas of Focus	Alcohol	Y
	Mental Health & Dementia	Y
	Obesity	Y
	Family	Y
	Personal Responsibility	Y
Joint Strategic Needs Assessment		Y
Finance		N
Legal		N
Equalities		Y
Other Implications (please list)		N

How will this contribute to improving health and wellbeing in Doncaster?
Good quality performance management arrangements ensure that priorities are achieved and good quality services delivered to the residents of Doncaster. Also this report should highlight progress against the key health and well-being priorities identified as priorities in Doncaster.

Recommendations
The Board is asked to:- a) Note the performance against the key outcomes b) Receive and note the short presentation from the 'Dementia' area of focus c) Agree what area of focus the Board would wish to have further information in Q2 2016-17

This page is intentionally left blank

Doncaster
Metropolitan Borough Council

Agenda Item No. 7
Date: 01/09/16

To the Chair and Members of the
HEALTH & WELL BEING BOARD

PERFORMANCE REPORT Q1 2016-17

EXECUTIVE SUMMARY

1. A refreshed 'outcomes based accountability' (OBA) exercise was completed parallel to the refresh in the Health and Well-being strategy. The five outcome areas remain and a new outcome on drugs has been introduced for 2016-17. A number of specific indicators have been identified which will measure our progress towards these outcomes in 2016-17. The 6 outcomes are;

   - Outcome 1: All Doncaster residents to have the opportunity to be a healthy weight
   - Outcome 2: All people in Doncaster who use alcohol do so within safe limits
   - Outcome 3: Families who are identified as meeting the eligibility criteria in the expanded Stronger families programme see significant and sustained improvement across all identified issues.
   - Outcome 4: People in Doncaster with dementia and their carers will be supported to live well. Doncaster people understand how they can reduce the risks associated with dementia and are aware of the benefits of an early diagnosis
   - Outcome 5: Improve the mental health and well-being of the people of Doncaster ensures a focus is put on preventive services and the promotion of well-being for people of all age's access to effective services and promotes sustained recovery.
   - Outcome 6: Reduce the harmful impact of drug misuse on individuals, families and communities

2. Further information and narrative around the performance is available in **Appendix A**.

EXEMPT REPORT

3. NA

RECOMMENDATIONS

4. The Board is asked to:-
   a) Note the performance against the key outcomes
   b) Receive and note the short presentation from the 'Dementia' area of focus
   c) Agree what area of focus the Board would wish to have further information in Q2 2016-17

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

5. Good Performance Management arrangements of the priorities set out in the Health and well-being strategy will ensure services improve and peoples experience in the health and well-being system is positive.

BACKGROUND

6. The Health and Well Being Board have chosen to use Outcomes Based Accountability (OBA) to support the delivery of improvement against the key priorities in the health and well-being strategy. ***Appendix A*** sets out the five outcomes and the main *indicators* associated with each. The OBA methodology moves away from targets for the whole population indicators and this is reflected in this report, instead the trend and direction of travel is the key success criteria.

7. We have introduced a basic forecast into some of the indicators contained within Appendix A which should help the board to assess if the direction of travel is acceptable and if not seek to understand the options and implications of such a trend. The forecast is a linear forecast and only used if there is an acceptable amount of data to base a forecast on. Furthermore if there have been any significant deviation within the period that may impact on the validity of a linear trend a forecast has not been made.

8. As agreed with the board in Q1 2015-16 a short presentation on one of the areas of focus will be provided at each quarterly performance update. In Q4 the board agreed to invite the lead officer for Dementia to give a short update in Q1 2016-17. The Board will need to decide which area of focus should be invited for Q2 2016-17.

OPTIONS CONSIDERED

9. NA

REASONS FOR RECOMMENDED OPTION

10. NA

IMPACT ON THE COUNCIL'S KEY OUTCOMES

11.

Outcome	Implications
All people in Doncaster benefit from a thriving and resilient economy. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	
People live safe, healthy, active and independent lives. *Mayoral Priority:* Safeguarding our Communities *Mayoral Priority:* Bringing down the cost of living	Reduce Obesity. Reduce Alcohol Misuse Dementia Mental Health
People in Doncaster benefit from a high quality built and natural environment. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Safeguarding our Communities* • *Mayoral Priority: Bringing down the cost of living*	
All families thrive. • *Mayoral Priority: Protecting Doncaster's vital services*	Stronger Families Programme
Council services are modern and value for money.	
Working with our partners we will provide strong leadership and governance.	

RISKS AND ASSUMPTIONS

12. NA

LEGAL IMPLICATIONS

13. There are no specific legal implications for this report.

FINANCIAL IMPLICATIONS

14. Any financial implications will be associated with specific indicator improvement and will be associated with separate reports as appropriate.

EQUALITY IMPLICATIONS

15. There are no specific Equalities implications associated with this report. However specific programmes or projects aimed at improving performance and changing services will need to have a comprehensive analysis detailing the impacts on protected groups.

CONSULTATION

16. This report has significant implications in terms of the following:

Procurement		Crime & Disorder	
Human Resources		Human Rights & Equalities	
Buildings, Land and Occupiers		Environment & Sustainability	
ICT		Capital Programme	

BACKGROUND PAPERS

17. NA

REPORT AUTHOR & CONTRIBUTORS

Allan Wiltshire
Head of Performance & Data
01302 862307
Allan.wiltshire@doncaster.gov.uk

Dr. Rupert Suckling
Director of Public Health

This page is intentionally left blank

Doncaster Health & Well Being Board

Performance Report

Q1 2016-17

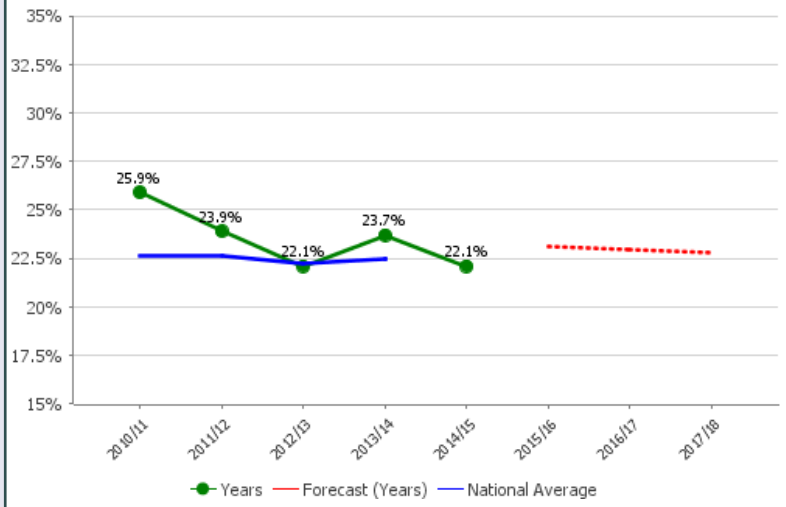
Appendix A

*Values below 5 have been rounded to 0 or 5
** If performance is outside of a control limit the text [Beyond Control Limit Q1 2016-17] will be used.

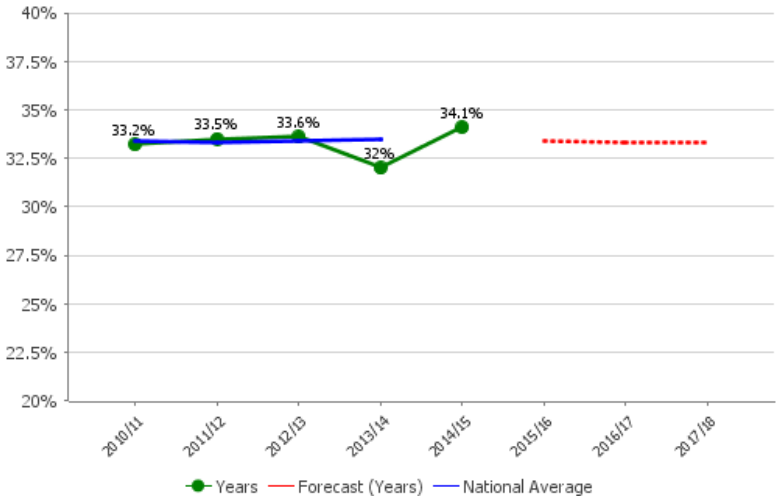
OUTCOME 1	All Doncaster residents to have the opportunity to be a healthy weight

INDICATORS

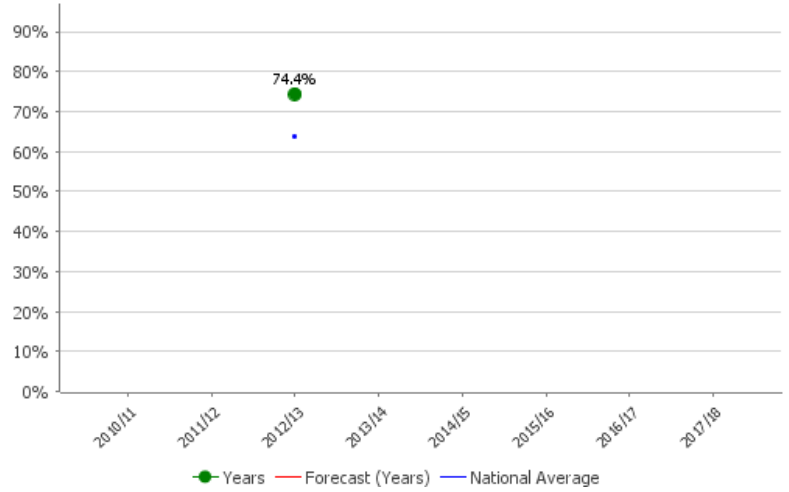
a) % of Children that are classified as overweight or Obese (Aged 4/5)



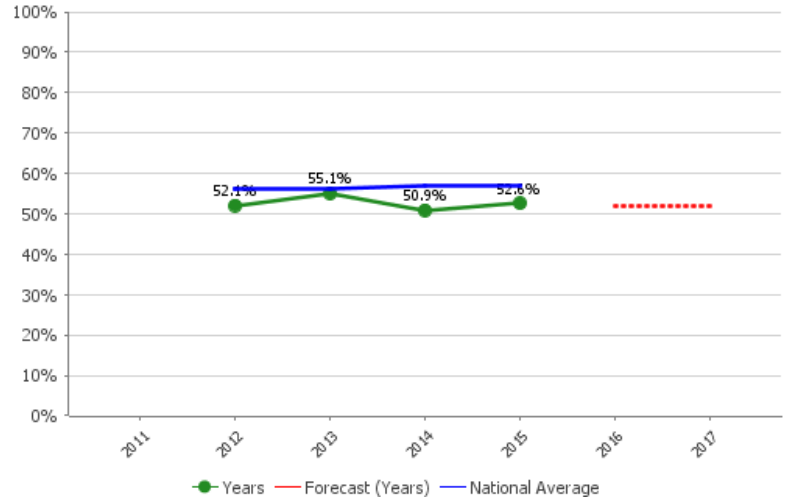
b) % of Children that are classified as overweight or Obese (Aged 10/11)



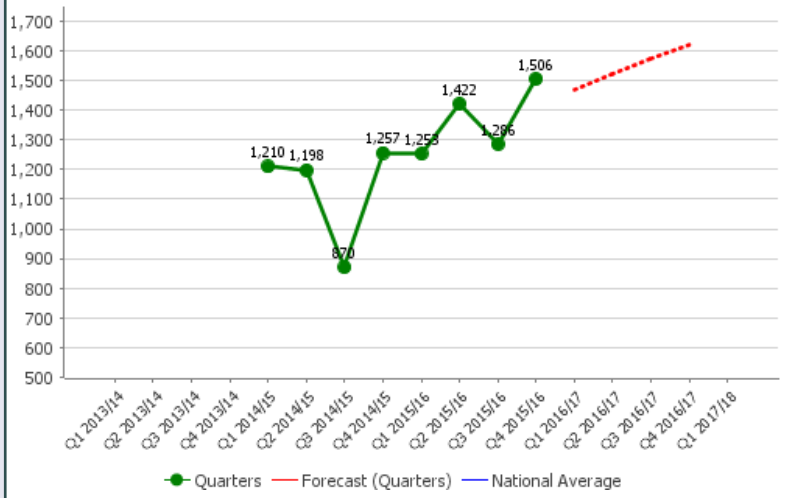
c) % of Adults Overweight or Obese



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



e) Number of people participating at DCLT Leisure Centres per 1000 population (includes multiple visits)



STORY BEHIND THE BASELINE

National Child Measurement Programme (NCMP) data will be available in November (Q3) hence there is no update around the NCMP for this quarter. Research is currently being undertaken around trends in NCMP data and a hotspot analysis is being undertaken and will be available in Q3. Letters from PHE were distributed to schools in Q2 indicating average rates of overweight and obesity in reception and Year 6 children across Doncaster schools. These results have been collated in a spreadsheet for the hotspot analysis alongside mapping of childhood obesity activity from the childhood obesity workshops held in Q1. The Tier 3 weight management service has been reviewed and a new pathway has commenced with a focus on pre-bariatric service. Contract meetings have commenced and the provider has produced a Q1 report indicating current uptake in the service.

NCMP Breakdown 2014/15: Proportion of cohort in each category (may not add up to due to rounding)

	Reception (aged 4-5)		Year 6 (aged 10-11)	
	National	Doncaster	National	Doncaster
Underweight (%)	0.96	0.8	1.42	1.22
Healthy Weight (%)	77.2	77	65.3	64.8
Overweight (%)	12.8	12.7	14.2	14
Obese (%)	9.1	9.5	19.1	20

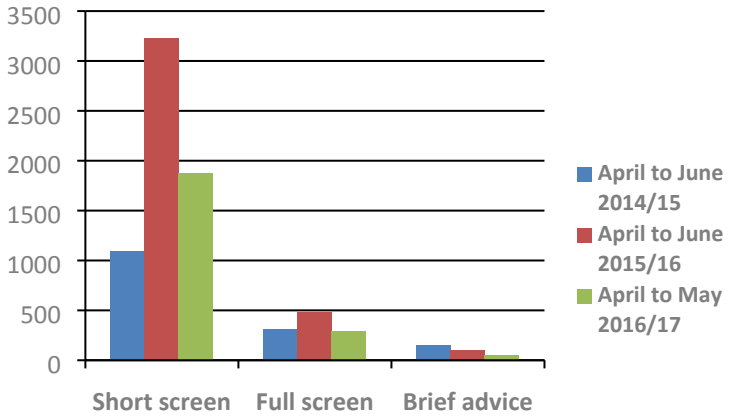
Research is currently underway around the areas of food insecurity and takeaways and will be available in Q3. An Obesity Alliance is currently being established and a draft work plan is also in development. Feedback will be available in Q3. Obesity 'map' in development. Ongoing work with planning/environment and Local plan looking at health policy and a whole system approach. Physical activity initiatives are ongoing including 'Let's Get Active/Move More Doncaster' etc. Review of healthy schools model taking place and links made with Let's get Cooking project in Q2. Further food policy conversations in the pipeline learning from good practice elsewhere e.g. London/Hertfordshire. A local food plan has been developed and will be distributed by Q3.

	Interim figures from the Active People Survey for a related target of 1 x 30mins of sport per week have shown a slight decrease in participation of 2.6%. However the interim results do not take into account the seasonality of sport and the potential uplift from summer activity when the full results are released in November /December. The 1 x 30mins indicator does not pick up activity such as walking and recreational cycling. The newly commissioned Move More Doncaster service for adults aged over 50 years began on the 1st April and has launched a Facebook page, website and had 36 residents accessing services. The Discover Lakeside Trail was launched on the 9th July. It uses QR code trails to help residents discover more about the area around the lake, giving a different way to enjoy the outdoors and local scenery. Residents can walk, explore, read and even answer questions that will help unlock fun and interesting facts. Systematic review of physical activity, leisure and sport has commenced entailing a review of Doncaster Active Partnerships and specialist adviser interviewing key decision makers and stakeholders to provide recommendations for the future. Two presentations to GPs on the benefits of physical activity delivered by Dr Chris Garnett on behalf of Public Health England and Clare Henry, Public Health	
ACTION PLAN	**What we will achieve in 2016-17**	**What we will do next period**
	1. Public Health are working in collaboration to address healthy food options; the work around proximity of takeaways and healthy food choices is underway and results will be provided when available. Two research studies are being undertaken around food takeaways and food banks. 2. Physical activity proxy measures through discount promotions are being explored. 3. The One You Campaign has been launched and a walking campaign is to be launched in September 2016. 4. NCMP Hotspot analysis. 5. Ongoing work around the development of health policies into the local plan. 6. The outcomes of the 3 childhood obesity workshops will inform the priorities and will enable the development of a Childhood obesity Alliance using a whole systems approach.	1. Obesity Alliance and work plan in place by Q3 2. Findings from NCMP hotspots analysis and food insecurity research available by Q3 3. NCMP data available in Q3 4. Food plan distributed by Q3 to key stakeholders 5. Ongoing work around local plan, food policy and PA initiatives 6. Whole Systems Approach to Physical Activity, Leisure and Sport Stakeholder Event 16th September. 7. Pre-site assessments for open spaces utilising 106 agreement money 8. Physical activity element of Healthy Schools Standards/Awards 9. One You campaign launched locally 10. Policies on active travel, green spaces, community facilities, urban design included in the Local Plan

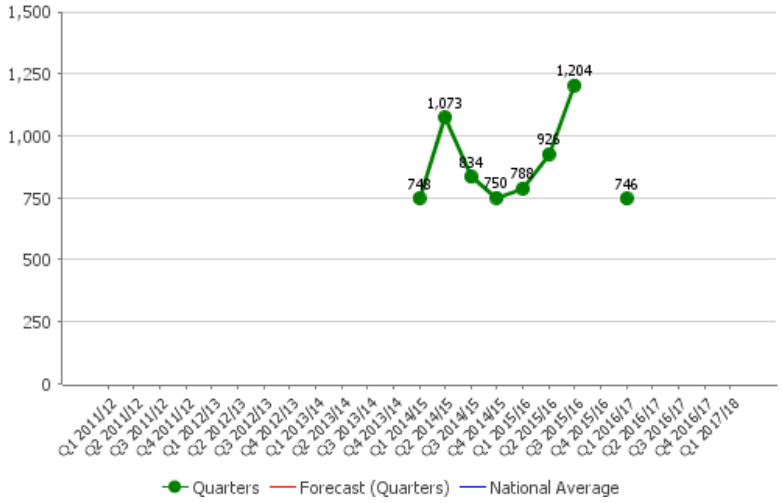
OUTCOME 2	All people in Doncaster who use alcohol do so within safe limits

INDICATORS

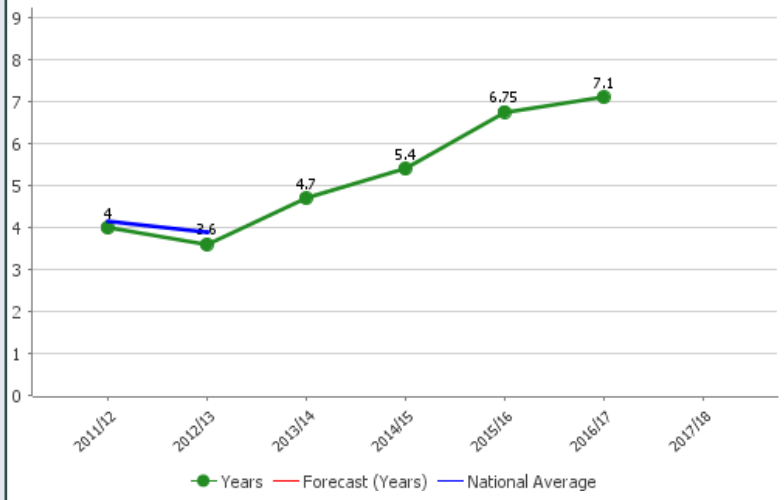
a)Numbers of people being screened for alcohol use and, where appropriate, receiving brief advice



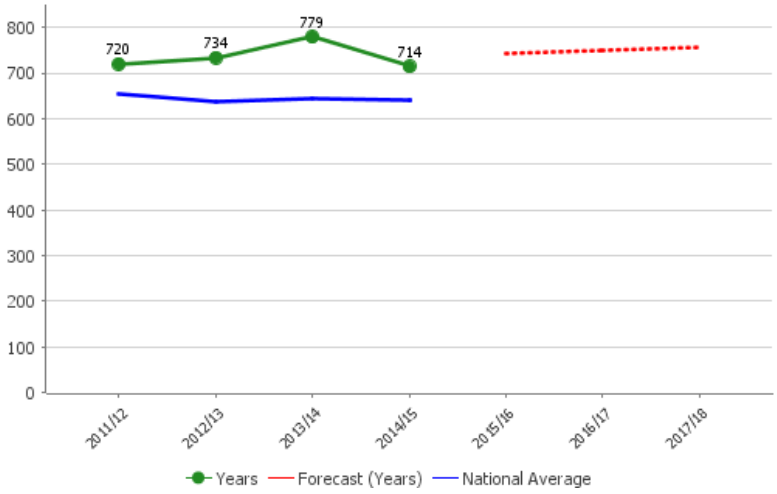
b) Alcohol-related attendance at A&E (Doncaster Residents)



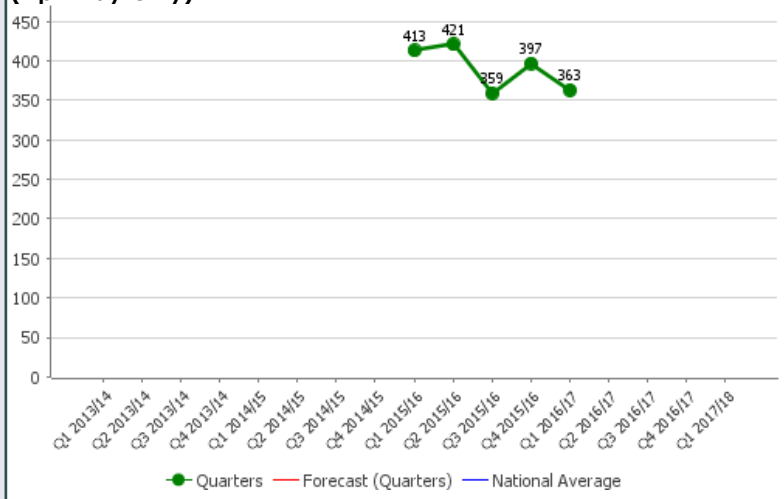
c) Alcohol-related violent crime per 1000 pop (2016/17 YTD Only)
[Beyond Control Limit Q1 2016-17]



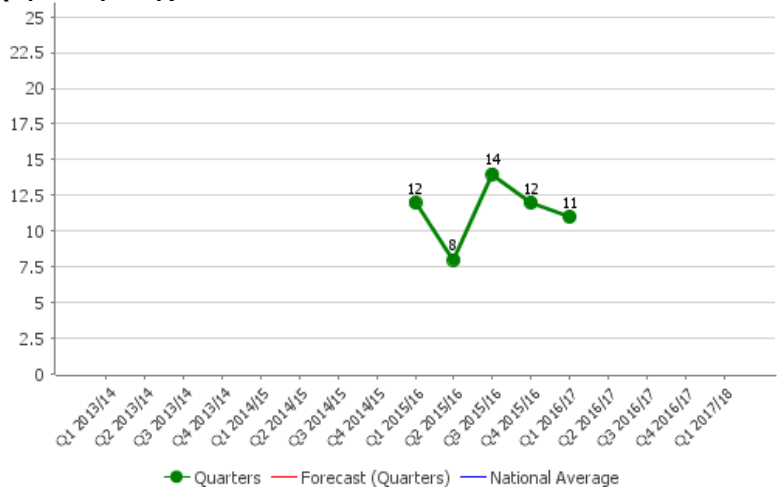
d) Alcohol related admissions to hospital



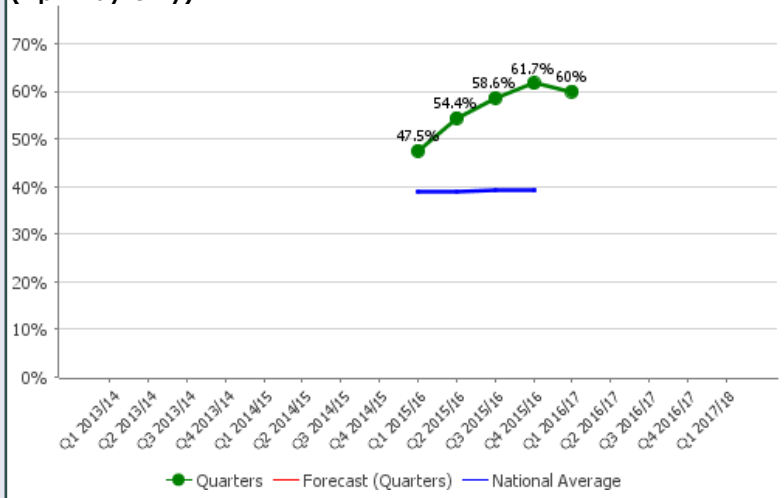
e) Number of people in specialist alcohol treatment (Apr-May Only)



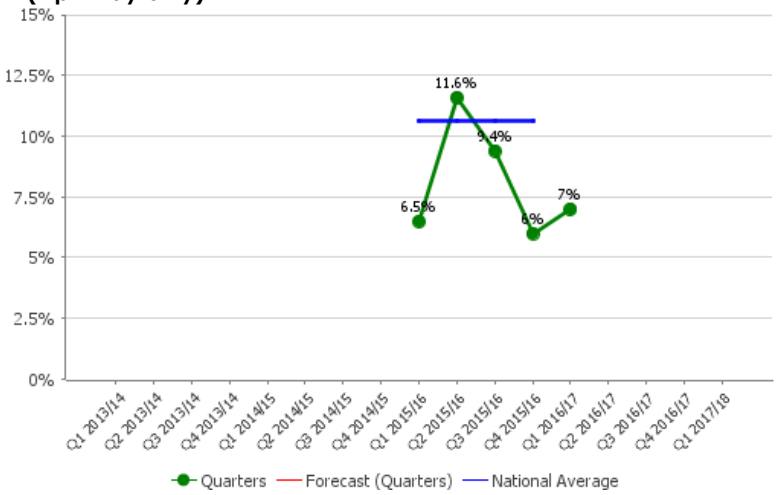
f) Number of people in specialist alcohol treatment entering via the CJS (Apr-May only)



g) Successful exits for people in specialist treatment (Apr-May Only)



