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Doncaster Council

Agenda

To all Members of the

HEALTH AND WELLBEING BOARD

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

Venue Room 007a and b - Civic Office, Waterdale, Doncaster, DN1 3BU

Date: Thursday, 7th November, 2019

Time: 9.00 a.m.

PLEASE NOTE START TIME FOR THIS MEETING

Items for consideration:		**Time/ Lead**
1.	Welcome, introductions and apologies for absence	2 mins (Chair)
2.	Chair's Announcements.	5 mins (Chair)
3.	To consider the extent, if any, to which the public and press are to be excluded from the meeting.	1 min (Chair)
4.	Public questions. **(A period not exceeding 15 minutes for questions from members of the public.)**	15 mins (Chair)

Damian Allen
Chief Executive

Issued on: Wednesday 30th October 2019

Governance Services Officer for this Meeting: Amber Torrington,
Governance Officer
Tel. 01302 737462

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5.	Declarations of Interest, if any.	1 min (Chair)
6.	Minutes of the Meeting of the Health and Wellbeing Board held on 5th September 2019. *(Attached – pages 1 – 10)*	3 mins (Chair)
7.	Report from Health and Wellbeing Board Steering Group and Forward Plan. *(Paper attached – pages 11 – 38)*	15 mins (Dr Rupert Suckling)
8.	Doncaster Safeguarding Children Partnership Annual Report 2018-19. *(Paper attached – pages 39 – 76)*	30 mins (Tony Holmes)
9.	Doncaster Place Plan Refresh. *(Presentation/Paper attached – pages 77 – 146)*	15 mins (Dr Rupert Suckling)
10.	South Yorkshire & Bassetlaw Integrated Care System Response to NHS Long Term Plan. *(Paper attached – pages 147 – 220)*	15 mins (Dr Rupert Suckling)
11.	Health and Wellbeing Board Outcomes Framework Update - November 2019. *(Presentation/Cover Sheet attached – pages 221 – 222)* **(Report to follow)**	45 mins (Laurie Mott)

Date/time of next meeting: Thursday, 16 January 2020 at 9.00 am in Room 007a and b - Civic Office, Waterdale, Doncaster.

Members of the Health and Wellbeing Board

Chair – Councillor Rachael Blake – Portfolio Holder for Adult Social Care
Vice-Chair – Dr David Crichton, Chair of Doncaster Clinical Commissioning Group

Councillor Nigel Ball	Portfolio Holder for Public Health, Leisure and Culture
Councillor Nuala Fennelly	Portfolio Holder for Children, Young People and Schools
Councillor Cynthia Ransome	DMBC Conservative Group Representative
Dr. Rupert Suckling	Director of Public Health, Doncaster Council
Kathryn Singh	Chief Executive of Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
Steve Shore	Chair of Healthwatch Doncaster
Karen Curran	Head of Co-Commissioning NHS England (Yorkshire and Humber)
Richard Parker	Chief Executive of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Phil Holmes	Director of Adults, Health and Well Being, Doncaster Council
Riana Nelson	Director of Learning, Opportunities and Skills, Doncaster Council
Jackie Pederson	Chief Officer, Doncaster Clinical Commissioning Group
Chief Superintendent Shaun Morley	District Commander for Doncaster, South Yorkshire Police
Paul Tanney	Chief Executive, St. Leger Homes of Doncaster
Shayne Tottie	District Manager, South Yorkshire Fire and Rescue
Alan Adams	Interim Chief Executive of Doncaster Children's Services Trust
Peter Dale	Director of Regeneration and Environment, Doncaster Council
Laura Sherburn	Chief Executive, Primary Care Doncaster
Lucy Robertshaw	Assistant Director darts, Doncaster Community Arts (Health and Social Care Forum representative)

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DONCASTER METROPOLITAN BOROUGH COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY, 5TH SEPTEMBER, 2019

A MEETING of the HEALTH AND WELLBEING BOARD was held in Room 007A AND B - CIVIC OFFICE on THURSDAY, 5TH SEPTEMBER, 2019, at 9.00 a.m.

PRESENT:	Vice-Chair -	Dr David Crichton, Chair of Doncaster Clinical Commissioning Group (In the Chair)
Councillor Nuala Fennelly		Portfolio Holder for Children, Young People & Schools
Councillor Cynthia Ransome		Conservative Group Representative
Dr Rupert Suckling		Director of Public Health, Doncaster Council
Steve Shore		Chair of Healthwatch Doncaster
Julie Mepham		Director of Children's Social Care, Doncaster Children's Services Trust, substituting for Paul Moffat
Peter Dale		Director of Regeneration and Environment, Doncaster Council
Richard Parker		Chief Executive of Doncaster & Bassetlaw Teaching Hospitals Foundation Trust
Paul Tanney		Chief Executive, St Leger Homes of Doncaster (SLHD)
Lucy Robertshaw		Assistant Director, Darts
Chief Inspector Jayne Forrest		South Yorkshire Police, substituting for Chief Superintendent Shaun Morley
Rebecca Mason		Head of Engagement and Partnerships, L&O:CYP, Doncaster Council, substituting for Riana Nelson
Ray Hennessy		Deputy Head of Operational Business Support, Rotherham, Doncaster and South Humber NHS Foundation Trust, substituting for Kathryn Singh

Also in attendance:

Dr Victor Joseph, Public Health Consultant, Doncaster Council
Anna Brook, Public Health Registrar
Jennie Daly, Tenancy Sustainability Service Manager, SLHD
Olwen Wilson, Better Care Fund Project Manager, Doncaster Council

13 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies were received from Councillor Rachael Blake, Councillor Nigel Ball, Kathryn Singh, Jackie Pederson, Paul Moffat, Phil Holmes, Riana Nelson, Chief Superintendent Shaun Morley, Steve Helps and Laura Sherburn.

14 CHAIR'S ANNOUNCEMENTS

There were no announcements made by the Chair.

15 PUBLIC QUESTIONS

Mr Doug Wright referred to his previous requests that meetings of the Health and Social Care Joint Commissioning Management Board (JCMB) be opened to the public and have the facility for public questions/statements on agendas. He explained that this would bring it in line with other meetings of the Doncaster Clinical Commissioning Group (DCCG) and Doncaster Council which were open to the public and received public questions/statements. He also pointed out that the JCMB minutes had not been included on any DCCG Governing Body agendas for some time, and that the minutes before this Board today dated back to May 2019. Mr Wright stressed that he had been calling for this since February 2018 and asked whether this simple request could be implemented by January 2020.

In reply, the Chair, Dr David Crichton and Dr Rupert Suckling confirmed that Mr Wright's requests had always been given due consideration at the time of being raised. However, it was explained that there was no mandate for holding the JCMB meetings in public and therefore the compromise position had been reached whereby the JCMB minutes were received at meetings of the DCCG's Governing Body and at this Board, which provided an opportunity for the public to scrutinise and ask questions on the minutes in both of these forums. They undertook, however, to bring Mr Wright's request to the attention of Jackie Pederson (Chief Officer, DCCG) and Damian Allen (Chief Executive, Doncaster Council).

16 DECLARATIONS OF INTEREST, IF ANY

There were no declarations of interest made at the meeting.

17 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 13TH JUNE 2019

RESOLVED that the minutes of the meeting held on 13 June 2019 be approved as a correct record and signed by the Chair.

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

The Board considered a report which provided an update on the work of the HWB 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.

In particular, the report included updates for the Board on:

- Suicide Prevention and Mental Health Awareness;
- Motor Neurone Disease Update;
- Board Effectiveness;
- Forward Plan for the Board;
- Minutes of SY&B Shadow Integrated Care System Collaborative Partnership Board held on 10 May 2019; and
- Minutes of Joint Commissioning Management Board held on 9 May 2019* *[*NOTE: these minutes had been omitted from the agenda pack and subsequently circulated to members on 29 August to replace the set of JCOG minutes which were wrongly included in the agenda pack]*

With regard to suicide prevention and mental health awareness, Dr Rupert Suckling confirmed that all GP Practices in the Borough had signed up to a number of initiatives aimed at promoting ways to achieve better mental health and raising awareness of suicide, and he therefore wished to thank Primary Care partners for their support. Councillor Nuala Fennelly reported that one school in Doncaster, which had been affected by the suicide of two pupils in the past two years, had introduced a new programme for Year 7 pupils aimed at encouraging young people to talk about mental health issues.

In referring to the Motor Neurone Disease Charter, which this Board had signed up to in March 2018, Dr Rupert Suckling advised that updates would be sought from Board members by the end of September 2019 on their progress in signing up to the Charter.

Members noted that a review of the Board's effectiveness had been carried out by Mitchell Salter, a National Management Trainee in Public Health, against the 21st Century Public Servant Model, using a series of interviews and a Board observation. The findings of this work would be discussed at the Board's development workshop in December 2019.

RESOLVED:

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

(2) that the proposed Forward Plan, as detailed in Appendix A to the report, be agreed.

(3) to note that Dr Rupert Suckling and Louise Robson will be contacting Board members outside of the meeting seeking updates from their respective organisations on their progress in signing up to the Motor Neurone Disease Charter.

19 TOBACCO CONTROL UPDATE

Further to the discussion held at the Board's last meeting, Members considered a report and accompanying presentation on the latest position with regard to Tobacco Control. The proposal outlined in the report was aimed at addressing smoking prevalence in Doncaster, drawing on lessons from a peer assessment carried out in March 2019; and a wide range of initiatives from public consultation on smoke-free environments. It was reported that, if implemented, the actions were likely to reduce smoking prevalence, thus improving the health of the people of Doncaster.

In reply to a question by Councillor Nuala Fennelly with regard to the processes in place for dealing with the estimated 1,300 children and young people per year who were expected to start smoking, Anna Brook explained that a specialist support service was provided. This service did not achieve as high a quit rate amongst its clients as the adult service, but it was noted that this was not uncommon. Councillor Fennelly advised that she would be happy to give her support and assistance under her portfolio, such as in engaging with schools, on this issue.

Richard Parker, Chief Executive of Doncaster and Bassetlaw Teaching Hospitals (DBTH), explained that measures were being taken to try and tackle the issue of smokers congregating outside hospital entrances, so that patients such as those

suffering from cancer, did not have to walk through clouds of smoke on their way in and out of hospital. He added, however, that this work needed a joined up approach, as DBTH serviced two different Clinical Commissioning Groups in its area.

Dr David Crichton drew two initiatives to the Board's attention. Firstly, he reported that Doncaster was one of ten targeted centres in England which would be running lung health checks for people with a smoking history who were aged 55 - 74 years. Smoking cessation support would be provided as part of this project. Secondly, Dr Crichton informed Members that under the Yorkshire and Humber's IVF policy, in order to be eligible for NHS funded specialist fertility treatment, couples were required to demonstrate that they had been smoke free for at least 3 months. This was based on national guidance about how smoking had a negative effect on the chances of successful IVF treatment.

During discussion on smoke free public spaces, Anna Brook confirmed that from the public consultation carried out on the SmokeFree Doncaster proposal, it was evident that there was significant public support for smoke free spaces, particularly family areas. The Board also acknowledged that there was scope for doing more to encourage pubs and cafes to designate their outside spaces as smoke free zones, so that non-smokers could also enjoy sitting outside.

During further discussion, Members made a number of observations/comments in relation to Tobacco Control and reducing smoking prevalence, including the following:-

- Paul Tanney, Chief Executive of St Leger Homes of Doncaster (SLHD), stated that SLHD would be happy to assist in promoting no smoking initiatives through its tenants' newsletters and website.

- Dr David Crichton pointed out that there was a strong correlation between poverty and high instances of smoking. In response, Lucy Robertshaw, Assistant Director of Darts, explained that her organisation often worked in areas of deprivation within the Borough and stressed that community activities could be a useful distraction from smoking for some people.

- Chief Inspector Jayne Forrest advised that South Yorkshire Police were able to help with arranging for test purchases of cigarettes to be to be carried out in shops.

It was then

RESOLVED that:

(1) the contents of the report and appendices and accompanying presentation be noted;

(2) the recommendations as detailed in the report, including sign off by all organisations, be endorsed as follows:-

- CLeaR Peer Assessment:
  - Publish the report on the Council's website;
  - Prioritise some of the recommendations for immediate action;

- Agree all the responses to the recommendations and work through them over time;
- Repeat the self-assessment in 12 months' time to track how the score changes;
- Consider commissioning a CLeaR peer re-assessment in 2022

- Revised strategic approach and plan-on-a-page:
  - Agree the revised strategic approach

(3) the Smoke-free Doncaster proposal be submitted to the Cabinet and Full Council.

20 ARTS AND HEALTH UPDATE

The Board received a presentation by Lucy Robertshaw, Assistant Director of Darts, which provided an update on 'Arts on Prescription in Doncaster' and the various initiatives being undertaken to maximise the health and wellbeing benefits for Doncaster residents by encouraging them to participate in creative activities.

Lucy explained that there was evidence from clinicians to demonstrate that the Arts brought tangible health and wellbeing benefits, and could help people to keep well, aid recovery and support longer lives better lived. The Arts could also help meet major challenges facing health and social care, ageing, long-term conditions, loneliness and mental health. The Arts could also help save money in the health service and social care.

It was reported that the Arts and Health Project Board, whose membership included various health partners and other organisations such as Cast, Darts, Heritage Doncaster and Doncaster Council, had now been running for a year. It was noted that Doncaster was at the forefront of this work, which was attracting local and national attention. Lucy confirmed that the 4 priorities for 2019-21 were Mental Health, Dementia, Increasing Physical Activity and Loneliness and Social Isolation.

Lucy then summarised the funding secured in 2019-21 (£2.1m), and the various areas across the Borough where the different programmes of activity were taking place. She outlined how these projects were being evaluated, and summarised the early results, which were showing that participants were feeling more connected and independent, and their wellbeing was improving in terms of satisfaction with life and anxiety/depression scores. With regard to next steps, it was hoped that stronger connections with GP Practices could be established, and that the profile of this work could be raised.

Lucy concluded by explaining that the longer-term aspiration was to develop this work so that it moved from being a series of short term grant funded projects to a wider service that all GPs could refer people to, thus enabling it to reach thousands rather than hundreds of people.

During subsequent discussion, Board Members asked various questions and/or made observations, as follows:-

- Dr David Crichton felt that it should not be the case that people had to visit their GP in the first instance in order to find out more about these activities

and be referred to a programme. Instead, he suggested that front desk staff in Practices had an important role to play in signposting people to these activities, where appropriate.

- Dr Rupert Suckling stated that there was a need to give consideration as to how to make these Arts and Health initiatives more sustainable for when the grant funding ceased. In reply to a query regarding the grant funding received, Duncan Robertshaw, Chief Executive of Darts, explained that the bulk of the funding came from national bodies such as Big Lottery and Arts Council England. He stated that, by comparison, only a small amount of private sector funding had been received to date. Duncan confirmed that Darts was fortunate to have strong fund raising teams, but he stressed that the challenge would be in rolling out this programme on a Borough-wide basis.

- Duncan Robertshaw explained that while the Arts on Prescription programme was currently only focused on adults, there would be scope in future to refine the models and widen the activities to also target children and young people.

- In terms of expanding this scheme and getting all GPs in the Borough on board, Dr David Crichton stressed that evaluation was a key factor from a commissioning perspective. He explained that if there was evidence available which demonstrated the value of these pilots in terms of bringing tangible health and wellbeing benefits to people, then that would be the mechanism for developing this as a mainstream service in the future.

- Steve Shore advised that Healthwatch Doncaster would be happy to help with regard to publicity and signposting people to these activities.

After Dr Rupert Suckling had suggested that the Arts and Health Project Board could be tasked with taking this work forward, with further updates being received by this Board at the appropriate time, it was

RESOLVED to:

(1) note the content of the presentation and support the further development of arts and health in Doncaster; and

(2) note that this work will be taken forward by the Arts and Health Project Board, with further updates being received by this Board at the appropriate time.

21 HEALTHWATCH DONCASTER - ANNUAL REPORT AND SERVICE UPDATE

The Board received the Healthwatch Doncaster Annual Report for 2018-19, together with a briefing paper which provided a service update outlining Healthwatch's future plans and projects.

In presenting this item, Steve Shore, Chair of Healthwatch Doncaster, outlined the context within which Healthwatch Doncaster operated, being one of approximately 150 Healthwatch bodies in the UK. He explained that Healthwatch Doncaster's 3 key functions were to engage, inform and influence. It was noted that Healthwatch was

focusing more on widening its digital footprint in order to reach as wide an audience as possible. Steve explained that although Healthwatch Doncaster had a relatively low profile amongst the general public, it was nevertheless very successful when asked to engage with people. As an example, he reported that Healthwatch Doncaster had engaged with over 1300 people seeking their views on the NHS Long Term Plan, which was launched in January 2019.

Steve also highlighted Healthwatch Doncaster's Micro-Grants scheme, which allowed local community organisations to apply for a small amount of money (up to £500) to assist them to engage with local people to listen to their views about health and care services. This was seen as a useful networking mechanism, with a network of 40 small organisations/community groups now in place, and Steve stressed that Healthwatch was also keen to strengthen the existing partnerships it had with other organisations. The Board also noted that Healthwatch acknowledged there was a need to change the perception held in some quarters, that it was some kind of 'watchdog' body. This was not the case and, in reality, Healthwatch aimed to work in partnership with others as a critical friend.

It was noted that, to a large extent, Healthwatch Doncaster was dependent on funding from Doncaster Council, although it was trying to reach a position whereby that level of dependency lessened.

During discussion on the outcomes from the Healthwatch Doncaster report on Missed Appointments, it was noted that a new text reminder service had been introduced to help reduce the number of missed appointments.

In reply to a question as to whether there were currently any hot topics that the public were interested in or concerned about, Steve Shore advised that young people were increasingly concerned about issues relating to Mental Health and Suicide. He added that the Health and Wellbeing Board could feel reasonably assured that the issues that were the subject of the public's current concerns were already on its radar.

Members acknowledged the valuable work carried out by Healthwatch Doncaster in its role as the independent champion for people using local health and social care services.

RESOLVED to receive and note the Healthwatch Doncaster Annual Report 2018-19 and service update outlining Healthwatch Doncaster's future plans and projects.

22 UNIVERSAL CREDIT UPDATE

The Board received a presentation by Paul Tanney, Chief Executive of St Leger Homes of Doncaster (SLHD) and Jennie Daly, Tenancy Sustainability Service Manager (SLHD) on the impact of Universal Credit focussing mainly on the work of the St Leger Homes Tenancy Sustainment Team and their work to help support tenants to remain in their Council homes.

In introducing this item, Paul Tanney explained that having a safe and secure home had a huge impact on people's health and wellbeing. He explained that as a result of Universal Credit, people's stress and anxiety levels had increased due to worries over increasing debt and rent arrears, and the seriousness of people's situations was evident in the increased use of food banks.

Jennie Daly then gave a presentation on the work carried out by the Tenancy Sustainment Team, including supporting tenants through welfare reform, helping them to maximise income and reduce debt, reduce rent arrears and reduce evictions.

In response to a question about the links between the Tenancy Sustainment Team and health services, Jennie explained that many of the cases dealt with by the team often involved substance misuse and mental health issues, so the team assisted people by referring or signposting them to the appropriate services so that they received the help and support they needed. The team also liaised with local job centres to assist those individuals who needed additional help in applying for Universal Credit.

In reply to a further question as to whether Board members could provide any additional support from an anti-poverty perspective, Paul Tanney explained that there was scope for improving attendance at the Anti-Poverty Strategy Group, as partner organisations were not always represented at meetings of the Group.

RESOLVED to note the content of the presentation.

23 BETTER CARE FUND 2019-20 DRAFT PLAN

The Board received a report which requested feedback on Doncaster's draft plan for the use of the Better Care Fund (BCF) in 2019-20. In introducing this item, Dr Rupert Suckling confirmed that given the delay in funding announcements, the majority of existing schemes had been rolled over into 2019-20.

Olwen Wilson, BCF Project Manager, then outlined the timeline and key stages for agreeing the Doncaster BCF Plan. It was noted that informal pre-submission feedback on the draft Plan would be received from the Regional Assurance Panel by 13 September, and that the final BCF submission was to be made by 27 September. It was noted that a supporting Section 75 Agreement would be developed once the final Plan was signed off. With regard to the sign off arrangements of the final plan, the Board was being asked to agree that the Director of Public Health be given delegated authority to sign off the final Plan in consultation with the Chair of this Board.

RESOLVED to:

(1) note the draft Doncaster BCF Plan for 2019-20;

(2) agree that the Director of Public Health be given delegated authority to sign off the final plan in consultation with the Chair, pending feedback from regional assurance on 13 September 2019, for submission by the deadline of 27 September, 2019;

(3) note that a supporting Section 75 Agreement will be produced incorporating the final plan; and

(4) agree to review progress of Doncaster's BCF Plan for 2019-20 and evaluation of schemes at future meetings.

CHAIR:_____ DATE:_____

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Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 7 November 2019

Subject: Report of the HWB Steering Group and Forward plan

Presented by: Dr Rupert Suckling

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

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

How will this contribute to improving health and wellbeing in Doncaster?
This report provides an update on Health and Adult social care overview and scrutiny, health inequalities and Board effectiveness. There has been one meeting of the South Yorkshire and Bassetlaw, Shadow Integrated Care System Collaborative Partnership Board since the Health and Wellbeing Board's last meeting and one meeting of the Doncaster Joint Commissioning Management Board. It also provides a forward plan for the Board.

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

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Doncaster Council

Agenda Item No. 7
7 November 2019

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.

EXEMPT REPORT

2. N/A

RECOMMENDATIONS

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

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

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

BACKGROUND

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 not met since the last Board in September 2019. The ongoing need for this group will be kept under review as part of the development of the next borough strategy. It is refocussing to ensure progress on the Health and Wellbeing Strategy and key Board priorities including health inequalities, loneliness/social isolation, oral health, the areas of focus (alcohol, obesity, dementia, and mental health) and prevention. Key updates include:

Health and Adult Social Care overview and scrutiny panel recent reviews

The Health and Adult Social Care Overview and Scrutiny committee recently reviewed local approaches to:

Hidden Harm: the impact of parental substance misuse on children and young people

Childhood obesity and tooth decay.

Both these topics fall under the Board's area of responsibility and the final outcomes will be shared with Board members as soon as they are received.

Health Inequalities – updated from July Workshop

We know that the social and economic environment in which we are born, grow up, live, work and age, as well as the decisions we make for ourselves and our families collectively have a bigger impact on our health than healthcare alone. These conditions are not fixed, but are amenable to change through interventions.

Over the last few months, the Health Inequality Working Group (HIWG) has delivered a Health Inequality Workshop for Board members, which aimed to celebrate local interventions such as: the Minority Partnership Group, Get Doncaster Moving and the Inclusive Health pilot work. The workshop also aimed to refresh the HWBB as central to tackling health inequalities within Doncaster.

We have also taken part (along with Wakefield and Kingston-Upon-Hull) in an audit of progress against the Due North recommendations. The Due North report was published in September 2014 and highlighted some of the key inequalities between the north and south and made several recommendations for local government, PHE and other partners. For Doncaster, many of the Due North recommendations can be seen within our policies and strategies. However, there are gaps and areas where more might be done, for example within our Inclusive Growth work how we better share power over resources and increase the influence that the public has on how resources are used to improve determinants of health.
Over the next quarter we intend to use this gap analysis to populate the work plan of the HIWG. This current workplan has three aspects:

- Advocating for addressing health inequalities in strategy and policy
- Support for, monitoring and celebrating key interventions or programmes such as Well Doncaster and the Minority Partnership Group
- Systematically reviewing population health data on unequal access or outcomes within Doncaster and advocating for action.

We intend to build on these three aspects of addressing health care throughout the next year and will share the new action plan with the HWBB. At the recent workshop we reported on the impact of the Minority Partnership Group (MPG). We are evaluating the Minority Partnership

Group (MPG), one early finding is that the MPG is a supportive forum and acts as a broker or enabler. For example, the MPG was able to address a need identified within the BAME needs assessment focus groups for access to meeting places. The MPG has been able to signpost and facilitate this with St Ledger Homes. Members of the MPG have also been able to access support to apply for funding.

Board Effectiveness

The effectiveness of the Board has been reviewed against the 21st century public servant model using a series of interviews and a Board observation. The next steps in the Board's development will be discussed at the development workshop in December. The key themes for the Board to reflect on are:

Effective use of the time and expertise of public servants
Maximising the impact of political collaboration
Maximising the impact of public collaboration
Maintaining momentum

South Yorkshire and Bassetlaw Shadow Integrated Care System Collaborative Partnership Board

The minutes of the 12th July 2019 meeting are attached for information.

Doncaster Joint Commissioning Management Board

The minutes of the 19th September 2019 meeting are attached for information.

Forward Plan

The Forward Plan for 2019/2020 (Appendix A) is presented for debate, discussion and agreement.

OPTIONS CONSIDERED

6. None

REASONS FOR RECOMMENDED OPTION

7. None

IMPACT ON THE COUNCIL'S KEY OUTCOMES

8.

	Outcomes	Implications
	Doncaster Working: Our vision is for more people to be able to pursue their ambitions through work that gives them and Doncaster a brighter and	The Health and Wellbeing Board will contribute to this priority

	prosperous future; • Better access to good fulfilling work • Doncaster businesses are supported to flourish • Inward Investment	
	Doncaster Living: Our vision is for Doncaster's people to live in a borough that is vibrant and full of opportunity, where people enjoy spending time; • The town centres are the beating heart of Doncaster • More people can live in a good quality, affordable home • Healthy and Vibrant Communities through Physical Activity and Sport • Everyone takes responsibility for keeping Doncaster Clean • Building on our cultural, artistic and sporting heritage	The Health and Wellbeing Board will contribute to this priority
	Doncaster Learning: Our vision is for learning that prepares all children, young people and adults for a life that is fulfilling; • Every child has life-changing learning experiences within and beyond school • Many more great teachers work in Doncaster Schools that are good or better • Learning in Doncaster prepares young people for the world of work	The Health and Wellbeing Board will contribute to this priority
	Doncaster Caring: Our vision is for a borough that cares together for its most vulnerable residents; • Children have the best start in life • Vulnerable families and individuals have support from someone they trust • Older people can live well and independently in their own homes	The Health and Wellbeing Board will contribute to this priority
	Connected Council: • A modern, efficient and flexible workforce • Modern, accessible customer interactions	The Health and Wellbeing Board will contribute to this priority

	• Operating within our resources and delivering value for money • A co-ordinated, whole person, whole life focus on the needs and aspirations of residents • Building community resilience and self-reliance by connecting community assets and strengths • Working with our partners and residents to provide effective leadership and governance	

RISKS AND ASSUMPTIONS

9. None

LEGAL IMPLICATIONS

10. No legal implications have been sought for this update paper.

FINANCIAL IMPLICATIONS

11. No financial implications have been sought for this update paper.

HUMAN RESOURCES IMPLICATIONS

12. No human resources implications have been sought for this update paper.

TECHNOLOGY IMPLICATIONS

13. No technology implications have been sought for this update paper.

HEALTH IMPLICATIONS

14. There are no additional health implications in this report.

EQUALITY IMPLICATIONS

15. The primary care committee and the Working Win approach both address the needs of some of the most vulnerable people in Doncaster. Assessing the impact of these approaches will be important.

CONSULTATION

16. None

BACKGROUND PAPERS

17. None

REPORT AUTHOR & CONTRIBUTORS

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Dr Rupert Suckling
Director Public Health

APPENDIX A

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2019/20

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

5th December 2019 (closed session)	**Workshop**
	Development session (Board members only)
		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 events
			• Relationship with Team Doncaster and other Theme Boards
			• Relationship with other key local partnerships
			• 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

APPENDIX A

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2019/20

16th January 2020	**Board meeting** • HWBB Steering group • Health and Social Care/BCF update • Get Doncaster Moving update • Children and Young people Impact report update • Safeguarding Adults Board annual report	Civic office rooms 007a and 007b		
6th February 2020	Workshop Topic tbc	Venue tbc		
12th March 2020	**Board meeting** • HWBB Steering group • Outcomes framework Health and Social Care/BCF update	Civic office rooms 007a and 007b		

APPENDIX A

DONCASTER HEALTH AND WELLBEING BOARD: DRAFT OUTLINE BUSINESS AND DEVELOPMENT PLAN 2019/20

2019/20 Health and Wellbeing Board: future meetings

16 January 2020 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

12 March 2020 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

11 June 2020 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

3 September 2020 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

12 November 2020 (Venue: Rooms 007a/007b, Civic Office, Waterdale, Doncaster)

Health and Wellbeing Workshop Dates – Topics/venues/dates to be confirmed

5th December 2019 9-12 Board Development session (tbc)

6th February 2020 9-12 Topic tbc

2nd April 2020 9-12 Topic tbc

2nd July 2020 9-12 Topic tbc

8th October 2020 9-12 Topic tbc

3rd December 2020 9-12 Topic tbc

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South Yorkshire and Bassetlaw Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

12 July 2019

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Decision Summary

Minute reference	Item	Action
31/19	**Update from Paul Johnstone, Public Health England**	(a) That PJ would link with Director of Public Health colleagues to align with plans in the Long Term Plan (LTP).
32/19	**Priorities for joint working for Local Authorities**	(a) That RS would liaise with RB around a collaborative project in West Yorkshire between the Fire Service, the Police and the Yorkshire Ambulance Service to work with community groups regarding violence to investigate opportunities for South Yorkshire and Bassetlaw
39/19	**ICS Highlight report**	(a) That work would take place to present a summary RAG status dashboard for future meetings. (b) That a show and tell event would be scheduled for Complex Lives and Connectedness and a comprehensive update on progress will be given at the September CPB.

South Yorkshire and Bassetlaw Integrated Care System

Collaborative Partnership Board

Minutes of the meeting of

12 July 2019

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Name	Organisation	Designation	Present	Apologies	Deputy for
Sir Andrew Cash CHAIR	South Yorkshire and Bassetlaw Integrated Care System	Chief Executive, SYB ICS	√		
Adrian England	Healthwatch Barnsley	Chair	√		
Ainsley Macdonnell	Nottinghamshire County Council	Service Director	√		
Alison Knowles	NHS England	Locality Director North of England,		√	
Andrew Hilton	Sheffield GP Federation	GP		√	
Angela Potter	Nottinghamshire Healthcare NHS Foundation Trust	Director and Business Development and Marketing		√	
Anne Gibbs	Sheffield Teaching Hospitals NHS Foundation Trust	Director of Strategy		√	
Anthony Fitzgerald	NHS Doncaster CCG	Director of Commissioning	√		Jackie Pederson
Anthony May	Nottinghamshire County Council	Chief Executive		√	
Ben Jackson	Academic Unit of Primary Medical Care, Sheffield University	Senior Clinical Teacher		√	
Catherine Burn	Voluntary Action Representative	Director		√	
Chris Edwards	NHS Rotherham Clinical Commissioning Group	Accountable Officer		√	
Clare Hodgson	East Midlands Ambulance Service	Deputy Director of Strategy and Transformation		√	
Damien Allen	Doncaster Metropolitan Borough Council	Chief Executive		√	
Des Breen	South Yorkshire and Bassetlaw Integrated Care System	Medical Director	√		
Sarah Norman	Barnsley Metropolitan Borough Council	Chief Executive		√	

Greg Fell	Sheffield City Council	Director of Public Health		√	
Helen Stevens	South Yorkshire and Bassetlaw Integrated Care System	Associate Director of Communications and Engagement	√		
Ian Atkinson	NHS Rotherham Clinical Commissioning Group	Director of Commissioning	√		Chris Edwards
Idris Griffiths	NHS Bassetlaw Clinical Commissioning Group	Accountable Officer	√		
Jackie Pederson	NHS Doncaster Clinical Commissioning Group	Accountable Officer		√	
Jeremy Cook	South Yorkshire and Bassetlaw Integrated Care System	Director of Finance	√		
John Mothersole	Sheffield City Council	Chief Executive		√	
John Somers	Sheffield Children's NHS Foundation Trust	Chief Executive		√	
Julia Burrows	Barnsley Metropolitan Borough Council	Director of Public Health	√		
Kathryn Singh	Rotherham, Doncaster and South Humber NHS Foundation Trust	Chief Executive		√	
Kathy Scott	Yorkshire and Humber Academic Health Science Network	Chief Operating Officer			Richard Stubbs
Kevin Smith	Yorkshire & the Humber Public Health England Centre	Deputy Director – Health and Wellbeing	√		
Kirsten Major	Sheffield Teaching Hospitals NHS Foundation Trust	Chief Executive	√		
Kevan Taylor	Sheffield Health and Social Care NHS Foundation Trust	Chief Executive		√	
Lesley Smith	NHS Barnsley Clinical Commissioning Group and NHS Sheffield Clinical Commissioning Group	Chief Officer NHS Barnsley CCG, Interim Accountable Officer, NHS Sheffield CCG	√		
Lisa Kell	South Yorkshire and Bassetlaw Integrated Care System	Director of Commissioning Reform	√		
Louise Barnett	The Rotherham NHS Foundation Trust	Chief Executive		√	
Louise Tuckett	The Rotherham NHS Foundation Trust	Director of Strategy, Planning and	√		

		Performance			
Matthew Groom	NHS England Specialised Commissioning	Assistant Director	√		
Mike Curtis	Health Education England	Local Director		√	
Neil Priestley	Sheffield Teaching Hospitals NHS Foundation Trust	Director of Finance		√	
Neil Taylor	Bassetlaw District Council	Chief Executive		√	
Paul Moffat	Doncaster Children's Services Trust	Director of Performance, Quality and Innovation		√	
Richard Henderson	East Midlands Ambulance Service NHS Trust	Chief Executive		√	
Richard Jenkins	Barnsley Hospital NHS Foundation Trust	Chief Executive	√		
Richard Parker	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Chief Executive	√		
Richard Stubbs	Yorkshire and Humber Academic Health Science Network	Chief Executive		√	
Rob Webster	South West Yorkshire Partnership NHS Foundation Trust	Chief Executive		√	
Rod Barnes	Yorkshire Ambulance Service NHS Trust	Chief Executive	√		
Rupert Suckling	Doncaster Metropolitan Borough Council	Director of Public Health		√	
John Brewin	Nottinghamshire Healthcare NHS Foundation Trust	Chief Executive		√	
Salma Yasmeen	South West Yorkshire Partnership NHS Foundation Trust	Director of Strategy	√		Rob Webster
Sharon Kemp	Rotherham Metropolitan Borough Council	Chief Executive		√	
Simon Morritt	Chesterfield Royal Hospital NHS Foundation Trust	Chief Executive		√	
Steve Shore	Healthwatch Doncaster	Chair		√	
Teresa Roche	Rotherham Metropolitan Borough Council	Director of Public Health	√		
Tim Moorhead	NHS Sheffield Clinical Commissioning Group	Clinical Chair		√	

Will Cleary-Gray	South Yorkshire and Bassetlaw Integrated Care System	Chief Operating Officer	√		

In attendance
Paul Johnstone, Regional Director, Public Health England
Rachel Gillott, Programme Director (UEC and MH/LD Workstream), South Yorkshire and Bassetlaw Integrated Care System
Emma Challens, Deputy Chief Operating Officer, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Lisa Wilkins, Consultant in Public Health Medicine, South Yorkshire and Bassetlaw Integrated Care System
Melanie Hall, Strategic Commissioner Mental Health Adult Social Care, Vulnerable Persons Commissioning Service

Minute reference	Item	Action
28/19	**Welcome and introductions** The Chair welcomed members to the meeting.	
29/19	**Apologies for absence** The Chair noted the apologies for absence.	
30/19	**Declaration of Interest** Members were asked to declare any items not already made previously. None were noted.	
31/19	**Update from Paul Johnstone, Public Health England (PHE)** PJ introduced himself and his role within the North of England as Regional Director for PHE. It was reported that PHE would align with the new regions set up by NHS England/Improvement (NHSE/I). This presented a unique opportunity to bring together various sectors particularly to support the LTP. PJ would be addressing how the new regions would take forward the public health agenda. PJ reported on leading national work to bring PHE and the NHS together on health inequalities. It was noted that two information packs to assist with health inequalities planning would be released in two weeks time. The Collaborative Partnership Board (CPB) were asked to note that if South Yorkshire and Bassetlaw (SYB) would like particular support around this from the regional and national team, that this could be arranged through PJ. AJC reported on headline issues from the SYB Integrated Care System (ICS) development session on 9 July 2019, established in preparation for the response to the LTP, noting that the SYBICS had three priorities for health and social care developed by the Local Authorities (LA). Of these, health inequalities needed a strong focus. Work was taking place at Place level but key things to happen at system level needed consideration. Utilising PHE for this would be beneficial. It was agreed that PJ would link with Director of Public Health colleagues to support narrative for the LTP response.	**PJ/DPHs**

	PJ was thanked for his update.	
32/19	**Priorities for Joint Working for Local Authorities** **Complex lives** RS updated the CPB on work done by Chris Marsh with the SYB LAs, to focus on developing a set of principles and priorities for action. Mental Health Support was being identified as a common issue. Next steps for this would be a show and tell session in September to include all areas sharing good practice to build on. The CPB noted opportunistic work taking place, including a bid to PHE's Rough Sleepers grant combining a focus on support for women in this cohort from Sheffield and then extending this learning across SYB. CPB were alerted to the importance of and time taken to engage elected members with this bid. There were also opportunities emerging from the initial conversation including developments around forensics and social care, transforming care and violence reduction units. RB mentioned a collaborative project in West Yorkshire between the Fire Service, the Police and the Yorkshire Ambulance Services was being developed to work with community groups regarding violence. RS agreed to investigate any opportunities to bring this to SYB. It was noted that this work was an opportunity for SYB to tackle the wider determinants of health and a platform for joint discussions and working collaboratively. Work was taking place to break cycles of trauma with psychologists working in hostels. A query was raised whether this work would reduce the numbers of rough sleepers in future years. It was confirmed this work was around breaking family cycles of repeated behavior. This was a solution focused approach. **Connectedness** Work was taking place to build capacity in local areas, using some capacity from the ICS. The NHS LTP implementation framework had been released and this piece of work needs taking into account. Discussions with Primary Care Networks (PCNs) was key to this work as well as others, eg Housing Officers, District Nurses, and a systematic approach would be required to support social isolation and connectness. A show and tell event would be scheduled and a more comprehensive update on progress will be given at the September CPB. **Physical activity/active travel** It was noted that work was taking place on this around infrastructure and relationships and that these were well embedded at place level. Opportunities for work at ICS level would be explored to build the scope was underway. The South Yorkshire Active Travel Commissioner was being linked in with this and they were keen for NHS input into this work and for a contribution to an advisory board. The CPB were asked to note this important joint working with health and Local Authorities and ICS resource was being drawn upon for this work on the above three agreed joint priorities. The CPB noted a further element of this work of the Sheffield City Region (SCR) and the connections between this and the ICS. A query was raised around excess winter deaths as part of the SCR work. This	**RS** **RS** **TR**

	was being driven by the Mayor, Dan Jarvis. A round table discussion had taken place with the SCR Mayor and people across the NHS and local government where links between this work and this ICS was discussed. From an ICS perspective, this work is already being taken forward at place.	
33/19	**Minutes of the previous meeting held 10 May 2019** The minutes of the previous meeting were agreed as a true record and would be posted on the website after this meeting. **www.healthandcaretogethersyb.co.uk**	
34/19	**Matters arising** **Hosted Networks** RJ confirmed work was proceeding and roles for Programme Managers, Analysts and Clinical Leads would be put out to advert shortly. **New Management Arrangements for CPB** WCG was leading on this work and would be ready by the end of August 2019 to be discussed at the September CPB.	
35/19	**ICS System Leader Update** AJC reported on changes to personnel, noting that: - Nick Balac was the new Chief Officer Lead and Jackie Pederson the new Primary Care Senior Responsible Officer for the next stages across the system to work alongside Karen Curran as Primary Care Programme Director. - Suzanne Bolam was now Allied Health Professional Lead for the SYB ICS on 1 day per week basis until the end of March 2020. - Kevan Taylor would be working for a period of 1 year with the SYB ICS to allow new arrangements to take place at Sheffield Health and Social Care NHS Foundation Trust. Kevan Taylor would lead on looking at economic relationships with local government and establishing the SYB NHS Assembly and workforce arrangements. AJC reported on meeting with the Chairs of the Health and Well Being Boards (HWB), noting a well-represented and productive session. It was anticipated that part of the new arrangements moving forward would include this group on the CPB. It was noted that the HWB Chairs had requested to view a draft of the LTP as it developed. CPB were asked to note this to be aware of the ways that the inputs were being fed into the development of the plan collectively and at place level. The CPB were asked to note that the connection with HWB Leads meeting and HOB noting that one member had joined the HOB to represent the Chairs. Positive feedback from the region focused discussion on 16 May was noted. AJC reported on the Guiding Coalition event on 9 July. The second event would take place in October. The SYB 5 year response to the NHS Long Term Plan which is currently being drafted but the ICS and it partners would be circulated to all key meetings and to the public as part of the engagement process and the final plan would be submitted to NHSE/I by the end of November in line with the national timeframe. The plan would focus on the needs of the SYB population to improve population health, reduce health inequalities and improve outcomes, quality and experience for people through more integrated care approaches and	

	transforming care.	
36/19	**Prevention Workstream Update** LW updated CPB on the work of the SYB ICS prevention workstream noting: 1. Embedding the treatment of tobacco dependence in secondary care – the QUIT programme - a business case has been written and discussed at HEG 2. Systematic quality improvement in the identification and management of clinical risk factors for cardiovascular disease - a) That primary care networks have been asked to submit expressions of interest for AHSN support to develop improvements in self-care for their patients with or at risk of Cardiovascular disease b) That early scoping work is being done with the British Heart Foundation and two universities regarding developing new integrated models for cardiac and pulmonary rehabilitation. 3. To increase access for a wider range of residents of SYB to social prescribing as a gate way to accessing non-medical forms of support and to empower clients to enhance their own well-being. Regarding social prescribing, AJC asked the DPHs for their views, including whether this was progressing equally in all five places. In response, it was felt this this was working well at present in all Places in SYB and this was due to the development of the services being based on local need. It was noted that NHSE expects a rapid increase in the number of link workers as part of the Primary Care Networks DES but there was a funding gap with NHSE funding only for the link worker salary and no funding for the services that patients are referred on to. A request for local discussion to address resource issues was made TR also noted that to build the capacity would take time and money and moving too quickly on increasing the number of link workers could run the risk of the services not being as effective. RS highlighted the need to be clear on what success would look like in each place and not to see social prescribing as a panacea. LW noted that her team have been developing a paper on potential relationships between the ICS and the voluntary sector, which is planned to go to the next ICS Delivery Group meeting for discussion. A discussion took place around the population health management approach and the relationship and involvement with the voluntary sector and the ICS, noting the involvement at Place level and the connectivity at a local level was crucial. It was noted that learning from local systems should also be taken. Adrian England commented that as well as the voluntary sector having a strong role at Place level, they also worked strongly at neighbourhood level. The CPB noted progress on the 3 agreed priorities since the last update and the importance of prevention and population Health within the LTP response.	
37/19	**Developing SYB ICS Long Term Plan** The CPB noted that the implementation framework had been published and LK updated the board on the key elements of this.	