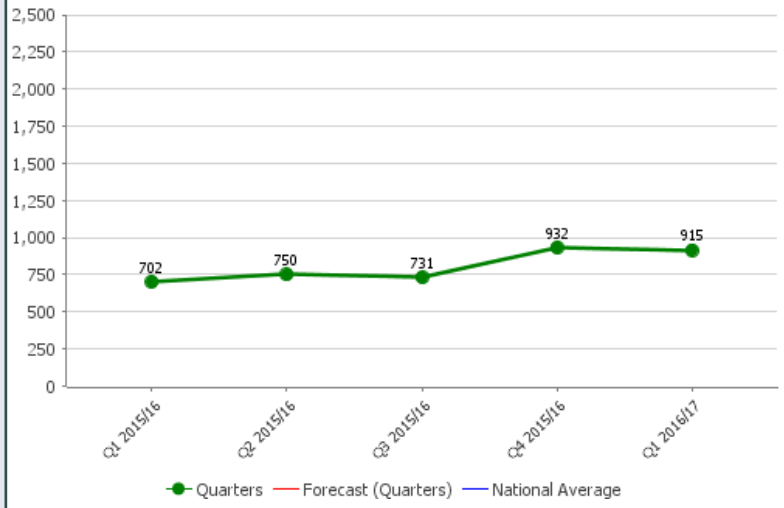
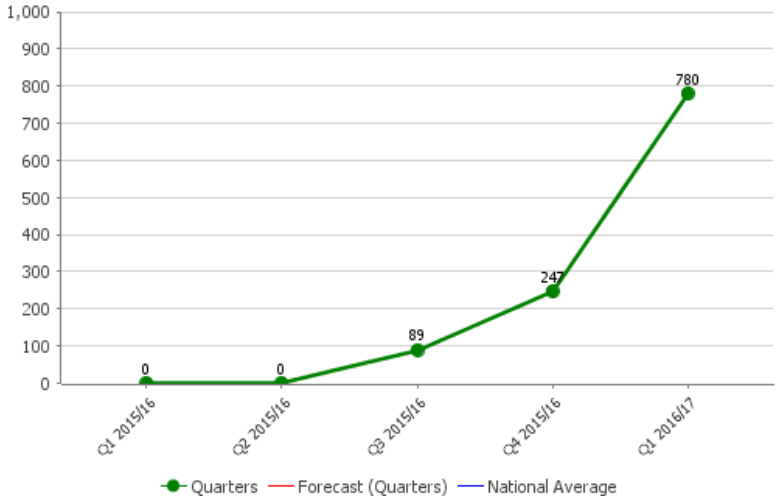
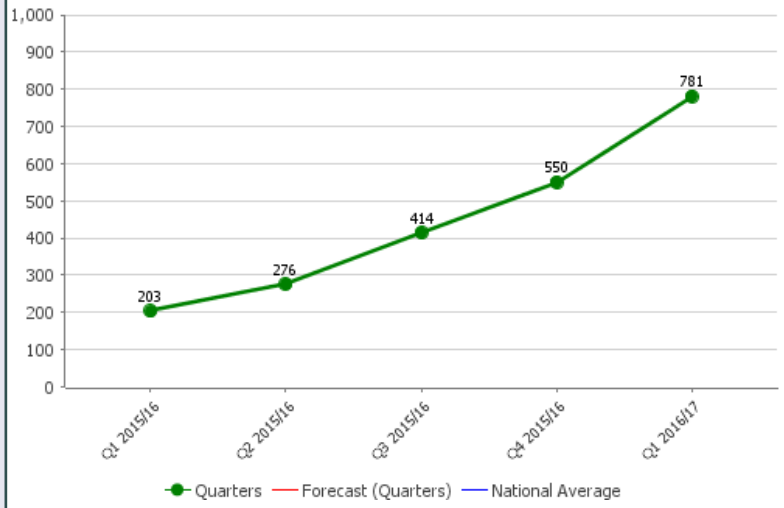
h) Representations for people in specialist treatment (Apr-May only)



STORY BEHIND THE BASELINE

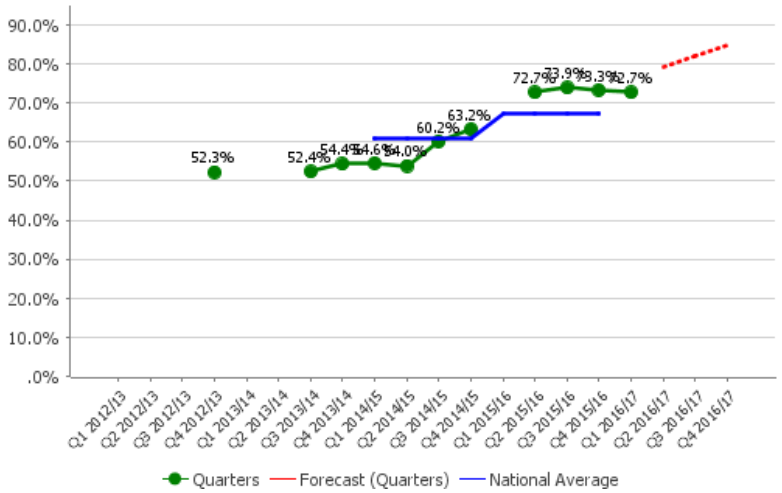
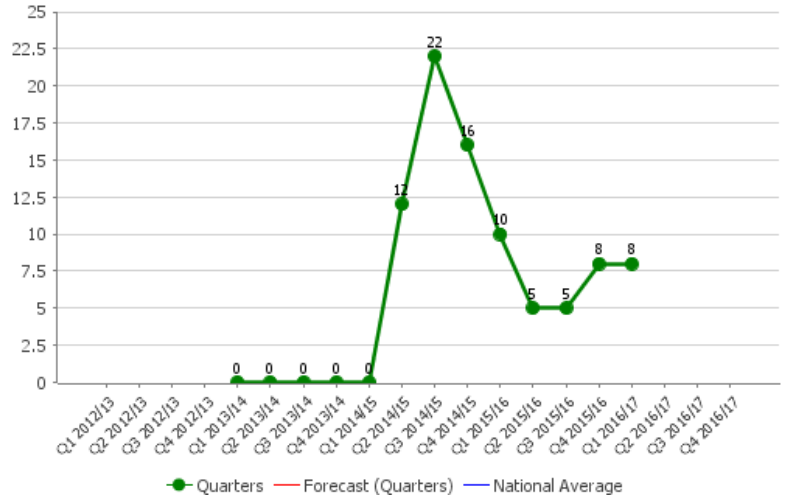
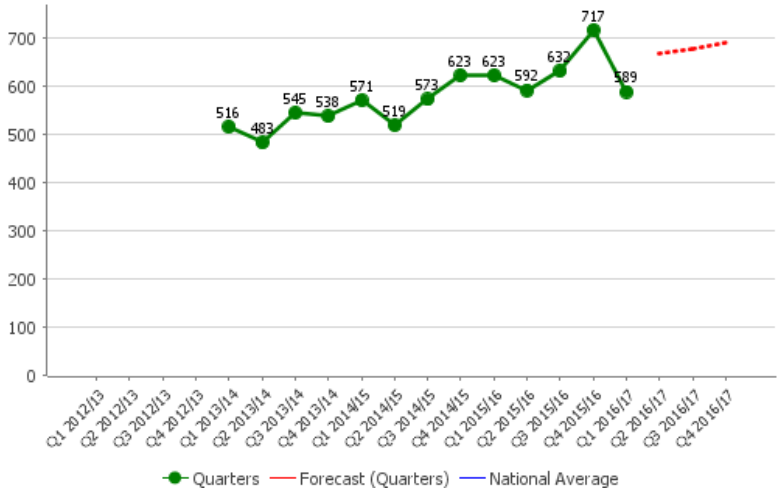
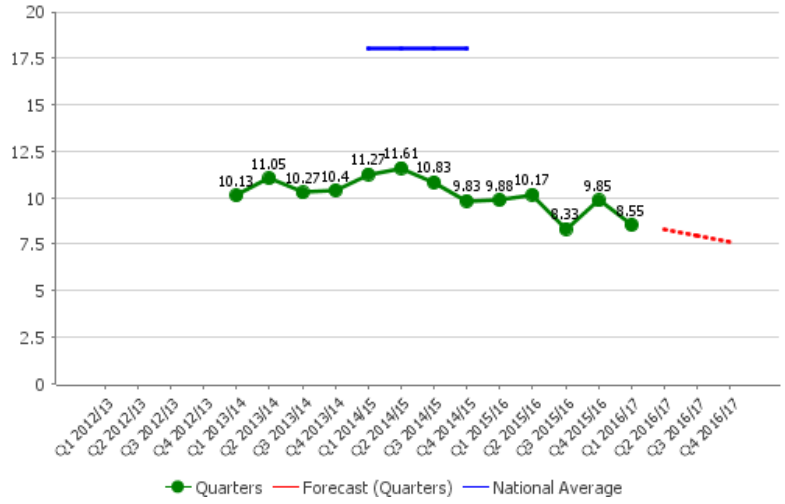
The number of people being screened for alcohol use is provided by ASPIRE (April & May data only) who are now managing the contracts directly and although some decrease in activity, it is planned that through liaison with the LMC more practices will sign up. The Latest data available for Alcohol-related admissions shows increases up to 2013/14 and consistently above the England average. The rate for 2014/15 has decreased much quicker than what has occurred nationally and there is a narrowing of the gap but Doncaster is still significantly worse than the national average. These admissions are primarily

	linked to cancer, unintentional injuries and mental/behavioural disorders. At present, there is no definition of alcohol-related violence within the National Crime Recording Standard (NCRS) or Home Office Counting Rules (HOCR), although there is guidance within the National Standard for Incident Recording (NSIR). (Latest available data) Alcohol-related crime has increased significantly from a low in 2012/13 and continues to do so. The number of attendances at A&E related to Alcohol is broadly similar in Q1 16-17 as it has been in the same period for the previous two years. The numbers in specialist treatment have remained relatively stable over the past 12 months. There are estimated to be approximately 5,600 dependent drinkers in Doncaster therefore the aim is to increase the number of people accessing services. The Numbers entering via the criminal justice system (CJS) are low and the aim is to increase the numbers entering via this pathway (as a benchmark the Probation Service historically targeted 80 service users per year). This decrease may be a result of changes in the CJS, reducing the number of Alcohol Treatment Requirements (ATRs) issued by Magistrates (e.g. less use of alcohol conditional cautions, the reorganisation of probation into the National Probation Service and Community Rehabilitation Companies).	
ACTION PLAN	**What we will achieve in 2016-17**	**What we will do next period**
	1. Work with GP practices to expand and improve screening and interventions from this year to next, delivered via RDASH/Aspire subcontract. 2. Learn from the evaluation of the Community Alcohol Partnership (CAP) in Askern, Campsall and Norton. The model was expanded to Conisbrough and Denaby in November 2015. CAP is a partnership approach to address underage sales and antisocial behaviour. Utilising communities and addressing underage consumption will be key in the future. 3. Make greater use of campaigns to raise public awareness and influence attitudes to alcohol in the population. Fixed national dates include Alcohol Awareness Week and Dry January while local campaigns will likely include topics such as alcohol and cancer, alcohol in pregnancy, alcohol and older people and the link between alcohol and house fires. 4. Improve the referral pathway between hospitals and the treatment system and enhance the identification and support to people repeatedly attending A&E or admitted to wards. Alcohol Concern defines these as 'Blue Light' clients - people who become vulnerable and isolated so that emergency services are their only source of support. Similarly there are vulnerable people, including alcohol misusers, who revolve through the Criminal Justice System. 5. Increase public and professional awareness re alcohol and older people through partnership with services which work with older people. A leaflet and poster campaign has been produced and distributed across Doncaster highlighting the increasing issue. The pathway between dementia services and alcohol services will be looked at following on from an Alcohol Related Brain Injury seminar at DRI held on the 24th of May. Subsequent meeting has been arranged for September for commissioners and clinicians and service managers to look at more joint working and pathway. 6. Continue to look at the feasibility of a 'safe haven' via the development of a business case and potential piloting of the intitiative.	1. Monthly monitoring of exits and representations. 2. Mobilising the new recovery system around the lead provider (RDASH) from 1April 2016 3. Continuing to monitor and screening and brief interventions through GP practices contracted via RDASH from 1April 4. Delivering public awareness campaigns and planning for the year. 5. Promotion of 'age well drink wiser' highlighting alcohol and older people 6. Meeting with commissioners and clinicians in September following on from Alcohol Related Brain Injury seminar to look at pathway and closer working together 7. A leaflet specifically for dependent drinkers called 'Dying for a drink' has been produced and distributed to A&E and DRI, custody suite and other areas 8. Discussions with management at A&E re appropriate referral pathway into services 9. Look at the feasibility of a 'Safe Haven' in Doncaster Town Centre on Saturday nights to 'treat' people with alcohol related issues/harm to alleviate pressure on emergency services and DRI 10. Launch a film and promotional campaign highlighting alcohol and fire safety in the home across the South Yorkshire area 11. Assisting the Town Centre Management and the Mayor with working to address the homelessness, begging and ASB

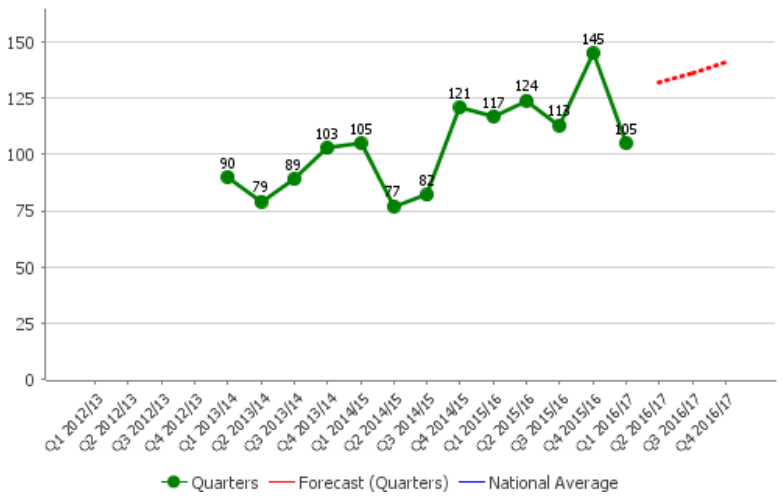
OUTCOME 3	**Families who are identified as meeting the eligibility criteria in the expanded Stronger families programme see significant and sustained improvement across all identified issues.**
INDICATORS	**a) Number of Families Identified as part of the Phase 2 Stronger Families Programme**  **b) Number of families achieving positive outcomes through the Stronger Families Programme**  **c) Number of Families Engaged in the Expanded Stronger Families Programme** 

STORY BEHIND THE BASELINE	Our current total of identified and validated families is 915. During Quarter 1 a full review has taken place to verify the baseline assessment against the eligibility criteria for every family. When families are first identified (either from data sources or via referral from services) initially not all families issues may be known and therefore following a whole family assessment the baseline criteria becomes the basis for which progress and resulting claims are measured against. During this review exercise it was noted that some families previously on the cohort did not in fact meet 2 or more of the required criteria, therefore resulting in them being removed from the Stronger Families list also as anticipated families moving out of the area or not constituting a family unit as expressed in the Financial Framework, were also removed. This has impacted on the previously reported figures which have been retrospectively adjusted following this verification back to the start of the Expanded programme (Quarter 1 2015/16). The current outturn of 915 families as being identified as being eligible is slightly below the Quarter 1 target however from the annual identification process there are approximately 250 additional families to be allocated to teams, if the additional identified families were taken into account they would have taken us over the profiled target for this quarter. Plus as part of the ongoing service transformation and families being identified via the Early Help Hub evidence suggests that this will provide further families We are currently engaged and working with 781 families who meet 2 or more of the eligibility criteria which is on target. We expect the target for the remainder of the year to be met by existing eligible families who are yet to be engaged with, a cohort identified through the data match process plus the families that are currently been identified and assessed through the Early Help Hub. The next claim is in September 2016 and results will be reported in Quarter 2 2016/17. While Claims may only be made for sustained and significant progress against all assessed outcomes, or, continuous employment, progress against individual outcomes has been made by many families. This total represents counts of individual progress against outcomes and not individual families. Therefore a family can be counted under more than one outcome so this does not relate to 780 individual families. The latest progress is: Outcome 1 (Crime & ASB): 214 Outcome 2 (Children Attending School): 94 Outcome 3 (Children Needing Help): 148 Outcome 4 (Worklessness & Financial Exclusion): 201 Outcome 5 (Domestic Violence): 56 Outcome 6 (Health): 67

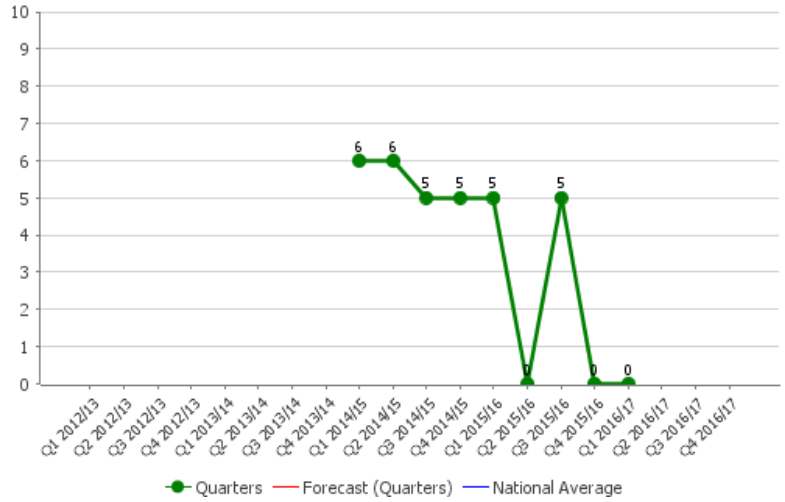
	What we will achieve in 2015-16	**What we will do next period**
ACTION PLAN	1. To identify as many families who meet the criteria as we can 2. Implement the case management system to allow for easier case management , tracking and progress reporting 3. Commission services needed by families following evaluation of the SF programme. 4. Train multi-agency staff in working with families, 'early help' assessment and case management system inputting.	1. Implement 'Go live' of EHM system 2. Prepare for September 2016 claims 3. Train staff in Signs if Safety processes 4. Review areas to be commissioned / where there are gaps.

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

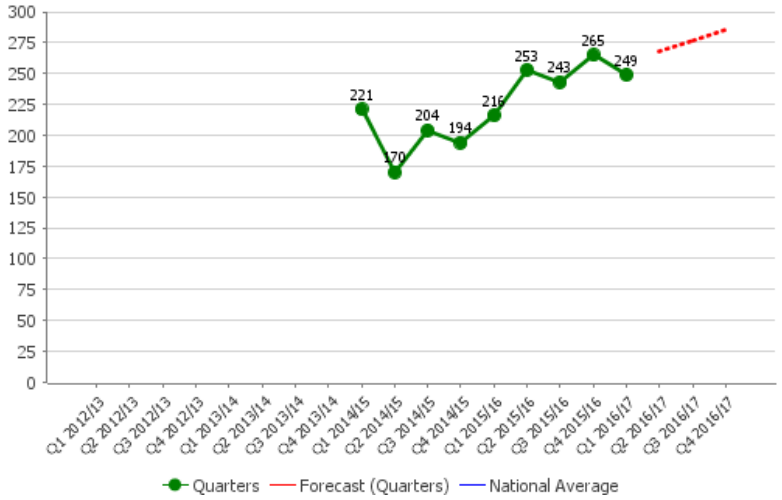
e) Hospital re-admissions within 30 days (DRI) for people with Dementia



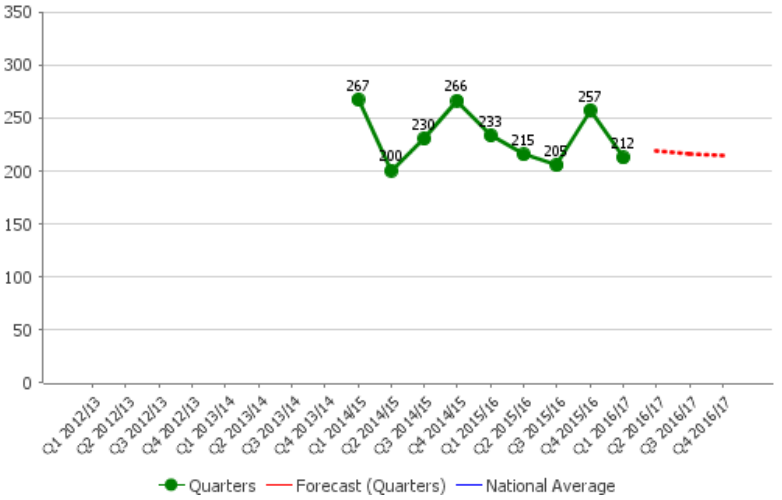
f) Number of patients having any delayed discharges at RDaSH



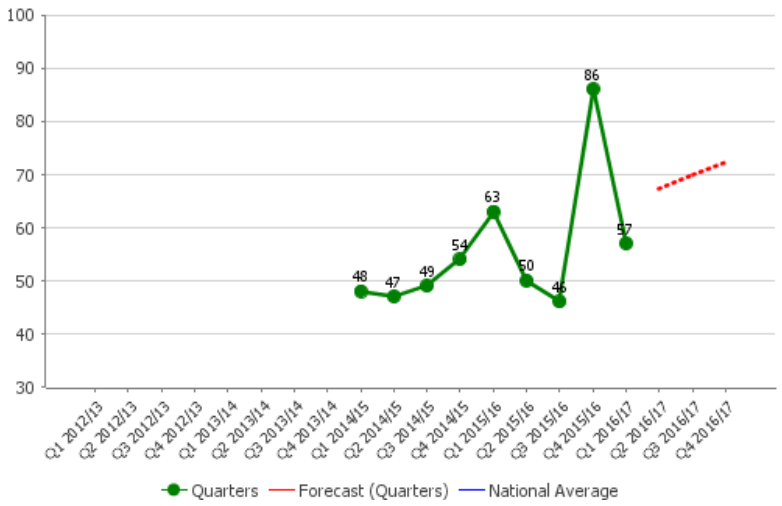
g) Attendances at A&E for people with dementia



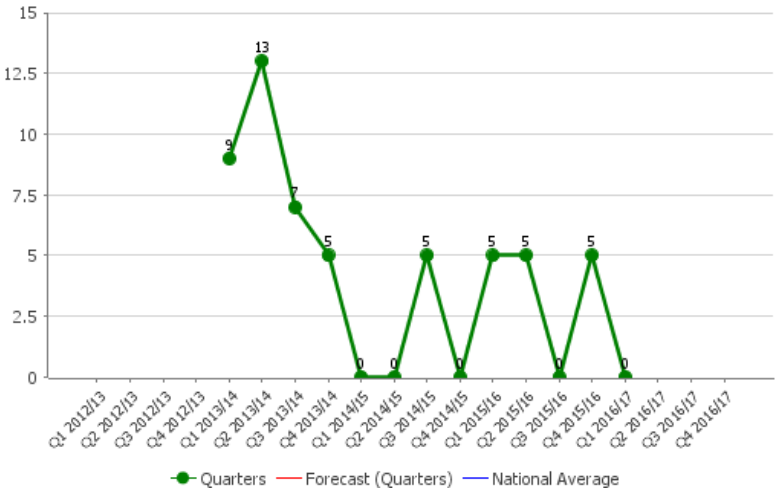
h) Number of people with dementia being admitted from care homes to DRI



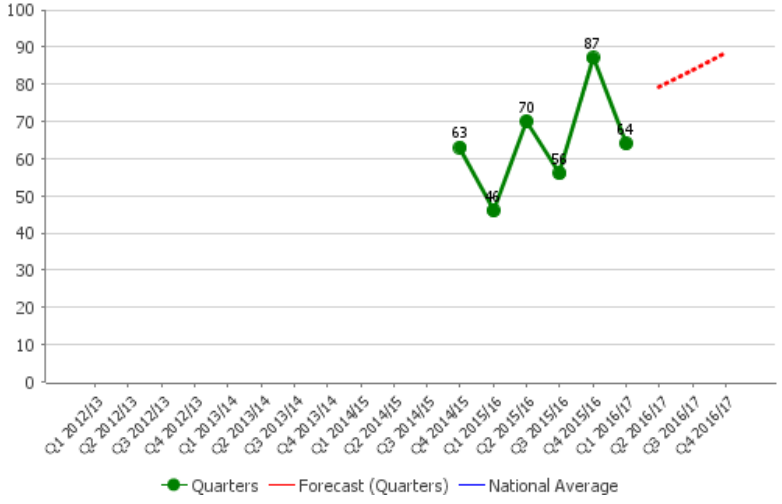
i) Number of Hospital deaths for patients with dementia



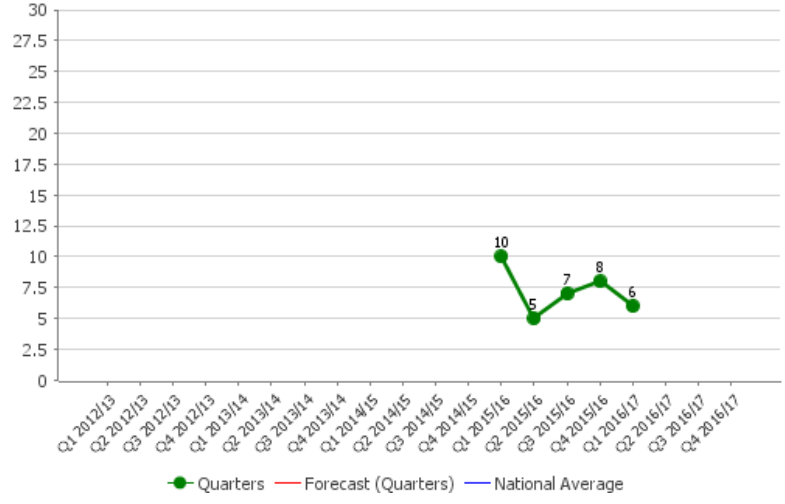
j) Unplanned episodes of Respite for people with Dementia