	A discussion took placed around setting out the vision across the system in line with the expectations across SYB and the national timeline and requirements as set out in the LTP implementation framework. A task and finish group has been established with representation from all five places to collaboratively develop the plan with narrative from each of the place plans underpinning the 5 year LTP will be shared in draft with CPB members as part of the LTP engagement process. The CPB noted timescales, key milestones and progress.	
38/19	**ICS Finance update** CPB noted two key risks: Sheffield Children's NHS Foundation Trust (SCFT) financial risk and Doncaster and Bassetlaw Hospitals NHS Foundation Trust planned alignment risks. Meetings were in place to discuss the risks. Regarding the SCFT issue, a Sheffield Place meeting would be established to agree a place based response. This would be reported back to the ICS. Further discussions around this issue would take place outside of the CPB.	**JC**
39/19	**ICS Highlight report** The highlight report was presented by LK to outline progress of the ICS transformation programme over the last month Issues identified were around the lack of capacity to take forward some of the work programmes by expectation were noted as: Financial risks around support to take the programs forward and work was taking place with the Programme Directors to address capacity (elective and diagnostics and medicines optimization) It was noted that work would take place to present a RAG status report for future meetings.	**LK**
40/19	**Any Other Business** Funding for Sheffield As part of the LTP, the government had committed support between schools and colleges and NHS Services. Two sites within Sheffield had been given funding. Accuracy of papers LT highlighted an error on p19 of the key performance report overview which was showing as green on A&E and noted this needed amending.	
	Date and Time of Next Meeting The next meeting will take place at 9.30am to 11.30am on 13 September 2019 in the Boardroom, 722 Prince of Wales Road, Sheffield, S9 4EU.	

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Doncaster Council

NHS Doncaster Clinical Commissioning Group

Meeting: Joint Commissioning Management Board

Date: 19th September 2019 **Time: 9.30 -11am**

Location: Room 413, Civic Building, Waterdale, Doncaster, DN1 3BU

Attendees

Damian Allen – Chief Exec Doncaster Council (alternate Chair)	Jackie Pederson - Chief Officer Doncaster CCG (Chair)	Phil Holmes - Director of People – Doncaster Council
Anthony Fitzgerald - Director of Strategy & Delivery Doncaster CCG	Cath Doman - Director of Health & Social Care Transformation	Hayley Tingle - Chief Financial Officer Doncaster CCG
Rupert Suckling – Director of Public Health	Dr David Crichton – Clinical Chair Doncaster CCG	Andrew Russell – Chief Nurse Doncaster CCG
Lee Golze – Head of Business Transformation & Strategic Commissioning Doncaster Council	Linda Tully – Lay Person	Denise Bann – Strategic Lead Commissioning Doncaster Council
Amy Coggan – Head of Performance and Intelligence Doncaster CCG – for agenda item 5	Stephen Emmerson – Head of Strategy and Delivery – Doncaster CCG – for agenda item 9	Doug Wright – shadowing Anthony Fitzgerald

Gill Parker – note taker

Apologies

Cllr Rachael Blake – Portfolio Holder Doncaster Council	Faye Tyas – Assistant Director of Finance and Chief Financial Officer Doncaster Council	Leanne Hornsby – Assistant Director Commissioning and Business Development Doncaster Council
Riana Nelson Director of Learning, Opportunities and Skills Doncaster Council		

Item	Discussion/Comments	Action
1	**Welcome, introductions and apologies** Introductions were made around the table and apologies received as per above.	
2	**Minutes of the previous meeting and matters arising** David referred to an error on page one item two of the JCMB minutes from 9th May 2019, with reference being made to the Chair of the Joint CCGs. This should have said the Chair of Joint Overview and Scrutiny. Gill to amend and share the minutes. **Action Log Update** Item 79 – Hayley informed the CCG figures were to be collated with the Council figures next week – item to remain open. Item 82 – Hayley to provide an update. Item to remain open.	**GP**

	Item 85 – Andrew and Cath have met to discuss our approach to Integrated Care Partnership Quality Assurance. Andrew will develop a proposal for the Partnership Board, including a formal Quality Assurance Process. **Actions:** **I. GP to correct minutes from 09/05/2019 and circulate** **II. AR to draft quality assurance paper in readiness for October Partnership Board**	**AF**
4	**<u>Joint Commissioning Strategy – Team Capacity</u>** Anthony updated following the workshop held on 1st August. Each of the three Life Stages now have executive sponsors. The Starting Well staffing structure referred to in appendix III still has much work to be done, so has not been shared as yet. The Starting Well Board meetings have commenced - Damian advised the Voluntary Sector were involved and that he was on the board. As Living Well has such an extensive scope, the initial focus will be on Learning Disability and Autism, however the sponsors will ensure that the rest of the programme is progressed. An LD and Autism Lead to work across both organisations will be appointed. Phil and Andrew to look at consistency across both the council and CCG. There will also be focus on Mental Health. For Aging Well, a lead is required across both organisations. JCMB noted that the role of sponsors will need to add value and not extend the decision making process. Anthony advised that governance and decision-making was still to be developed. There is an opportunity to reduce the number of meetings. Phil advised Riana has done a lot of work around this in LOCYP JCMB agreed to support the next steps and the recruitment of a Lead for Living Well, who will focus on LD and Autism. Progress was noted and also the Place Plan re-fresh.	**PH/AR**

3	**Place Plan re-fresh** Cath drew the Board's attention to the new design and informed the process has been overseen by the Doncaster Integrated Care Delivery Board. The Refresh will be launched on 16th October to Chairs, Non-Execs, Lay Members and Councillors. The Integrated Neighbourhood new care models are being tested and will be rolled out to other localities and there will be a greater focus on Population Health early intervention and prevention. JCMB noted that the following areas need to be developed: • New Area of Opportunity – Children living with long-term conditions and disabilities to be scoped and co-produced with children and parents. • To develop the local model for Population Health and • To clarify the capacity for delivery. • Resolve governance and decision making issues Jackie commented there will be a need for conversations about how the Provider Alliance will improve outcomes in the identified areas – we have not commissioned in this way before so we need to ensure the new models gives us what is needed. We need to define what area based commissioning looks like. The overarching model is very important. Rupert feels we need to move to commissioning a system rather than individual services. The financial framework is currently lagging behind a person-centred, whole system approach. The costing model is very important and needs to be clarified. Phil declared a conflict of interest, as he sits on the Provider Exec Board. He asked who the conduit should be with regard to the Providers – Laura Sherburn was suggested. A conversation is required regarding alignment with the Providers. Jackie expressed concerns at how we will maintain the neighbourhood work going forward, and feels further discussions are required around this. Damian proposed getting the DGT Portfolio Group involved to bring the work to a higher level. Jackie is hoping we can create a model we can add to in the future – i.e. not just Health and Social Care, but to add on such as Housing. The DICDG will lead on the development of the approach. **Actions:** 1. **CD to update the Refresh to reflect JCMB's advice.** **(Post-meeting note: action completed and Refresh approved by the DICPB on 27.09.19)**	

5	**Performance & Intelligence / Strategy and Performance Unit Joint Working** Amy updated on the progress made with regard to joint working on intelligence between the Council and CCG and advised strong relationships had been built. There has been progress made in joint reporting on Integrated Care, S117, heat mapping and Health inequalities. Linked data sets will shortly be going live – starting with Adult Social Care – this requires further expansion, but will provide much more intel for our clients. The joint intelligence teams are also supporting the Life Stages. They are able to show need in different areas of the borough and will inform and drive our priorities going forward. This is all monitored via PENTANA, and we will be able to see what is outstanding at each Life Stage. Amy advised there were areas for improvement and they are trying to align timescales for the Council and CCG, as there has been some previous confusion over who was responsible for actions. Jackie clarified JCMB was being asked to note the report and support the next steps. Rupert commented it was impressive and feels a forward plan would be useful. Jackie commented PENTANA was only as good as the information put into it. Damian commented it would be the first time we'd have information in one place.	

6	**Update on Finance and Contracting work stream**
	
	Hayley informed Directors of Finance had finally managed to arrange a meeting, which is scheduled for 4th October.
	
	• The recommendations are to:
	  ○ Set-up a working group to further develop the systems costing model – identify additional independent capacity and review implications for each organisation.
	  ○ The working group would also undertake reviews of business cases in a consistent way. The first area we need to gain collective agreement on the financials is Intermediate Care; aiming for the 27th September.
	  ○ Representatives will be attending the NHS Costing event led by NHSE/I. Covering the following:
	  ▪ Summarise the model development / handover from KPMG (and BDO for Doncaster)
	  ▪ Summarise the actions each local site agreed to "optimise" the model
	  ▪ Highlight the local work completed to date on model optimisation
	  ▪ Detail any outstanding actions, or future planned actions, to further develop the model
	  ▪ Specifically detail and forecasting / modelling capacity developed, planned or needed
	  ○ Development of a system transformation fund.
	
	A paper on the transformation fund is to come to the next JCMB meeting – Gill to add to forward plan.
		GP/FT/HT

	Anthony advised JCOG were receiving feedback on all BCF funded streams, many of which are funded by non-recurrent money. JCOG are developing a prioritisation mechanism for future funding. **Actions:** **I. Faye & Hayley to bring a paper on the System Transformation Fund to 31st October JCMB.**	
7	**Commissioning Agreement** The refresh of the commissioning Agreement is to be progressed prior to expiry in March 2020.	
8	**Better Care fund Update** Rupert informed JCOG are currently considering the final amendments. He has been given delegated authority from Health and Wellbeing Board to sign this off. Very positive feedback has been received on the draft plan through the informal Regional Assurance process. Section 75 is to be completed by December 2019 – we must ensure our Terms of Reference are finalised and signed off before then. Addressing inequalities will be a major part of the agreement. JCMB noted the positive feedback and agreed to the defined terns and delegations for the S75 refresh agreement.	
9	**Business Cases for approval** • **Dementia Post Diagnostic Service** Option 1 – to continue to fund this for a further two years was the option recommended by JCOG. Stephen commented the service was receiving a lot of praise internally, as teams are working well together. JCMB approved a two year extension. **Key Decision:** **II. Dementia Post Diagnostic Service to be funded for a further two years**	
10	**Messages from JCOG**	

	Anthony commented these had mainly all been cover within the agenda. All BCF schemes are now coming to JCOG.	
11	**Any other business** • **Doncaster Partner Governor, Lay and Members Event 16th October** Anthony updated this event was taking place at the Network Rail College from 4.30 – 7pm on 16th October. There have been 30 registrations received so far. The Communications and Engagement Team are leading the event, which is to focus on innovation work and as a launch of the Place Plan re-fresh. Cath added that its focus is also to update chairs, councillors, non-exec and lay members and explore their role. • **Update on SY & B ICS Commissioner Development** Jackie informed the main ICS focus is on the long-term plan. Anthony added this is currently in draft format. Rupert is involved with this and expecting national direction on it. Phil informed the Chief Exec of West Yorkshire was resisting plans to change CCG responsibility. We need to think more clearly at Place level. Jackie commented if there is one ICS pot of money for Doncaster and Bassetlaw, we need to be clear on the model and how the money is spent. The five CCGs across our area need to maintain their autonomy. The local authorities need to convey this message at the November meeting.	
Date and time of next meeting: **Thursday 31st October 2019 from 9.30am – 12.30pm in the Boardroom at Sovereign House** **Joint meeting with JCOG**		

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 07.11.19

Subject: Doncaster Safeguarding Children Partnership Annual Report 2018/2019

Presented by: Tony Holmes, Principal Social Worker and Safeguarding and Standards Manager

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

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

How will this contribute to improving health and wellbeing in Doncaster?
Children's needs being met in their care arrangements and risk being effectively managed, mitigated and reduced will improve their long term life chances, in particular long term health and mental health outcomes.

Recommendations
The Board is asked to note the contents of this report.

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Doncaster Safeguarding Children Partnership Annual Report 2018 - 2019

Foreword

As the safeguarding partners for Doncaster, as defined by the Children and Social Work Act 2017, we are very pleased to present our Annual Report 2018 – 2019 on local multi-agency arrangements to safeguarding children. This report provides an overview on what has been done to keep children safe from abuse and neglect, through delivering the requirements of the Government's statutory Working Together to Safeguard Children, 2018.

The new safeguarding partnership arrangements build on and replace those of the Doncaster Safeguarding Children Board. We wish to acknowledge the dedication and hard work of all those involved in keeping children in Doncaster safe since local safeguarding children boards were established in 2006.

The world is changing fast for children, families and communities, and with it the pressures and the risks that must be safeguarded against. The safeguarding of children continues to evolve at local, national, and even international levels, so we must continue to meet the challenges with an open attitude of learning. This of course extends across the partnership of all agencies and organisations working together to safeguard children, and we also need to be learning from the children, families and communities we work with.

Doncaster Clinical Commissioning Group, South Yorkshire Police and Doncaster Council with Doncaster Children's Services Trust are designated by the Children and Social Work Act 2017 as 'safeguarding partners' for Doncaster borough, and as such we are accountable for the effectiveness of the local arrangements to keep children safe. Safeguarding is, however, ***everyone's*** responsibility, and through the Doncaster Safeguarding Children Partnership we are working together with a wide range of other agencies including health services, schools, early years settings, social care, and voluntary, community and faith organisations.
Our vision is clear:
We work together to help Doncaster children and young people to be safe!

Damien Allen
Acting Chief Executive
Doncaster Council

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Contents

Executive Summary

The Children and Social Work Act 2017 designate Doncaster Clinical Commissioning Group, South Yorkshire Police and Doncaster Council with Doncaster Children's Services Trust as 'safeguarding partners' for Doncaster borough, and are accountable for the effectiveness of the local arrangements to keep children safe. These new local arrangements centre on partnership working with a wide range of relevant agencies through Doncaster Safeguarding Children Partnership (DSCP), which builds on and replace those of the Doncaster's Local Safeguarding Children Board.

National statutory guidance Working Together 2018 (Chapter 3, paragraphs 41 – 46) requires safeguarding partners to publish a report at least every 12 months setting out what has been done because of the local safeguarding children arrangements.

Local safeguarding arrangements include the following elements:

- Family life
- Universal services
- Early Help
- Statutory services – children's social care
    - Child in Need Plan
    - Child Protection Plan
    - Child in Care

The intention is that intervention will be at the lowest appropriate level, so that children and their families are not involved in safeguarding procedures if that can be avoided.

Doncaster has a population of approximately 307,374. It is the 48th most deprived out of 326 local authority areas in England, with an estimated 13,930 children and young people aged 19 and under, the number of children living in conditions of poverty is higher than the national average. Hence, a significant proportion of families in Doncaster will face significant challenges in caring for and raising their children. While we should not assume that economic and social deprivation are a direct cause of safeguarding issues in a community, deprivation is nevertheless regarded as significant among the conditions in which child maltreatment, abuse and neglect occur.

The demand for children's services in Doncaster is higher than the national average: referral rates to children's social care are higher in Doncaster than national, as are the rate of Child Protection Plans and Children Looked After. The higher s.47 Child Protection enquiries and Child Protection Conference rates are also a feature of this higher level of overall demand.

Early Help services have a key role in addressing lower levels of need and in preventing family difficulties escalating to the point where children's social care might be needed. The provision of single-agency Early Help continues to increase, though there has also been some decline in multi-agency Early Help.

The Multi-Agency Access Point received 16,698 contacts requesting a service in 2018-19, reflecting a broad awareness of needs and safeguarding issues amongst partner agencies, and the level of deprivation in the borough. Approximately a quarter of contacts are taken forward by children's social care for an assessment, and of these 30% then proceed to a statutory service (which may include child protection investigation). The level of children in need of a statutory service is declining though remains above national averages. Work to understand the true nature of the patterns of demand in Doncaster remains ongoing.

The trend is a steady decline over recent years, and there are no Child Protection Plans that have been in place for two years or longer. This suggests that effective early intervention is preventing problems from escalating to a point where child protection procedures are required.

Participation of children and young people in their Child Protection Conferences in significantly high in Doncaster, as a result of pro-active work by Doncaster Children's Services Trust. This has resulted in many benefits including more meaningful contributions and greater engagement with Child Protection Plans, reduction in length of plans, more successful 'stepdown' to Child in Need or Early Help Plans, and better engagement with other professionals including school.

Effective 'Pre-Proceedings' processes – where a there is prospect of a Care Order being sought to take a child into care – has resulted in 44% of cases being resolved through no further progression to Court, hence successfully diverting children from care.

At the end of the year, 534 children are in the care of Doncaster Children's Services Trust. The continued reduction of the number of cared for children reflects a number of successful strategies including Edge of Care interventions, Pre-Proceedings, and multi-agency working to explore all possibilities to re-unite children with parents or family members.

DSCP has received assurance of effective partnership working in respect of Children Missing from Home and Care, Private Fostering and allegations against professionals and those in positions of trust.
DSCP also reports on progress against its Strategic Priorities:

- Strategic Priority 1 - DSCP is assured that effective arrangements are in place for responding to key safeguarding risks and that there is consistently good practice across safeguarding services.
- Strategic Priority 2 - DSCP has a clear understanding of the effectiveness of the safeguarding system in Doncaster and can evidence how this is used to influence the Board's priorities.
- Strategic Priority 3 - DSCP communicates effectively to ensure that the work of the Board is well publicised, that learning is disseminated and that the voice of children, young people, practitioners and the wider community (including minority groups and faith groups) are able to influence the Board's work.
- Strategic Priority 4 - DSCP is aware of emerging issues which have implications across the partnership and works effectively to ensure appropriate action is taken.

DSCP has also delivered a multi-agency training programme across a wide range of safeguarding issues which was accessed by 2117 professionals.

Purpose of the Report

Working Together 2018 (Chapter 3, paragraphs 41 – 46) requires safeguarding partners to publish a report at least every 12 months setting out what has been done as a result of the local safeguarding children arrangements. This is in order to bring transparency for children, families and all practitioners about the safeguarding activities undertaken.

It covers the work undertaken by Doncaster Safeguarding Children Partnership in the financial year April 2018 to March 2019, assessing the progress made by the Board as a multi-agency partnership in delivering its Business Plan.

The report is intended for professionals in partner agencies and voluntary organisations as well as others who have an interest in the safeguarding of children and young people, and is made available to the general public via the Doncaster Safeguarding Children Partnership's website http://www.dscp.co.uk/

The report will be presented to Doncaster Council's Children and Young People Scrutiny Panel. It will also be shared with the Schools, the Children and Families Strategic Partnership Board, and the Safer Stronger Doncaster Partnership, all of whom have a wider remit to promote better outcomes for children. DSCP leads and influences the children's safeguarding agenda in these wider political and partnership arenas and is held to account for its impact.

What are the local safeguarding arrangements?

The arrangements that each local authority area are required to have in place are described by the Children Act 2004, as amended by the Children and Social Work Act 2017, and the statutory guidance Working Together to Safeguard Children.

Family life - Parents have primary responsibility for their children. Public services have a duty to provide support to children and families. UN Convention on the Rights of the Child Article 18 (parental responsibilities and state assistance) states that *both parents share responsibility for bringing up their child and should always consider what is best for the child. Governments must support parents by creating support services for children and giving parents the help they need to raise their children.*

Universal Services - All services that provide services for children and families (child care, schools, health services, sports, leisure, etc.) are expected to provide those services in an environment that is safe. They are expected to have safeguarding policies and procedures, and to train their staff and volunteers to be aware of signs of abuse and neglect, and to raise issues of concern with their agency's safeguarding lead or refer to children's services. They are also expected to respond to allegations against staff in positions of trust with children.

Early Help – where difficulties for children begin to emerge they may receive additional help from universal services, possibly by services co-ordinating their support to a child and family through a 'Team Around the Child'.

Statutory Services – where there are concerns about possible or actual maltreatment, abuse or neglect, or more complex family problems, a family, a member of the public, or a member of staff from an agency involved with the child should make a referral to children's services.

Children's services, with the support of safeguarding specialists from agencies such as Health and Police, will consider whether there are safeguarding concerns, whether any immediate action should be taken, and will carry out a detailed assessment of need to identify what, if any, additional support may be needed. Children's Services will then either take no further action, agree an early help action plan or work with the child and family and other agencies involved through:

- A **Child in Need Plan** – a voluntary arrangement with children and families to receive support led by a social worker along with any other agency involved with the child and family.
- A **Child Protection Plan** – a social worker and any other agency involved with the child and family will identify what needs to happen or to change for the child to be safe at home.
- **Child Looked After by the local authority** – in the exceptional circumstances where a child's safety or welfare at home cannot be assured, children's services may apply to the Courts for an order allowing the child to found another place to live, for example, with foster carers. Where a home situation improves, a looked after child may be able to return home to live with parents or with close relatives. In some situations, a child might eventually be adopted, or a young person may live independently once they are of an appropriate age to do so.

The elements of the safeguarding arrangements work together as a ***system***. Wherever possible, responsibility remains with the child's family, the level of support provided the level of need, and statutory interventions such as involvement of children's services or Police are kept to a minimum.

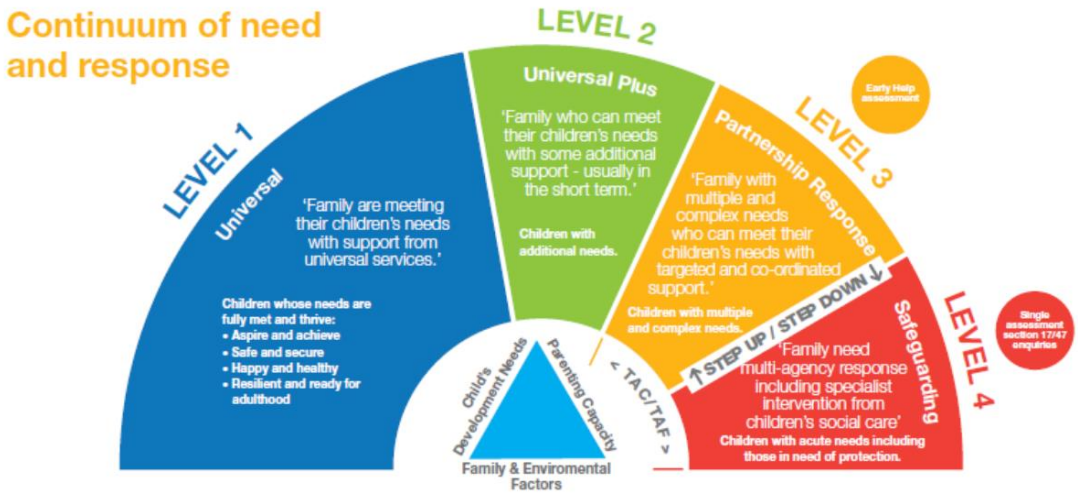


Figure 1: DSCP Levels of Need: the continuum of need and response.