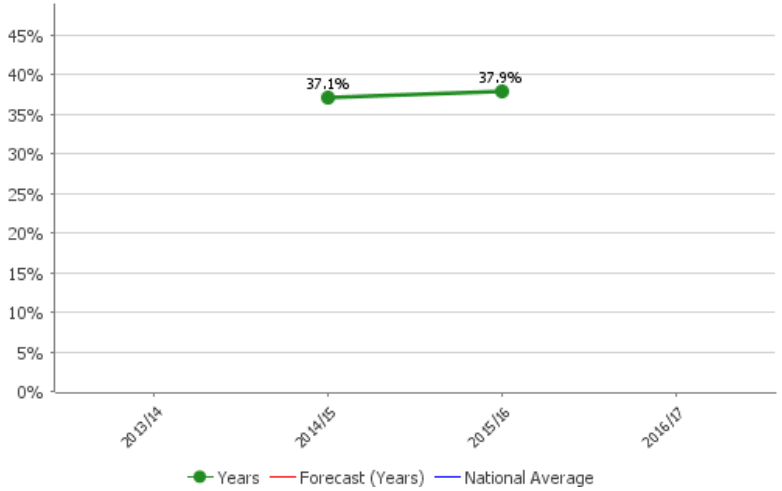
k) Number of installations for Assistive Technology that are for people with Dementia



l) Number of safeguarding referrals involving people with a PSR of Memory & Cognition



M) Proportion of People who access social care services and have a PSR of Memory Support & cognition living at home



STORY BEHIND THE BASELINE

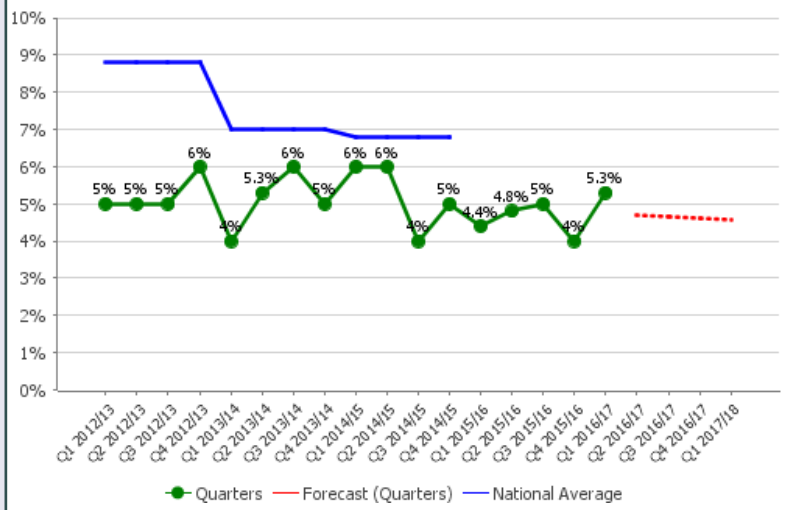
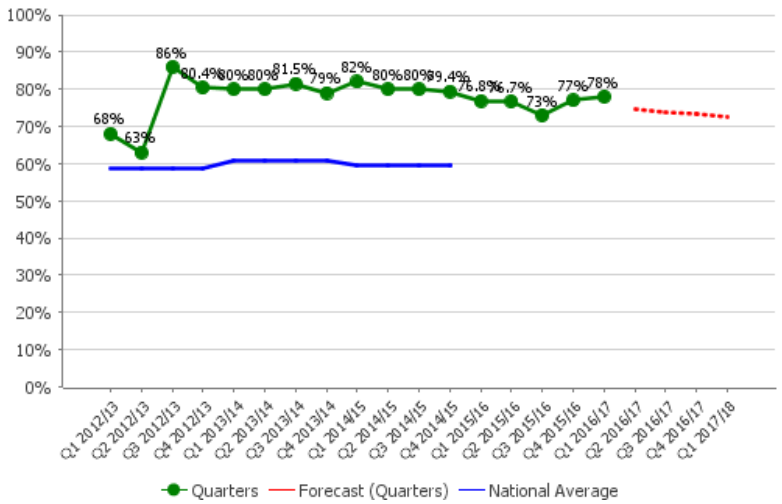
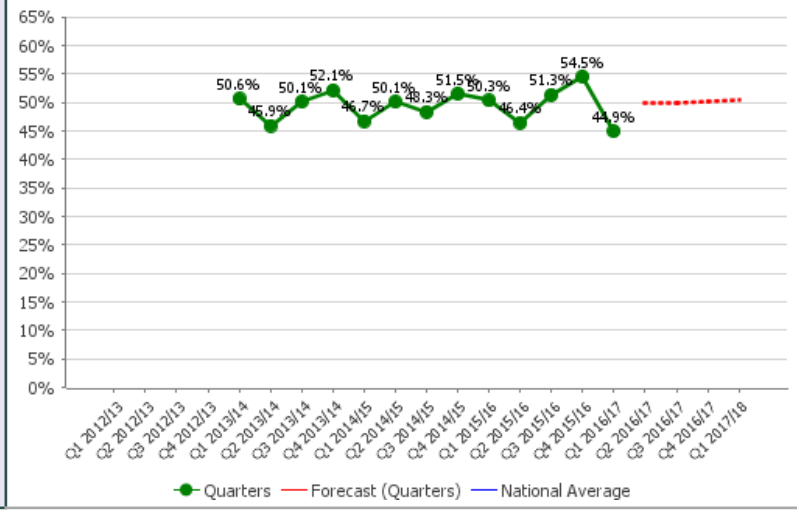
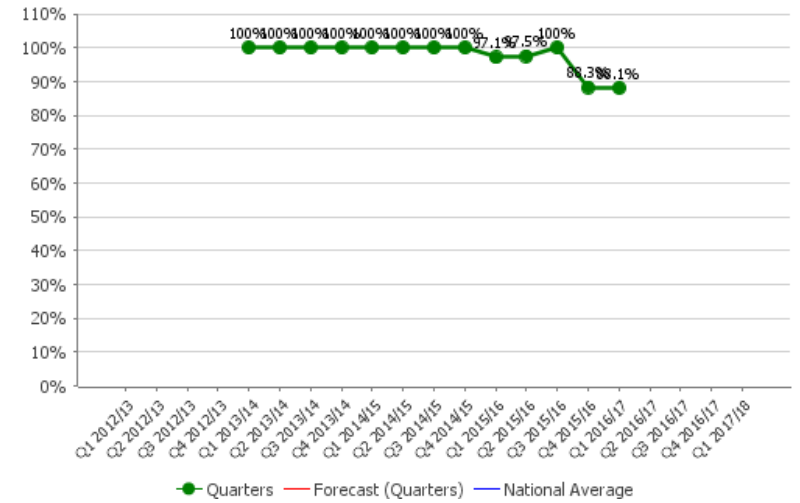
The measures capture the strategic direction of earlier and improving diagnosis rates, reducing inequalities and supporting people to live well with dementia by preventing crisis and helping people to be in control of their lives. Doncaster's dementia diagnosis rate is now well over the national ambition of 67% and above the National and Regional average. Doncastrer's diagnostic rate is 72.7% for people aged 65 + leaves an unknown gap of 1108 (All ages) By being able to identify people with dementia results in 2 key outcomes; firstly it enables people with dementia and their carers to access the right services and support and secondly assists commissioners to identify more accurately activity in the health and social care system so improvements can be made.

The measures that saw a spike in Q4 have mostly returned to levels seen during the rest of 2015-16, in particular the amount of admissions for people with dementia has reduced in Quarter 1 by 128 in comparison to the previous quarter. Of the 589 admissions 523 were non elective, with 13 of the patients also having a diagnosis of Parkinson's Disease. The number of assistive technology installations is down on the Q4 figure but generally the trend is increasing.

ACTION PLAN

What we will achieve in 2016-17	What we will do next period
For 2016/17 the action plan will address the 5 Key Areas of Focus as presented in Dementia Strategy for Doncaster, Getting There, launched in March 2015. These are: • Raising Awareness and reducing stigma – Information, Advice and Signposting, • Assessment and Treatment, • Peri and Post Diagnostic Support, • Care Homes • End of Life.	1. Continue with the post diagnostic support pilot the 'The Doncaster Admiral Service. 2. Launch and promote "Dementia Prevention" leaflet. 3. Commence research project using technology with people with dementia. 4. Pilot a standard set of Outcome Tools for the dementia pathway with providers. 5. Commence HEE Tier 2 workforce training across relevant sectors (DBH, RDaSH & Care Homes)

	This will ensure we build on the success of 2015/16 but also address identified gaps and areas for improvement. This year the people of Doncaster will be able 1. to access reliable and consistent dementia information and support in a timely manner; 2. there will be reduced variance in assessment and treatment pathways ensuring every referral receives an equal, timely and effective response; 3. there will be an integrated and co-ordinated support pathway/service for people with dementia and their carers/families before and after diagnosis; more people will live at home with dementia and be in control of their life/care, delaying the need for possible residential care ; 4. when people with dementia need residential care they receive high quality care locally 5. people with dementia will die with dignity and in a place of choice through planned empowerment.	

OUTCOME 5	**Improve the mental health and well-being of the people of Doncaster ensures a focus is put on preventive services and the promotion of well-being for people of all age's access to effective services and promote sustained recovery.**
INDICATORS	**a)Proportion of adults in contact with secondary mental health services in paid employment** 
	b) Proportion of adults in contact with secondary mental health services living independently, with or without support 
	c) Proportion of People Completing Treatment and Moving to Recovery 
	d) CAMHS: % of referrals starting a treatment plan within 8 weeks 

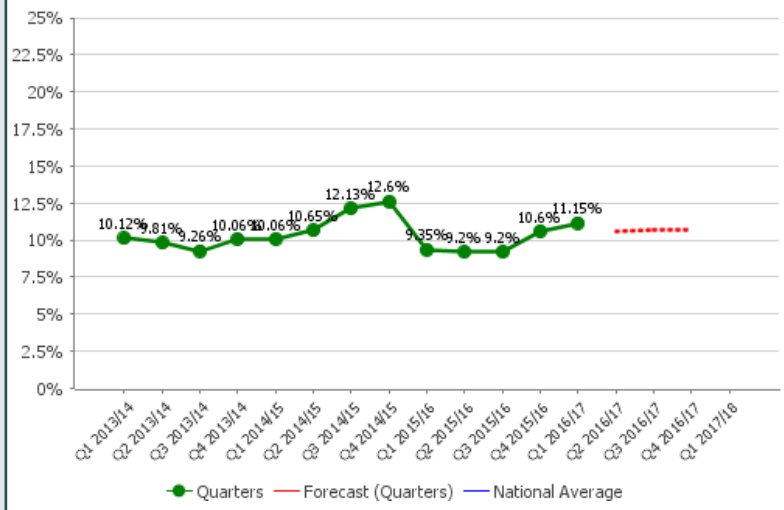
STORY BEHIND THE BASELINE	Indicator A: The initial indicator provided us with information to understand how people were accessing employment and/or training opportunities. We need to expand this to include an audit to understand how providers are supporting people to access employment activities that may not be paid but builds resilience and confidence. Indicator C: Although we are below our 50% target at Q1, supportive measures such as reliable improvement are around 65% which is above England average. This demonstrates how the service is overall working with clients to achieve personal outcomes and working towards recovery. The CCG and RDASH are working on an action to monitor the activity and work to make improvements to the service as required. Indicator D: Performance is being reviewed around this area to identify the reasons for breaches, underperformance and any potential actions which could be implemented. Quarterly meetings are held between the provider (RDASH) and the CCG to discuss all the services provided by CAMHS and any issues arising

	What we will achieve in 2016-17	**What we will do next period**
ACTION PLAN	1. Continue to implement the recommendations of the Mental Health Review and by doing so, support the delivery of the National Mental Health Agenda – 5 Year Forward View for Mental Health Continue the development and implementation of the Mental Health Development. Programme and pathway redesigns – 3 year development programme (currently in year two) a. Delivery of the Crisis Care Pathway b. Review in-patient care and community teams to ensure capacity to meet the needs, including collaboration with substance misuse service commissioning c. Refresh of the Suicide Prevention Action, Building Emotional Resilience 6. Collaborate with Public Health to ensure that the Joint Strategic Needs Assessment has a strong focus on mental health and physical wellbeing. 3. Implement the local Crisis Care Concordat Action Plan with regular progress reports to the Health & Wellbeing Board	1. Present the Summary Progress Report on the Doncaster Crisis Care Concordat Action Plan to the Health & Wellbeing Board and response to the 5 Year Forward View for Mental Health (DoH 2016) 2. Redesign of the Eating Disorders pathway which will be combined with the new children's planning guidance for improving access for young adults to rapidly access Eating Disorder services locally 3. Redesign of the Attention Deficit Disorder pathway for young people in transition to adult secondary care services and support general practice to manage people in the community who have ADHD 4. The National Guidance for improved Access to Early Intervention in Psychosis has been published and Doncaster CCG will be working with RDASH to improve access response to 2 weeks from referral. 5. Support the development of a Psychiatric Liaison Service between RDASH and DBHFT. 6. Develop IAPT services to support people with enduring mental health issues (IAPT Plus)

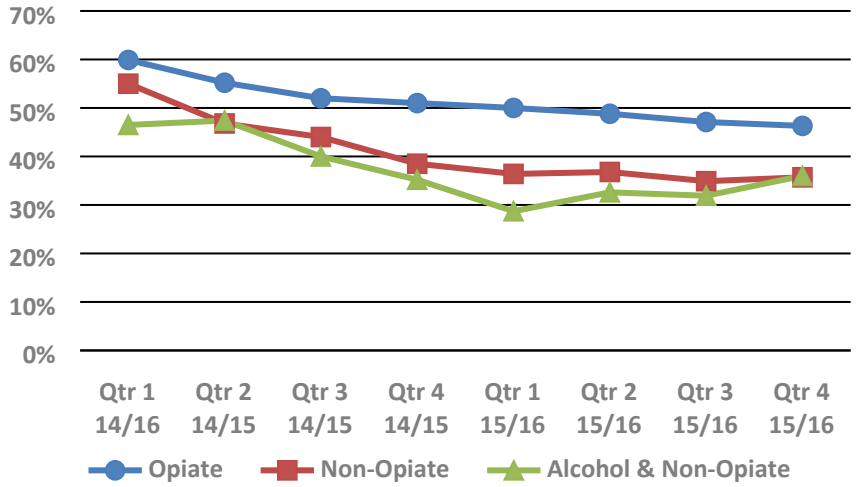
OUTCOME 6	Reduce the harmful impact of drug misuse on individuals, families and communities.

INDICATORS

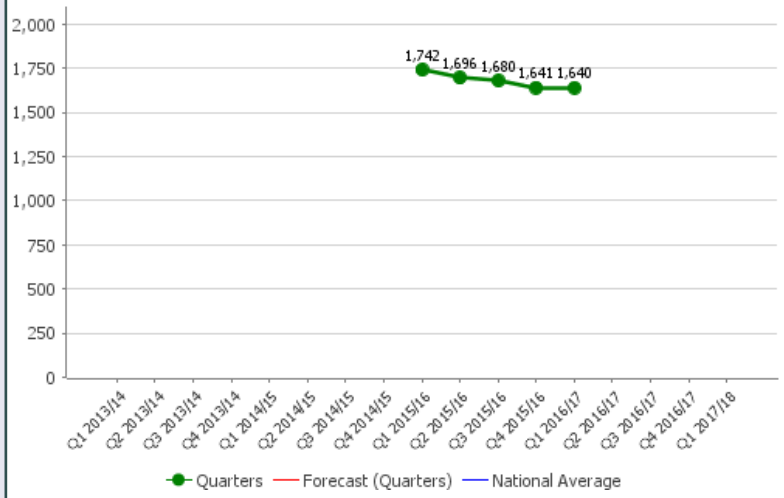
a) Proportion of all in treatment, who successfully completed drug treatment and did not re-present within 6 months (Opiate & Non Opiate)



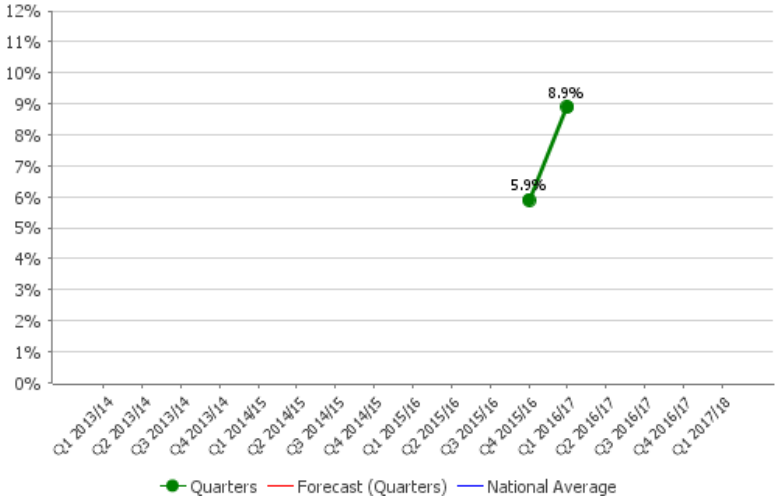
b) The proportion of clients in treatment who live with children



c) Number of People in Treatment (Opiate and Non Opiate)



d) Re-presentations to drug Treatment



STORY BEHIND THE BASELINE	There has been an improvement in the performance of people who successfully completed drug treatment and did not re-present within 6 months since Q4 15/16. Performance is slowly improving for the non-opiate group, but opiate users have not improved performance. Some of the reasons why this is, may be due to lack of recovery capital and complex needs of this client group such as aging opiate users who are somewhat 'stuck' in the treatment system. An action plan with number of opiate user discharges needed at a keyworker level has been developed and agreed with the provider. This indicator is linked to 2.5% of the annual contract value (top quartile performance to be achieved). The 14% target is an average of performance for Opiate and Non-Opiate and currently stands at 11.15%. Non-Opiates are performing in the Top quartile range at 50.7% whereas the Opiate group is performing at 1.3% below the Top quartile range. It could be argued that a decrease in number of clients in treatment who live with children is preferable. However, due to the protective nature of treatment and support, an increase in number of clients in treatment is still a positive outcome for the families affected. Latest available data is Q4 15/16. We are aiming to increase the proportion of non-opiate users into the treatment system relative to the number of opiate users over the 4 year period of the whole system contract. There is national evidence that numbers of younger (i.e. under 25 years) opiate users is falling, and new drug trends are emerging (New Psychoactive Substance, club drugs, Image and Performance Enhancing Drugs, Over The Counter medication). There is an ageing population of opiate users in the treatment system that has complex health needs that need to be met. Representations of people in drug treatment continue to perform better than target, although there has been an increase from Q4 15/16. We are working on a measure on drug related crime and offending which should be available in future performance reports.

	What we will achieve in 2016-17	**What we will do next period**
ACTION PLAN	1. Mobilisation of new whole system model delivered by Aspire from 2. A Hidden Harm Strategy is being developed for Doncaster jointly owned by key strategic partners, overseen by the H&WBB with an action plan due to be delivered in 2016/17. 3. Targeted awareness/prevention/education campaign is being devised across Doncaster 4. A new specialist needle/syringe exchange provision has opened across the Aspire service, including phased implementation at community hubs	1. Mobilisation of new whole system model delivered by Aspire from 1st April 2016. Monthly operational group meetings are taking place in order to monitor the developing service. 2. A Hidden Harm Strategy is being developed for Doncaster jointly owned by key strategic partners, overseen by the H&WBB with an action plan due to be delivered in 2016/17. 3. A targeted IPED awareness/prevention/education campaign is being devised targeting gyms across Doncaster 4. A new specialist needle/syringe exchange provision has opened across the Aspire service, including phased implementation at community hubs

Doncaster
Metropolitan Borough Council

Doncaster Health and Wellbeing Board

Agenda Item 7
1 September 2016

Subject: Dementia

Presented by: Joint Dementia Team

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

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

How will this contribute to improving health and wellbeing in Doncaster?
Dementia is intrinsically linked to age. With a growing and ageing population and increasing diagnosis rates supporting people with dementia and their families to live healthily, safely and independently will contribute to the overall wellbeing of Doncaster.

Recommendations
The Board is asked to:- Note progress, note current and impending challenges to further success and engage with the areas highlighted where Board members can help Doncaster do better regarding dementia.

This page is intentionally left blank

Health and Wellbeing Board (HWB)
1st September 2016
Doncaster and Dementia

Introduction

This one page brief is designed to accompany the dementia related agenda item and associated presentation. The objective of the presentation is to inform and engage members with the progress made and the challenges faced from a dementia perspective using the following three headlines:

- What's gone well?
- What's not gone so well?
- How can the HWB help to enable us to do better?

The presentation will provide a summary of progress but a detailed and comprehensive "2015/16 Progress Report" can be found on Doncaster's Dementia Roadmap along with all other relevant documents; See http://dementiaroadmap.info/doncaster/wp-content/uploads/sites/15/Dementia-Report-v.11.pdf

The dementia pathway

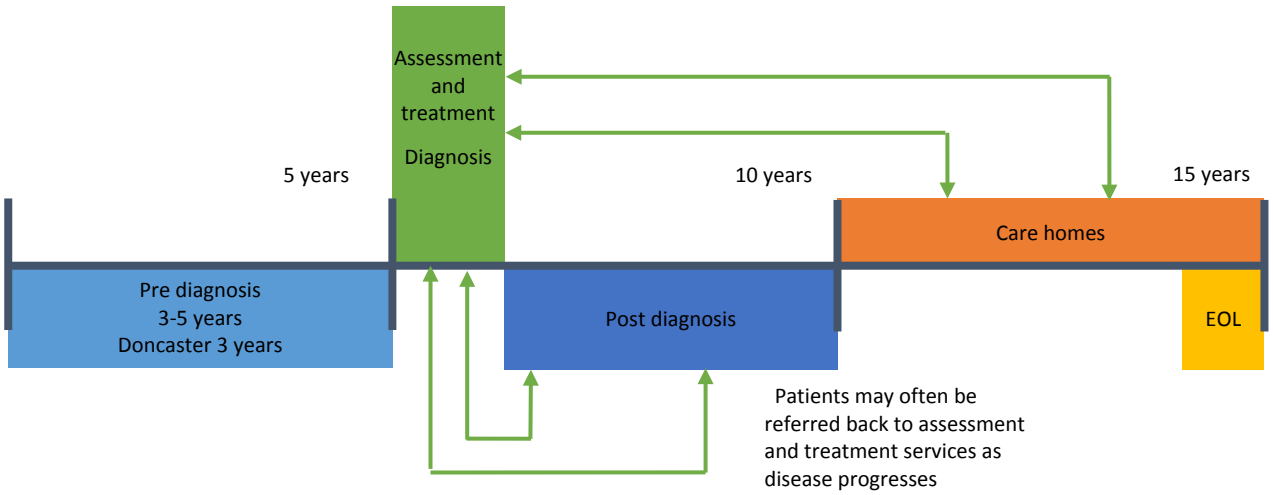
The dementia pathway can be difficult to understand due to the complexities of the disease. Any approach has to consider not just issues surrounding the patient but also the carer and family, the community and the many services involved in caring and supporting the person with dementia. A short animated video will be shown to commence the dementia presentation to assist the understanding of the dementia pathway. Dementia does not have a linear pathway but like many other life limiting illnesses and long term conditions, it does have a start and an end. The purpose of our Dementia Strategy is to improve that pathway "*adding years to life and life to years*".

Outcomes and experience

There are many types of dementia, with varying lengths of disease progression, affecting people in different ways. The time lines below illustrate where Doncaster was pre Strategy and where we hope to be post Strategy.

In 2013 the Doncaster Dementia Diagnosis rate was as low as 52%. Too many people were dying without a diagnosis and, if they did receive a diagnosis, it was often too late. The diagnostic pathway was variable resulting in inconsistent experiences, which often involved lengthy waits. Without a diagnosis, access to services was limited often resulting in a crisis situation involving the person with dementia and/or the carer, admission to residential care and the potential for an undignified and unprepared death.

Pre Strategy Pathway



Post Strategy Pathway – the vision

The time frames are a guide and represent an ageing and growing population being healthier. However, the key difference to note for the dementia pathway pre and post strategy is people will be:

- Diagnosed earlier and quicker
- Live independently at home longer (including EOL where appropriate) post diagnosis.
- If residential care is required it is for needs rather than circumstance and will include EOL as necessary.
- Returns to acute care are avoided/reduced.

To deliver the post Strategy pathway, work has been divided into five Key Areas of Focus with the following objectives:

- to raise awareness, increase understanding and reduce stigma so people who may be experiencing symptomology are supported and offered the opportunity to receive a diagnosis at the earliest opportunity.
- to deliver a diagnostic assessment and treatment process that is consistent and effective resulting in a timely diagnosis that is delivered sensitively and with the offer of on-going support.
- to deliver post diagnostic supported to enable people with dementia and their families to live well.
- to ensure If and when residential care is necessary, this should be the last resort and that the care received will be of high quality.
- to ensure End of Life is planned, empowering the person with dementia to be in control as soon and for as long as possible, promoting a dignified death in a place of choice.

The Presentation

The presentation will summarise the progress made and the challenges to face in delivering against the Strategies Five Key Areas of Focus and the objectives above.

Other associated success and challenges will be presented before concluding with some key points for the HWB members to acknowledge and consider enabling partners “to do better”. Improving the pathway of course, has consequences, the key consequence being the need for resources to “follow the patient” and have a community focus.

It is hoped that this brief will enable members to attend the meeting on the 1st September with an understanding of where Doncaster was, is now and where we could be in the future regarding dementia. We hope that this will prompt effective debate and discussion and ultimately action so continued and sustainable improvements can be made for people with dementia and their families.

Doncaster Dementia Team
August 2016

Doncaster
Metropolitan Borough Council

Doncaster Health and Wellbeing Board

1 September 2016

Subject: Hidden Harm Strategy

Presented by: Andy Maddison & Kirsty Thorley

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

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

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

In 2003, The Advisory Council on the Misuse of Drugs (ACMD) produced a report considering the negative consequences of parental drug misuse on children and young people. It highlighted that often the children were unidentified by services and therefore appropriate support was not offered. The report described the adverse consequences for the children as multiple and cumulative in nature, varying according to age, stage of development and the level of protective factors within the wider environment.

By providing the right help at an early stage and by recognising the needs of the whole household we will reduce the need for more intensive intervention at a later stage leading to better outcomes for children and their families.

Recommendations
The Board is asked to:- Provide governance and hold to account those partners integral to the success and implementation of the strategy.

Doncaster Hidden Harm Strategy Drug and Alcohol Misuse in the Household

2016 - 2019

3 year strategy to identify, support, safeguard and improve the health and well-being of families where there is drug and alcohol misuse.

Introduction

In 2003, The Advisory Council on the Misuse of Drugs (ACMD) produced a report considering the negative consequences of parental drug misuse on children and young people. It highlighted that often the children were unidentified by services and therefore appropriate support was not offered. The report described the adverse consequences for the children as multiple and cumulative in nature, varying according to age, stage of development and the level of protective factors within the wider environment.

The most recent biennial analysis of serious case reviews undertaken by Brandon et al published in 2012 relates to the period 2009-11. Analysis of the prevalence of parental substance misuse indicates that it was a feature for 42% of families; with a context of drug misuse in 29% of families and alcohol misuse in 27% of the cases. In some families there was misuse of both alcohol and drugs. In 22% of cases substance misuse co-existed with domestic violence and mental ill health. (New Learning from Serious Case Reviews: Brandon et al 2012).

According to the Department for Education's Working Together to Safeguard Children guide, safeguarding children is the responsibility of all agencies and individuals that come into contact with families and children. The Advisory Council on the Misuse of Drugs (2003) - Hidden Harm: responding to the needs of the children of problem drug users highlight 35 per cent of the treatment population live with children, and substance misuse can affect families and communities as well as the individual who has a drug or alcohol problem. The Hidden Harm report cautioned that parental substance misuse can cause serious harm to children from conception to adulthood, but suggested also that effective treatment of the parent can have a significant positive impact for the child. The National Institute for Health and Care Excellence (NICE) quality standards for drug use disorders recommend that service providers establish systems which enable them to offer the families of people who use misuse substances an assessment relating to their own need, and advise that commissioners should commission these types of services.

The NSPCC suggests that substance misuse services have an important role to play in child safeguarding. It points to research to show that 78 per cent of parents with a drug or alcohol problem who had not received treatment abused or neglected their children following their return from care, compared with 29 per cent of parents without drug and alcohol problems. When asked what support they needed, parents prioritised treatment for drug and alcohol problems, coupled with clarity about the consequences of taking no action with regards to their substance misuse problem. However, while approximately half of mothers and one fifth of fathers to whom children were returned were known to have substance misuse problems, only 5 per cent had been provided with treatment. This highlights the need for greater access to treatment for parents with drug and alcohol problems.

Beyond supporting parents to reduce their substance misuse, drug and alcohol services can play an important role in delivering enhanced outcomes relating to child safeguarding and families; by providing treatment and supporting recovery for parents they play a part in facilitating the safe return of children in care to their families. The Hidden Harm report

suggests that drug services should play a crucial role in efforts to support parents with substance misuse problems and their children. It makes a series of recommendations which include enquiring about children and their care, reducing or stabilising the parent's drug use, and discussing the safe storage of drugs and needles in the home. The report cautions against drug services attempting too much single-handedly, emphasising the importance of working closely with other agencies such as GPs and the local child protection team.

Key messages from research and evidence based practice:

A 'whole family' approach must be adopted when providing support to those affected by alcohol or drug misuse to harness the resource of the family to support those in treatment, and to effectively identify and reduce harm to other family members. **Over the limit: the truth about families and alcohol (2012).**

Services need to redouble efforts to identify families for whom alcohol or drug use is a problem and in addition provide clear and unambiguous advice to all expectant and existing parents, father as well as mother, about the harm that alcohol and drugs can do to family life. **Over the limit: the truth about families and alcohol (2012).**

Pregnancy is a crucial opportunity for engaging and working with substance misusing parents, with childbirth being a potential motivator towards behaviour change in the interests of the unborn child. **All Babies Count: Spotlight on drugs and alcohol (2013)**

Being a parent of resident children can be a protective factor for those in treatment and can support recovery goals. Conversely, parents who have had their children removed are likely to have more complex problems that are difficult to overcome and are more likely to struggle with addressing their substance misuse. **NTA Report – Parents with Drug Problems: How Treatment Helps Families (2013)**

Opioid substitution treatment will improve as a result of changes at a system, service and individual level. These include: treatment that works alongside peers and families to give people direct access to, or signposts and facilitates support to, opportunities to reduce and stop their drug use, improve their physical and mental health, engage with others in recovery, improve relationships (including with their children), find meaningful work, build key life skills, and secure housing. **NTA - Medications in recovery: Re-orientating drug dependence treatment (2012)**

The 2010 Drug Strategy lists four kinds of recovery capital, or resources;
- social: support from and obligations to family, partners, children, friends and peers
- physical: finances and safe accommodation
- human: skills, mental and physical health, a job
- cultural: values, beliefs and attitudes held by the individual. **The potential of recovery capital (2010)**

Effective multi-agency working is crucial to offering support to families where drug and alcohol misuse is a feature. **Juggling Harms: coping with substance misuse (2010)**

Cannabis must not be ignored. Its use is linked with mental health problems for the user, and poor speech development and vocabulary for children living in the household. **Southampton Serious Case Review (SCR) (2012)**

When assessing the care of babies, children and young people, practitioners must not ignore the long term impact of living in households with drug and alcohol misuse or the fact that drug and alcohol misuse impacts on all parts of everyday life. **Bristol SCR (2012)**

Toxic trio (mental health, domestic abuse and drug and alcohol misuse) – professionals can be overwhelmed by the number and complexity of the problems. Children often become "lost" within the chaos. **Community Care inform (Oct 12)**

The effect alcohol misuse has on the individual and family life has been ignored for too long. There is limited data available to know the true number of adults and children affected. **Silent Voices: Supporting children and young people affected by parental alcohol misuse (2012)**

A desire to think the best of adults and to hope they overcome their difficulties should not trump the need to rescue children from chaotic, neglectful and abusive homes. **Working Together to Safeguard Children (2013)**

Doncaster Demographics

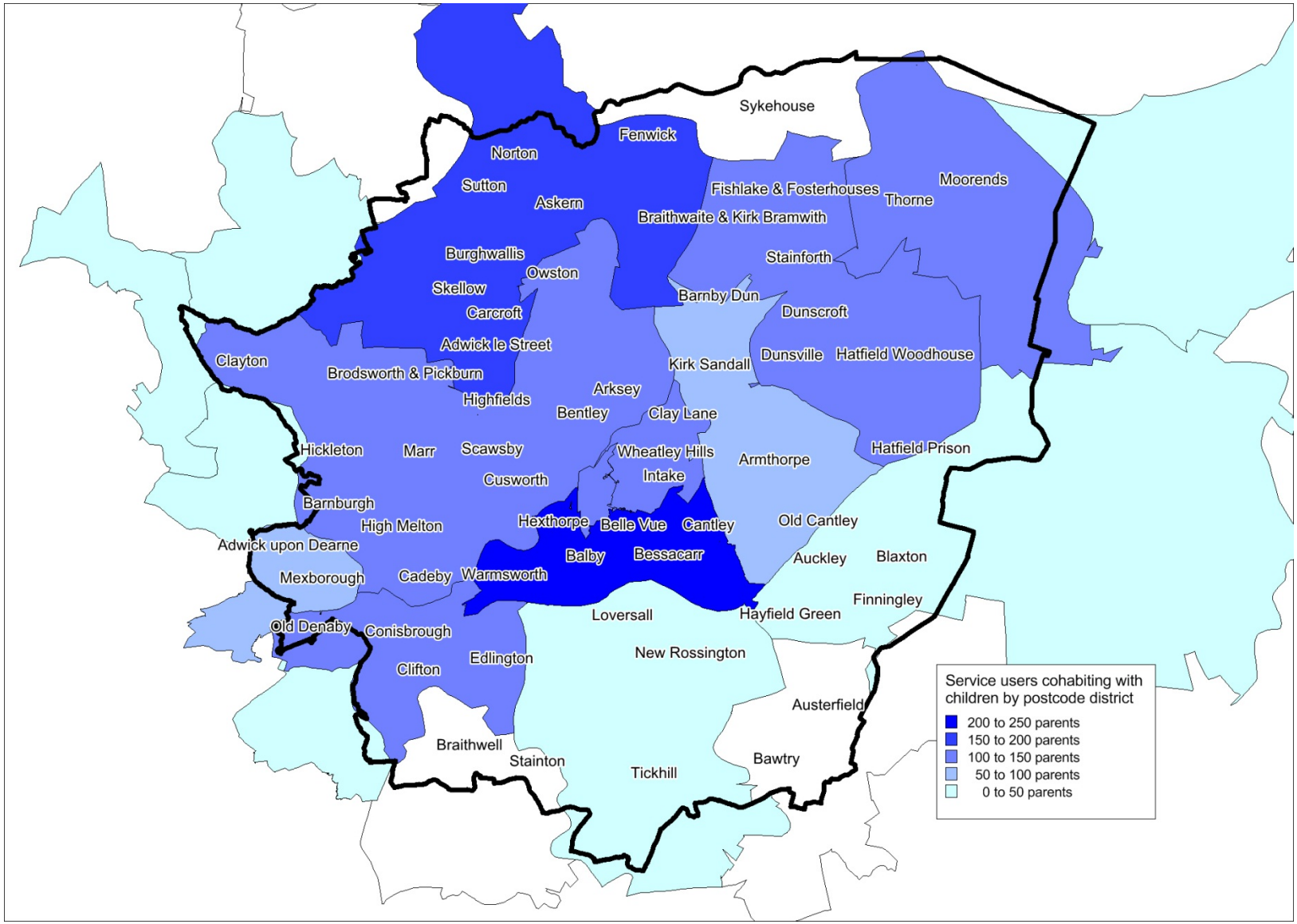
Of clients in substance misuse treatment in Doncaster, the following have children under 18 living with them:

- Opiate users 914 out of 1527 (59.9%) The National average is 32.5%
- Non-Opiate users 93 out of 169 (55%) The National average is 26.4%
- Alcohol users 221 out of 596 (37.1%) The National average is 27.2%

Figures below show clients starting substance misuse treatment while pregnant:

- Pregnant opiate using females 4 out of 123 (3.3%) The National average is 4.1%
- Pregnant non-opiate using females 2 out of 28 (7.1%) The National average is 4.8%
- Pregnant alcohol using females 2 out of 209 (1.0%) The National average is 4.4%

The below map shows the number of service users cohabiting with children by postcode district:


Sykehouse
Fenwick
Norton
Sutton
Askern
Fishlake & Fosterhouses
Moorends
Thorne
Braithwaite & Kirk Bramwith
Burghwallis
Owston
Stainforth
Skellow
Barnby Dun
Dunscroft
Carcroft
Adwick le Street
Clayton
Brodsworth & Pickburn
Kirk Sandall
Dunsville
Hatfield Woodhouse
Arksey
Highfields
Bentley
Clay Lane
Hickleton
Marr
Scawsby
Wheatley Hills
Armthorpe
Hatfield Prison
Intake
Cusworth
Barnburgh
High Melton
Hexthorpe
Belle Vue
Cantley
Old Cantley
Adwick upon Dearne
Balby
Bessacarr
Auckley
Blaxton
Mexborough
Cadeby
Warmsworth
Finningley
Loversall
Hayfield Green
Old Denaby
Conisbrough
New Rossington
Edlington
Clifton
Austerfield
Braithwell
Stainton
Tickhill
Bawtry
Service users cohabiting with children by postcode district
200 to 250 parents
150 to 200 parents
100 to 150 parents
50 to 100 parents
0 to 50 parents

Doncaster, where are we now?

Since 2014 progress has been made by developing a hidden harm training package which addresses parental substance misuse, mental health issues and domestic violence (formally known as “toxic trio” training) within Safeguarding Level 3 Training for all frontline staff. Development of substance misuse referral alcohol screening tool via GPs. Gathering information about parental status is routine within adult substance misuse services. Implementing the MPACT (Moving Parents and Children Closer Together) programme in Doncaster which is commissioned by Public Health Substance Misuse and Stronger Families. *See appendix A.*

Doncaster already has some good practice that has helped establish some effective multi-agency care pathways for families where there is drug and alcohol misuse, which we now need to build on.

Local Services

Adult Substance Misuse Services

Doncaster Drug & Alcohol Service has a nominated Safeguarding Children Lead and participates in an Annual Safeguarding Audit; this includes ensuring all staff attend safeguarding children training.

Every adult accessing the Doncaster Drug & Alcohol Service is asked whether they are a parent/carer. If they are, detailed information is collected regarding the child(ren) on a Substance Misuse Safeguarding Children’s assessment and, where consent is given, on the National Drug Treatment Monitoring Service (NDTMS).

Safer storage boxes are provided to every adult with a child in their household who is taking home substitute medication (e.g. methadone)

Substance misuse services routinely attend meetings regarding the child in the family and complete reports using a specific substance misuse reporting template. Safeguarding Children support on complex cases is provided internally (via RDaSH) to Substance Misuse Safeguarding Children Leads and an established local referral pathway is well embedded. Quarterly group safeguarding supervision is in place for all clinical staff with Doncaster Drug & Alcohol Services. All staff complete relevant training (Safeguarding level 3) to meet requirements of safeguarding and is part of a Multi Agency Safeguarding Team (MAST).

Following accreditation, 4 substance misuse workers (2x DDAS, 2x Depot) are trained and delivering MPACT 8 week programmes (2 cohorts per annum minimum). MPACT is a voluntary programme, families are assessed before being accepted onto the programme.

Agreed database and KPI is in place to ensure that safeguarding assessments take place for all service users.

GPs are routinely copied into safeguarding concerns. However, recent audits demonstrate GPs are not consistently updated on TACS, meetings and therefore do not always have the context of what is going on in a family when a patient presents for a consultation.

Routine information sharing from DDAS to universal services. They currently have a shared electronic record and records can be shared with consent and special permissions including fathers accessing services and or other men that have caring responsibilities for children.

Pregnancy

Currently in Doncaster all pregnant woman are routinely asked when they book for their antenatal care around any drug or alcohol issues (including opiate users, dependant drinkers, recreational users and binge drinkers) – if disclosed they are referred to the Specialist Substance Misuse Midwife. Some women may already be accessing substance misuse services, if not they are encouraged to attend Doncaster Drug and Alcohol Services (DDAS) for assessment. The community midwife contacts the Substance Misuse Specialist Midwife after informing the client and then contact is made with the client to arrange any further appointments. These clients are then discussed at the monthly pregnancy liaison meeting. The members include a social care representative, Health visiting representative, substance misuse specialist midwife and Named midwife for safeguarding which improves information sharing and allows multiagency discussion around plans for birth. Data is not routinely collected but can be made available via system one at Drug services or the maternity unit.

Clients are referred to a named consultant at Doncaster Woman's Hospital and all receive consultant led care. The Substance Misuse Specialist Midwife works alongside the consultant on a Tuesday to ensure continuity of care and management plan. There are guidelines and pathways in place in The Doncaster Woman's hospital in regards to care of these clients.

Health Visiting

All families have a universally delivered Healthy Child Programme which includes core contacts at key times in a child's development. As part of these contacts a full health needs assessment is completed with the family and this includes parental health needs and exploration of parenting capacity. The misuse of substances by parents is explored at key contacts with parents and parents to be; this forms part of any risk assessment in understanding any safeguarding concerns for children and unborn babies. This relies on parental disclosure to universal services.

There is in place a process of liaison by midwifery if substance misuse is disclosed at booking or the client is accessing intervention, multiagency meetings are then arranged.

Any family requiring social care intervention will receive a multi-agency support package. Social care share information, with universal services (health visiting) routinely, about any concerns with parental substance misuse to inform any future health needs assessment.

Doncaster health visiting service provides a specific team that provides care for families requiring a more specialised and intensive package of support. Care is provided by the Universal Partnership Plus team; which provides a progressive universal health visiting service for families identified with more complex and acute health and social needs. Families where parents are using substances may receive support from this team if health needs require a multi-agency package of support.

Health visitor will make referrals to MPACT as required.
There is not a commissioned specialist role within health visiting to support parents and families with Hidden harm concerns.

Young People's Drug and Alcohol Service

Provides targeted and specialist interventions and treatment to young people under 18, and advice and information to family members and significant others who may be worried about or affected by a young person's substance misuse.

Project 3 has a nominated Safeguarding Children Lead and all staff attend safeguarding children training. Following accreditation, 2 substance misuse workers are trained and are delivering MPACT 8 week programmes (2 cohorts per annum minimum). MPACT is a voluntary programme, families are assessed before being accepted onto the programme.

Project 3 write to GP's for every substance misuse contact at the start of an episode and at the point of discharge. If medical reviews are taking place as part of a substitute prescribing regime then the prescribing medic sends copies of all review letters to the GP.

Early Help

Early Help provide universal services to children and young people through their delivery at Childrens centres. All staff within these settings is trained to level 3 safeguarding. Hidden Harm may be identified within these settings by close observations of the child, their interactions with parents and if they are meeting their developmental mile stones.

Early Help also offer targeted interventions working directly with the family within the family home.
Within this work hidden harm can be identified as the impact on the child from parents who are misusing substances is recognised.
There will be a Team around the Child approach in place for these children. Specialist adult substance misuse services and also specialist programmes/ services may be invited to attend the Team around the Child meeting to offer additional support to meet the needs of

the children. Team around the Child members will work together applying a whole family approach to prevent escalation into statutory Social Care Services.

Education

Education does include hidden harm and all safeguarding procedures are adhered to following DSCB/South Yorkshire Child Protection procedures' as per the 'Safeguarding Children and Young People Policy 2016.

Everyone who comes into contact with children and their families has a role to play in safeguarding children. School and college staff are particularly important as they are in a position to identify concerns early and provide help for children, to prevent concerns from escalating. Schools and colleges and their staff form part of the wider safeguarding system for children. This system is described in statutory guidance Working Together to Safeguard Children 2015. Schools and colleges should work with social care, the police, health services and other services to promote the welfare of children and protect them from harm.
Each school and college should have a designated safeguarding lead who will provide support to staff members to carry out their safeguarding duties and who will liaise closely with other services such as children's social care. This is in line with Keeping children safe in education 2016 (revised Sept 2016)

Following local procedures all designated safeguarding leads will support any child, young person or family identified at risk due to hidden harm and make the appropriate referral and maintain relationships to ensure all young people have access to support and are protected from significant harm by following local procedures.

Doncaster Childrens Services Trust

The Doncaster Childrens Services Trust is a new and independent organization set up to deliver social care and support services to children, young people and families in Doncaster. We provide support and Children's Social Care for children in Doncaster, except for education and learning. We work with our local partners to do the best for children and young people who support in their daily lives. Doncaster Childrens Services Trust works to keep young people safe, and we have a number of services across each of our three localities, which include East, North and Central Doncaster. These are front door services, including Early Help, Referral and Response, Child Sexual Exploitation and the locality teams, which include assessment and child protection services, Children in Care and 18+ services for young people leaving care. The misuse of substances by parents is explored during any assessment or review undertaken by Childrens social care, this will inform part of any risk assessment undertaken to ensure that if any children or young people are at risk where there are additional safeguarding concerns, these can then be appropriately supported by Doncaster Childrens Services Trust and our partner agencies.

Arrangements in Doncaster

DSCB Training

The hidden harm training which addresses parental substance misuse, mental health issues and domestic violence (formally known as "toxic trio" training) has been incorporated into Level 3 Effective Partnership back in summer 2014.

In brief this covers Doncaster's figures regarding both alcohol and substance misuse; an overview of drug services, the impact on children; the cycle of change and how to broach the subject of substance misuse with parents. The offer of further training to organisations is also discussed and a number of organisations have undertaken this.

The trainers have also delivered two DSCB seminars and workshops. This has also covered the work of MPACT (Moving Parents And Children Together). This session has also been delivered to all GPs at TARGET as part of their level 3 safeguarding children update.

The training always receives good feedback and fits in well with the other course content as it usually follows our look at the Daniel Pelka case where high levels of substance misuse and a lack of referrals to specialist services were a significant factor.

This training has proved extremely successful and been positively evaluated. However due to increasing levels of demand the decision has been made by the Workforce Development Sub Group to run core training with elective modules in the form of short courses and seminars. Substance misuse will form a key part of these modules and will be delivered by experienced substance misuse professionals specialising in this area.

Research has shown that multi-agency training in particular is useful and valued by professionals in developing a shared understanding of child protection and decision making. Carpenter et al (2009). *The Organisation, Outcomes and Costs of Inter-agency Training to safeguard and promote the welfare of children. London: Department for Children, Schools and Families.*

Where do we want to be?

Households where there is drug and alcohol misuse come into contact with a range of different services on a daily basis. There is scrutiny, oversight and intelligence surrounding individuals who are in formal structured drug or alcohol treatment. The majority of opiate and crack using parents are known to adult substance misuse treatment services; their children are identified throughout the care pathway and systems are in place to ensure good multi-agency working especially if the child is preschool age.

However there appears to be greater difficulties within universal services in identifying fathers, mothers, carers who use drugs viewed as "recreational" e.g. cannabis; powder cocaine; new psychoactive substances ('legal highs'); over the counter and prescribed analgesic preparations as well as alcohol. In some cases this may be because the father, mother, pregnant woman does not consider that they have a problem with drugs or alcohol; or the drug and alcohol misuse just becomes one more factor in an overall complex range of issues e.g. domestic abuse, mental health issues, eviction.

Doncaster needs a commitment by all our partner agencies to drive forward the required changes to bring about better outcomes for this vulnerable group of children and their families.

This agenda, strategy and accompanied action plan will be led by the Doncaster Health & Wellbeing Board who will ask for assurances from the Doncaster Children's Safeguarding Board including regular updates with regards to actions taken forward.

This strategy should highlight new initiatives in Doncaster regarding Hidden Harm, consider the findings from National and local research and encompass the direction of other key priorities for Doncaster.

Joint strategic priorities are translated within Appendix A into clear, measurable actions which will be updated on an annual basis to ensure it remains effective and relevant.

By providing the right help at an early stage and by recognising the needs of the whole household we will reduce the need for more intensive intervention at a later stage, leading to better outcomes for children and their families.

Doncaster Metropolitan Borough Council

Doncaster Health and Wellbeing Board

1 September 2016

Subject: Prevention

Presented by: Dr R Suckling; Sarah Smith

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

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

How will this contribute to improving health and wellbeing in Doncaster?
Prevention is described in the Health and Wellbeing strategy, this briefing provides the Board with additional information and an illustration through the presentation of what and how a strategic shift to prevention might be achieved.

Recommendations
The Board is asked to:- DISCUSS and AGREE next steps.

This page is intentionally left blank

Prevention: A Discussion Paper for Doncaster Health and Wellbeing Board

Introduction

The purpose of this discussion paper is to provide the Health and Wellbeing Board sufficient background on the issue of prevention to enable the Board to set the direction for the next phase of prevention work in Doncaster.

Background

Debates about prevention, either by itself or together with early intervention are becoming increasingly common in UK health and social policy. At the most basic level prevention is about intervening before something becomes a problem whilst early intervention is about responding where there is already a problem. The reasons for the interest in prevention are numerous, but in essence boil down to an increased awareness of avoidable early deaths, increasing numbers of people living with one or more chronic diseases, better understanding of causes and interventions for major diseases, a focus on 'high risk' groups and an realisation that unless these increases in demand can be abated there is simply not enough money or resource in the system to cope with the demand of an aging population.

Nationally this situation has reignited the policy debate on prevention with not only the Care Act 2014, but also the Five Year Forward View (FYFV) rediscovering the 'fully engaged scenario' of the Wanless reports of 2002 and 2004. In the FYFV it states 'the NHS needs a radical upgrade in prevention if it is to be sustainable'. Whilst the 2002 Wanless report did not argue that prevention was 'cash saving' it did predict that if the 'fully engaged' scenario was adopted health expenditure would be £30 billion lower than the 'slow progress' scenario by 2022-23. This relates to a 29% increase in costs under a 'fully engaged' scenario as opposed to 44% with 'slow progress'. The funding of prevention is also under the spotlight with reducing budgets lading to organisational decision making as opposed to system wide decisions e.g. HIV prevention.

Locally this is reflected in recent Health and Wellbeing Board discussions and activity. Prevention has been identified and mentioned in the most recent Doncaster Health and Wellbeing strategy in terms of the contribution it could make to the 'areas of focus' especially alcohol, dementia and obesity. Prevention is also focussing in 'Sustainability and Transformation' plans and in the Clinical Commissioning Group's new strategic approach to primary care

Prevention defined

Section 2 of the Care Act 2014 places a duty on local authorities to ensure the provision of services that prevent, reduce or delay the need for care and support. In the statutory guidance that accompanies the Act, these three forms of prevention were emphasised equally.

Prevent = primary prevention/promoting wellbeing.

Aimed at people who have no identified health or care needs

Reduce = secondary prevention/early intervention

Aimed at people who have an increased risk of developing health or care needs

Delay = tertiary prevention

Aimed at minimising the effect of disability or deterioration for people with an established or complex health or care need

These duties are mirrored by the duties on Clinical Commissioning Groups and the NHS to reduce health inequalities.

Challenges of becoming more prevention focussed

If the Board wished to become more prevention focused there are a number of challenges that would need to be overcome and these include:

1. Using a common language to talk about and harness action on prevention.

2. Understanding prevention is not a one off event but applies across the life course.

3. Agreeing what to 'prevent' and 'target' setting.

4. The need to layer interventions and address population, sub-population and individual levels.

5. Recognising that there is a risk that prevention can 'medicalise' wider social issues.

6. Understanding the time horizon for return on investment of preventative interventions.

7. Recognising the dilemma of affordability even for a cost effective approach and the 'dose' of the intervention.

8. Operating collectively and less as individual organisations.

9. Prevention can focus on needs not assets and can divert attention from positive behaviours e.g. eating, eating, sleeping and talking.

Possible Next Steps

Commit to using the prevention definitions of the Care Act 2014.

Commit to a strategic shift to prevention as evidenced by:

Preventive services in every clinical pathway and care pathway
Brief and very brief interventions delivered by frontline staff
Linking clinical with community services including leisure and culture
Embed self management in chronic disease pathways
Increase % of resources in prevention year on year, starting with an allocation from the Better Care Fund

Identify one or more high impact areas and prototype how this area could be addressed

Map prevention spend across Doncaster

R Suckling 21/08/2016

Doncaster
Metropolitan Borough Council

Doncaster
Health and Wellbeing Board
1 September 2016

Subject: Doncaster's Local Plan and Health & Wellbeing

Presented by: Clare Henry (Public Health) and Teresa Hubery (Local Plans Team)

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

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

How will this contribute to improving health and wellbeing in Doncaster?
The built environment is one of the many complex factors that influence the health and wellbeing of people and the places in which they live, work and play. Doncaster's Local Plan is the new planning strategy for the borough. The Local Plan provides the borough's most important planning policies and sets out detailed development management policies to guide new development in the borough. This presentation will provide a brief update on the development of the Local Plan and where opportunities to support residents to lead healthier lives have been incorporated.