An illustration of the overall system for services to children and families is provided in DSCP's Levels of need document (November 2017) which uses figure 1 above to illustrate a continuum of need and response. In the Levels of Need diagram, 'safeguarding' – that is, protection from abuse and neglect – is described as Level 4. However, the diagram also shows the importance of earlier intervention and support in reducing or removing the need for children and families to become subject to safeguarding procedures. The intention is that intervention will be at the lowest appropriate level, so that children and their families are not involved in safeguarding procedures if that can be avoided.

Safeguarding partners and Doncaster Safeguarding Children Partnership

The local safeguarding children arrangements are the responsibility of the three 'safeguarding partners' – Chief Officers of Doncaster Council, Clinical Commissioning Group, and the Police. The safeguarding partners have agreed a structure to oversee the implementation and effectiveness of the local arrangements – this involves a much wider group of agencies that have key safeguarding responsibilities, and is referred to as Doncaster Safeguarding Children Partnership (DSCP). This provides governance and accountability so that all agencies involved are clear about their safeguarding responsibilities and that they work together to co-ordinate all their safeguarding activities.

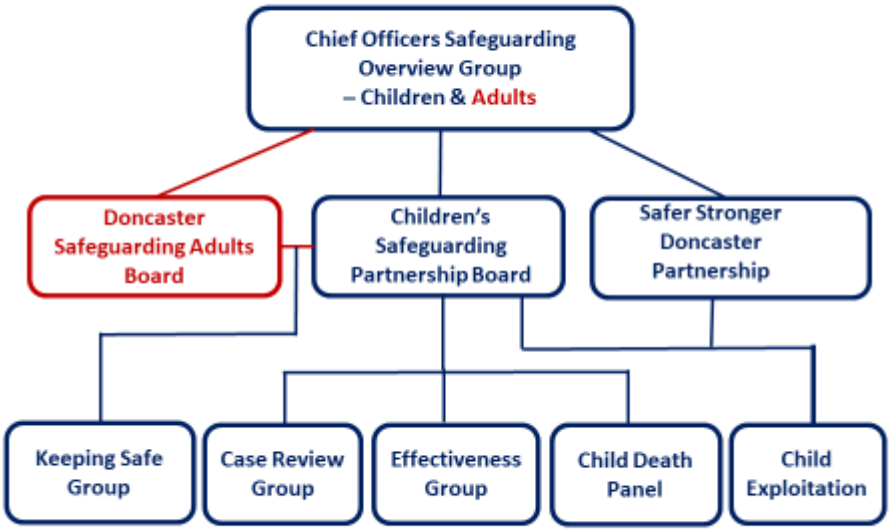


Figure 2: Structure of Doncaster Safeguarding Children Partnership

For further details of the local safeguarding arrangements, see the document Local Safeguarding Partnership Arrangements to succeed Doncaster Safeguarding Children Board in response to Working Together 2018 available on the DSCP website.

Links with other strategic partnerships

The DSCP works very closely with a number of other multi-agency strategic partnerships:

- Doncaster Safeguarding Adults Board
- Health and Wellbeing Board
- Safer Stronger Doncaster Partnership
- Children & Young People's Partnership and Early Help Strategy Group

There are overlapping areas of concern across these partnerships and others. Doncaster has recently put in place a Chief Officers Safeguarding Overview Partnership (COSOP) in order to ensure that there is co-ordination across partnerships and linkages with other partnerships and plans such as Doncaster Growing Together, and the plan for the strategic partnership Team Doncaster.

The local context for safeguarding in Doncaster

Population

Approximately 307,374 people live in Doncaster, in terms of the Indices of Multiple Deprivation (IMD) 2015 Doncaster is:

- 48th most deprived out of 326 local authority areas in England
- 4th most deprived out of 21 local authority areas in the Yorkshire and Humber Region
- The 2nd most deprived area in South Yorkshire
- The 4th most deprived area in its comparator group
- 1 in 5 Lower Super Output Areas in Doncaster is in within the most deprived 10% of the UK.

A rise in the number of cohabiting partners, step families, lone parents and the recording of same sex relationships in the past 10 years has changed family composition in Doncaster. The latest 'Information for Doncaster' (information provided by DMBC) shows that nearly 71.9% of families with dependent children are a couple; which means nearly 1 in 3 families (28.1%) are lone parent families. The main difference between Doncaster and the national picture is the higher proportions of families that are cohabiting, particularly where this involves step-families.

The population of young people aged 0-24 is 89,500 which is 29.1% of the total population. This is the same as our comparator group and but slightly lower than national proportions at 30.2%.

The number of children in poverty in Doncaster is 21.0%, which is higher than the national average of 16.6%. This equates to around 13,930 children and young people aged 19 and under. Poverty is not distributed equally across the borough with some lower super output areas (LSOA) having over 50% of children in poverty compared to other area only having 5%.

In Doncaster, 6.2% of residents were born outside the UK. The main group outside of white British is 'white other' which equates to 3.1% of the population aged 0-24. The main language in Doncaster, for people aged 3-15, if not English, is Polish.

Doncaster is the second largest economy in South Yorkshire; a large proportion of the population is in receipt of state benefits. Approximately 3.3% of the population in Doncaster claim job seekers allowance or universal credit compared to 2.2% nationally. In the 18-24 age category, 5.5% of the population are claim job seekers allowance or universal credit compared to 3.0% nationally.

The number of 16-18 years old not in education, employment or training is 5.3% of the population as at June 2017. This is higher than the national average.

The proportion of people in Doncaster who achieve a Level 2 or level 3 qualifications by the age of 19 is 78.9% and 44.5% respectively. This is lower than the regional (81.6%) and (53.6%) and national (83.6%) and (57.5%) averages respectively.

The NSPCC have estimated that one in five children in the UK is impacted by domestic abuse. However, Growing Futures estimate that in Doncaster this is one in three children. This suggests that more children compared to the national or regional average may require additional services to achieve their best outcomes.

Ethnicity

The numbers of pupils in Doncaster are predominantly White British (34,458), and White other (2,639).

Doncaster has fewer school age children from ethnic minority groups than regional and national averages. The percentage of primary and secondary school age children from ethnic minority groups is 15.9% and 13.0% respectively. This is much lower than the regional (26.3% and 23.3%) and national (32.1% and 29.1%) averages respectively.

Health

The health and wellbeing of children in Doncaster is generally worse than the England average. The infant mortality rate of 4.8 per 1000 is higher than both the regional and national rate of 4.1 and 3.9 respectively (2014-16).

The smoking status of mothers at time of delivery in Doncaster is higher, at 13.0%, compared to the national average of 10.7% (2016/17).

Children in Doncaster have average levels of obesity: 23.0% of children aged 4-5 years and 35.8% of children aged 10-11 years. (2016/17).

Life expectancy at birth for males, in Doncaster is 77.8, lower than the regional and national averages in 2014-2016. There is a higher life expectancy for females at 81.5 however this still compares unfavourably with regional and national averages.

Family Composition

Family composition is changing in numbers, with variable arrangements rather than the traditional married family household. A rise of cohabiting partners, step families, lone parents and same sex relationships in the past decade has resulted in a very different profile of family composition in Doncaster. The latest information shows that over 71.9% of families with dependent children are couples, with almost one in three children living in lone parent families (28.1%). A key difference between the family composition profile in Doncaster and that found nationally, is the higher proportion of families that are co-habiting.

Deprivation

Doncaster is currently ranked 48 out of 326 local authorities according to the index of multiple deprivation and is fourth worst of the 21 Yorkshire and Humber local authorities (latest Government release of Index of Multiple Deprivation is 2015). One in five of Lower Super Output Areas (a geographical area with typically a population of 1500 people) in Doncaster is in the most deprived 10% nationally. This is illustrated in figure 3 below.

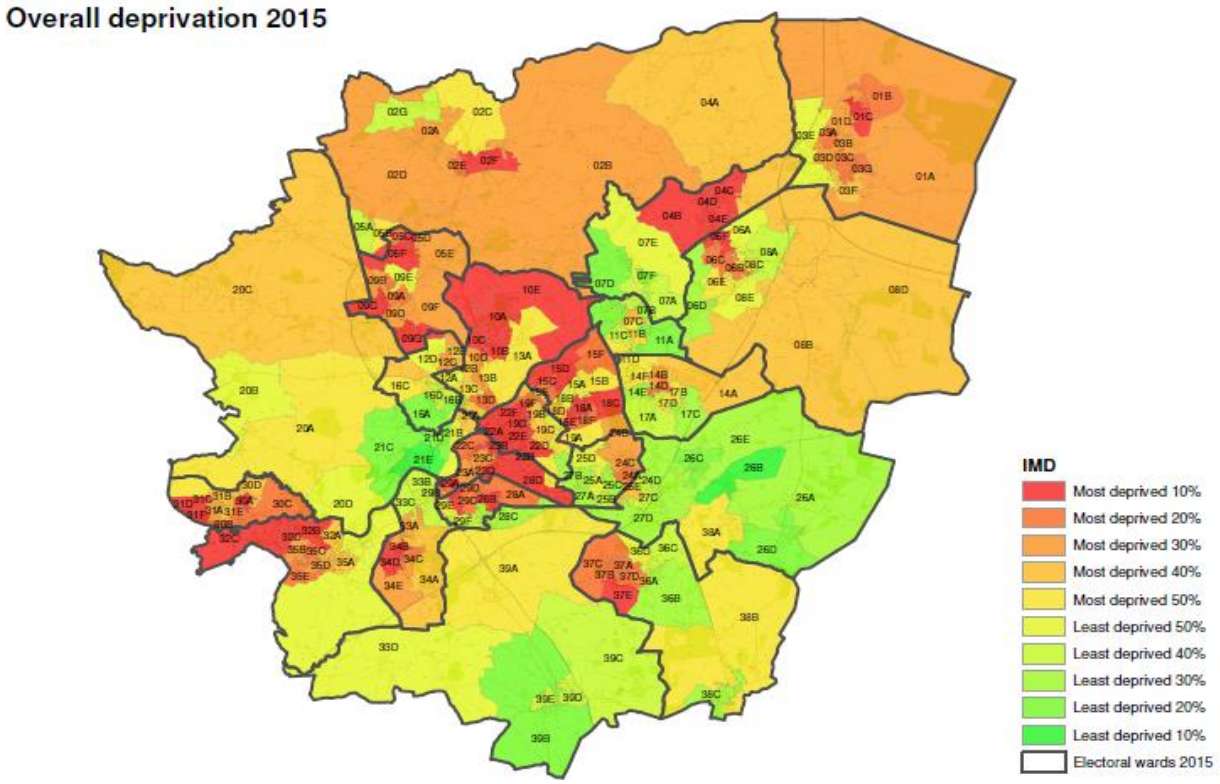


Figure 3: Deprivation levels in Doncaster Borough in relation to national figures.

Eligibility for free school meals (June 2018) is means-tested on household income, principally welfare benefits, so is a useful proxy indicator for deprivation. Doncaster is above national and statistical neighbour percentages for primary and secondary schools.

	Primary	Secondary	Special	PRU
Doncaster	16.6%	15.3%	35.6%	30.7%
National	14.2%	13.3%	36.7%	41.8%
South Yorkshire	16.4%	15.5%	38.2%	43.4%
Statistical neighbours	16.2%	14.9%	37.9%	40.0%

Table Z: % Eligibility for free school meals.

*Doncaster Councils 'statistical neighbours' – 10 local authorities with similar demographic characteristics – are Rotherham, Barnsley (both considered 'extremely close' to Doncaster), North East Lincolnshire, Wigan, Wakefield, Tameside, Dudley, North East Lincolnshire, Telford and Wrekin, and Redcar and Cleveland ('very close').

A report **By us, for us: A youth-led commission on child poverty in Doncaster**, commissioned by the Children and Families Executive Board (September 2018) concluded the following:

> *in Doncaster almost 1 child in 3 lives in poverty – that's over 20,000 children. Poverty affects children's lives in lots of different ways: their family may not be able to afford enough food, heat their home, buy birthday presents, or could fall into debt. Young people can lose their homes, or become victims of crime if their area is unsafe. Poverty affects how well children do in school, how healthy they are and how they behave. It also affects their future – what kind of jobs they can get and whether they end up being poor as adults.*

Summary

The data above suggests that a significant proportion of families in Doncaster will face significant challenges in caring for and raising their children. While we should not assume that economic and social deprivation are a direct cause of safeguarding issues in a community, deprivation is nevertheless regarded as significant among the conditions in which child maltreatment, abuse and neglect occur.

Other research, **The relationship between poverty, child abuse and neglect: an evidence review**, Bywaters et.al., 2016, states that *There is a strong association between families' socio-economic circumstances and the chances that their children will experience child abuse and neglect...The greater the economic hardship the greater the likelihood and severity of child abuse and neglect*. For example, Child Protection Plan rates in neighbourhoods among the most deprived 10 per cent in England as a whole were almost 11 times higher than rates in the most advantaged 10 per cent of neighbourhoods (Bywaters et.al. 2014). However, it should be noted that this is 'co-relation,' not necessarily 'causation,' and there will be other social and structural factors that are significant in the causation of child abuse and neglect. Nevertheless, the data in this section confirm that services for children and families in Doncaster face a significant challenge in responding to children's safeguarding issues.
Demand for children's services in Doncaster is higher than the national average: referral rates to children's social care are higher in Doncaster than national, as are the rate of Child Protection Plans and Children Looked After. The higher s.47 Child Protection enquiries and Child Protection Conference rates are also a feature of this higher level of overall demand.

Effectiveness of the Safeguarding Arrangements

Working Together 2018 requires the safeguarding partnership to use data and intelligence to assess the effectiveness of the help being provided to children and families, including early help, and report on effectiveness in its Annual Report.

Early Help

The Early Help Strategy for Children, Young People and their Families 2017 – 2020 aims to provide prevention and earlier intervention, by providing support to families when a need is identified or as soon as a problem emerges, at any point in a child's life. This can be from the point of conception through to the teenage years, to prevent or reduce the need for statutory services, though Early Help relates to a much wider set of outcomes for children beyond safeguarding (for example, ready for school, school absence, mental health, etc.). We might expect to see that Early Help has some impact on reducing the need for Children's Social Care involvement, that significant proportion of safeguarding referrals to children's services had already been known to Early Help, and that a significant use of Early Help when a child's case is 'stepped down' from a Child Protection Plan, or when a child returns home from care.

During 2018 – 2019, there were 6181 referrals made for Early Help support.

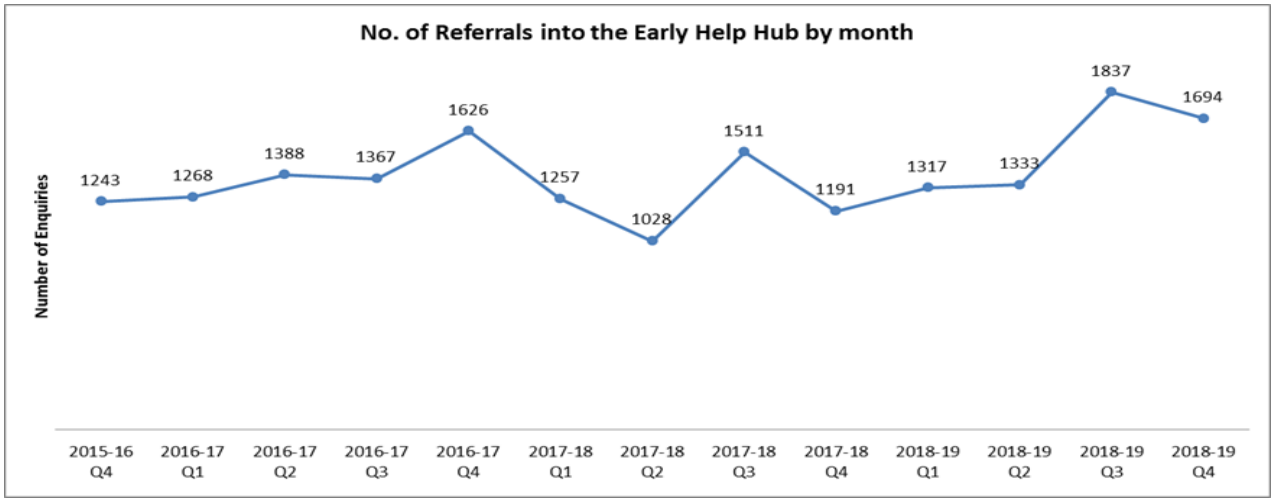


Figure 3: Referrals to the Early Help Hub

When the need for Early Help is identified by any agency, contact is made with the Early Help Hub to agree the level of intervention and who should act as Lead Professional. This Early Help 'Pathway' is used well by Education and the Parenting and Family Support service, with Health partners tending to use the system for more complex cases. There has been significant input from the Early Help Coordinator team and intervention from the Early Help Strategy group over the last year to encourage Health Services to play a bigger role in Early Help.

	2017-18	2018-19
Single agency Early Help	535 – 25%	1003 – 41%
Multi-agency Early Help	1640 – 75%	1429 – 59%
Total	2175	2432

Table 1: Early Help open cases at the end of the year

The use of the Single Agency Early Help (Level 2 in the DSCP Levels of Need framework) continues to increase for less complex Early Help and when former multi-agency cases progress well. Single Agency cases do not require an assessment or multiagency meeting process; this means support to the family can happen rapidly and develops practitioner capacity to work with more families. Out of the current single agency cases just over half are led by Education providers.
Multi-agency Early Help has, in contrast declined over the year; this is noteworthy as multi-agency Early Help is at Level 3 in the Levels of Need framework, which plays a role in preventing family difficulties escalating to the point where Children's Services need to be involved (Level 4).

The Parenting and Families Support Service (PAFSS) and Education remain the main case holders for multi-agency Early help, the proportion of their multi-agency Early Help cases have remained static over the last year at 40.7% and 44.9% respectively (reference: Early Help Progress Report to DSCP, April 2019).

Waiting times for help remain an issue. The average timescale from allocation to completion of an assessment remains over the 30 day target, though has improved over the course of 2018-19. Waiting and assessment times over timescale will impact on children and their families and may affect disengagement and step up rates.
The closure during the year of the waiting list for the Parenting and Family Service will have had an impact on case management and may impact the wider disengagement of partner agencies and step up of cases to children's social care.

Over 2018-19, 2545 Early Help cases were closed, the outcomes being as follows:

- 31.2% because the Early Help Plan was completed;
- 24.9% due to family disengagement;
- 26.5% due step-up to Children's Social Care;
- 11.7% because the assessment did not identify support needs;
- 5.8% for other reasons (move out of area, or ongoing SEND support only).

The Early Help Strategy group is investigating the level of family disengagement, and also the level of step-up to Children's Social Care.

Social Care referrals with previous Early Help involvement have increased from 10.6% Quarter 4 2017-18 to 21.26% at Quarter 4 2018-19. This increase is due to the targeted work of the Early Help Coordinator team in promoting Early Help across the partnership and working collaboratively with organisations to train their staff. Further improvement in this data is required. Work will continue with RDaSH staff to support further use of the Early Help pathway and work with Doncaster & Bassetlaw Hospitals Midwifery service began in April 2019.

Referral for safeguarding concerns

Working Together 2018 requires that anyone who has concerns about a child's welfare should make a referral to local authority children's social care and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so. This is reinforced by DSCP's Training Strategy which requires all partner agencies to ensure that their staff (and volunteers) are competent in recognising the signs and indicators of abuse and respond appropriately. This would include raising any safeguarding concern with their own agency's designated safeguarding lead, or making a referral to children's social care.

Where referring agencies are clear about their safeguarding responsibilities and about the pathways for referral, we may expect to see referrals from a wide range of agencies arriving at children's social care with good quality information, leading to a high conversion rate of referrals into s.17 assessments, s.47 enquiries, and Child Protection Plans.

Referrals are made to the Multi-Agency Access Point (MAAP) where initial screening and information gathering takes place.

	Total
South Yorkshire Police (including all Domestic Abuse notifications)	1479
Health	224
Education	914
Other	2101
Total	4718

Table 2: Referrals made to the Multi-Agency Access Point (MAAP) by agency.

In 2018 – 2019:

- there were 16,698 contacts received requesting a service
- 3187 proceeded to Early Help
- 4717 proceeded as a referral to Children's Social Care
- 47% of cases proceeding as referrals to Children's Social Care had previously had some involvement with Early Help in the previous 12 months – were on the Early Help Pathway, or had an initial or reviewed Early Help Plan.
- Children's Social Care proceeded with 4543 Children & Families Assessments.

Doncaster has high levels of deprivation and this translates into a high level of referral for statutory services, though the rate at which cases progress from an assessment into Children's Social Care is 30%, with more than half of referrals receiving information and advice or no further action.

	Percentage
Child In Need Plan or Child Protection Plan	30
Strategy Discussion	2
Early Help/another agency	14
Information and Advice/No Further Action	54

Table 3: Outcomes of first Children & Families Assessments by Children's Social Care

Work to understand the true nature of the patterns of demand in Doncaster remains ongoing. Within the Children & Young Person's Plan, work will be focussing on building family and community resilience which in the medium to long term will have a positive impact on demand for statutory services. (Children & Young Person's Plan Impact Report 2018).