Recommendations
The Board is asked to:- **receive** the information and **consider** the relevance to their organisation.

This page is intentionally left blank

Doncaster
Metropolitan Borough Council

Doncaster Health and Wellbeing Board
Date: 1 September 2016

Subject: Doncaster Local Digital Roadmap

Presented by: Andrew Clayton, Head of Health Informatics, NHS Doncaster CCG

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

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

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

The Doncaster Local Digital Roadmap is a plan to join-up information and systems across health and care providers in Doncaster, with the ambition of delivering comprehensive shared health and care records, available to all appropriate practitioners at the point of care, by 2020. Delivery of the roadmap will provide both practitioners and patients with greater access to health information and services, which will contribute to the improvement of health and wellbeing through:

Better information sharing between practitioners across health and care services will improve the quality and safety of services provided.

Access to more digital health and care services and the increased capability provided by these services to support patient self-care will help to improve health and wellbeing in Doncaster.

Recommendations
Representatives from the CGG and providers, both from health and social care across Doncaster have been involved in developing and approving the Local Digital Roadmap. It is a requirement that Health and Wellbeing Boards are engaged and therefore the Board is asked to endorse the Doncaster Local Digital Roadmap.

Doncaster Local Digital Roadmap

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Doncaster Children's Services Trust

fcms

NHS Doncaster Clinical Commissioning Group

Rotherham Doncaster and South Humber NHS Foundation Trust

Doncaster Metropolitan Borough Council

Contents

Section	Page No
1. Introduction	3
2. Vision	5
3. Baseline Position	13
4. Readiness	21
5. Capability Deployment	24
6. Universal Capabilities Delivery Plan	27
7. Information Sharing	28
8. Infrastructure	31
9. Minimising Risks Arising From Technology	34
10. Glossary	35
11. Executive Sign-Up	37

1. Introduction

The Doncaster Local Digital Roadmap (LDR) has been developed by the Doncaster Interoperability Group. This group, which is chaired by the Doncaster CCG Chief Officer, has been established to support the development and delivery of the LDR and includes clinical and informatics representatives from all organisations identified in the Doncaster LDR footprint submission of October 2015. These organisations, which have all made a significant contribution to the development of the roadmap, are:

- NHS Doncaster Clinical Commissioning Group
- Doncaster Children's Services Trust
- Doncaster Metropolitan Borough Council
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- FCMS

Lead individuals from all these organisations have met to understand the Digital Maturity Index and baseline position across Doncaster. A small multi-agency group has then collaboratively developed the plan over the next 5 years and shared the development of the LDR within their individual organisation for comments and feedback. The LDR has been shared across the system in organisational meetings and also in system wide meetings to ensure that there is a broad understanding of the direction of travel, approval of the LDR content and ambition, and commitment at a very senior level to support the implementation of the LDR.

There are strong links between the development of the Doncaster LDR and the South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformation Plan. The Doncaster CCG lead for the LDR participates in and SY&B LDR leads group, which includes both of the Accountable Officer Leads for the Digital Health work stream within the Sustainability and Transformation Plan. Through this group there has been the opportunity for input into the STP Digital Health work stream and this has supported the alignment of the Doncaster LDR with the STP, which is reflected in the shared vision presented later in this document.

During development the LDR has been discussed in a number of forums for comment including the:

- Doncaster Health and Wellbeing Board
- Doncaster CCG Governing Body
- Doncaster Interoperability Group
- Doncaster LMC
- Doncaster Transformation Governance Group
- South Yorkshire and Bassetlaw LDR Development Group
- DBHFT IT Departmental Meeting

- DBHFT Pharmacy Team
- RDaSH Health Informatics sub-committee
- RDaSH Finance, Performance and Informatics Committee
- FCMS Board
- DCST Chief Executive Group

We want to engage widely with other partners within the Doncaster footprint as our LDR develops and following submission we will share the initial roadmap with Healthwatch Doncaster and local third sector organisations.

The Doncaster Local Digital Roadmap (LDR) has been endorsed by the Chief Officers of all partner organisations. Following submission at the end of June it will be further endorsed as follows

Organisation	**Endorsed by**	**Date**
Doncaster	Doncaster Health and Wellbeing Board	1st September 2016
NHS Doncaster CCG	Governing Body	21st July 2016
Doncaster Children's Services Trust	Executive Group	July 2016
Doncaster and Bassetlaw Hospitals	Management Board	1st August 2016
Rotherham Doncaster and South Humber	Finance, Performance and Informatics Committee	21st July 2016
DMBC	AHWB Directorate Leadership Meeting	July 2016
DMBC	Adults Improvement Board	July 2016
DMBC	Directors Meeting	July 2016
FCMS	Board	1st June 2016

2. Our Vision

Our vision for the health and care community of Doncaster is to join up information across care pathways and settings so that health and care practitioners have easy access to all the information they need to provide high quality, safe and effective services. IT services will be interoperable to allow practitioners access to information in all care settings.

Doncaster's digital vision has been developed in the on-going context of:

- The change in financial outlook for the NHS and the Council
- The need for enabling programmes, including information technology, to drive the delivery of increased Quality, Innovation, Productivity and Prevention
- Integration between the NHS and the Council

We know from discussions with Doncaster patients and public at various engagement events that there is a local appetite for being able to access NHS services in new, innovative ways, operating in tandem with more traditional methods.

Only by the partners working on an integrated Digital roadmap will NHS and the Council achieve the Vision as set out above.

During the development of our Choose Well Doncaster app for smartphones we consulted with students at Doncaster College. They were keen to see more real time information about local services made available and also wanted us to explore further the prospects that mobile technology offers.

Local GPs and other healthcare professionals also want to harness the opportunities that digital technology offers, highlighting, for example, the benefits of the i-nurse project, which has been trialled in one geographical area of the borough to help free up more GP time. It enables practice nurses to make patient home visits and use an iPad to be in visual contact with a GP at their surgery for any medical advice they need during the consultation.

This is Doncaster's initial draft of a digital roadmap and we will continue to refine it in line with feedback we get from local patients and public as part of our on-going engagement discussions.

The vision has been identified and developed through discussion with GPs and partners across the Doncaster Health and Social Care community. Consequently the vision impacts across primary, secondary and community and social care as well as commissioners, and will require the engagement and support of all partners to be fully realised.

We will use technology to drive forward improved communication between patients, carers and partner organisations. Our aim is to use patient information to improve commissioning decisions and use technology to improve integrated, personalised, co-ordinated care across partner organisations.

Implementation of our vision we will create a culture that promotes the sharing of accurate and useful information and will provide access to the care record, where appropriate, to practitioners, patients and carers.

Our vision will support the delivery of Doncaster's strategic ambitions for care out of hospital, care of the frail, co-ordinated care and the provision of high quality urgent care.

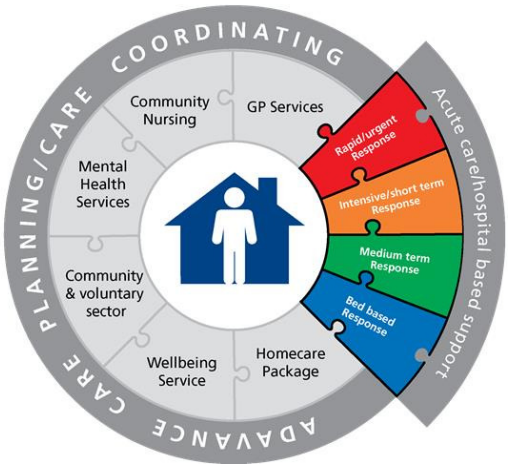
In Doncaster we are committed to a programme of work to transform Intermediate Health and Social Care Services, which is central to providing care out of hospital and avoiding unnecessary hospital admission. A summary of the intended programme outcomes is shown below:

In the future intermediate care in Doncaster needs to…

1. Respond to needs and personal goals of the person and their family/carers NOT diagnosis.
2. Work collaboratively and flexibly to meet physical, mental health and social care needs.
3. Be simple to access and experienced as one seamless service.
4. Offer responsive, time limited evidence based interventions.
5. Consider all options to safely support someone in their home environment first before transferring them to a bed based service.
6. Have a single system for record keeping, sharing information and a single assessment process.
7. Focus on enablement, maximising independence, promoting self-care and maintaining social networks.
8. Ensure care is co-ordinated while a person is with the service and arrangements are in place for on-going care co-ordination and navigation where required on discharge from the service.
9. Take a multi-disciplinary approach with an appropriately skilled workforce, access to specialist skills and assessment and the flexibility to meet a range of physical, mental health and social care needs.
10. Be commissioned and lead in a way that promotes and facilitates integrated working and empowers staff.
11. Sit in the community, alongside primary care services and in-reach into acute services to facilitate discharge from A&E and hospital admissions.
12. Be monitored and evaluated on an on-going basis as a single service with a shared set of quality indicators.
13. Demonstrate value for money and sustainability

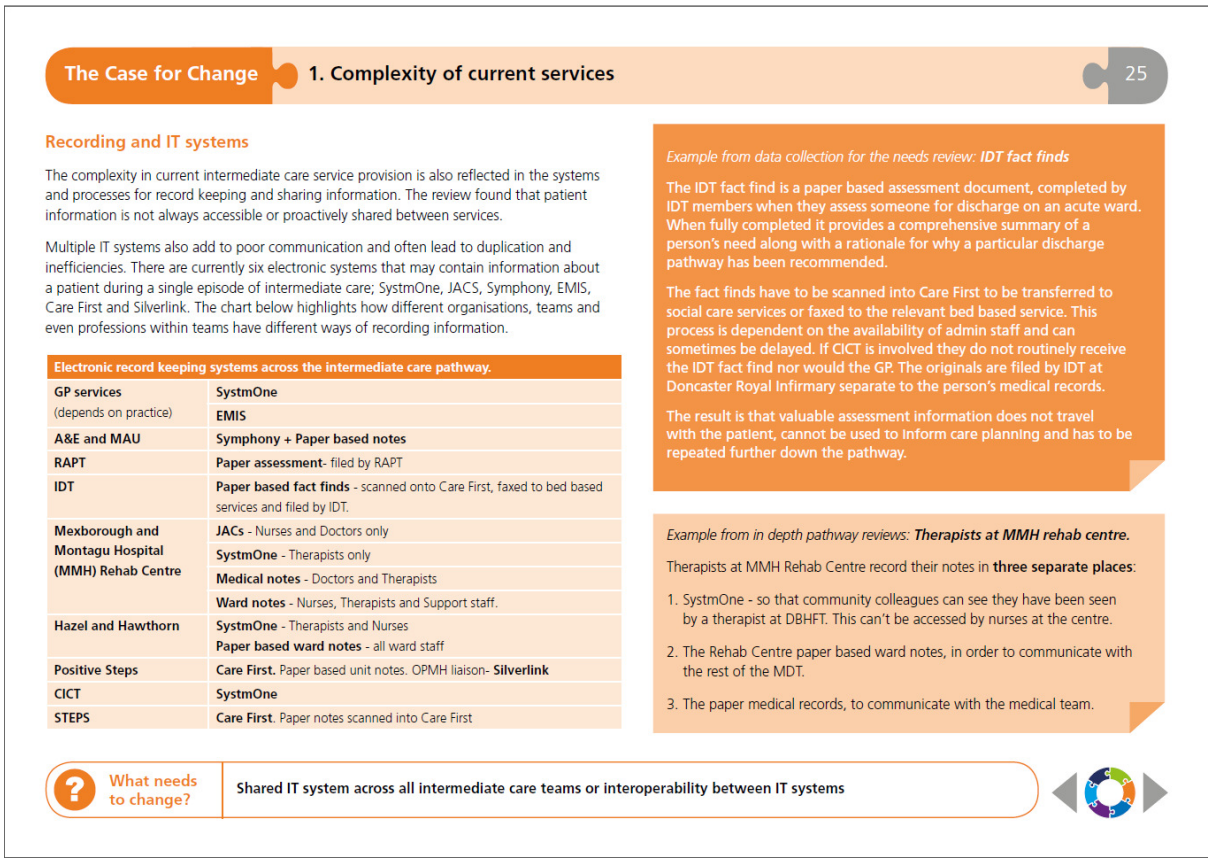
Provide 4 types of intermediate care response

1. Rapid or urgent
2. Intensive, short term interventions (few days)
3. Medium term (up to 6 weeks)
4. Bed based response



In the analysis carried out to develop the Intermediate Care case for change it has been clearly identified that there is a need to integrate and share information across health and care systems. This is a multi-level approach from business intelligence to a single patient record. The implementation of our LDR vision will deliver this integration and sharing and act as a key enabler for the required transformation. A

summary of the Recording and IT Systems analysis from the Intermediate Care case for change is shown in the following diagram:



The Case for Change | 1. Complexity of current services | 25

Recording and IT systems

The complexity in current intermediate care service provision is also reflected in the systems and processes for record keeping and sharing information. The review found that patient information is not always accessible or proactively shared between services.

Multiple IT systems also add to poor communication and often lead to duplication and inefficiencies. There are currently six electronic systems that may contain information about a patient during a single episode of intermediate care; SystmOne, JACS, Symphony, EMIS, Care First and Silverlink. The chart below highlights how different organisations, teams and even professions within teams have different ways of recording information.

Electronic record keeping systems across the intermediate care pathway.	
GP services (depends on practice)	**SystmOne**
	EMIS
A&E and MAU	**Symphony + Paper based notes**
RAPT	**Paper assessment**- filed by RAPT
IDT	**Paper based fact finds** - scanned onto Care First, faxed to bed based services and filed by IDT.
Mexborough and Montagu Hospital (MMH) Rehab Centre	**JACs** - Nurses and Doctors only
	SystmOne - Therapists only
	Medical notes - Doctors and Therapists
	Ward notes - Nurses, Therapists and Support staff.
Hazel and Hawthorn	**SystmOne** - Therapists and Nurses **Paper based ward notes** - all ward staff
Positive Steps	**Care First.** Paper based unit notes. OPMH liaison- **Silverlink**
CICT	**SystmOne**
STEPS	**Care First**. Paper notes scanned into Care First

Example from data collection for the needs review: ***IDT fact finds***

The IDT fact find is a paper based assessment document, completed by IDT members when they assess someone for discharge on an acute ward. When fully completed it provides a comprehensive summary of a person's need along with a rationale for why a particular discharge pathway has been recommended.

The fact finds have to be scanned into Care First to be transferred to social care services or faxed to the relevant bed based service. This process is dependent on the availability of admin staff and can sometimes be delayed. If CICT is involved they do not routinely receive the IDT fact find nor would the GP. The originals are filed by IDT at Doncaster Royal Infirmary separate to the person's medical records.

The result is that valuable assessment information does not travel with the patient, cannot be used to inform care planning and has to be repeated further down the pathway.

Example from in depth pathway reviews: ***Therapists at MMH rehab centre.***

Therapists at MMH Rehab Centre record their notes in **three separate places**:

1. SystmOne - so that community colleagues can see they have been seen by a therapist at DBHFT. This can't be accessed by nurses at the centre.
2. The Rehab Centre paper based ward notes, in order to communicate with the rest of the MDT.
3. The paper medical records, to communicate with the medical team.

What needs to change? | Shared IT system across all intermediate care teams or interoperability between IT systems

The digital priorities for Doncaster fall within the following wider visions as set out in Doncaster Council's Digital Programme and the South Yorkshire and Bassetlaw Sustainability and Transformation Plan Digital Work Stream as detailed below.

Doncaster Council Digital Programme

Doncaster Council are delivering 4 transformation streams that complement and enable aspects of this roadmap:

- Digital Council Programme – a modern digital authority both internally and externally, with all services online, providing a modern, high quality and efficient integrated front office with resulting improved service delivery through redesigned business processes, improved technology, mobile working and higher skilled staff. Utilising the resulting business intelligence to become a more intelligent and proactive organisation.

- Digital Inclusion Strategy – working across Doncaster's community, voluntary and private sector to sign-post residents in accessing the training and skills required to get online and access services, health and employment provision. This work stream is also working across the Superfast South Yorkshire Programme to

improve connectivity and access across Doncaster as well as providing improved access facilities across the Doncaster Library network.

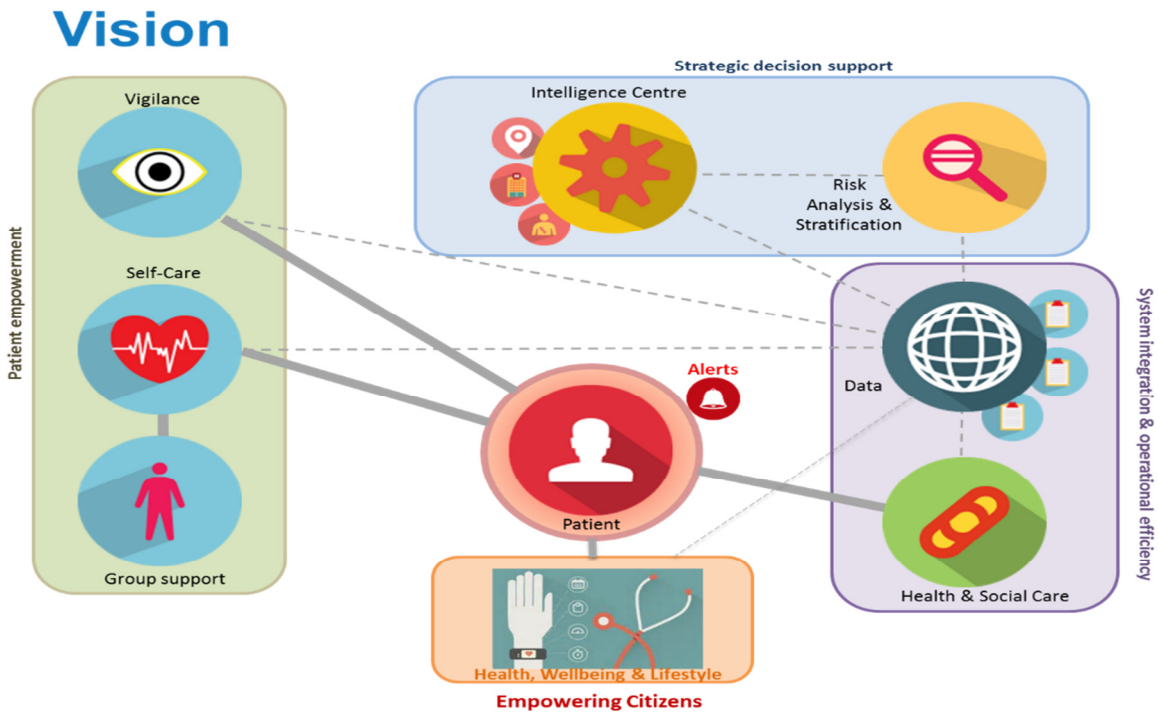
- Adults Transformation – delivering a modern adult social care function that supports residents living at home independently for longer, directed away from traditional social care interventions, this is enhanced by a digital access platform, allowing residents to easily find information, advice and guidance early and get access and support from community, voluntary and private organisations as opposed to the traditional local authority social care provision. The transformation programme will change the focus of social work to a strengths based, community led approach and will use technology to remove barriers to allow assessments to take place more effectively in community setting as opposed to the traditional home setting.

- Social Care Systems – reviewing the existing core systems in place to support adult and child social care and exploring opportunity to deliver a single point of truth across these systems to more effectively monitor the child to adulthood as well as the ability to share appropriate records

South Yorkshire and Bassetlaw Sustainability and Transformation Plan Digital Vision

Our digital health strategy has three essential elements.

- Citizen and Patient Empowerment
- System integration and operational efficiency
- Strategic decision support



Our future technology enabled communities will therefore be characterised by:

- Enabling health and care providers' access to all patient clinical electronic data across traditional boundaries, agnostic of staff employer or organisation. Having a Shared Care Record in place, accessible to clinical staff or those who need it wherever they are, is the single most important change we need to make. As we develop our plans for clinical services across the wider SYB footprint, we will inevitably see more patients moving between organisations to receive care. Therefore it makes sense that our ambition for shared care records extends across this larger footprint. Access to Shared Care Records is particularly important for urgent and emergency care, but such a system would have significant benefits for clinical care. This ambition:

    - will require up to date hardware and wireless networks so that access to data is fast and easy for our citizens, patients, carers, staff or wider health and care communities;
    - will require us to develop clear rules within which we operate to ensure appropriate governance and security for patient data as well as interoperability of systems and technologies now and into the future. Consequently data, data management and systems will be subject to agreed national and local standards supporting ongoing interoperability;
    - will incorporate data from multiple sources (including NHS and social care as well as other public and voluntary or charitable organisations) and include citizen generated data from citizen controlled devices and innovations (e.g. Apps);

- will means citizens and patients take greater ownership for their health and wellbeing. They will be supported to do this through technology which promotes risk prediction, prevention as well as self-care and management.

- Innovation and learning will be part of our DNA, translated into rapid deployment of technology (e.g. related to access, devices, apps etc.) and signposting where helpful to achieve improved health and wellbeing outcomes. This will need us to also concentrate on improving digital literacy so that interventions help to bridge, not exacerbate, the digital health divide and health inequalities across our broad socio-economic communities. Personal health and wellbeing digital data needs to be as 'consumable' for health and care professionals as for citizens and patients in order to maximise potential.

- Robust population based analytics, supporting risk stratification and system alerts which result in rapid response and appropriate interventions tailored to the individual's needs.

Within the next five years our system will therefore deliver a new way of supporting and working in partnership with our communities to achieve improvement in health and wellbeing outcomes and address current health and care challenges.

Gap	How we will address the Gap
Care and quality	• Shared records offering increased access to relevant, real time, information about a patient by health and care providers as well as patient authorised viewers • Improved interoperability to enable more effective and efficient transfer of care across providers (e.g. through e-referral and discharge processes) supporting reduced waiting times and access to appropriate support • Promote mobile working of practitioners through Wi-Fi accessibility and roll-out of remote working solutions for practitioners. These solutions should ensure practitioners from all partners can access Wi-Fi, e.g. health practitioners in Council buildings • Use population data to help identify and provide evidence for best practice and quantitatively assess quality outcomes • Ensure better informed clinical decisions enabling more appropriate cost effective and safe care (e.g. avoiding drug contra-indications) as well as support for safeguarding

	• Improved patient experience through not having to repeatedly provide clinical details and not having to undergo unnecessarily repeat clinical tests
Health and wellbeing	• Patients will have significantly more control over their care, and experience better outcomes through improved treatment and medication adherence as well signposting to appropriate services within their community • Increased citizen, patient and carer awareness of, and involvement in, health and care support and delivery will result in better knowledge about condition management, better self-care and achievement of patient determined outcomes • Increased interoperability and strategic system intelligence will support proactive care. This will reduce the frequency of exacerbation, and support co-ordination of care to address health and care needs holistically - including mental health • Promotion of remote monitoring, new forms of consultation (e.g. video, phone) and mobile health (mHealth) will also support care based in the citizen's own home, reducing the burden of routine care on patients, their carers and families, and health professionals. The council will enhance these capabilities by transforming its Telecare offering to introduce greater use of sensors and other facilities to keep people safe and well in their own home
Finance and sustainability	• We will develop combinatorial innovations (including technologies as well as service changes) to promote increased efficiency in the ongoing care and management of patients • Greater integration of care will mean increased opportunity for admission avoidance • Increased reliance on validated risk stratification and population analytics will enable more efficient case finding and targeted intervention • Remote monitoring and surveillance will mean earlier intervention to avoid unnecessary use of secondary care resources and effective use of community based resources

	• Better tracking and scheduling of staff resources will enhance operational efficiencies • Reduced DNAs through easy access to GP booking systems, reminders, patient self-reporting/recording and active self-management • Clinicians able to use their time more effectively through the use of technology.

3. Baseline Position

In preparation for development of the Local Digital Roadmap the two secondary care providers in the Doncaster footprint carried out a Digital Maturity Assessment between in November 2015 – January 2016. A summary of the results from this initial assessment of the two providers is shown in the table below:

Section	Type	Rotherham Doncaster and South Humber NHS Foundation Trust	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	National Average
Strategic Alignment	Readiness	85	80	76
Leadership	Readiness	95	60	77
Resourcing	Readiness	80	70	66
Governance	Readiness	70	70	74
Information Governance	Readiness	75	83	73
Records, Assessments & Plans	Capabilities	68	30	44
Transfers Of Care	Capabilities	13	57	49
Orders & Results Management	Capabilities	15	69	52
Medicines Management & Optimisation	Capabilities	11	56	29
Decision Support	Capabilities	68	17	36
Remote & Assistive Care	Capabilities	25	33	33
Asset & Resource Optimisation	Capabilities	40	30	42
Standards	Capabilities	60	29	41
Enabling Infrastructure	Enabling Infrastructure	73	75	68
Readiness Average	**Readiness**	**81**	**72**	**73**
Capabilities Average	**Capabilities**	**37**	**40**	**40**
Enabling Infrastructure Average	**Enabling Infrastructure**	**73**	**75**	**68**

As can be seen from the table above the assessment scores for the Doncaster footprint identify that our current level of development is consistent with the national position. A key insight is that organisational readiness is strong but capabilities still need to be developed. Nationally the capability areas where it has been identified that there is particular room for growth are medicines management, decision support

and remote care. Our scores indicate that these are also key development areas for Doncaster along with transfers of care and orders and results management.

In addition to the secondary care Digital Maturity Assessment exercise Doncaster CCG submitted a Digital Maturity Assessment for primary care at the end of April 2016. Analysis of the results for this assessment will be included in future developments of the LDR.

An overview of the current digital maturity of the primary, secondary and social care providers within the Doncaster LDR footprint along with a summary of their recent achievements and current initiatives is given below:

Primary Care

All of the general practices in Doncaster have implemented the latest version of their chosen GP clinical system and use either TPP SystmOne (53% practice) or EMIS Web (47% practices).

Key recent achievements within primary care include:

- Mobile devices (laptops with 4G and software to support connectivity over Wi-Fi) have been deployed to all GPs, registrars and appropriate practice nursing staff.
- 100% Practices have been switched on for patient online services
- 77% Practices are ETP enabled
- 100% practices have had ICE software implemented to support order comms with Doncaster and Bassetlaw Hospital and allow a view of historic test results

The key initiatives currently on-going in primary care are:

- Development of an improved and extended Wide Area Network that will connect all Doncaster practices to a set of IT systems and services
- The rollout of Wi-Fi networks into all practice premises is underway
- A programme of work is underway that will help practices meet quality data quality standards for recording and sharing information and improve the utilisation of GP clinical systems and utilisation of universal and local capabilities

Doncaster and Bassetlaw NHS Foundation Trust (DBH)

DBH's current level of digital maturity for capabilities is consistent with the national average across secondary care providers. Their self-assessment indicates that growth is required in their capabilities for records, assessments and plans, decision support, remote and assistive care, asset and resource optimisation and standards.

DBH commenced a programme of work in 2012 to drive forward with a several major implementations across the Trust which delivered a new A&E system in 2014 and a

replacement pas SYSTEM 2015. Following the completion of these system implementations the Trust is now evaluating how it can move forward to better integrate a range of clinical systems across the Trust and how it can share information with partners across the wider health community.

Key recent achievements at DBH include:

- Implementation of new 'best of breed' A&E and PAS systems
- Delivery of a combined service for GU Med between RDASH and DBHFT

The key initiatives currently on-going at DBH care are:

- Implementation of an Electronic Document Management System
- Implementation of Electronic whiteboards
- Development of Trust wide clinical viewer
- Implementation of e-discharge summaries
- ICT Infrastructure Upgrade almost complete (including Wi-Fi to all areas).

.

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

RDaSH's current level of digital maturity for capabilities is also consistent with the national average across secondary care providers. Their self-assessment indicates that growth is required in their capabilities for transfers of care, orders and results management, medicines management and optimisation and remote and assistive care.

RDaSH are addressing these growth areas through their 5 year strategy published in April 2016 "Information Communication and Technology Strategy – *Towards a Digitally Integrated Healthcare Environment*". This ambitious strategy which will see all Trust services transferred onto a unified EPR system has the four key strategic aims identified below:

- Improving patient experience
- Supporting agile working
- Enabling paper-free care delivery
- Reducing administrative overheads

Key recent achievements at RDaSH include:

- Procurement phase for the new EPR is underway and is due to complete end of Q2 2016
- Large remote sites have been moved on to the Yorkshire and Humber Public Sector Network

- An upgrade of the Trust's core IT infrastructure upgrade was carried out during 2014-2016

The key initiatives currently on-going at RDaSH are:

- Procurement, configuration and implementation of a new EPR
- Development of an Agile working strategy
- A review of IT security and governance procedures
- A review of the Trust email services
- Investment in data warehouse capability

FCMS

FCMS use a fully electronic clinical system (Adastra) to deliver their clinical services in Doncaster. They also have a live (refreshed daily 24 hours behind) BI portal accessible by themselves and Commissioners. FCMS staff are provided with remote working capability using toughened laptops.

Key recent achievements at FCMS include:

- Development and implementation of a new IMT strategy
- Implementation of the Business Intelligence Portal
- Cisco Jabber has been procured to support televised meetings

The key initiatives currently on-going at FCMS are:

- Implementation of teleconsultation via Cisco Jabber
- Deployment of an electronic HR record
- Data warehouse and Bi expansion
- Development of a Virtual Waiting Room
- Integration with the Medical Interoperability Gateway/SCR locally in Doncaster

Doncaster Children's Services Trust (DCST)

Currently Social care and Early Help case work is recorded on two separate client record systems. Trust staff have access to both of these systems. Partners (Health, Education, etc) can have access to the Early Help system.

Key recent achievements at DCST include:

- Upgrade of Business Intelligence application to Business Objects 4.1

- Deployment of "MOMO" mobile phone app allowing children and young people to engage with the Trust via their phone.
- Introduction of an eHelpdesk for internal support for these applications

The key initiatives currently on-going at DCST are:
- Upgrading Business Intelligence application to Business Objects 4.1 to give broader access
- A development fund is in place to improve social care pathways on the case management system
- Introduction of improved system governance arrangements
- The CP-IS project is approaching completion

Doncaster Metropolitan Borough Council (DMBC)

A formal assessment of digital maturity has been carried out by the Council considering not only the position of itself in relation to adult social care transformation but also against its wider strategic digital transformation vision. The assessment shows that good progress has been and is continuing to be made within the Council to drive forward these visions. Whilst the assessment identifies that further work is to be done, the Council have a number of core transformation programmes tasked with these and development and progress is closely monitored and scrutinised against detailed delivery plans.

Key recent achievements within adult social care transformation include:

- Review and improvements to the quality of information, advice and guidance provided to residents online to promote independent living through support across the community, voluntary and private sector as opposed to traditional local authority social care.
- The development of an online self-help questionnaire, signposting residents to the most appropriate information, advice and guidance and where appropriate, access to traditional social care assessments.
- Improvements to the Adult Social Care contact model to improve demand management, sign-posting online and the introduction of email monitoring into performance analytics allowing a reduced waiting time and those in crisis to access the help they need.
- Business process re-engineering of the assessment process, allowing the process to be delivered more effective and efficiently whilst maintaining the quality and purpose of the processes.
- Improvements in lone working facilities and ensuring staff have the required communication and technology toolkit available to them to undertake their role within a community environment through remote and mobile working, removing

traditional papers from the process and ensuring the social care system provides live client information and the data risk of paper records and assessments is minimised.

The continuation of transformation with Adults, Health and Wellbeing will further contribute to this digital road map through the future introduction of:

- A community led support model, underpinned by digital and technology as enablers to promote independent living and local support within community setting, away from the traditional social care models delivered by local authorities.
- Review of the existing adult social care system and consideration of a cross functional case management system between children and adult social care supporting improved data sharing and collaboration between key agencies involved in a social care environment to ensure there is a single record of truth for the resident in respect of their social care needs and arrangements.

In addition to those specific digital transformations in adult social care, the Council has a wider transformation programme in delivery to achieve the strategic vision of a modern digital authority by the 31st March 2017, this programme is transforming service delivery both internally and externally, with key deliverables including:

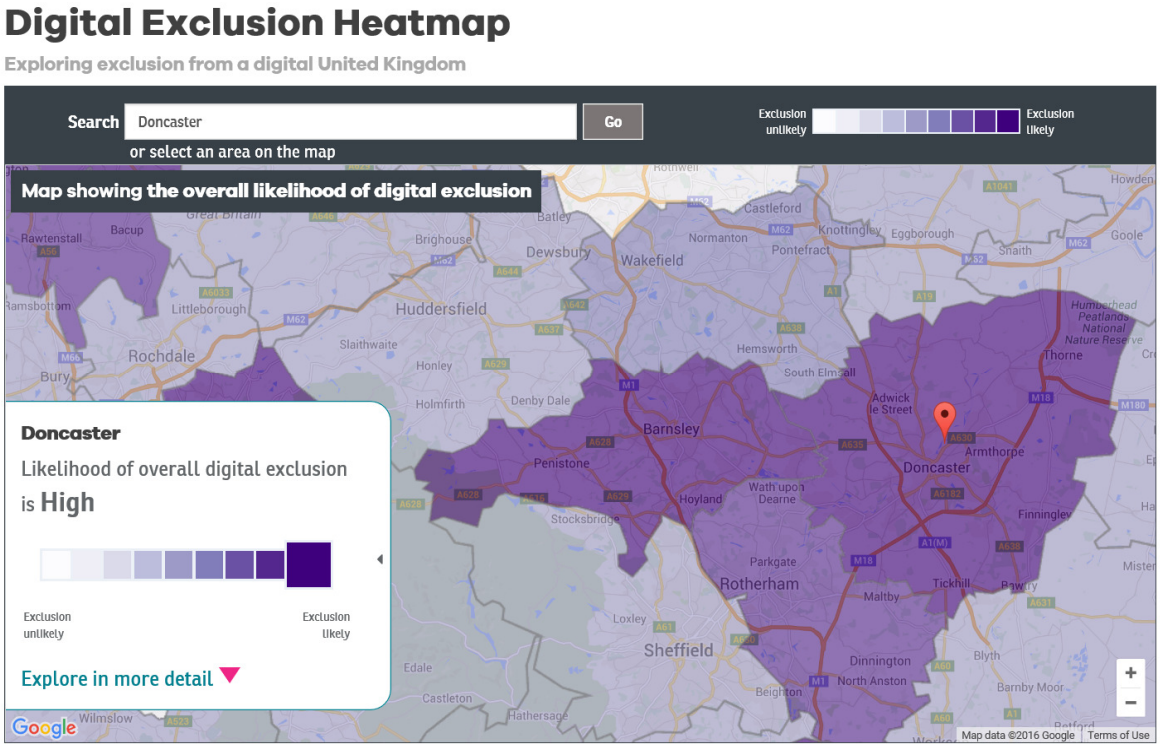
- Modern online access to most Doncaster Council services enabling the people of Doncaster to access services when and where it suits them
- A high quality experience for those who prefer to use traditional contact channels
- The ability for customers to “Tell Us Once” for key life events and we will take care of the rest
- The resident at the heart of service design and delivery
- Streamlined, quicker and efficient services delivered behind the scenes, delivering what and when the Council promises
- The ability to route, performance manage and track service delivery
- A single customer record and joined up service systems enabling the Council to have an informed picture of need and become more proactive in providing services
- Business intelligence to inform the Council and partners of those individuals and families with the greatest need, assisting in more accurate decision making, services delivery and resource allocation
- Online access to more stream lined internal and support services so the Council operates more efficiently with increased value for money
- A higher level of digital skills across the organisation
- Improved reputation of the organisation
- Reduce the organisations operating budget by allowing Doncaster’s evolving population to operate digitally

The success of the Council's transformation programme is monitored by a number of key performance indicators including:

1. % Transactions online
2. % Services Available online
3. £ Reduction in operating budget

The Programme is currently reporting 20% of transactions are now undertaken online, an increase of 15% from July 2015 with 46% of Doncaster Council Services available online.

In understanding the barriers that residents face in getting online to access services, health and employment, the Council has undertaken significant consultation to understand the barriers facing residents. A national digital inclusion map places Doncaster has higher excluded:



Source: https://doteveryone.org.uk/resources/heatmap/ (June 2016)

The exclusion heat map identifies a number of social indicators across Doncaster that contribute to the exclusion:

- 18.2% of adults in Doncaster are over the 65
- 45.70% of adults in Doncaster have no qualifications and/or no Level 1 qualifications
- £19,700 is the average income per taxpayer in Doncaster
- 21.7% of adults in Doncaster have long-term illness or disability

The partners in Doncaster must collectively deliver improved outcomes to reduce the impact of these social factors. The Council is delivering a Digital Inclusion Strategy to ensure inclusion can be minimised, considering these factors and those barriers identified through public consultation. The deliverables under the Council's strategy that will produce benefits across all Doncaster residents and partners are:

1. Access to the internet and public Wi-Fi across all Doncaster Council access points and public spaces
2. One-stop information point to find training and support available in residents areas
3. One-stop information point to find free internet access in residents areas, and facilities to bring your own device
4. Working with the Superfast South Yorkshire Programme to improve internet speed and coverage across Doncaster
5. Meet regularly with residents to shape how online services are designed around their needs
6. Work with employers across Doncaster to promote and support basic ICT skills for all

Rate Limiting Factors

There are a number of rate limiting factors in progressing paper free at point of care delivery across the Doncaster footprint. The key factors have been identified as:

- The inability to share coded data between clinical systems due to APIs not being available
- Very limited capital and revenue funds are available
- Late feedback on capital funding bids delays ability to move forward with IT improvements and efficiencies in a timely manner
- Delayed decisions internally regarding planned projects
- Lack of single clinical system across Trust's can result in reduced functionality including the ability to share data
- Lack of interoperability within the health and social care community
- Limited capacity of internal system development teams
- Lack of available budget to procure additional system development
- The alignment and interdependencies of transformation projects and programmes across all Doncaster agencies including Local Government, Police and Health
- Reliance on external partners

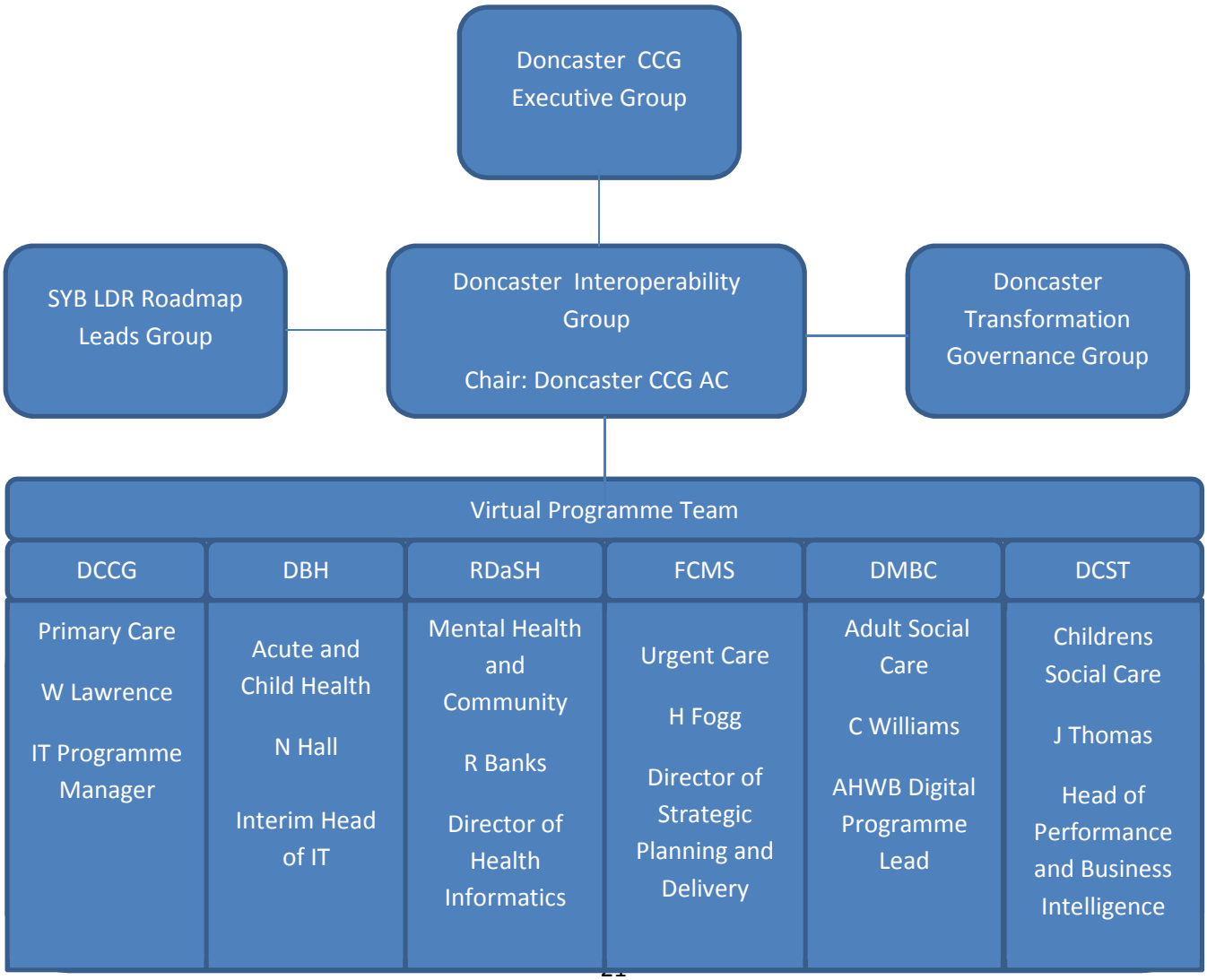
4. Readiness Assessment

As identified in section 1 we have established a new group, the Doncaster Interoperability Group, to support development and manage the delivery of our LDR. The group is chaired by the Doncaster CCG Chief Officer and has clinical and informatics representatives from all organisations. Clinical representation includes the CCG Chair, an LMC representative and the Medical Directors of both secondary care providers. The seniority of the group membership helps to provide strong leadership and links back to LDR partner organisations.

The Interoperability group is accountable to Doncaster CCG's Executive Committee, but also reports to Doncaster's Health and Social Care Transformation Governance Group, an executive steering group that includes the Chief Officers of all health partners and the Director of Social Services.. This link also helps to ensure that all partner organisations are clearly sighted and supportive of the roadmap objectives.

Progress on the delivery of the LDR will be reported to Interoperability Group and to existing provider informatics groups as per existing governance arrangements.

The current governance and programme structure for the Doncaster LDR is shown in the diagram below:



As can be seen from the diagram above Doncaster doesn't currently have a shared Programme Management Office or project resources. Therefore initially delivery of the LDR will be managed using the project resources of the partner organisations, working together to ensure that changes are managed and communicated effectively, including ensuring clarity of resource implications for each partner, balancing these against current projects and priorities. Monitoring and reporting on the LDR delivery will be carried out by Doncaster CCG as part of their responsibility for the Doncaster Interoperability Group. Over the course of the LDR programme we will review and assess the structure and resources required to support effective delivery through the Interoperability group and make changes as required. We will also continue to participate in the development of potential programme/project resources at the SYB STP level, to identify where resources supporting the LDR could be best shared across the wider area.

Within our LDR footprint at present there isn't a common change model or benefits management approach. Discussions at the Interoperability Group have identified that currently the approach to managing technology enabled change and benefits management at an organisational level does not follow a standard methodology. Our discussion on benefits management in particular has raised awareness that partner organisations may not currently have the required skills or resources to provide a formal benefits management programme. We are clear that to achieve benefits requires addressing three elements: people, process and technology. It also requires significant documentation of the baseline position so that variances from the baseline can be observed and accounted for. We will therefore identify appropriate change and benefits management models and implement them within our LDR community. These requirements have also been discussed at the South Yorkshire and Bassetlaw LDR Leads group and they were noted as a common requirement across several of the constituent LDR footprints. We will therefore seek to assess if these skills and resources could be provided and shared on a wider footprint.

The existing budgets for IT Capital and Revenue are already over committed throughout Doncaster. It is therefore expected that to drive digital maturity further and faster we will need access to additional funding. We have identified the following potential sources for this:

- The Driving Digital Maturity Investment Fund
- The Estates and Technology Transformation Fund
- Sustainability and Transformation Plan Funding
- Prime Minister's Access Fund
- Additional funding opportunities e.g. through Local Government

Working together in partnership to deliver the LDR for Doncaster will enable and require much greater engagement and co-working between the informatics departments across the footprint than before. It is expected that through this closer

working we will be able to identify opportunities to share and rationalise systems, services, skills and resources for the benefit of the whole community.

5. Capability Deployment

Operating Paper-free at the Point of Care is about ensuring health and care professionals have access to digital information that is more comprehensive, more timely and better quality, both within and across care settings. It's scope is defined by the following seven groups of capabilities:

- Records, assessments and plans
- Transfers of care
- Orders and results management
- Medicines management and optimisation
- Decision support
- Remote care
- Asset and resource optimisation

The current level of maturity of Doncaster's secondary care providers for the above groups of capabilities, as assessed by the digital maturity assessment, is detailed below:

Group of Capabilities	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Rotherham Doncaster and South Humber NHS Foundation Trust
Records assessments and plans	30	68
Transfers of care	57	13
Orders and results management	69	15
Medicines management and optimisation	56	11
Decision support	17	68
Remote Care	33	25
Asset and resource optimisation	30	40

The above identifies that the level of maturity across our two providers for these capability groups is variable with some low levels of maturity for both providers in certain groupings. The assessment indicates that there is further work to be done

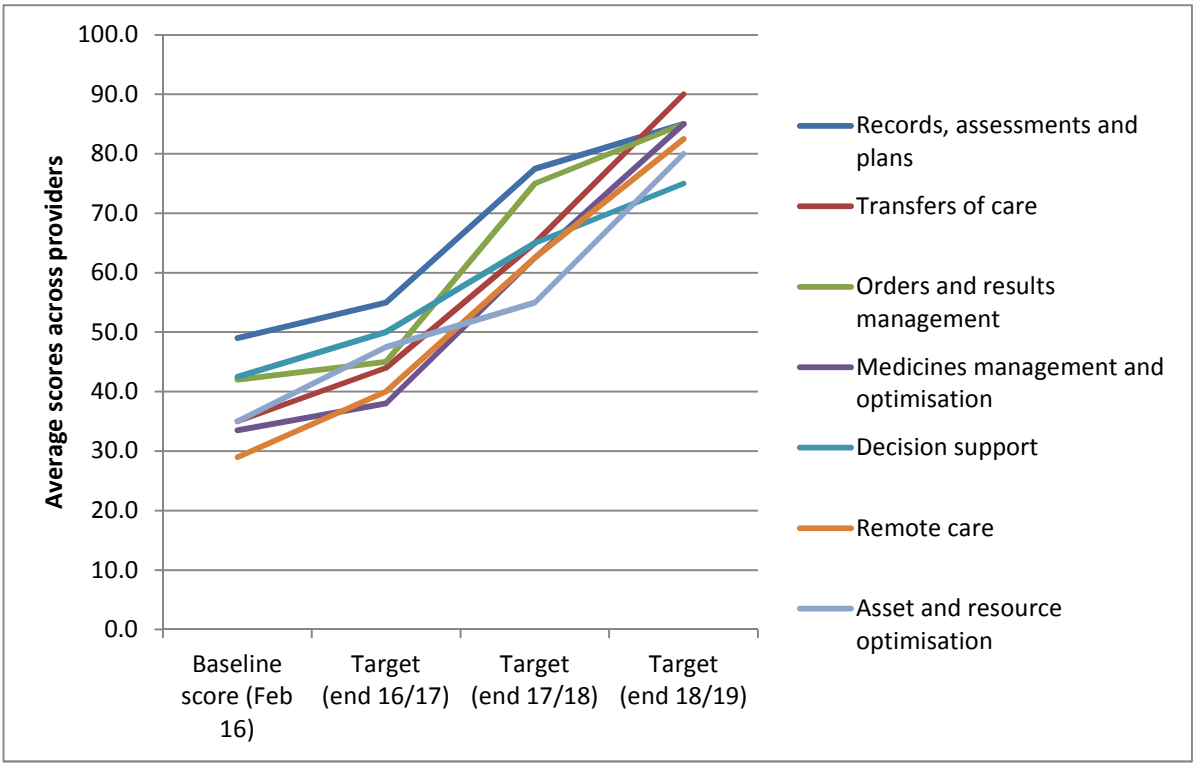
across all capability groupings to enable Doncaster to realise the ambition of operating paper free at the point of care.

As described in our vision the partners in the Doncaster LDR footprint are committed to the delivery of digitised and shared care records across Doncaster as these will be essential to the delivery of many of our strategic ambitions including the transformation of intermediate care services and the provision of care out of hospital. We are also committed to working with our partners across the wider South Yorkshire and Bassetlaw STP footprint to deliver shared care records across the whole STP footprint.

To address the growth areas above we have identified a range of projects across the LDR Doncaster footprint that will support development of the necessary capability. The outputs from these projects have been captured in the Capability Deployment Schedule shown in Appendix 1. The deliverables for 2016/17 are based on in-flight projects that will delivered this year. Deliverables for future years are aspirational and will be dependent on approved business cases and funding. To deliver on our roadmap we will require finance and support and will make bids against the available technology funds for this.

Over the course of the next three years, as we deliver on the ambitions set out in this roadmap, our capabilities for the delivery of paper free care will be significantly increased. The estimated trajectories for the overall increase in the capabilities of our secondary care providers in shown in the Capability Trajectory diagram below (and in appendix 2):

	Average scores across providers			
Capability group	**Baseline score (Feb 16)**	**Target (end 16/17)**	**Target (end 17/18)**	**Target (end 18/19)**
Records, assessments and plans	49.0	55.0	77.5	85.0
Transfers of care	35.0	44.0	65.0	90.0
Orders and results management	42.0	45.0	75.0	85.0
Medicines management and optimisation	33.5	38.0	62.5	85.0
Decision support	42.5	50.0	65.0	75.0
Remote care	29.0	40.0	62.5	82.5
Asset and resource optimisation	35.0	47.5	55.0	80.0


100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Average scores across providers
Baseline score (Feb 16)
Target (end 16/17)
Target (end 17/18)
Target (end 18/19)
Records, assessments and plans
Transfers of care
Orders and results management
Medicines management and optimisation
Decision support
Remote care
Asset and resource optimisation

6. Universal Capabilities Delivery Plan

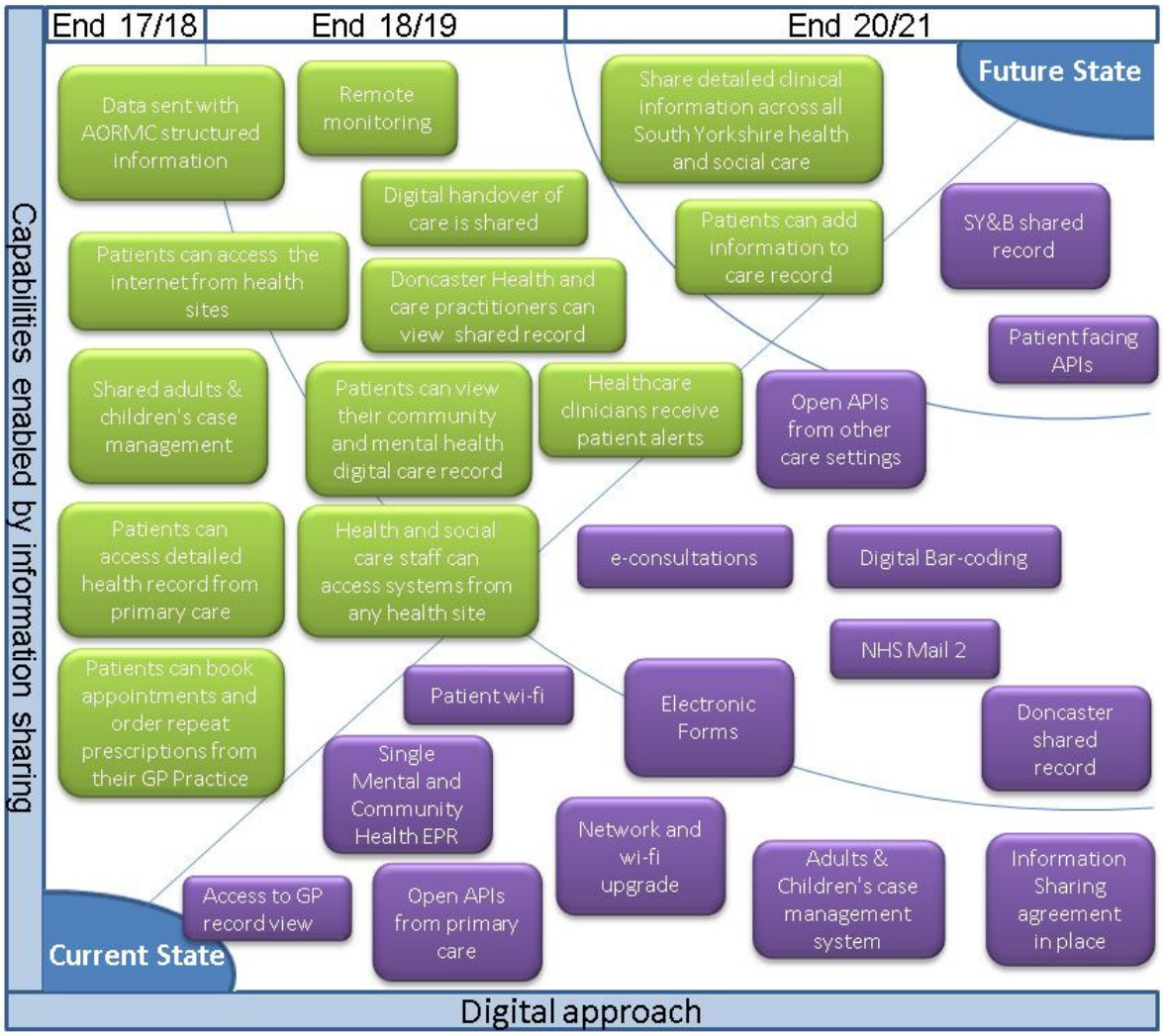
The Doncaster health and care system will make progress on the 10 universal capabilities, listed below,

- Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
- Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
- Patients can access their GP record
- GPs can refer electronically to secondary care
- GPs receive timely electronic discharge summaries from secondary care
- Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care
- Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
- Professionals across care settings made aware of end-of-life preference information
- GPs and community pharmacists can utilise electronic prescriptions
- Patients can book appointments and order repeat prescriptions from their GP practice

Our approach for addressing each of these capabilities is detailed in the Universal Capability Delivery Plan in appendix 3. The delivery plan details the baseline, ambition, key activities and approach to evidencing progress for each of the capabilities.