Children in Need

The Department for Education's definition for 'child in need' includes children in care, children on a protection plan, children in need plans, open for more than 63 days and new referrals awaiting assessment. On average, the rate of children in need in Doncaster during 2018/19 was 401 per 10,000 population (approximately 1230 children in total). Following previous years' trend, this is expected to remain above the national and statistical neighbour averages (see table X below) – this may be as expected given the level of deprivation and its relationship to safeguarding, as noted above.

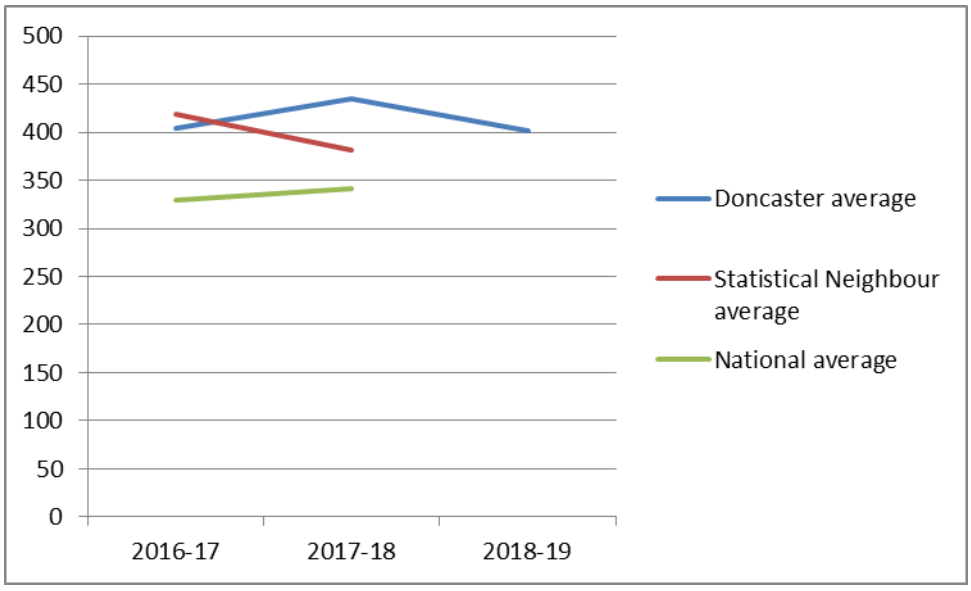


Figure 4: Children in need of care, protection and accommodation in Doncaster with statistical neighbour and national comparators.

Child in Need Plans

The 'entry level' service provided by Children's Social Care is the Child in Need Plan, support agreed with a family on a voluntary basis, with a qualified Social Worker as the Lead Professional co-ordinating support from any other agency involved. Child in Need Plans may be a good way to engage a family in a constructive way without having to resort to Child Protection Procedures, which may feel threatening for the family.

Strategy Discussions and S.47 Enquiries

Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving local authority children's social care, the police, health and other bodies such as the referring agency.

Following a multi-agency strategy meeting, a section 47 enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of or likely to be suffering significant harm. This is a critical decision point in the safeguarding process; where concerns of significant harm to a child are substantiated, the next step would be to convene an Initial Child Protection Conference.

- In 2018 – 19,937 children were subject to a s.47 Child Protection enquiries carried out, and of these 411 (44%) children proceeded to an Initial Child Protection Case Conference.

An analysis was conducted for DSCP of Doncaster's s.47 decision-making considering those that were progressed to Initial Child Protection Conferences and those that were not, against regional, national and statistical comparators. This indicated that demand for safeguarding services for children in Doncaster has stayed consistently above comparators for a number of years. It also demonstrates, however that at this level of demand the conversion at each stage of intervention is broadly similar with all comparators. This tends to indicate that safeguarding practice in Doncaster is no different than elsewhere.

Child Protection Conferences and Plans

- The Year 18/19 began with 374 children subject to Child Protection Plans, and closed with 300 children subject to child protection plans.

The trend is a steady decline over recent years, and there are no Child Protection Plans that have been in place for two years or longer. This suggests that effective early intervention is preventing problems from escalating to a point where child protection procedures are required. When child protection plans are required the gradual reduction in duration of these plans suggests that effective and timely planning and support for children and families is being provided. This is generally desirable as child protection procedures can feel intrusive and threatening for families, hence it is preferable to be able to engage families voluntarily at an earlier stage.

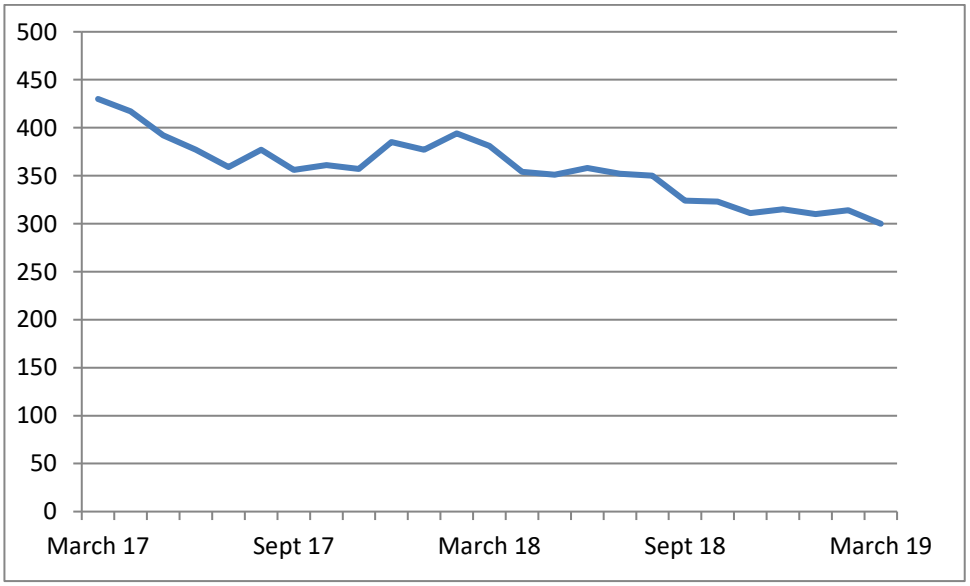


Figure 5: Number of children in Doncaster subject to child protection plans

Government published data in the **Characteristics of children in need: 2017 to 2018** show that Doncaster use of Child Protection Plans at 31st March 2018 was at a rate per 10,000 children of 56.8, which was higher than the national rate (45.3) but below that of statistical neighbours (60.3). (National data for 2018-19 is not published until later in 2019).

	Total 2016/17	Total 2017/18	Total 2018/19
Initial Child Protection Conferences (Child Protection Plans transferred from another area)	310	315	232 (20)
Review Child Protection Conferences	632	585	482
Total number of Conferences	942	900	734

Table 4: Child Protection Conferences held in 2018 - 2019 – the figures relate to families as siblings will be considered at the same Conference even though each child will have a separate Plan.

- 16% child protection plans during 2018/19 were for a second or subsequent time within 2 years, which is an improvement from 24% during 2017/18.
- For comparison, the national figure during 2017/18 for the percentage of child protection plans which were for a second or subsequent time was 20.2%, and for Statistical Neighbours was 16.8%.

Children becoming subject to a child protection plan for a second or subsequent time within a 2 year period is an area of performance that is receiving on-going scrutiny from the child protection conference service to ensure that interventions are affective and decision making appropriate.

The consistent decline in the use of Child Protection Plans may be the result of a wide variety of factors, the DCST Conferencing and Review Service having worked in partnership with other agencies and their safeguarding leads to improve the quality and proper management of plans through the Child Protection Conferences and the multi-agency core groups of practitioners that meet in between the conferences.

DCST have adopted the Signs of Safety approach to child protection, and this has enabled professionals to be very clear with families what the worries are and what needs to happen to keep a child safe. Parents' engagement in Child Protection Conferences has improved, as have the contribution of children and young people subject to plans, supported in some cases by an advocate who can support them to ensure their views and wishes are heard – see the next section below 'Participation in Child Protection Conferences.' Services within DCST – Family Group Conferencing, Edge of Care, and Multi-Systemic Therapy for Child Abuse and Neglect – may also provide additional intensive support within the context of a child protection plan.

The Conferencing and Review Service (which provides independent chairing of the Conferences) has continued to work closely with the Clinical Commissioning Group to engage General Practitioners in the safeguarding process, though regular GP network meetings, a co-developed conference reporting format for GPs, and direct liaison between individual Conference Chairs and GPs around specific cases. This has greatly improved working relationships.

South Yorkshire Police have provided a Police Safeguarding lead to work alongside Conferencing and Review Service to increase Police engagement in the Conferencing process as appropriate. This support has also included assisting with the daily management of meetings, waiting areas, etc. particularly where there may be conflict between family members.

The Conferencing and Review Service has also maintained monthly liaison with safeguarding leads in partner agencies to promote their understanding and engagement. One example is contact with the Community Rehabilitation Company which revealed that it was undertaking a significant amount of single-agency early help with families where there was domestic abuse.

	end of 2017/18	end of 2016/17	end of 2015/16	end of 18/19
Emotional abuse	48%	14.9%	20.50%	56.7%
Neglect	39.1%	74.9%	69.24%	34.3%
Physical abuse	9.7%	4.9%	5.86%	6%
Sexual abuse	3.1%	5.3%	4.31%	3%

Table 5: Percentage of Child Protection Plan categories of abuse at end of year - Fluctuations in figures for emotional abuse and neglect reflect, at least in part, the changing recording policies in relation to the impact of domestic abuse on children in the home; taken together, emotional abuse and neglect remain the lead category for approximately 90% of Child Protection Plans.

Participation in Child Protection Conferences

Generally, children over the age of 11 are expected to be considered for invitation to their case conference, with account being given to a range of factors such as their age, wishes, and whether attendance would cause harm or distress. Practices have developed to encourage and support children and young people's attendance and participation, for example, child-friendly invitation and consultation documents, afterschool slots, more child-friendly venues, the promotion of advocacy to allow children's voices to be heard, and changes in the way that Conferences are chaired.

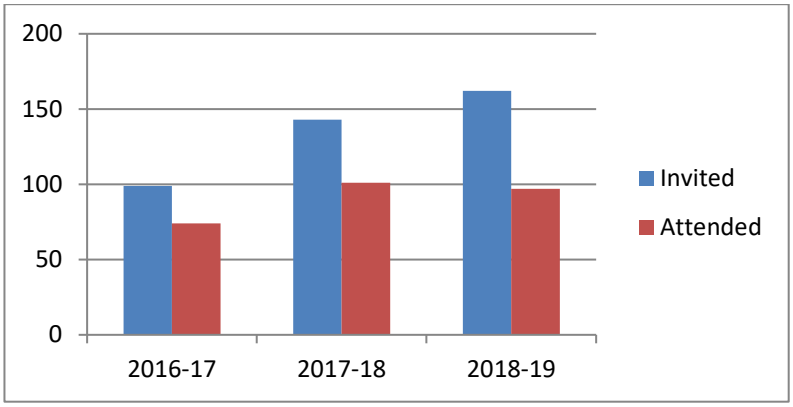


Figure 6: Total participation for 18/19 of eligible children invited to conference

As a result, there has been an increase in children and young people's attendance at conferences and at core groups, with more meaningful contributions and greater engagement with the plan. This has contributed to reduction in length of plans, more successful 'stepdown' to Child in Need or Early Help Plans, and better engagement with other professionals including school. There is also a shift in culture leading to other professionals habitually seeking the views of young people and championing their involvement and contributions. Overall, this represents a very successful area of practice.

Child Protection Plan outcomes - Pre-Proceedings

In some instances, the risk to the child remains significant despite intervention through the Child Protection Plan. In such instances, Doncaster Children's Trust may seek legal advice about applying to the Family Court for the Child to be accommodated elsewhere, at the same time making further efforts to work with the family to try to avoid this – this is referred to as 'Pre-Proceeding'.

In the year 2018 – 19, 82 cases were progressed to Pre-Proceedings:

- 19 (23%) were in Pre-Proceedings at the end of the year (31st March 2019)
- 27 (33%) progressed into legal proceedings, an application being made for a care order
- 36 (44%) no further Action – this may have been because the family responded positively to the prospect of the child being accommodated, and hence an effective intervention diverting a child from care.

When there is a risk of a child becoming Looked After, Doncaster Children's Trust may look for additional services to keep a child at home:

- Edge of Care service – intensive family support.
- Family Group Conference.
- Multi-systemic Therapy for Child Abuse and Neglect service (MST-CAN) - three therapists, a case worker, a psychiatrist and a supervisor, are available to work intensively with all members of the family.
- Growing Futures' team of Domestic Abuse Navigators (DANs), help children and their families quickly find the support they need to stay safe and move on together.

Looked after Children

A child is 'Looked After' when they are provided with accommodation by children's social care (or a provider on their behalf) for more than 24 hours.

While many children who become Looked After will have been subject to a child protection plan, some may not have, for example, when a S.47 investigation considers that the risk of significant harm in the home environment is too high for the child to remain.

Children may also become looked after for reasons other than their protection, for example, when a parent becomes ill and there is no one else in the family network to provide care, or when a child with disabilities needs a very high level of residential care which extends beyond 75 nights in a 12 month period.

Doncaster Corporate Parenting Board works to ensure that the Council and the Doncaster Children's Services Trust effectively discharge their role as Corporate Parent for all the children and young people in its care. It works closely with our Children in Care and Care Leavers council and with the Multi-Agency Looked after Partnership to ensure the welfare of all looked after children including their safeguarding.

Doncaster Corporate Parenting Board publishes its own Annual Report.

Care Plans for Looked After Children are regularly reviewed with a multi-agency group of professionals chaired by an Independent Reviewing Officer. Children and young people are encouraged to attend or participate in their Reviews, as are family members where this may be appropriate.

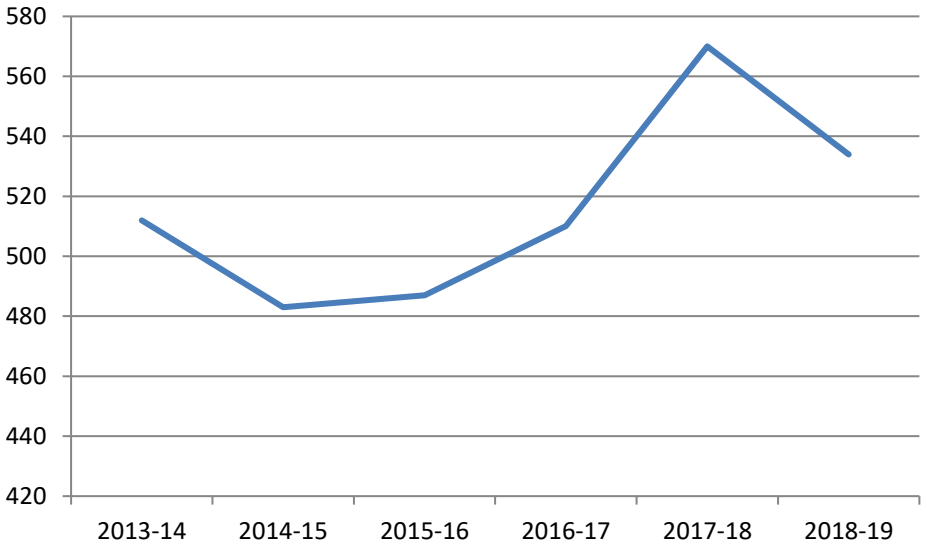


Figure 7: Children In Care 2013 – 2019 - Please note - figures for March 2019 will not be confirmed until the SSDA903 CIC Return is submitted to the Department for Education.

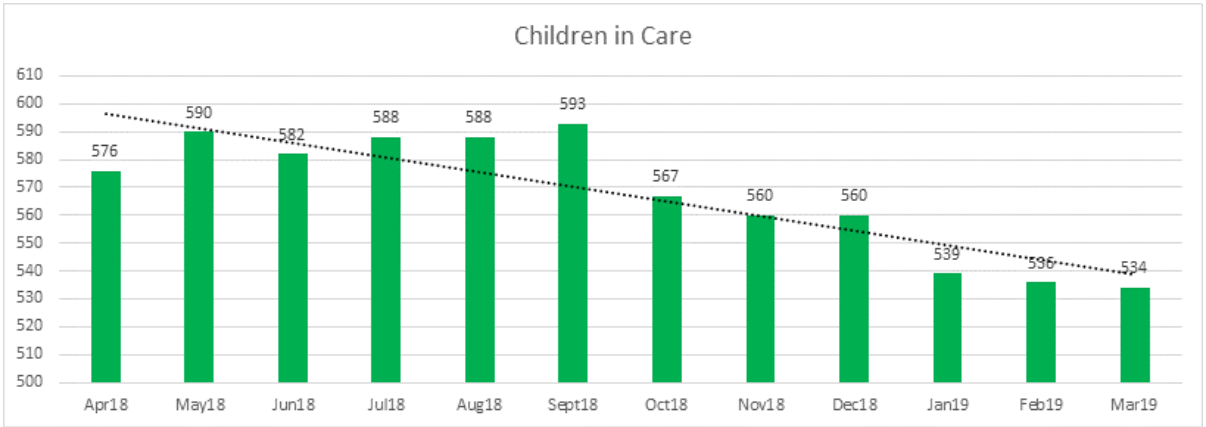


Figure 8: Children in care April 2018 – March 2019

At the end of the year, 534 children are in the care of Doncaster Children's Services, at a rate of 81.0 per 10,000 children. This is a further reduction of 26 children and young people since the end of the previous quarter, where the rate was 85.0 per 10,000 children. The current rate of children in care is higher than the national rate of 64 per 10,000 but lower than our Statistical Neighbour rate of 90.1, based on 2017 - 18 out turns. Increases in children in care have continued to be reported across the country and region and in particular with our Statistical Neighbours, all of which have reported an increase in the 2017 - 18 outturns, with statistical neighbours increasing from 82.1 in 2016/17 to 90.1 in 2017 - 18. (Figures for 2018 - 19 will not be available until later in 2019). This should be recognised as a very positive achievement for Doncaster.

	Number of Children 31 March 2018	Number of Children 31 March 2019
Interim Care Order	99	106
Full Care Order	331	317
Placement order granted	39	33
Remanded to Local Authority accommodation or to Youth Detention	1	0
Under police protection and in local authority accommodation	2	0
Under Child Assessment Order in local authority accommodation	0	1
Single period of accommodation under Section 20	97	77
Accommodated with breaks (no care episodes recorded)	1	0
Total	**570**	**534**

Table 6: Legal Status of children in care

Much work has being undertaken by a Children in Care Strategic group within DCST which is a collaboration of all the relevant services in the Trust and the Doncaster Council's Virtual School for Children in Care. This group has been reviewing cases and identifying children who can be brought back to local placements from placements out of authority and children who can leave care safely with the right support through Child Arrangement Orders or Special Guardianship Orders. Through the reviewing process no children have been identified who should not have been placed in care.

The number of children being cared for by family or connected people has seen a significant increase. This identifies that social workers are effectively identifying more family members, both within and outside Doncaster, who can safely care for children. This has ensured that many children have, following appropriate assessment, been able to remain with family members or friends and do not require the protection of a formal looked after status.

	2017-18	2018-19
Adopted – application unopposed	19	24
Adopted - consent dispensed with	12	16
Left care to live with parents, relatives, or other person with no parental responsibility	0	6
Accommodation on remand ended	0	1
Moved abroad	0	1
Care taken over by another LA in the UK	0	2
Returned home - Residence order	5	7
Special guardianship order made to former foster carers	11	20
Special guardianship order made to carers other than former foster carers	19	21
Return home to live with parents, relatives, or other person with parental responsibility as part of the care planning process (not under a Residence Order or Special Guardianship Order)	31	28
Return home to live with parents, relatives, or other person with parental responsibility which was not part of the current care planning process (not under a Residence Order or Special Guardianship Order)	10	12
Independent arrangement with formalised support	8	4
Transferred to adult social services	5	2
CLA ceased for any other reason	73	100
Sentenced to custody	2	1
Total	**195**	**245**

Table 7: Reason for children Ceasing Care

Children who are Privately Fostered

Private fostering is an arrangement made by a child's parents for a child under the age of 16 (or under 18 if the young person disabled) to be cared for by someone other than a parent or close relative with the intention that it should last for 28 days or more.

Children's social care has a responsibility under the Children (Private Arrangements for Fostering) Regulations 2005 for ensuring that the welfare of privately fostered children is promoted and safeguarded. Each child known to be living in a private fostering arrangement in Doncaster is monitored and supported through statutory visits by a social worker. The child is required to be seen alone during each visit unless this is thought to be inappropriate in which case the social worker would record the reasons for not seeing the child alone.

DCSP receives an annual report from DCST on the arrangements for privately fostered children, which has provided the following data for 2018-19:

- 9 new private fostering notifications were received.
- 5 notifications did not progress to full assessment.
- 4 notifications progressed to full assessment.
- 6 arrangements ended.

A wide variety of awareness raising activity has taken place across the year, for social care staff, with partner agencies and with community groups. In particular a private fostering awareness raising week was held between 3rd and 7th July 2018. The awareness raising and publicity activities were targeted towards the public, professionals working with children and young people and adults, communities including Faith and Culture groups. Work included leaflets being given out through the Doncaster Safeguarding Week at different locations within Doncaster, including an awareness event at Lakeside, and similar information being disseminated via social media.

It is to be acknowledged that notification has remained very low with no evidence of referrals made by parents or carers. Although low notification appears to be a national issue, the challenge is to uncover the hidden private fostering arrangements, as the children living in those unknown arrangements are particularly vulnerable and lack the protection provided through the private fostering regulations.