7. Information Sharing

A diagram showing how new information sharing capabilities will be deployed in Doncaster over the next 5 years and the corresponding solutions that will enable this information sharing is shown below (and in appendix 4):



Doncaster CCG is currently signed up to the Yorkshire Inter-Agency Information Sharing Protocol. This protocol covers the sharing of person-identifiable confidential data, with the individual's express consent, unless a legal or statutory requirement applies.

Locally across Doncaster, we have developed an Information Sharing Agreement to enable the sharing of real time clinical information across health organisations. This is a framework on how we will share information with all the agencies involved in our patients' care. For each new information sharing objective we will supplement the protocol with specifics regarding what and how the information will be shared and who with. A privacy impact assessment will be put in place to ensure we have measured all the risks associated with the information sharing approach. It is the trusts duty to share information for effective patient care with all legitimate parties. As part of the local digital roadmap we will aspire to deliver a clinical portal technology,

incorporating existing information sources, across the Doncaster health community in line with other health community successful models including the Bristol and Leeds Care Records. We will ensure we comply with all the regulatory requirements to ensure the safe interoperability of information throughout the health community and beyond whilst recognising that we have a duty to share information to enable the provision of safe care to our patients.

As part of our work within the wider SYB footprint we recognise the need to have a shared approach to information sharing (through both an information governance framework and technical solutions). Our intention is to engage in a wider joint approach across all SYB (or wider) health and care organisations and we will be seeking to take this work forward within the SYB STP governance arrangements.

The current level of adoption of the NHS Number across health and care providers in Doncaster is shown in the table below:

Provider	% records in key systems with NHS number	Action Plan
DBH	84.2%	Since the Trust adoption of their new spine connected PAS in October 2015 the % of records with a verified NHS number has risen to 98% for records with activity since system implementation.
RDaSH	99.9%	None required
FCMS	80.0%	FCMS have approximately 80% coverage due to staff in the previous service not having smart cards. They have now secured a local RA agent and the staff are rotating through the process. They plan to have full coverage of new cases by August 2016.
DCST	43.0%	43% of children's social care records have an NHS number although the proportion differs dependent upon the level of care. 63% of Looked after children have an NHS number. As part of the CP-IS project, matching activity is taking

		place to improve the rate of children in care or subject to a child protection plan with an NHS number in order to facilitate information exchange. This is currently with HSCIC. There is no statutory requirement to hold this information for children in need, and the requirement to hold an NHS number will depend upon the level of support that is being delivered.
DMBC	80.0%	Adult social care will be undertaking work to improve the number of records with the NHS number in 2016/17

In order to extract the most value from the sharing of information, the SNOMED-CT and Dictionary of Medicines and Devices (dm+d) information coding standards will have to be rolled out across the local health and care system. Our plans and milestones for the adoption of these standards are summarised in the table below:

Provider	Action Plan
Primary Care	SNOMED is already implemented in EMIS Web. We will seek confirmation from the GPSoC programme of when it will be available in SystmOne. dm+d is already available in EMIS Web and SystmOne.
DBH	The Trust are currently establishing how SNOMED-CT can be supported in their CaMIS PAS system
RDaSH	The implementation of SNOMED and dm+d will be facilitated by the new EPR system
FCMS	Adastra is ready to support the adoption of SNOMED-CT codes as and when the standard is introduced into everyday use

8. Infrastructure

The development of network connectivity between sites and mobile infrastructure has been developed significantly in Doncaster over recent years. We have been working to rationalise and deploy network connections from the Yorkshire and Humber Public Sector Network (PSN) across primary care, secondary care and local authority sites for several years. These network connections are now fully deployed in DBH, RDaSH and DMBC and continue to be rolled out into primary care, giving us increased capability to share information and services across providers. Doncaster has supported the development of the NHS Roam Wi-Fi solution, developed under the Working Together Partnership, and this has been implemented in sites at DBH, RDaSH and the CCG allowing staff to move and work across sites. In the future we aim to further develop this capability to allow seamless mobile working for health and care practitioners across all health and care sites in Doncaster.

A summary of the current mobile working capability in Doncaster and plans to develop this further is shown below:

Primary Care	All GPs and Registrars and identified practice nurses within Doncaster practices have been allocated a laptop with mobile provision. The mobile connection is delivered by a solution that provides access over 4G and Wi-Fi networks helping to maintain a secure and reliable connection to system. To support mobile connectivity in GP practices we have invested in a GP practice Wi-Fi solution for all sites and plan to deploy it at 50% of sites in 16/17 and the remaining sites 17/18.
DBH	DBHFT operate an AirWatch MDM solution with 500 device licenses and 300 + Apple iPads / iTouch / iPhones. This is underpinned by a new ac wifi network installed to RFID standards in clinical areas. In future with the mass deployment of RFID surveyed ac Wireless in progress, the Trust expects that it will have complete Trust coverage for wireless working. External to the Trust, DBHFT utilises the NHSRoam wireless and leverages the functions within AirWatch (through the Secure AirWatch Browser) to access internal applications (including clinical systems). As part of the plans to deploy Electronic Whiteboards and e-obs, the Trust anticipates a further deployment of hand-held devices to support the recording of patient details and vitals at the bedside
RDaSH	Infrastructure to facilitate mobile working (3G/4G plus VPN) is available. Staff have the ability to access this infrastructure depending on need. Wi-Fi is deployed to areas across the Trust. A Mobile/Agile programme is now in place to support the Trust wide Transformation Programme. This will include extending Wi-Fi coverage across the whole Trust.
DMBC	DMBC delivers wide and varied remote and mobile working solutions across its workforce based on the needs of the individual and their role. The Council utilises the ability to allow staff to access systems remotely and issues appropriate devices as required.

	A majority of DMBC sites provide public and organisation Wi-Fi supporting multi agency site location as well as the ability for staff to access core systems outside of council estate also. The infrastructure solutions also provide the ability for the workforce to access 3G/4G connectivity through the Council unified communications provider. The Council delivers a PSN compliant network with security compliance to standards with encryption and data security protocols.
DCST	The majority of case holding staff have access to a laptop and mobile phone. Remote access to the case management system is possible. Wi-Fi is available across most sites (delivered by DMBC through SLA). In future DCST aims to provide access to laptops and mobiles for all key workers. In addition DCST's case management system suppliers (Liquid Logic) are developing a mobile APP for case management system. This solution is not currently scheduled in the DCST development plan, however it may be considered future.
FCMS	All FCMS mobile clinicians use Adastra Aremote to access the full Adastra record remotely. The ability to embed MIG/SCR within this system is available now and awaiting local implementation. FCMS are currently implementing VMWare Horizon as a Business Resilience system to allow clinicians to be on call and work from home. They are also investigating the possibility of using this system at allow staff to connect to work resources using personal devices. FCMS already provide telemedicine services in other areas and the FCMS infrastructure in Doncaster for the provision of teleconsultations is ready to go live. FCMS are looking at rolling out Cisco Virtual Waiting room. This will be only the second site in the country to be live. The system will provide a virtual waiting room for televised consultations as opposed to visiting or bringing the patient into a site.

As detailed above the providers in Doncaster have implemented connectivity to a common wide area network infrastructure (PSN) and have discussed how this could be used to support collaboration and shared infrastructure in the future. There are currently no agreed plans for tools to support collaboration across the Doncaster footprint but adoption of the NHSmail2 service is currently under consideration for primary care, RDaSH and the CCG and we are keen to see how the development could support a future collaboration platform. In addition to this DCST is currently in deployment of "Professional Portal" that will allow professionals access to their case management system.

In Doncaster we have some areas of shared infrastructure in place across groups of organisations. RDaSH provide an IT service that covers themselves, all General Practices and the CCG. This service has significant areas of shared infrastructure and this continues to develop as the IT services grow and are rationalised across organisations, including the recent development of a shared storage area network. Similarly the IT services for DCST are provided by DMBC on a shared infrastructure and they share client case systems allowing joint access for lead professionals on open cases.

As our LDR programme develops and the partner organisations develop their digital maturity we will use the opportunities provided by working in partnership to identify where infrastructure, systems and IT services could be shared across the Doncaster footprint or possibly wider across the STP or Working Together areas. Working with our partners across the STP footprint we aim to encourage the development connectivity of IT systems and services that will enable practitioners to work seamlessly from any health and social care location with full access to all the information they need.

9. Minimising Risks Arising from Technology

All partners within the Doncaster LDR footprint have their own well established Information Governance functions and will remain responsible for minimising risks associated with data security, clinical safety, data quality, data protection, privacy, business continuity and disaster recovery.

The routine reporting of risks and issues has been established at the Doncaster Interoperability Group and we will use this process to ensure that key risks to LDR delivery and operation are communicated across the footprint and mitigated as appropriate. In addition as part of our LDR development we have commenced discussions on the establishment of a footprint wide Information Governance Group, operating as sub-group to the Interoperability Group. We have also recognised that there is the opportunity for working more collaboratively on the wider STP footprint to support this agenda and we will continue to engage with partners across this wider area.

DBH and RDASH are both developing plans for the GS1 standards. DBH have confirmed that they intend to implement GS1 standards on patient wristbands during 2016/17.

10. Glossary

A&E (Accident and Emergency)	A medical treatment facility specialising in acute care of patients who present without prior appointment.
CCG (Clinical Commissioning Group)	Clinical commissioning groups will cover the whole of England and will be responsible for commissioning the majority of healthcare for their local population. They will work with partners including NHS England and local authorities, who have responsibility for commissioning areas such as specialised services, primary care and public health, to commission integrated care for patients.
DMA (Digital Maturity Assessment)	The Digital Maturity Assessment measures the extent to which healthcare services in England are supported by the effective use of digital technology. It will help identify key strengths and gaps in healthcare providers' provision of digital services at the point of care and offer an initial view of the current 'baseline' position across the country.
EPS (Electronic Prescription Services)	The Electronic Prescription Service is an NHS service that allows a GP to send prescriptions directly to a patient's chosen pharmacy. This means that patients can choose to have a paper-free prescription.
GP (General Practice)	General practice (GP) General practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.
GPSoC (GP Systems of Choice)	GP Systems of Choice is a programme through which the NHS funds the provision of GP clinical IT systems in England.
Local Digital Roadmap (LDR)	Local health economies are required to produce Local Digital Roadmaps detailing the actions they will take to deliver the ambition of being paper-free at the point of care by 2020. Local Digital Roadmaps will generate momentum and drive transformation across local health economies, inform local investment priorities and support local benefit realisation strategies.
NHS Digital (HSCIC)	The national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. NHS Digital (HSCIC) is an executive non-departmental public body, sponsored by the Department of Health.
NHS e-RS (NHS	NHS e-Referral Service replaced Choose and Book in 2015. This

e-Referral Service)	service is used to manage all appointments referred to secondary care from primary care
PF@POC (Paper Free at the Point of Care)	Paper free at the point of care means that all authorised care givers can access a patient's relevant digital records when and where they need them.
PSN (Public Services Network)	The Public Services Network (PSN) is the UK government's high-performance network, which helps public sector organisations work together, reduce duplication and share resources.
SCR (Summary Care Record)	The Summary Care Record is an electronic record used to support patient care. The SCR is a copy of key information from a patient's GP record, such as medication, allergies and adverse reactions. It provides authorised healthcare staff with faster, more secure access to essential patient information
Social Care	Social care in England is defined as the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.
SNOWMED	SNOMED CT (Systematized Nomenclature of Medicine -- Clinical Terms) is a standardized, multilingual vocabulary of clinical terminology that is used by physicians and other health care providers for the electronic exchange of clinical health information.
Sustainability and Transformation Plan (STP)	Local health and care blueprints for accelerating implementation of the Forward View.
Working Together Programme (WTP)	Working Together is a partnership involving seven hospital Trusts in South Yorkshire, Mid Yorkshire and North Derbyshire. Collaborating on a number of common issues will allow the Trusts to deliver benefits that they would not achieve by working on their own.

11. Executive Sign-Up

The signatories below confirm that their organisation is in agreement to the Doncaster Local Digital Roadmap and is committed to its delivery:

Signed on behalf of NHS Doncaster Clinical Commissioning Group	Name: J PEDERSON Signature: Designation: Chief Officer 24/6/16
Signed on behalf of Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Name: SEWA SINGH Signature: Designation: MEDICAL DIRECTOR
Signed on behalf of Rotherham Doncaster and South Humber NHS Foundation Trust	Name: NAVJOT AHLUWALIA Signature: Designation: EXECUTIVE MEDICAL DIRECTOR.
Signed on behalf of FCMS	Name: GILLIAN GREGORY Signature: Designation: DIRECTOR OF QUALITY & PERFORMANCE
Signed on behalf of Doncaster Metropolitan Borough Council	Name: KIM CURRY Signature: Designation: DASS 24/6/16
Signed on behalf of Doncaster Children's Services Trust	Name: Paul Moffat Signature: Designation: CX DCST

This page is intentionally left blank

General instructions

The 'Capability deployment schedule' worksheet should be completed.

This template is described in section 6.17 of the guidance, and illustrated in Annex 2.

Column E onwards can be used for locally defined attributes, as described in section 6.20 of the guidance.

Please do not amend any of the reference data without first checking with england.digitalroadmap@nhs.net.

This template can be downloaded at www.england.nhs.uk/digitaltechnology/info-revolution/digital-roadmaps.

Footprint:	Doncaster

Capability				Locally defined attributes	
Who	What	Year	Capability group		
GPs	Receive Academy of Medical Colleges coded e-discharge messages	16/17	Records, assessments and plans		
GPs	Use standardised templates to capture information required for local LES/DES requirements	16/17	Records, assessments and plans		
GPs	Use standard electronic referral forms to improve quality of referrals	16/17	Records, assessments and plans		
GPs	Ability to create local templates to support data capture	16/17	Records, assessments and plans		
H&SC	Have an agreed consent model to support data sharing across H&SC	16/17	Records, assessments and plans		
OOH and ED clinicians	Clinicians in U&EC settings can access key GP-held information for attending patients	16/17	Records, assessments and plans		
Patients	Can access detailed health record from primary care	16/17	Records, assessments and plans		
Patients	Can book appointments and order repeat prescriptions from GP practice	16/17	Records, assessments and plans		
GPs	Receive timely electronic discharge summaries	16/17	Transfers of care		
GPs	Receive coded NHS 111 ITK Messages	16/17	Transfers of care		

Footprint:	Doncaster

GPs	GPs can refer electronically to secondary care	16/17	Transfers of care		
GPs	Ability to request and view test results	16/17	Orders and results management		
Community Pharmacists	Can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions	16/17	Medicines Management and Optimisation		
Community Pharmacists	Ability to receive electronic prescriptions for patients	16/17	Medicines management and optimisation		
GPs	Ability to send electronic prescriptions to nominated pharmacies	16/17	Medicines management and optimisation		
Patients	Ability to nominate a pharmacy to receive electronic prescriptions	16/17	Medicines Management and Optimisation		
All mobile clinicians	Mobile / Portable Working across all Doncaster Acute Trust locations	16/17	Remote care		
DBH	Business Continunity risk mitigation	16/17	Asset and resource optimisation		
GPs	Ensure data quality standards for recording and sharing information are met	16/17	Asset and resource optimisation		
GPs	Improve utilisation of GP clinical systems and utlisation of universal and local capabilities	16/17	Asset and resource optimisation		
Secondary Care Clinicians	Meeting National Blood Bank standards	17/18	Records, assessments and plans		
Secondary Care Clinicians	Ability to view secondary care shared electronic information	17/18	Records, assessments and plans		

Footprint:	Doncaster

All Community and MH Clinicians	Information is collected/recorded once; healthcare professionals do not have to copy or re-enter it from one system to another	17/18	Records, assessments and plans		
All Community and MH Clinicians	Healthcare professionals use digital systems to record relevant patient information at the point of collection	17/18	Records, assessments and plans		
GPs	Receive Academy of Medical Colleges coded for all local clinical correspondence	17/18	Records, assessments and plans		
Patients	Patients are able to view and download information from their community and mental health digital care record	17/18	Records, assessments and plans		
Social Services	Shared Adults and children's case management system	17/18	Records, assessments and plans		
GPs	Receive timely electronic clinical letters	17/18	Transfers of care		
All Community and MH Clinicians	Healthcare professionals can track the status of requests at all times, including receipt, authorisation, scheduling and completion.	17/18	Orders and results management		
All Community and MH Clinicians	Ability to view test results within clinical system.	17/18	Orders and results management		

Footprint:	Doncaster

Community and MH prescribing staff	Medicines and infusions are automatically scheduled for administration and the outcome is digitally recorded, including reasons for non-administration.	17/18	Medicines management and optimisation		
Community and MH prescribing staff	Dgitally monitoring of prescribed medications administered early, late or not administered at all, and reviews the reasons recorded.	17/18	Medicines Management and Optimisation		
GPs, Community, Secondary Care, Hospice	All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected.	17/18	Decision Support		
Mental Health Clinicians	Ability to identify patients and medicines prior to administration through automatic identification and data capture using barcode technology	17/18	Decision Support		
GPs and Patients	Ability to have remote consultations	17/18	Remote care		
GPs, Patients	Ability to consult with suitable patients using video consultations	17/18	Remote care		

Footprint:	Doncaster

Patients	Empower patients to triage and check symptons to make a better decision to the right place of care	17/18	Remote care		
Patients	Ability to use applications to self-manage care	17/18	Remote care		
Secondary Care Clinicians	Reduction in risk / GS1 Standard enabling	17/18	Asset and resource optimisation		
All Community and MH Clinicians	Healthcare professionals use digital systems to manage inpatient beds throughout the organisation	17/18	Asset and resource optimisation		
GPs	Ability to view and input data from the GP system across a federation when providing services across practice boundaries	17/18	Asset and resource optimisation		
GPs Secondary care clinicians	Ability to electronically communicate with clinicians across care settings, with the ability to add attachments and other supporting information to support advice and virtual clinics	17/18	Asset and resource optimisation		
GPs, Community Nursing, Health Visitors, Midwives, Social Services staff	Can access wi-fi across Doncaster Health sites	17/18	Asset and resource optimisation		

Footprint:	Doncaster

GPs, Nurses, health visitors, midwives, hospice clinicians and mental health clinicians	Ability to send electronic tasks and messages between clinical systems	17/18	Asset and resource optimisation		
Patients	Ability to access the internet from the primary care sites	17/18	Asset and resource optimisation		
Primary Care, Secondary Care, Community Care	Shared digital data network across local health economy	17/18	Asset and resource optimisation		
All Community and MH Clinicians	Increase the proportion of patient information relating to handovers of care within the organisation that is shared by Healthcare professionals digitally	18/19	Transfers of care		
All Healthcare Professionals	Receive digital system patient alerts	18/19	Decision Support		
Patients	Ability to self-monitor and submit results electronically	18/19	Remote care		
Community Clinicians Patients	Remotely monitor groups of patients who have been discharged home but are at high risk of readmission	18/19	Remote care		
Secondary Care Clinicians/Admin	Inventory Management & Patient Care	18/19	Asset and resource optimisation		
All Community and MH Clinicians	All information is available at the point of care; paper records are used by exception.	19/20	Records, assessments and plans		

Footprint:	Doncaster

All Community and MH Clinicians	Remote/virtual clinical consultations and clinical advice are available to patients using tools such as online meetings, videoconferencing, skype, email or instant messaging,	19/20	Records, assessments and plans		
H&SC	Share detailed clinical information across all South Yorkshire health and social care	20/21	Records, assessments and plans		
H&SC	Ability to use patient acquired information	20/21	Records, assessments and plans		
Primary Care, Secondary Care, Community Care and Social Care	Transfer onto HSCN data network across Health and Social Care	20/21	Asset and resource optimisation		
[Insert further rows above as necessary]					

Year

- 16/17
- 17/18
- 18/19
- 19/20
- 20/21

Groups of capabilities

- Records, assessments and plans
- Transfers of care
- Orders and results management
- Medicines management and optimisation
- Decision support
- Remote care
- Asset and resource optimisation
- Other 1
- Other 2
- Other 3

This page is intentionally left blank

General instructions

The summary worksheet is fed from the data in the subsequent worksheets - do not enter directly in to the sheet.

Within the subsequent worksheets, there is a sheet for each of the 7 groups of capabilities.

Within these worksheets, a row should be completed for each secondary care provider who completed a Digital Maturity Self-assessment.

An unweighted average across all providers will be automatically calculated.

The baseline score to be recorded should be taken from the results of the Digital Maturity Self-assessment, shared with providers and CCGs.

The target future scores should be set with reference to the baseline, the DMSa questions, and the capability deployment schedule.

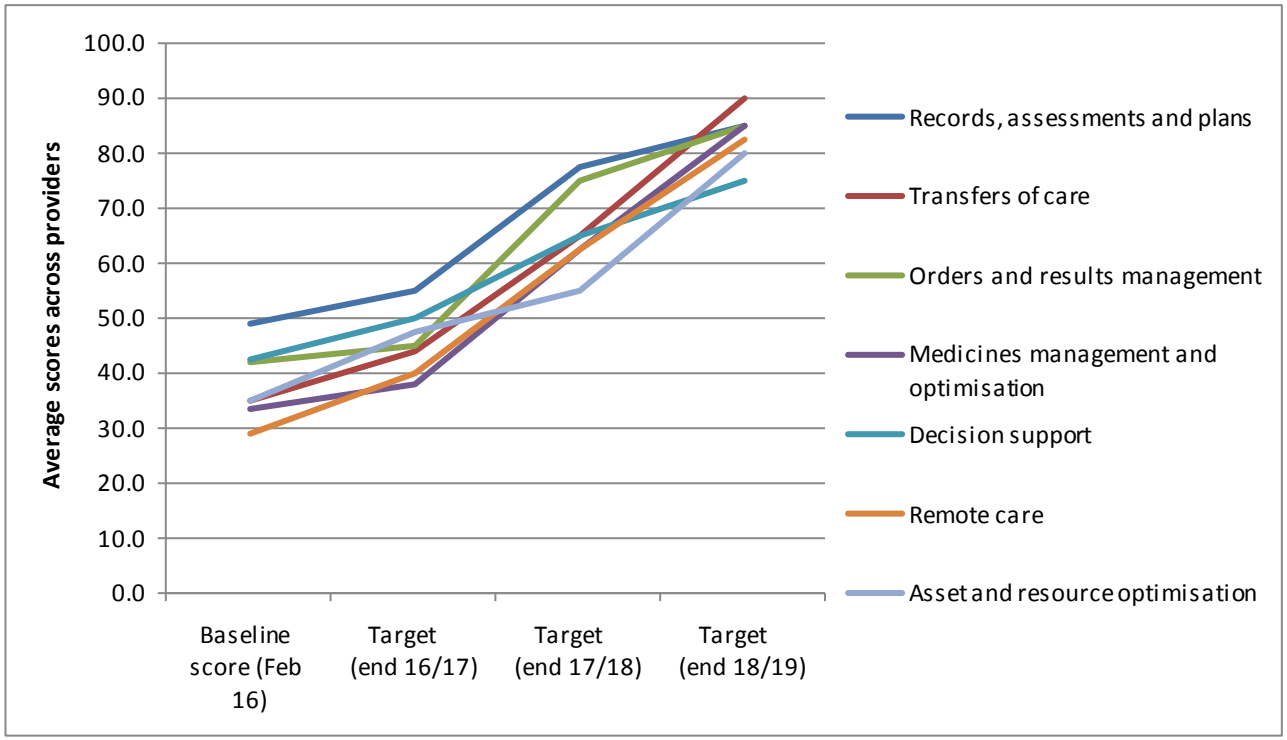
Refer to section 6.23 of the guidance for background information on the capability trajectory template.

Refer to Annex 3 of the guidance for an illustration of a capability trajectory summary.

This template can be downloaded at www.england.nhs.uk/digitaltechnology/info-revolution/digital-roadmaps.