Children Missing from Home and Care

Safeguarding Partnerships are required to work within the **Statutory guidance on children who run away or go missing from home or care** (Department for Education, January 2014), with partners from children's social care, police, health, education and other services work effectively together through a local protocol to prevent children from going missing and to act when they do go missing . The local protocol covers South Yorkshire, as South Yorkshire Police are a key agency receiving all reports of missing children.

When a child is located safe and well checks are undertaken by Police Missing Persons Investigators, and an approach to the young person is made by a Children's Trust officer to undertake a return home interview. There is close liaison with the Child Exploitation Team (regarding possible sexual and criminal exploitation), and Return Home interviews now include assessment of the risk of criminal exploitation. Although only a few cases of CE have been identified (3% of return home interviews), this is an important opportunity and has led to significant new disclosures.

For missing children or young people subject to Child Protection Plan or are Looked After, daily notifications are sent to their Conference or Review Chair for additional scrutiny.

	Number	%
Missing/absent episodes	1456	100%
• from home	829	57%
• from care placed by Doncaster	395	27%
• from care placed by other Local Authority	232	16%
Children with missing or absent	898	100%
• from home	614	69%
• from care placed by Doncaster	165	18%
• from care placed by other Local Authority	119	13%
Return home interviews - required	1007	100%
• offered	997	99%
• carried out	564	56%
• refused or non-co-operation	332	33%

Table 8: Children missing from home and care 2018–19

The South Yorkshire Police (SYP) Board representative has raised a number of concerns regarding children from other areas who are living in independent children's homes in Doncaster. These missing from home cases involve some of the most vulnerable children and the demand on the Police force to keep them safe has been very significant. SYP have engaged children's homes managers in the area in a monthly meeting discuss any issues, policies, procedures and what can be done collectively. Ofsted have also been invited to attend. The outcome has been extremely positive, with a significant reduction. A Memorandum of Understanding is being drawn up for all local children's homes to sign up to, and an approach is being made to the Independent Children's Homes Association who represent the majority of homes across the country.

Allegations against people who work with children

The role of the LADO (Local Authority Designated Officer) is to have management and oversight of allegations of abuse against people that work with children and covers all persons working within the children's workforce in either a paid or an unpaid capacity including volunteers. This includes providing advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure they are dealt with as quickly as possible, consistent with a thorough and fair process.

In Doncaster the LADO service is part of the Safeguarding, Standards and Policy Unit of Doncaster Children's Services Trust.

Work has continued to raise the awareness of the LADO role across a number of agencies and voluntary organisations. In order to reduce the number of consultations that are not pertinent to the LADO process, work has also been undertaken with the safeguarding leads for a number of agencies so that they provide the first port of call for advice within their own organisations. This has resulted in a decrease in referrals that do not meet the threshold by 7.3%. When compared to 2017/18. The number of referrals that do meet the threshold to hold a strategy meeting has increased by 3.13%. The main area of increase has been independent fostering agencies that rose by 56%. The may be due to the work undertaken to raise awareness and the training provided to these organisations by the LADO.

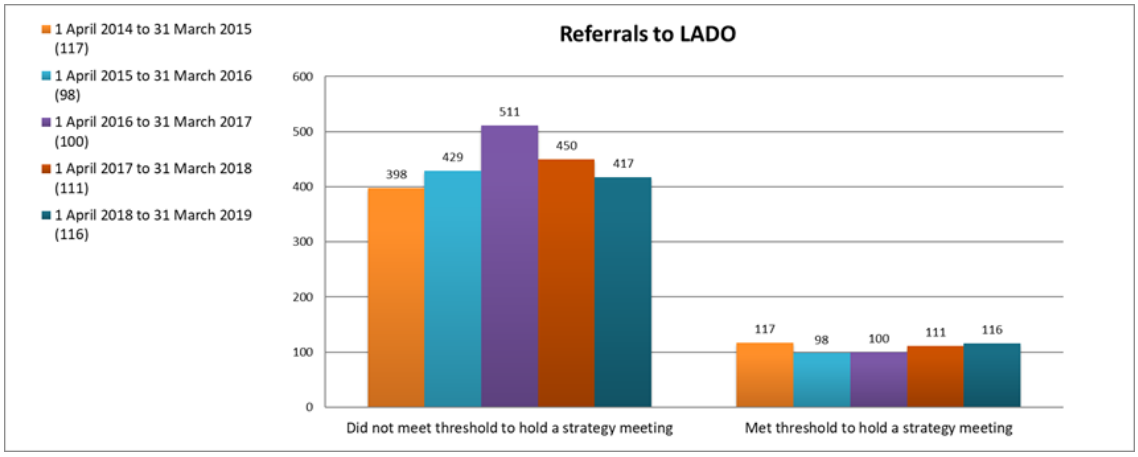


Figure 9: Referrals to the Local Authority Designated Officer

In the majority of cases the allegation was substantiated indicating that referrals are generally appropriately made and thresholds for referral to the LADO are understood. The LADO process is focused on the original allegation that was made. Although the outcome may be substantiated it does not necessarily mean that the accused adult poses an ongoing risk to children.

The LADO works closely with the adult safeguarding team to ensure the right service area is dealing with safeguarding allegations whether this involves children or adults at risk of harm.

Child Death Reviews

During 2018-19 there were 13 child deaths:

- 6 were expected, for example, due to life-limiting illness.
- 7 were unexpected, that is, they were not anticipated as a significant possibility 24 hours before the death.

	2016-17	2017-18	2018-19
Expected child deaths	12	12	6
Unexpected child deaths	5	12	7
Total child deaths	17	24	13

Table 9: Number of child deaths in Doncaster by year

12 child deaths were reviewed in 2018-19, all of which were carried over from the previous year (this is not uncommon as child deaths are often delayed for example by waiting for a Coroner's report).

In reviewing the death of each child, the CDOP should consider **modifiable factors**, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level. Factors identified as modifiable does not mean the factors fully explain the child death and does not indicate any implication of blame on any individual party, but they are considered to be contributing factors.

Modifiable factors and learning points arising from reviewed cases included:

- Smoking by either parent during mother's pregnancy
- Body Mass Index of mother
- Co-sleeping and parental compliance advice
- Internet safety and online information regarding self-harm
- Low birth weight of baby
- Delay in seeking medical attention by parents
- Prophylactic antibiotics
- Chorioamnionitis

This led to recommendations for action to be taken in relation to:

- Health staff training regarding safe sleeping and alcohol use, and smoking in pregnancy
- Young people's safe user use of the internet
- Cervical examination

Doncaster CDOP did not conclude that a serious case review should be carried out on any of the cases that were considered during 2018-19.

Significant progress has been made in meeting the requirements of Working Together 2018. The four South Yorkshire areas have collaborated to strengthen the existing shared learning forum that took place quarterly. This has involved developing a Memorandum of Understanding, Terms of Reference and Child Death Arrangements which was published jointly. The arrangements have been signed by the Child Death partners in each area i.e. the Local Authority and CCG demonstrating good partnership working. The governance arrangements are being reviewed for Doncaster CDOP with the aim of transferring responsibility over to the Health and Well Being Board via the Children and Young people's Partnership.

Progress against Strategic Priorities 2018 - 2019

<u>Strategic Priority 1</u> - DSCP is assured that effective arrangements are in place for responding to key safeguarding risks and that there is consistently good practice across safeguarding services.

The early help strategy is effectively implemented and there is evidence of the impact this has had on outcomes for children, young people and their families.

- See Early Help section above.
- Doncaster Early Help has adopted the Outcome Star, an evidence-based tool to support and measure change in specific outcome domains of a child and family's life, hence the overall impact of the Early Help intervention. Multi- agency training is on-going, and there is significant progress made in the use of Outcome Star over the past year, for example, with 452 Outcome Stars being completed in Quarter 3.

DSCP thresholds are understood by practitioners and are embedded in practice.

- The thresholds for responses to different levels of need are set out in DSCP Multi-Agency Levels of Need document published on its website. This aims to clarify the circumstances which will require referral to a specific agency to address an individual need, when to carry out an early help enquiry and when to refer to Children's Social Care Services where a child or young person is thought to be at risk of harm, either actual or likely. Practitioners across partner agencies are acquainted with this framework through the DSCP's multi-agency retraining programme.
- A report from the All Party Parliamentary group for Children titled **Storing Up Trouble** (July 2018) highlighted, thresholds for access to children's services are not uniformly applied across the country, and there may be different perceptions of the application of thresholds within a local authority area. This is an area of policy and practice that needs ongoing attention.
- The procedure for referring concerns into the Multi-Agency Access Point (MAAP) requires referrers to distinguish contacts for Early Help (level 3 in the Levels of Need) or Children's Social Care including safeguarding (level 4). The MAAP Team report that only a small number of contacts received for children's social care are re-routed to Early Help, and even fewer are re-assigned from Early Help to Children's Social Care. Generally there are few disputes over threshold decisions made by MAAP. This indicates that the multi-agency levels of need thresholds are generally understood by practitioners in partner agencies.
- However, in early 2018, the Neglect Strategy Group commissioned an analysis of child in need cases where neglect is a predominant factor of concern and there is no evidence of early help provision. This concluded that there remained some confusion as to what is a universal service provision and what constitutes early help, and when it is appropriate to refer to children's social care. These findings are being taken on to the Early Help Strategic Group, and have also influenced the setting up of a Neglect Operational Group reporting to the Neglect Strategy Group.

Systems are in place to effectively meet the needs of victims of child exploitation, including an understanding of the scope of criminal exploitation and online abuse

- A Child Sexual Exploitation Strategy 2017-2019 and Action Plan is overseen by a Child Exploitation and Missing (strategy) Sub Group, chaired by a senior Police Officer who is a member of the Partnership Board.
- The multi-agency CSE team hosted by DCST consists of 3 social work posts, one health, one education worker and 2 Barnardo's workers co–located with specialist police officer colleagues and 2 Missing Persons Investigators. Being co-located means that information can be shared in a timely way and responding to concerns can be undertaken quickly.
- Many of the issues around Child Sexual Exploitation (CSE) apply equally to Child Criminal Exploitation. In recognition of this the operational (multi-agency) Child Sexual Exploitation Team has widened its remit and become the Child Exploitation Team. The investigation of exploitation has improved as there is now a Single Point of Contact (SPOC) officer working within the Police's Protection Vulnerable People department who is supported by 2 co-ordinating support officers.
- The Industry Sector Group has worked hard to train taxi drivers, private landlords and hoteliers, to raise awareness of the signs and indicators of exploitation, and how to report.
- Some young people, whilst recognising that they are being exploited, are too afraid to cease their involvement for fear of reprisals from other gang members. Some young people can only be safely supported out of involvement in CCE if they and their families are helped to move away from where they currently live.
- South Yorkshire Police report that during 2018 – 19, there were 10,847 Non-Crime Investigations recorded across South Yorkshire, of which 322 had the keyword 'CSE' applied to investigation records, 17 of these being within Doncaster.
- South Yorkshire Police also report that of the 5809 violent crimes with a victim under 18 years old, there were 32 investigations where the keyword 'CSE' had been applied to records. The predominant offence was 'arranging or facilitating travel of another person with a view to exploitation.'

The DSCP is assured of the effectiveness of plans to tackle Domestic abuse.

Domestic abuse remains a significant issue of concern for interventions at all levels:

Early Help	**Monthly average 2018-19**
Early Help Open Cases	2366
• Early Help Open Cases with Domestic Abuse	229
• with Domestic Abuse and a Risk Assessment	4
Children's social Care	
Social Care Open Cases with an assessment	1901
• with Domestic Abuse	442
• with Domestic Abuse and a Risk Assessment	321
• with Domestic Abuse and a DAN allocated	29
• with "No" Domestic Abuse and a DAN allocated	23
Child in Need open Cases with Domestic Abuse	253
Child Protection Plan open Cases with Domestic Abuse	123
Children Looked After open Cases with Domestic Abuse	61
Dual CPP & CLA open Cases with Domestic Abuse	4

Table 10: Monthly average 2018-19 open Cases where Domestic Abuse is a feature

- Doncaster's Domestic and Sexual Abuse Partnership has a multi-agency Domestic Abuse Strategy 2017 - 2121 that aims to protect and support victims, holding abusers to account through support and challenge, and grow futures for children and young people through prevention and recovery. A key outcome is for families who are vulnerable to or experience domestic abuse are identified earlier and receive effective support to stay safe.
- The Domestic and Sexual Abuse Partnership Production of a new sexual abuse strategy and action plan, and a new domestic abuse action plan.
- DCST has recruited a team of Domestic Abuse Navigators (DANs) to tackle cases involving domestic abuse. They apply a whole family model of practice, working with victims, perpetrators and children. Support to children & young people is informed by the latest evidence-based therapeutic techniques. They have been so

effective that no families have been re-referred after working with them. This will have a positive impact on the outcomes of all those they support.

- Doncaster Council has provided a range of Domestic Abuse training, open to other agencies:
  - Domestic Abuse Awareness
  - DASH Risk Assessment and MARAC (Multi Agency Risk Assessment Conferences)
  - Stalking and Harassment
  - Young People Experiencing Intimate Partner Violence
  - Coercive and Controlling Behaviour
  - Honour Abuse, Forced Marriage and Female Genital Mutilation (FGM) -
  - Supporting Male Victims of Domestic Abuse
  - Supporting Children Living with Domestic Abuse (primary age)

1,160 practitioners in Doncaster attended multi agency domestic abuse training.

Doncaster Domestic and Sexual Abuse Partnership have also reported on the following achievements for 2018:

- The MARAC and IDVA service supported 372 victims at high risk of serious harm or death.
- The Domestic Abuse Caseworkers at Doncaster Council provided direct support, advice or information to 1,146 people throughout 2018.
- 1,160 practitioners in Doncaster attended multi agency domestic abuse training.
- Doncaster Children's Services Trust launched a new programme for young people who are abusive towards their parents/carers - called 'Getting On'.
- The Trust also launched a new Caring Dads programme so that fathers who abuse can be supported to recognise the value of responsible parenting and measure impact on change.
- South Yorkshire Community Rehabilitation Company launched a new voluntary perpetrator programme.
- 924 victims of sexual abuse were supported by Doncaster Rape and Sexual Abuse Counselling Service (DRASACS).
- New training courses on coercive and controlling behaviour and stalking were launched.
- The Ministry for Housing, Communities and Local Government awarded Doncaster Council and partners £98,000 to support victims of domestic abuse.
- Work started on a new Domestic Abuse Hub with co-located Police and Independent Domestic Abuse Advisors as part of the Multi Agency Safeguarding Hub (MASH). which This will increase capacity, allows for much better information sharing for more complex cases and make it easier for victims and practitioners to access services.

Practitioners are able to respond appropriately to the early signs of Neglect and evidenced through multi-agency audits

- Neglect is a persistent failure to meet a child's physical and / or psychological needs and which is likely to result in the serious impairment of the child's health and development.
- DSCP has developed a Neglect Strategy (2016) aiming to ensure the early recognition of neglect and improved responses to it by all agencies, so that life changes of children are promptly improved and the risk of harm is reduced. This is led by a Neglect Strategic Group, which is part of the Team Doncaster Children and Young People's Partnership.
- A key part of the strategy is a Neglect Toolkit: Tool for the assessment of Neglect, adapted from The Graded Care profile designed by Dr Leon Polnay and Dr O P Srivastava, Bedfordshire and Luton Community NHS Trust. As there has been limited use of this tool, the Neglect Strategy Group is considering rebranding and relaunching.
- Use of the Neglect toolkit within Early Help cases has increased from 3% in July 2018 to 30% Q4 2018-19.
- In early 2018, the Neglect Strategy Group commissioned an analysis of child in need cases where neglect is a predominant factor of concern and there is no evidence of early help provision. This concluded that there remained confusion as to what is a universal service provision and what constitutes early help, and when it is appropriate to refer to children's social care.
- DSCP provides training entitled Childhood Neglect - Recognition and Multi-Agency Response.

Services are in place to support young people's mental health and the impact of these services can be seen in a reduction of hospital admissions for self-harm and attempted suicide

- There have been two child deaths as a result of suicide and at least two incidents that could be described as near misses that have come to the attention of the DSCP. Each case is sensitively responded to by well-established local child death arrangements and a number of cases were referred to the DSCP Case Review Group and learning reviews have taken place. Doncaster also has a Suicide Prevention Group and a suicide prevention action plan. In addition, contagion concerns have been a factor in two of the suicides and protocols for responding in these situations do not yet appear to be well embedded in practice. The DSCP Case Review Group has signed off revisions to the contagion protocol.
- For general hospital inpatient emergency admissions for self-harm, there has also been a decreasing trend throughout the 4 years. There were 130 self-harm admissions in 2015/16 and the number has decreased to 112 in 2018/19.
- There continues to be improvements to children and young people's mental health as reflected in the reduction in T4 acute in-patient admissions and hospital admissions for self-harm. The rationale is largely due to improvements made within the Local Transformation Plan, in particular the introduction and support offered by the Child and Adolescent Mental Health Service (CAMHS) Intensive Home Treatment Service.
- In addition, each primary and secondary school in Doncaster has an allocated CAMHS locality worker who provides consultation, support and specialist CAMHS knowledge/ intervention. From September 2018- March 2019 the team collectively completed 1,921 consultations (planned and unplanned) with school staff and families. Of those consultations, 22 young people were stepped into specialist CAMHS pathways, thus evidencing the transformative and successful move towards reducing the number of children and young people accessing specialist CAMHs due to increasing our service offer in relation to early intervention and prevention.

The DSCP is assured that services provided to support children with special educational needs and disabilities (SEND) are effectively safeguarding the children they support.

- This are of safeguarding practice has not received attention during 2018 – 19, though there have been preparations for an Ofsted/Care Quality Commission inspection of local areas' effectiveness in identifying and meeting the needs of SEND children and young people which took place in May 2019.

There is a plan in place to address the issues raised as a result of children being placed in Doncaster by external Local Authorities

- South Yorkshire Police (SYP) have raised a number of concerns regarding children from other areas who are living in independent children's homes in Doncaster. These missing from home cases involve some of the most vulnerable children and the demand on the Police force to keep them safe has been very significant. SYP have engaged children's homes managers in the area in a monthly meeting discuss any issues, policies, procedures and what can be done collectively. Ofsted have also been invited to attend. The outcome has been extremely positive, with a significant reduction. A Memorandum of Understanding is being drawn up for all local children's homes to sign up to, and an approach is being made to the Independent Children's Homes Association who represent the majority of homes across the country.

<u>Strategic Priority 2</u> - SP2 DSCP has a clear understanding of the effectiveness of the safeguarding system in Doncaster and can evidence how this is used to influence the Boards priorities

DSCP data set provides the Board with appropriate information to enable it to identify the key safeguarding issues in Doncaster

- The Quality & Performance Sub-Group continues to explore the use of data and intelligence to inform the Partnership Board about the effectiveness of safeguarding arrangements, in response to the publication of the national statutory guidance Working Together 2018. A revised data set and reporting process has been agreed and will be implemented during 2019 - 20.

DSCP disseminates the lessons from case reviews, audits and complaints to practitioners and can evidence the impact this has had on practice

- There have been capacity issues within the DCSP's Business Unit, and as a result there has not been the resource to undertake multi-agency audits. However, learning from the previous year's audits have continued

to be disseminated in the form of practice briefings. Also, preparations were made for an audit of cases of child sexual abuse conducted in the first quarter of 2019-20 using the methodology from the Joint Targeted Area Inspection (JTAI). Lessons from the use of the JTAI methodology will inform the future quarterly DSCP auditing programme.

- No cases were referred to the Serious Case Review Panel.
- During 2018 – 2019, DSCP has responded to the publication of Working Together 2018 and the transitional arrangements in preparing to work with the National Panel for safeguarding child practice reviews (replacing serious case reviews). The DSCP Case Review Group will now oversee a rapid review of any case meeting the criteria for a 'serious child safeguarding case'. They will also notify the National Panel of the rapid review outcome and any decision for a local child safeguarding practice review is appropriate, or whether they think the case may raise issues which are complex or of national importance such that a national review may be appropriate.
- No cases were referred to the DSCP Case Review Group that met the criteria for notification to the National Panel.
- Following a Learning Lessons Review for a four-year old child T, a practice briefing was issued advising practitioners to negotiate with parents to check on the conditions in a child's bedroom, and also not to assume that other agencies would have already done this.
- Following another Learning Lessons Review, a practice briefing was produced and disseminated to promote the use of the DSCB "resolving professional differences protocol."
- Other Practice Briefing focused on Early Help Assessment and communication with siblings in specialist foster placement.
- Complaints Officer for Doncaster Children's Services Trust has reported that no issues arising from complaints had needed to be escalated to the DSCP or disseminated across the partnership for learning.
- The DMBC Education Service (Learning Standards and Effectiveness) handles all Ofsted complaints related to schools, and where these may have a safeguarding component there is close working with Learning and Opportunities: Children and Young People Safeguarding Manager. The Safeguarding Manager works closely with schools' designated safeguarding leads, and disseminates communications from the DSCP.

DSCP members have an understanding of the issues affecting front-line practitioners and can evidence how this has influenced the development of services

- Partnership Board meetings receive reports on data, intelligence, and audits from the Quality and Performance Sub-group, and case review learning from the Case Review Group.
- The Case Review Group's Learning Lessons Review promotes the participation of frontline practitioners and provides the DSCP with a detailed insight into issues and experiences in safeguarding casework. The Practice Briefings mentioned above are examples of the output of this process.
- The DCSP's Safeguarding Practitioner Forum meets quarterly and is well attended by the multi-agency workforce. It is chaired by the DCSP Independent Chair, so facilitates issues and perspectives from frontline staff to be input directly into DSCP's business.
- DSCP two multi agency conferences in 2018-19.
- Keeping children Safe Online was very well received with a total of 180 people in attendance. There was a key note speech from national campaigner Jim Gamble, and dramatic performance from Narelle Summers and Ian Baxter highlighting the key issues from a serious case review.
- The conference "Towards a Deeper understanding of Domestic Abuse was also well received, featuring presentations on Honour Based Abuse from Suzanne Jackson DI, SYP, and young adult Natasha K Benjamin reflecting on her experiences of witnessing family violence.