Footprint:	

	Average scores across providers			
Capability group	**Baseline score (Feb 16)**	**Target (end 16/17)**	**Target (end 17/18)**	**Target (end 18/19)**
Records, assessments and plans	49.0	55.0	77.5	85.0
Transfers of care	35.0	44.0	65.0	90.0
Orders and results management	42.0	45.0	75.0	85.0
Medicines management and optimisation	33.5	38.0	62.5	85.0
Decision support	42.5	50.0	65.0	75.0
Remote care	29.0	40.0	62.5	82.5
Asset and resource optimisation	35.0	47.5	55.0	80.0



Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)
RDASH	RXE	68	70	85	90
DBHFT	RP5	30	40	70	80
[Insert additional rows above if required]					
Average across providers		49.0	55.0	77.5	85.0

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)
RDASH	RXE	13	13	50	90
DBHFT	RP5	57	75	80	90
[Insert additional rows above if required]					
Average across providers		35.0	44.0	65.0	90.0

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)
RDASH	RXE	15	15	70	80
DBHFT	RP5	69	75	80	90
[Insert additional rows above if required]					
Average across providers		42.0	45.0	75.0	85.0

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)
RDASH	RXE	11	11	50	80
DBHFT	RP5	56	65	75	90
[Insert additional rows above if required]					
Average across providers		33.5	38.0	62.5	85.0

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)
RDASH	RXE	68	70	80	90
DBHFT	RP5	17	30	50	60
[Insert additional rows above if required]					
Average across providers		42.5	50.0	65.0	75.0

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)
RDASH	RXE	25	30	65	85
DBHFT	RP5	33	50	60	80
[Insert additional rows above if required]					
Average across providers		29.0	40.0	62.5	82.5

Provider	ODS code	Baseline score (Feb 16)	Target score (end 16/17)	Target score (end 17/18)	Target score (end 18/19)
RDASH	RXE	40	45	50	80
DBHFT	RP5	30	50	60	80
[Insert additional rows above if required]					
Average across providers		35.0	47.5	55.0	80.0

Universal Capabilities Delivery Plan

Footprint:	Doncaster

Instructions for Completion

- Please indicate your Local Digital Roadmap Footprint above
- Complete questions A to E in the subsequent pages – the same structure is used for each of the 10 universal capabilities
- For further guidance, refer to:
    - Sections 6.24 to 6.30 of the Developing Local Digital Roadmaps Guidance
    - The Universal Capabilities Information and Resources document
- This template and the documents referenced above can be downloaded from the LDR page on the NHS England website

Universal Capability:	A. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
Capability Group:	Records, assessments and plans
Defined Aims:	• Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients) • Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

The Summary Care Record has been uploaded by 100% practices. Access to the SCR is available in the Emergency Department and pharmacy of the hospital, the OOH service and community services. Plans are in place to also implement the MIG to provide further information to unplanned and emergency care services.

560 SCRs are viewed per week across Doncaster

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Increase the number of SCRs viewed across Doncaster. Deploy the Medical Interoperability Gateway to provide a more detailed record for the unplanned and emergency care services within Doncaster.
17/18	Integrate SCR information into local Mental Health and Community system to improve accessibility of SCR by clinical staff and remove requirement to log on to SCR separately.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Local workshops are being arranged by Midlands and Lancashire CSU for all South Yorkshire and Bassetlaw pharmacies, this has been arranged by HSCIC. • Review Information sharing agreements to support deployment of the MIG within unplanned and emergency care services
16/17 Q2	• Pilot the MIG within the OOH service • Practices sign-up to information sharing protocol.
16/17 Q3	• Roll-out MIG across primary care for OOH service • Plan MIG deployment within DBH to support accident and emergency services.
16/17 Q4	• Review MIG implementations and potential to expand to further services.
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	• Integrate SCR with Mental Health and Community EPR system.

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

In conjunction with the SCR, implementing access to the Medical Interoperability Gateway (MIG) to provide more detailed information straight from the primary care clinical systems.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

HSCIC SCR access reports % reported to the Doncaster Interoperability Group. MIG deployment Progress/Highlight reports to the Doncaster Interoperability Group.

Universal Capability:	B. Clinicians in U&EC settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
Capability Group:	Records, assessments and plans
Defined Aims:	• Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations • Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients)

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

The Summary Care Record has been uploaded by 100% practices. Access to the SCR is available in the Emergency Department and pharmacy of the hospital, the OOH service and community services. Plans are in place to also implement the MIG to provide further information to unplanned and emergency care services.

560 SCRs are viewed per week across Doncaster

Currently no additional information is recorded on the Summary Care Record.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Provide access to detailed primary care data to OOH and emergency care settings across Doncaster via the MIG.

17/18	

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Provide SCR enhanced workshops at practice managers meetings and clinical system users groups. • Include SCR enrichment in the paperlight and system optimisation practice work plan • Review Information sharing agreements to support deployment of the MIG within unplanned and emergency care services
16/17 Q2	• Pilot the MIG within the OOH service • Practices sign-up to information sharing protocol.
16/17 Q3	• Roll-out MIG across primary care for OOH service • Plan MIG deployment within DBH to support accident and emergency services.
16/17 Q4	• Review MIG implementations and potential to expand to further services.
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

In conjunction with SCR, implementing access to the Medical Interoperability Gateway (MIG) to provide more detailed information straight from the primary care clinical systems.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

HSCIC SCR access reports % reported to the Doncaster Interoperability Group. MIG deployment Progress/Highlight reports to the Doncaster Interoperability Group.

Universal Capability:	C. Patients can access their GP record
Capability Group:	Records, assessments and plans
Defined Aims:	• Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition • Patients who request it are given access to their detailed coded GP record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Patient online is deployed at 100% of practices

42% of practices have 10% or more patients with access to patient online services.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Increase no. of patients having access to their detailed coded record.
17/18	Increase no. of patients having access to their detailed coded record.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Promote patient online with practices via system optimisation programme
16/17 Q2	• Promote patient online with practices via system optimisation programme; identifying patients who might benefit from access to their detailed record. • Set-up local report to review patient online access against 2016/17 target, provide practices with monthly report.
16/17 Q3	• Provide monthly report against 2016/17 target to practices.
16/17 Q4	• Provide monthly report against 2016/17 target to practices.
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Provide patient online statistics per practice to the Doncaster Interoperability Group.

Universal Capability:	D. GPs can refer electronically to secondary care
Capability Group:	Transfers of care
Defined Aims:	• Every referral created and transferred electronically • Every patient presented with information to support their choice of provider • Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability) • [By Sep 17 – 80% of elective referrals made electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

An estimated 50% of referrals are sent via NHS e-referrals currently across Doncaster.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	70% elective referrals are sent via the NHS e-referral service. Mental Health referral process mapping and redesign in conjunction with primary care
17/18	100% elective referrals are sent via e-referral service.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Meetings arranged to discuss Doncaster position with HSCIC and primary care teams. • Training and support provided to practices via IT Project and data quality team where identified.
16/17 Q2	• Meetings arranged with DBH, CCG and HSCIC to discuss any issues re DOS and appointment slots. • Promote e-referrals with practices via system optimisation programme. • Training and support provided to practices via IT Project and data quality team where identified.
16/17 Q3	• Promote e-referrals with practices via system optimisation programme. • Training and support provided to practices via IT Project and data quality team where identified.
16/17 Q4	• Mental Health and community services referral process mapping and redesign in conjunction with primary care
17/18 Q1	•
17/18 Q2	•
17/18 Q3	• Implement new referral pathways in line with mental health and community EPR go live and September 17 target of 80% of elective referrals made electronically
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

% of GP referrals via NHS e-referral service reported to Doncaster Interoperability Group.

Universal Capability:	E. GPs receive timely electronic discharge summaries from secondary care
Capability Group:	Transfers of care
Defined Aims:	• All discharge summaries sent electronically from all acute providers to the GP within 24 hours • All discharge summaries shared in the form of structured electronic documents • All discharge documentation aligned with Academy of Medical Royal Colleges headings

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

E-Discharge summaries sent electronically from patients registered on the mental health and community units using SystmOne to all Doncaster practices.

The mental health trust has funded Silverlink to develop the current system to enable a 'system to system' transfer which has been delayed in its delivery due to an accreditation process with the HSCIC. The Information Team are currently working with Silverlink to ensure the necessary technical set up that is required across GP practices and will then be able to test the new functionality in house.

DBHFT will be building on existing process. ICT have requested clinical buy-in to ensure the process is carried out to meet the National Standards. Such e-discharges will be sent directly to GP clinical systems and meet the AoMRC headings. Anticipated date of completion Aug 16.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	All practices receive electronic discharge notifications with AoRMC headings by December 2016
17/18	

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Agreeing roll-out plan for e-discharge notifications with acute and mental health trusts • Messaging services moved to MESH from DTS. • Configuration of mental health system to enable transfer of discharge summaries
16/17 Q2	• Business change and training for mental health services • Technical changes to acute systems to set-up electronic discharge notifications • Pilot e-discharge messaging with identified primary care pilots.
16/17 Q3	• Finalise business change processes with staff. • Provide training and training material for staff. • Roll-out e-discharge notifications to all Doncaster practices.
16/17 Q4	•
17/18 Q1	•
17/18 Q2	•
17/18 Q3	• Mental health and community services transfer and update e-discharge functionality and processes with replacement EPR solution.
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress/Highlight Reports provided to Doncaster Interoperability Group.

Universal Capability:	F. Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care
Capability Group:	Transfers of care
Defined Aims:	• All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

No electronic discharges are sent to Social Care currently.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	DMBC and DCST to work in partnership to scope out requirement of new case management system to be implemented in 2018, with interoperability a key consideration in options appraisal and any subsequent tender.
17/18	Childrens and Adults Social care services have access to timely Assessment, Discharge and Withdrawal information in order to deliver continued support and care. Means of delivery will be appropriate and proportionate to state of relevant client systems.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	
16/17 Q2	• Initial exploration of potential discharge pathways from acute care to social care. Review of current case management systems and interoperability, including current common fields. This to include Adults and Social Care.
16/17 Q3	• Options appraisal for scope to transfer
16/17 Q4	•
17/18 Q1	•
17/18 Q2	• Adults and children's case management systems re-commissioned
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Scoping work to be reported back through DMBC IG Board. Options appraisal for client case management systems currently managed by DMBC and DCST. Progress/Highlight report sent to Doncaster Interoperability Group.

Universal Capability:	G. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
Capability Group:	Decision support
Defined Aims:	• Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children) • Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details • The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Data as at 23rd May 2016

	Total	With NHS No.	% With NHS No.
Number of Cases	2696	1168	43%
Number of Children in Need	1786	714	40%
Number of Looked After Children	499	316	63%
Number of Children on a Child Protection Plan	421	143	34%

43% of children's social care records have an NHS , number although the proportion differs dependent upon the level of care. 63% of Looked after children have an NHS number.

As part of the CP-IS project, matching activity is taking place to improve the rate of children in care or subject to a child protection plan with an NHS number in order to facilitate information exchange. This is currently with HSCIC.

There is no statutory requirement to hold this information for children in need, and the requirement to hold and NHS number will depend upon the level of support that is being delivered.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Delivery of CP-IS project this year
17/18	

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Matching of social care record with HSCIC data to improve NHS number rate
16/17 Q2	• CP-IS tested and working in accordance with protocol
16/17 Q3	• CP-IS Live
16/17 Q4	•
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Increased NHS number rate on children and adults social care record. CP-IS sign off Highlight/Progress report sent to Doncaster Interoperability Group

Universal Capability:	H. Professionals across care settings made aware of end-of-life preference information
Capability Group:	Decision support
Defined Aims:	• All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care • All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

No additional information currently added to enhanced SCR.
Local GP clinical templates created to support capture of end of life care preferences at 28% practices.
EPACCS template to record uniformed data across SystmOne GP and community services. Acute Trust has access to RDaSH end of life SystmOne patient via external access. (Palliative staff).

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	35% Doncaster practices using locally developed clinical system templates to record patient preferences. Improved use of local EPACCS across Doncaster Review SCR enriched records to support end of life care.
17/18	100% All practices recording patient preferences.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Rollout local template to one practice.
16/17 Q2	• Review SCR enriched records to support end of life care • Rollout local template to three further practices. • Provide guidance and training to practices on use of local template and updating SCR enriched record.
16/17 Q3	• Provide guidance and training to practices on use of local template and updating SCR enriched record.
16/17 Q4	• Provide guidance and training to practices on use of local template and updating SCR enriched record.
17/18 Q1	• Provide guidance and training to practices on use of local template and updating SCR enriched record. • Increase EPaCCs deployment to 51%
17/18 Q2	• Provide guidance and training to practices on use of local template and updating SCR enriched record. • Increase EPaCCS deployment to 67%
17/18 Q3	• Provide guidance and training to practices on use of local template and updating SCR enriched record. • Increase EPaCCS deployment to 83%
17/18 Q4	• All clinicians able to view end of life care information via SCR enriched record. • Complete EPaCCS deployment to 100% of practices

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Local templates are being used to capture end of life information across primary and community care settings.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress / Highlight reports are sent to the EPACCS Task and Finish Group and Doncaster Interoperability Group.

Universal Capability:	I. GPs and community pharmacists can utilise electronic prescriptions
Capability Group:	Medicines management and optimisation
Defined Aims:	• All permitted prescriptions electronic • All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic • Repeat dispensing done electronically for all appropriate patients • [By end 16/17 – 80% of repeat prescriptions to be transmitted electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

33 (77%) practices live with EPS
100% pharmacies live with EPS

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	All permitted prescriptions are sent electronically by practices. Rollout EPS R2 to five practices. By end 16/17 – 80% of repeat prescriptions to be transmitted electronically.
17/18	All permitted prescriptions are sent electronically by practices. Rollout EPS to the remaining five practices.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Rollout EPS to 1 practice. • Work with medicines management team and practices to increase utilisation.
16/17 Q2	• Rollout EPS to 2 practices. • Working with medicines management team and practices to increase utilisation.
16/17 Q3	• Rollout EPS to 1 practice. • Working with medicines management team and practices to increase utilisation.
16/17 Q4	• Rollout EPS to 1 practice. • Working with medicines management team and practices to increase utilisation.
17/18 Q1	• Rollout EPS to 2 practices. • Work with medicines management team and practices to increase utilisation.
17/18 Q2	• Rollout EPS to 1 practice. • Working with medicines management team and practices to increase utilisation.
17/18 Q3	• Rollout EPS to 2 practices. • Working with medicines management team and practices to increase utilisation.
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress/Highlight reports to Doncaster Interoperability Group and SY&B NHS England primary care team.

Universal Capability:	J. Patients can book appointments and order repeat prescriptions from their GP practice
Capability Group:	Remote care
Defined Aims:	• [By end 16/17 – 10% of patients registered for one or more online services (repeat prescriptions, appointment booking or access to record)] • All patients registered for these online services use them above alternative channels

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

100% of practices are enabled to provide ordering of repeat prescriptions appointment booking and access to patients record. 42% of practices have 10% or more patients with access to patient online services.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Provide all patients with the opportunity to access to book appointments, order repeat prescriptions and view their detailed care record
17/18	Optimise online appointments to increase number available.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Promote patient online with practices via system optimisation programme
16/17 Q2	• Promote patient online with practices via system optimisation programme
16/17 Q3	• Promote patient online with practices via system optimisation programme
16/17 Q4	• Promote patient online with practices via system optimisation programme
17/18 Q1	• Promote patient online with practices via system optimisation programme
17/18 Q2	• Promote patient online with practices via system optimisation programme
17/18 Q3	• Promote patient online with practices via system optimisation programme
17/18 Q4	• Promote patient online with practices via system optimisation programme

D. National Services / Infrastructure / Standards

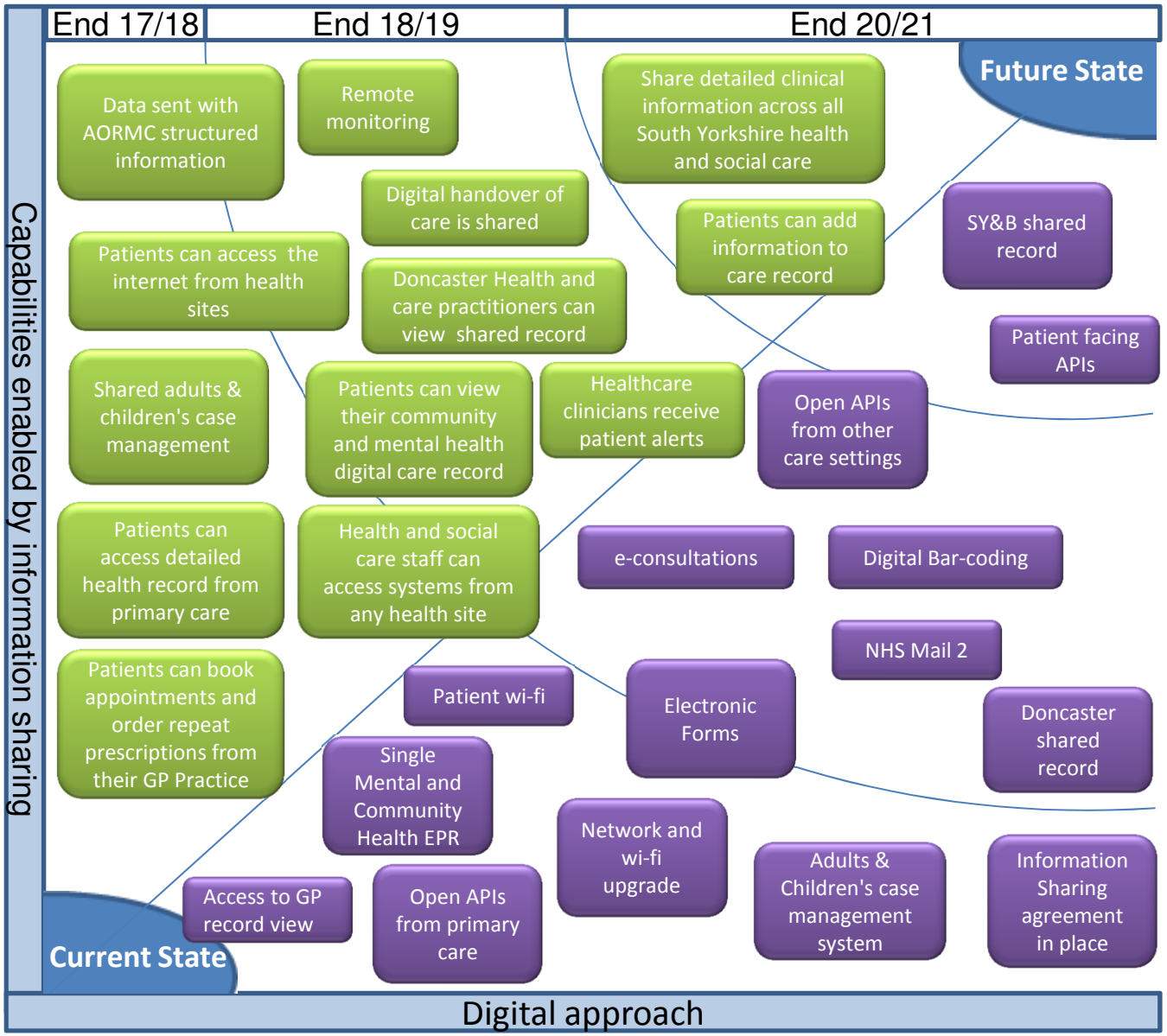
In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

% patients using online functionality reported to Doncaster Interoperability Group and Primary Care Development Group.

Information sharing approach – Doncaster



This page is intentionally left blank

Doncaster
Metropolitan Borough Council

Doncaster Health and Wellbeing Board

1 September 2016

Subject: Report of the Steering Group and Forward plan

Presented by: Dr R Suckling

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

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

How will this contribute to improving health and wellbeing in Doncaster?
This report provides an update on Obesity, the BME Health Needs Assessment, the Better Care Fund and Personal Health Budgets.

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

This page is intentionally left blank

Doncaster
Metropolitan Borough Council

Agenda Item No. 12
1 September 2016

To the Chair and Members of the
HEALTH AND WELLBEING BOARD

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

EXECUTIVE SUMMARY

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

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

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

EXEMPT REPORT

3. N/A

RECOMMENDATIONS

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

PROGRESS

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

The Steering group has had two meetings since the last Board in June 2016 and can report the following:

- **Obesity**

The first Doncaster Obesity Alliance will meet on 14th September. Board members who have yet to nominate a representative are asked to do so to Louise Robson.

- **Black and Minority Ethnic (BME) Health Needs Assessment**

Phase 1 and 2 of the work, i.e. the demographic information and the literature review of BME needs and assets have been completed. The final touches are being put together for the co-produced pieces of work with the BME community beginning in September.

- **Better Care Fund (BCF)**

The Doncaster BCF plan was approved earlier in the year. New guidance has been published that enhances the Health and Wellbeing Board's role in the governance of the fund. In future a quarterly report will be brought to Board evidencing not only how the BCF resource has been committed but also progress on the national conditions and next steps.

- **Personal Health Budgets**

The CCG's intention is to extend the offer and availability of personalised services with individualised care packages to more people, this will allow people more choice, flexibility and control over their care and support.

NHS Doncaster is already committed to commissioning more personalised models of care and to date we have worked closely with our end of life service provider and our community nursing service provider to achieve this. NHS Doncaster also has plans to roll this out to two further domiciliary services in the next six months. We acknowledge that further work is required and we intend to build on the individual offer for learning disability patients.

It is important to note that in the current challenging financial climate, there is no additional money available and resources are often committed within block contracts or are supporting other essential services. Personal health budgets should use existing NHS resources to meet assessed care and support needs in a different, more personalised way.

NHS Doncaster is already committed to commissioning personalised models of care as outlined above, however our initial plans around wider roll out of personal health budgets are set out below:

Continuing Healthcare – Adults

As per the current mandate all adults who are eligible for continuing healthcare have a right to have a personal health budget. In Doncaster personal health budgets are offered to all eligible patients who are living at home in the community, not in 24 hour care.

Continuing Care – Children & Young People

In line with current legislation personal health budgets are available for Children and Young People aged between 0 and 18 and who are eligible for continuing healthcare funding.

Children with Special Educational Needs and Disabilities

Children and young people

For children and young people with special educational needs and disabilities (SEND), if part of their care package is appropriate to be funded via a personal health budget, this is likely to form part of their personal budget for their Education, Health and Care (EHC) Plan.

Learning Disability

Our early thoughts around wider roll out for patients with a learning disability focus on the 'Transforming Care' cohort of patients who are currently detained in hospital. Our objective is that wherever clinically appropriate and possible these patients are discharged and repatriated to Doncaster, back into the community, with a personalised package of care.

The CCG leads for personal health budgets will be working closely with learning disability commissioners locally who are delivering the Transforming Care Plan, exploring the use of personal health budgets where possible.

Mental Health

We have no current plans to offer personal health budgets for mental health service users however any requests will be considered on an individual basis.

While personal health budgets are not offered routinely at the moment for mental health service users, currently patients who are entitled to Section 117 Aftercare services have the option of receiving their care & support via an integrated Personal Budget which would be administered by our local authority.

Long Term Conditions

We have no current plans to offer personal health budgets for patients with long term conditions, who fall outside of the above groups, however any requests will be considered on an individual basis.

- **Forward Plan for the Board.**

This is attached at **Appendix A**.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

6.

	Outcome	**Implications**
	All people in Doncaster benefit from a thriving and resilient economy. • *Mayoral Priority: Creating Jobs and Housing* • *Mayoral Priority: Be a strong voice for our veterans* • *Mayoral Priority: Protecting Doncaster's vital services*	The dimensions of Wellbeing in the Strategy should support this priority.

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

RISKS AND ASSUMPTIONS

7. None.

LEGAL IMPLICATIONS

8. None.

FINANCIAL IMPLICATIONS

9. None

EQUALITY IMPLICATIONS

10. The work plan of the Health and Wellbeing Board needs to demonstrate due regard to all individuals and groups in Doncaster through its work plan, the Joint Health and Wellbeing Strategy and Areas of focus as well as the Joint Strategic Needs Assessment. The steering group will ensure that all equality issues are considered as part of the work plan and will support the Area of Focus Leads to fulfil these objectives.

CONSULTATION

11. None

REPORT AUTHOR & CONTRIBUTORS

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

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

Dr Rupert Suckling
Director Public Health

This page is intentionally left blank

APPENDIX A - DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2016

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

13th October 2016	**Workshop**
	Health Inequalities TBC
		Venue TBC	• Plans and reports from
			  ○ CCG
			  ○ NHSE
			  ○ DMBC
			  ○ Health watch
			  ○ RDaSH
			  ○ DBH
			• Safeguarding reports
			• Better Care Fund
			• DPH annual report
			• Role in partnership stocktake
			• Wider stakeholder engagement and event
			• Relationship with Team Doncaster and other Theme Boards
			• Relationship with other key local partnerships
			• Health Improvement Framework
			• Health Protection Assurance Framework
			• Wellbeing and Recovery strategy
			• Adults and Social care Prevention Strategy
			• Housing
			• Environment
			• Regeneration
				• Areas of focus – schedule of reports and workshop plans
				• Integration of health and social care (BCF)) workshop plan
				• Other subgroups – schedule of reports
				• Communications strategy
				• Liaison with key local partnerships
				• Liaison with other Health and Wellbeing Boards (regional officers group)
				• Learning from Knowledge Hub

3rd November 2016	• Q2 Performance Report • Adults and Social Care Local Account TBC • Health and Social Care Transformation Update • HWBB Steering Group Report • Annual Safeguarding reports TBC • Health watch update TBC • Stronger Families update TBC	Civic Office		

8th December 2016 (*Please note change of date)	Workshop BME Needs Assessment TBC	TBC		
12th January 2017	• Q3 Performance Report • BME Needs Assessment • Health and social Care Transformation Update • HWBB Steering Group Report • Licensing update tbc			

***Supported Living and Wellbeing workshop/Fuel Poverty workshop /Learning Disabilities plan update** to be rescheduled in 2017/* **LGA workshop**: Prevention Matters to be scheduled early 2017

2017 Health and Wellbeing Board meetings

12 January 2017 (Venue: St Catherine's House, Balby)

16 March 2017* (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster) ***** **NOTE: Date moved from 9 March 2017**

8 June 2017 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster – TBC)

7 September 2017 (Venue: Montagu Hospital, Mexborough - TBC)

2 November 2017 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster – TBC)