<u>Strategic Priority 3</u> - DSCP communicates effectively to ensure that the work of the Board is well publicised, that learning is disseminated and that the voice of children, young people, practitioners and the wider community(including minority groups and faith groups) are able to influence the Board's work.

a) Partners demonstrate how they are communicating with children and young people and how this influences service provision:
   - Safeguarding partner agencies have responsibilities under section 11 of the Children Act 2004 as detailed Working Together (2015 and 2018) chapter 2 Organisational Responsibilities. This includes having 'a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services.' The last section 11 audit was carried out in 2017 – 18 and was reported on in the last Annual Report. Current plans for the section 11 audit, including reporting on the culture of listening to children,' are to move to an online reporting system during 2019-20.

- Doncaster Children's Services Trust has made extensive use of young advisors since its inception, with involvement for example in Trust recruitment, set-up of children's homes and providing training on the experience of children in care. In addition, there is a Children in Care Council, and a Speak Out Loud activity group for children in need and on Child Protection Plans, both of which provide good opportunities for consultation and involvement in the development of safeguarding practice.
- Doncaster Council's Local Office of the Children's Commissioner has also recently employed 10 young advisors to consult with other children and young people – particularly those considered 'harder to reach' - on service and practice developments.

b) DSCP ensures community groups such as Faith and cultural groups and sports clubs understand safeguarding issues and can demonstrate that they have key safeguarding standards in place as identified by the DSCP
- Engagement with the voluntary and faith and culture sectors further developed into the Keeping Safe Forum, to ensure that the sector is well represented in the Forum which serves as a voice and influence sub-group for both the Adult and Children's Boards.
- Community, faith and cultural groups and sports clubs are also invited to DSCP training events and conferences.

c) DSCP partners demonstrate how they are ensuring that the children's workforce is appropriately trained
- DSCP partner agencies will be providing evidence of compliance with this duty in future section 11 audits.
- DSCP partners are expected to make use of the DSCP multi-agency training programme and resources, or provide or commission their own single-agency safeguarding training.

<u>Strategic Priority 4</u> - DSCP is aware of emerging issues which have implications across the partnership and works effectively to ensure appropriate action is taken.

The DSCP has in place arrangements to safeguard children in line with the requirements of the Children and Social Work Act 2017.

- Consultation and development work took place during 2018 to develop structures compliant with the Children and Social Work Act's statutory guidance Working Together to Safeguard Children 2018, and at the same time to develop a closer relationship with Doncaster Safeguarding Adults Board and the Safer Stronger Doncaster Partnership. The new local arrangements – replacing Doncaster's Local Safeguarding Children Board with Doncaster Safeguarding Children Partnership (DSCP) is published in June 2019 and is available on the DSCP website https://dscp.org.uk/

DSCP promotes opportunities for working across geographical areas where this would provide a more cost-effective response or improvement to current working arrangements

- Doncaster is part of the South Yorkshire sub-region, a natural area for cross area working as it is the footprint for the Police Service.
- The Child Death Overview Panel, formerly the responsibility of the Local Safeguarding Children Board, is developing arrangements for new operations across South Yorkshire so that learning from child deaths is based on a larger sample size.
- Doncaster has also contributed to the work of a sub-regional Child Criminal Exploitation Group with neighbouring local authorities.

DSCP promotes opportunities for working with other strategic partnerships where this would provide a more cost-effective response or improvement to current working arrangements

- As part of the new multi-agency safeguarding arrangements, a Chief Officers Safeguarding Oversight Group takes a broad view of the cross-working and co-ordination of Doncaster Safeguarding Children Partnership, Doncaster Safeguarding Adults Board, and Safer Stronger Doncaster Partnership (community safety).
- DSCP has recognised many common themes shared with Doncaster Safeguarding Adults Board. Under new arrangements brought in in response to the Children and Social Work Act, both partnerships now meet on the same day, with joint as well as separate agendas and the same convenor. It is expected that this will allow for the emergence of further joint areas of concern and action. Both safeguarding partnership have also worked together on an annual safeguarding fortnight, with activities and communications to raise awareness about safeguarding and protection issues with the general public and professionals.
- DSCP is working closely with Safer Stronger Doncaster Partnership on the nationally emerging issue of child criminal exploitation, sharing a joint Child Exploitation strategic group.
- DCSP is has a close working relationship with the Children and Young People Partnership around strategies for Early Help and for Neglect.

- During 2019-20, priorities will be to also develop awareness and practice in relation to young people's online identities and on-line safety.
- Further development in the area of contextual safeguarding issues and transitional safeguarding, particularly picking up the link with the Doncaster Place plan theme around vulnerable adolescents.

Workforce Development

The Board has a strong commitment to multi-agency training and continues to invest in developing a multi-agency training pool to assist with delivery. The DSCP training programme covers a wide range of safeguarding issues based on a training needs analysis of the Partnership's priorities and the demands of partner agencies. Individual training places are provided at no charge, the programme being funded by annual partner contributions to the DSCP.

	Places	Attendance
Delivering Early Help :Role of the Lead Practitioners (2)	328	191
Introduction to Early Help and Thresholds for Intervention	809	610
Child Exploitation (CSE+ CCE Included)	314	198
Signs of Safety 2-Day	117	60
DSCB Neglect Strategy and Toolkit	274	195
DSCB Spring Conference- Keeping Children Safe Online	190	116
An Overview of the Typologies of Domestic Abuse	60	20
Early Help Outcomes and Plans and Closures (3)	250	101
Signs of Safety Roadshows	460	261
Signs of Safety 3 Day Practice Champion Training	12	3
Childhood Neglect: Recognition and the Multi Agency Response	150	67
Issues raised by men who sexually offend against children	120	37
Understanding the complexities of Domestic Abuse	280	16
Children and Young People with sexually harmful behaviour	48	19
Managing Allegations Against Professionals - Local Authority Designated Officer	50	12
An Introduction to 'Getting On' Programme	60	11
DSCB Autumn Conference - Understanding Domestic Abuse	190	149
Early Help Supervision	60	13
Engaging the Abusive Parent	30	10
A Tension of Services: Domestic Abuse and the Three Planets Model	30	3
Self-Harm & Suicide Awareness	31	25
Total	**3863**	**2117**

Table 11: DSCP Training programme sessions 2018-19

This represents a sizable contribution to workforce development across the partnership, and as attendance is multi-agency, the programme also supports the development of good working relationships between frontline practitioners across agencies.

All DSCP courses are evaluated via online surveys for participants' perceptions of the potential impact on practice. Some sections of the evaluation data is included below:

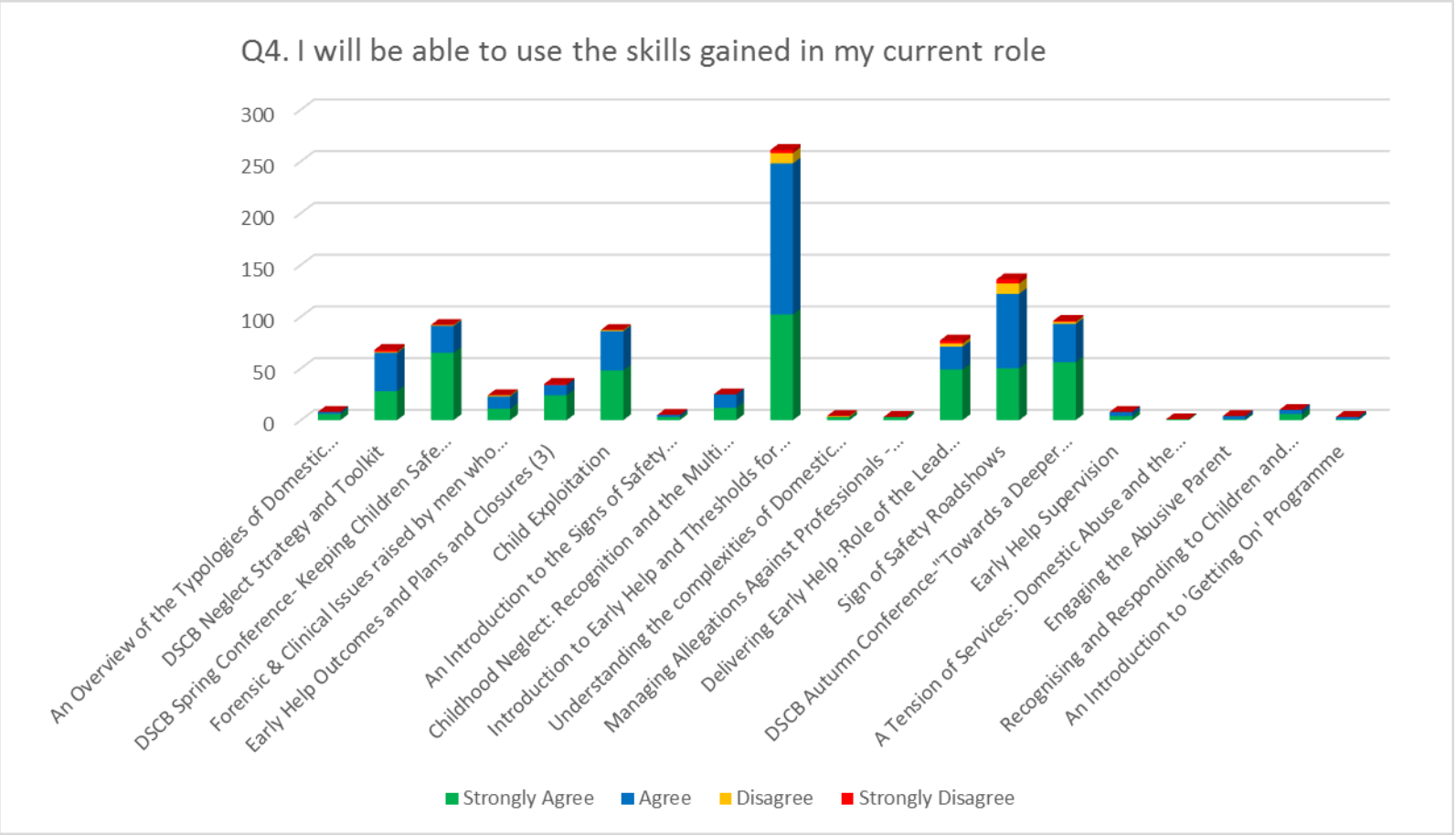


Figure 9: Evaluation returns from DSCP training sessions 2018 - 19

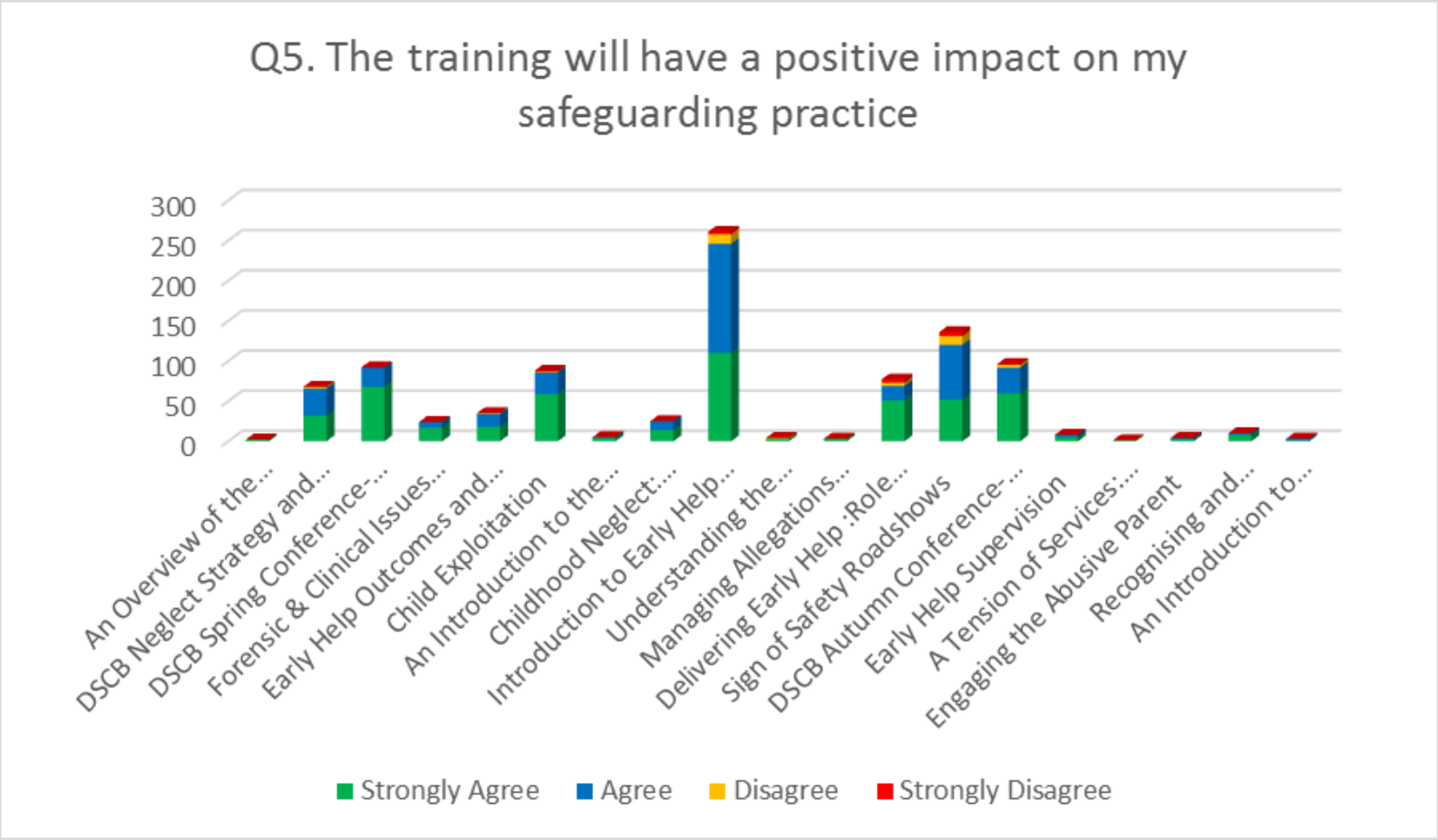


Figure 11: Evaluation returns from DSCP training sessions 2018 - 19

Analysis of impact on practice sometime after training has not been feasible due to capacity, but remains an aspiration for DSCP.

Independent Convenor's Review of the Effectiveness of Partnership Working

The most significant change to happen during the year has been the developments of new partnership arrangements for the overview and governance of the Safeguarding Children Partnership. This has resulted in much more streamlined arrangements being established that include recognising and harnessing the close relationship with safeguarding adults arrangements. The objective of establishing these new arrangements was to improve the governance of partnership working whilst making the process less onerous and more efficient for the partners. These changes risked losing or alienating those outside the core partnership Doncaster Metropolitan Borough Council, Doncaster Children's Services Trust, South Yorkshire Police and Doncaster CCG. However other arrangements that were put in place, as part of the changes, to support wider partnership engagement appear to have worked reasonably well. However this is something that I will keep under review.

I am the Independent Convenor of the newly established Doncaster Safeguarding Children Partnership. My roles include ensuring that the partners meet their statutory responsibilities and work together in an effective partnership. I am pleased to say that these new arrangements appear to be meeting their objectives. I am also pleased to report that I have seen many examples of the partners working together effectively.

A particularly good example is the problem of children, placed by other local authorities, missing from small private children's homes. In addition to placing vulnerable children at risk this problem was having a significant impact on police service resources, but it became clear that this population also impacted the provision of other services. South Yorkshire Police (SYP) led the response to this risk. Rapid reductions in the number of missing children were achieved following SYP developing partnership arrangements with these small organisations. Furthermore a more strategic approach was established using the planning powers of the local authority, a good example of a system led approach.

Another important realisation was the importance of building 'learning loops' into cross-agency procedures when, almost by accident, the power of feedback led to a significant improvement in practical processes for safeguarding.

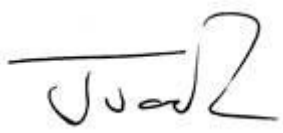
I have also been impressed by the increasing focus on prevention, including helping children and families avoid the need for formal safeguarding interventions. Not only is this very desirable from the point of view of child wellbeing but it is also a more efficient way of safeguarding children. However there is a risk that the increased effectiveness of these approaches will lead to complacency and disinvestment of the services that are achieving the desired improvements.

I welcome the change in policy that has led to children of families where there is domestic abuse having their needs recorded as emotional abuse rather than neglect. Not only is this way of clarifying harm more meaningful it also lays the ground for addressing the main impact of domestic abuse on children which is not just distress but also long-term emotional and psychological dysfunction which too often results in frank mental health problems. There is early work ongoing, led by the Director of Public Health, on reducing 'adverse childhood experiences' which are understood to be the mechanism by which the harm has its effect. This work was initiated through the work of the Safeguarding Adults Board, and is a good example of how the shared issues that cross children and adult safeguarding are increasingly addressed in a more systematic way.

I believe that there is evidence that partners increasingly look to one another when working on strategic safeguarding issues. I see this behaviour, which includes the assumption that challenges are always shared across agencies, as particularly positive.

I am also pleased that the systems that partners have developed for the engagement of safeguarding practitioners appear to be working. Direct contact with those individuals charged with making safeguarding work is important in order to keep the work of the Partnership truly child focused.

In addition to the development priorities outlined in the joint safeguarding development plan there is a need to ensure that board support arrangements are strengthened. This may include joint working with the support arrangements for the Safeguarding Adults Board. There is also a need to formalise new arrangements for the Child Death Overview Panel arrangements. It seems to me that this would be best achieved over a South Yorkshire footprint.



Dr John Woodhouse (GMC 2959711)
Independent Convenor

Doncaster Safeguarding Children Board

Working to make our children's lives safer

"Keeping Children and Adults Safe in Doncaster"

Principles:

- **Always put the wellbeing of the child, young person or adult first**
- **Ensure services address the impact of adverse childhood experiences across the life stages**
- **Promote a culture of creativity and curiosity**
- **Promote whole family working**

Strategic Priority 1	Strategic Priority 2	Strategic Priority 3	Strategic Priority 4
ASSURE EFFECTIVENESS AND IMPACT OF SAFEGUARDING ARRANGEMENTS	LEAD AND SHAPE SAFEGUARDING PRACTICE	ABILITY TO RESPOND TO CURRENT AND EMERGING ISSUES	COLLABORATE, TRUST AND BUILD PARTNERSHIPS

DSCB DSAB Safeguarding Strategic Plan 2019-21

We will seek to;

1. Ensure the voice of the Child / Adult informs all that we do
   "Nothing about me without me"
2. Listen to the voice of the front line practitioner
3. Ensure learning from critical incidents and serious cases is embedded in practice
4. Receive assurance through multi-agency practice audits across the partnership
5. Ensure that everyone working with Children and Adults is adequately trained and competent in safeguarding.
6. Ensure there is an effective multi-agency assurance process in place
7. Have Performance Frameworks that enable the Adults Board and Children's Partnership to see what is happening
8. Promote the use of person centred models based on asset / strengths based practice.
9. Promote and be assured of whole family approaches to;
   - Prevention and early intervention
   - Exploitation
   - Mental Health and wellbeing
   - Domestic Abuse
   - Neglect / Self-neglect
   - Contextual / Organisational issues
10. Explore the benefits of an all-age Multi-agency Safeguarding Hub
11. Develop a clear escalation process for resolving professional differences across the partnership
12. Engage the Voluntary, Community and Faith sector ensuring that *"Safeguarding is everyone's responsibility"*.
13. Ensure safeguarding is core to all strategic and partnership work in Doncaster.
14. Work across Children and Adult partnerships identifying further opportunities to work more closely together
15. Have an effective Communication and Engagement Strategy in place

Board Partner Financial Contributions and Expenditure 2018/19

Working Together 2018 states that '*"The safeguarding partners should agree the level of funding secured from each partner, which should be equitable and proportionate, and any contributions from each relevant agency, to support the local arrangements. The funding should be transparent to children and families in the area, and sufficient to cover all elements of the arrangements, including the cost of local child safeguarding practice reviews".*

Expenditure 2018/19	£
Staff costs (including agency worker cost)	191,091
Independent Chair costs	13,034
Survey Monkey licence	280
Virtual College e-learning	9,418
Display Boards for Safeguarding week	35
Association of Independent LSCB Chairs membership	1,500
Tri-X online multi-agency procedures	6,800
Conference costs and associated costs	9,593
Performance Fee for DSCAP meeting	500
Meetings costs - room hire & refreshments	5,482
Conference room refurbishment	3,500
Printing & stationery	6,214
Yorkshire & Humberside Safeguarding Trainers conference fee	125
British Association for the Study and Prevention of Child Abuse and Neglect	164
Future arrangements for the Board	9,000
Miscellaneous	19
Total Expenditure	**256,755**
Income 2018/19	
Doncaster Clinical Commissioning Group	97,880
South Yorkshire Police	26,000
Probation Service	1,565
Doncaster Council	146,930
Total Income	**272,375**
Out-turn	**+15,620**

It should also be noted that partner agencies support the DSCP work through 'in kind' support, for example the commitment of staff time to sub-groups and working groups, use of meeting rooms, and staff joining the training pool. In particular, Doncaster Children's Services Trust hosts the DSCP Business Unit, and in doing so provides in-kind support through management and office services.

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Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 7 November 2019

Subject: Doncaster Place Plan Refresh

Presented by: Rupert Suckling – Director of Public Health

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

How will this contribute to improving health and wellbeing in Doncaster?
Care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed.

Recommendations
The Board is asked to note the Place Plan Refresh and support the Direction of Travel.

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DONCASTER PLACE PLAN REFRESH 2019 – 2022

Contents

Part 1
Introduction

Introduction

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

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

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

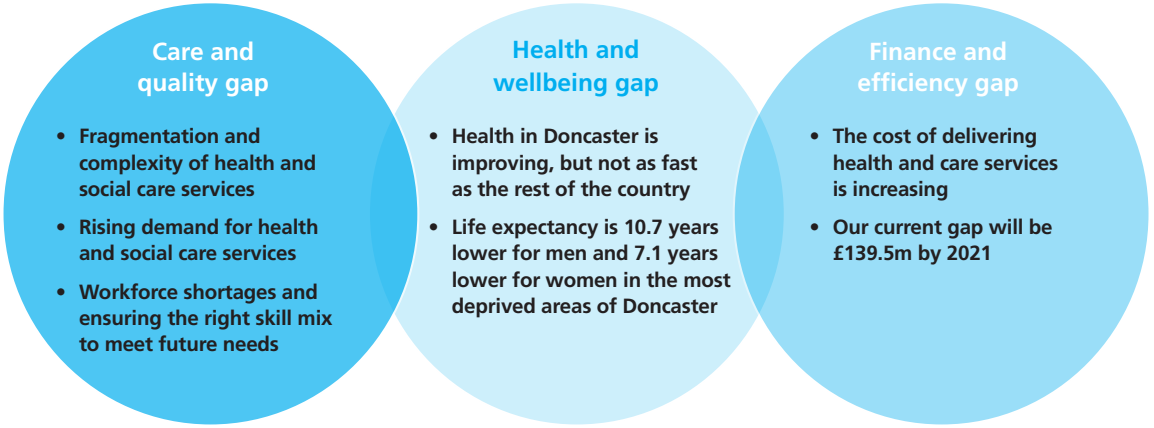
The vision remains the same:

Care and support will be tailored to community strengths to help Doncaster residents maximise their independence, health and wellbeing. Doncaster residents will have access to excellent community and hospital based services when needed.

The Doncaster Integrated Care Partnership remains the same:

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

The three major challenges remain the same:



A snapshot of our population

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

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

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

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

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

Risk factors and disease in Doncaster

Behaviours	
In general, Doncaster has less healthy lifestyles than the rest of the country. This is true for children as well as adults:	**22.7% of people over 16 are smokers**
	74.4% of adults are overweight or obese
	33.6% are physically inactive
	Doncaster is ranked 120/152 areas for Alcohol-Related Hospital Admissions
Diseases	
Diseases such as cancer, cardiovascular disease, liver disease and respiratory diseases account for between 80-90% of all preventable deaths, although local work to increase awareness of cancer symptoms, early identification and treatment over the past 2 years have resulted in some improvement	**2.2% of people are living with a diagnosis of cancer**
	3.8% of people are living with a diagnosis of Coronary Heart Disease
	2.6 of people are living with a diagnosis of COPD
	7.7% of adults are living with a diagnosis of diabetes
Older people	
There are increasing numbers of older people in the Borough, many live alone and require help and support to maintain their independence. The more the population grows and ages the more people will develop dementia.	

Why refresh?

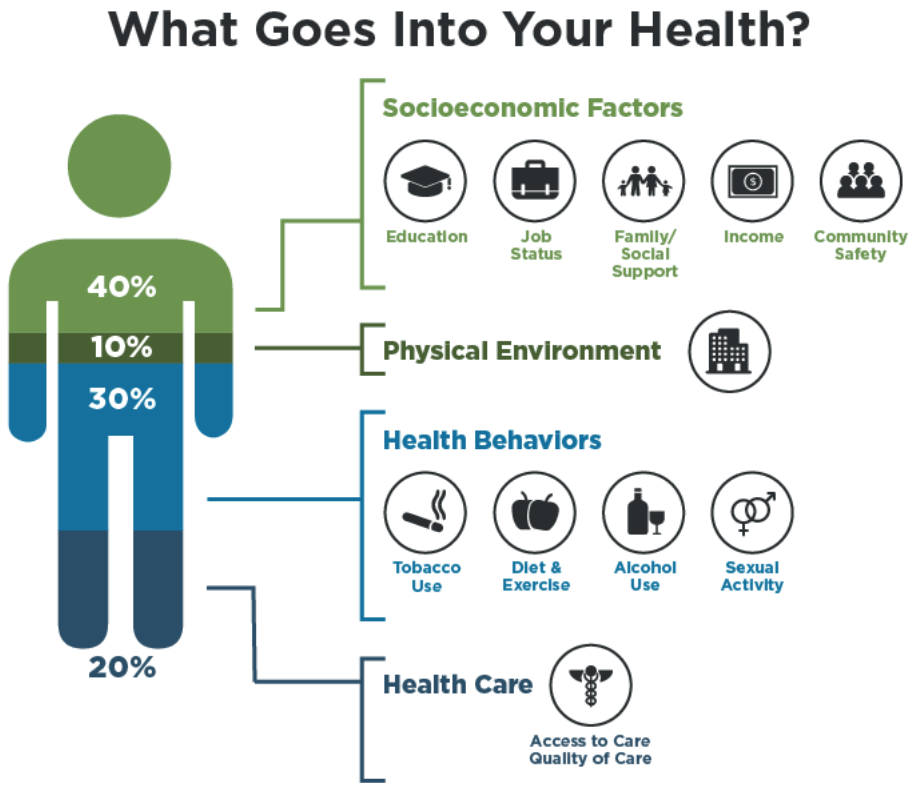
As we refresh our approach to enabling the health and wellbeing of local residents in the Borough, our understanding and thinking has begun to change. Whilst we know that the borough has many real challenges, some caused and reinforced by enduring deprivation, we also know that the towns and villages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

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

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

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

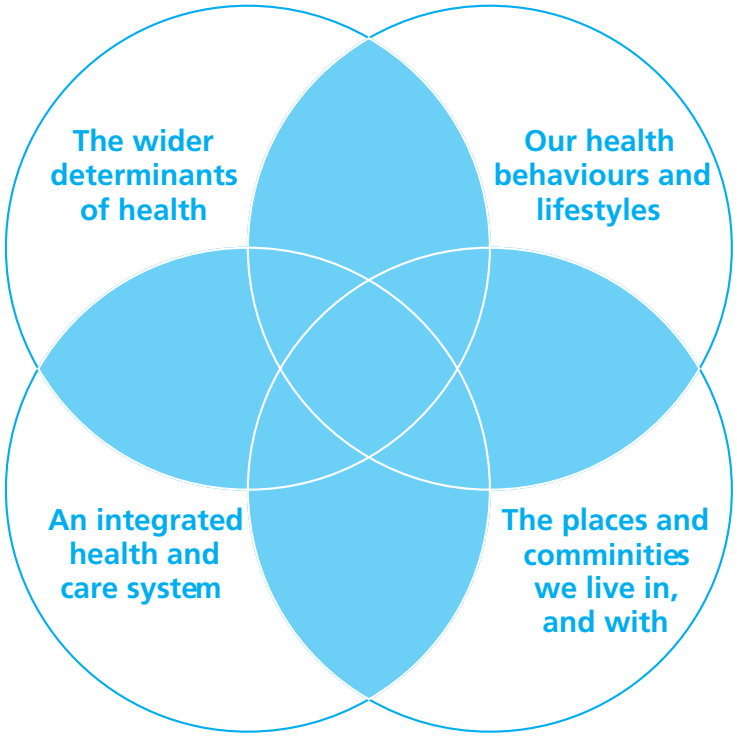
1. Population health
2. Prevention and early intervention
3. Doncaster Integrated Care Partnership's local four-layer framework around which we have built our refreshed plans, underpinned and enabled by Doncaster Clinical Commissioning Group and Doncaster Council's joint commissioning strategy and delivery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



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Adapted from The Bridgespan Group

Population Health



The King's Fund describes population health as:

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

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

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

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

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

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

Population segmentation and neighbourhood working

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

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

Population segmentation current thinking

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

1. Primary Care Networks

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

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

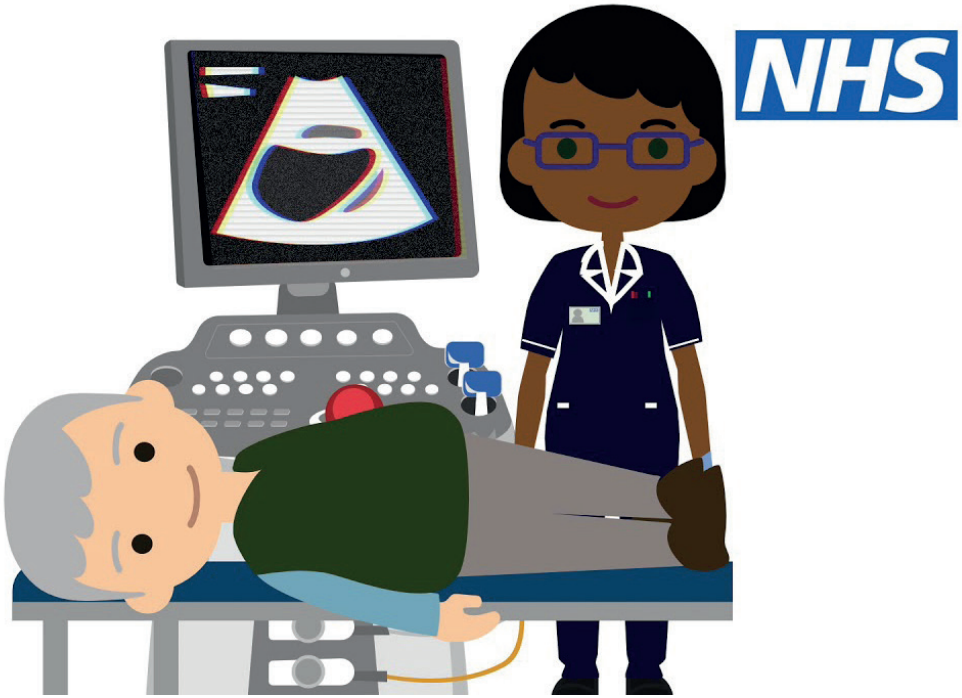
In Doncaster, there are 5 Primary Care Networks, formed around population sizes of between 50,000 and 75,000 patients, and each led by a Clinical Director. Central neighbourhood comprises two PCNs, with the East, South and North neighbourhoods each being largely co-terminus with one PCN each. These will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

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

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

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

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



2. NHS Long Term Plan

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

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

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

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

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

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

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

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

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

3. Prevention Green Paper

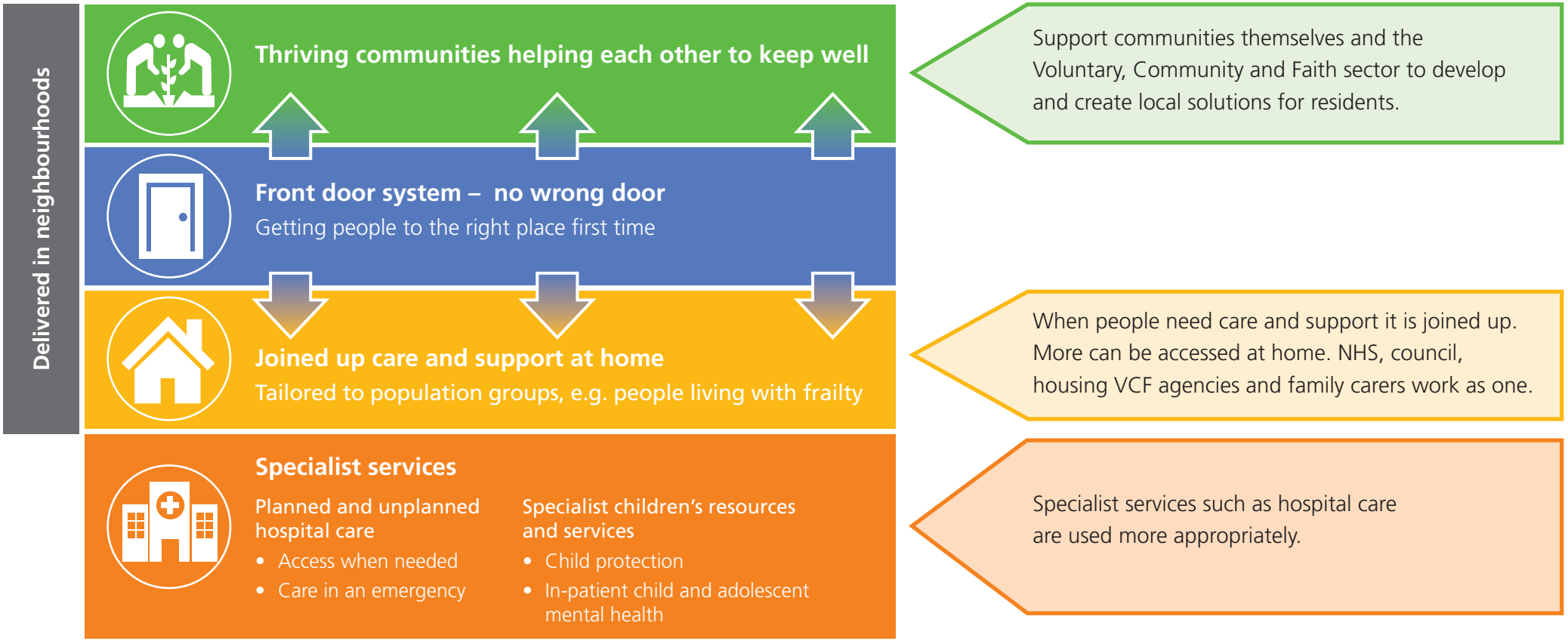
In July 2019 the national prevention green paper 'Advancing our health: prevention in the 2020s' was published.

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

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

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

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



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

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

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

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

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

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

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

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

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

Layer 2: **No wrong door**

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

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

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

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

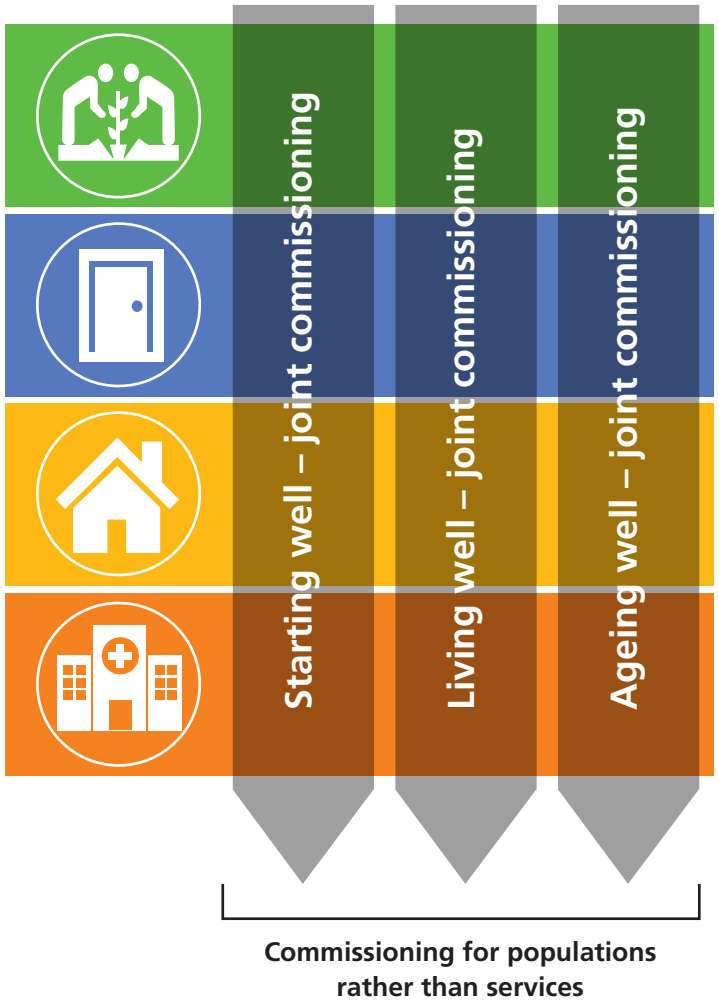
We are testing this through the work to prototype and new care model for people living with frailty in Thorne.

Layer 4: **Specialist services**

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

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

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



Prevention embedded throughout

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

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

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

Tertiary Prevention:
living with chronic conditions, preventing further disease

New ways of thinking and working

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

Whole family working and strength-based practice

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

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

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

New approach to assessment

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

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

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

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

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

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

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

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

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

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

New ways of thinking and working

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

What have we done already?

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

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

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

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

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

Part 2
Refresh

How the Refresh is structured

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

1. Progress on the original seven areas of opportunity

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

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

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

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

Complex lives

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

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

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

Intermediate care

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

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

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

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

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

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

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

Urgent and emergency care programme

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

The priorities are:

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

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

Doncaster's future UEC system will:

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

In reality, for people this will mean:

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

2. Delivery of neighbourhood-based integrated new care models

Introduction

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

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

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

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

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

The purpose of developing integrated neighbourhood working

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

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

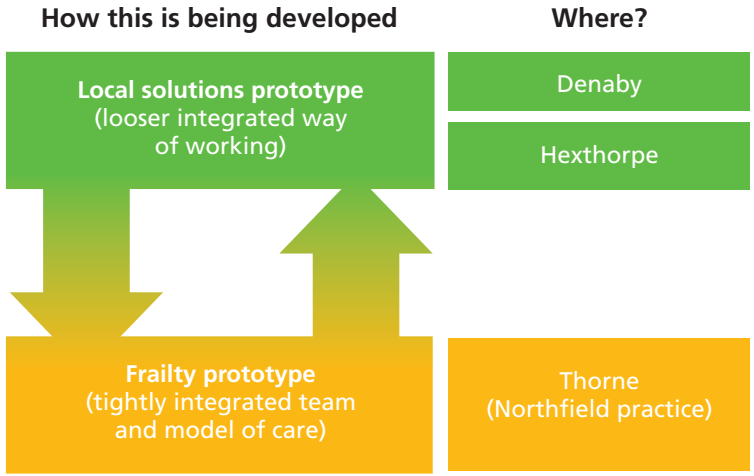
- Provide information, advice and guidance for families to be self-sufficient or respond to additional needs as they arise to promote better outcomes.
- Create a better experience of care and support for people who use services and their carers to achieve better outcomes
- For people with complex needs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

For services:

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

What we mean by integrated care in Doncaster

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



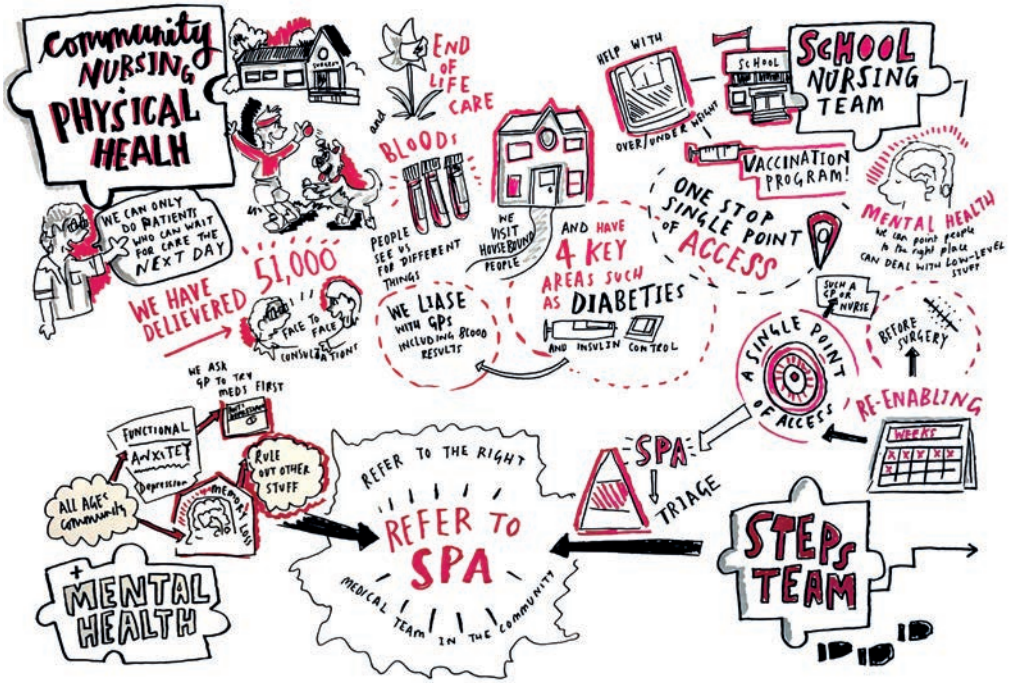
The Doncaster Innovates programme has been exploring and prototyping aspects of integrated working in different neighbourhoods, with different life stages and with testing different degrees of integration. The process has also started to describe a common methodology, for developing and implementing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

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

The foundations for integrated care in neighbourhoods

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

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



Local solutions prototype

THE PROTOTYPES

Children, young people and families.
Denaby and Hexthorpe

Why?

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

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

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

How it works

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

Application to other cohorts

LAYER 1

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

Local solutions: **wrapping services around people**

What happened when the Jones couple needed support?

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

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

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

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

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

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

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

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

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

How was the Local Solutions approach better?

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

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

2. Delivery of neighbourhood-based integrated new care models

Frailty prototype

Older people living with frailty in Thorne

Why?

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

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

How it works

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

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

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

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

2. Delivery of neighbourhood-based integrated new care models

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

Conversation starter:

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

Who and what are the things that matter to you?

What are your hopes for the future?

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

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

Resident of Thorne

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

Member of staff

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

Brenda, 82

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

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

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

Current state:

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

Future approach

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

Bert, 82

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

Current state:

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

Future approach

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

Application to other groups of people with different needs

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

The tightly integrated care team: tailored to population segments

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

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

The team shares

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

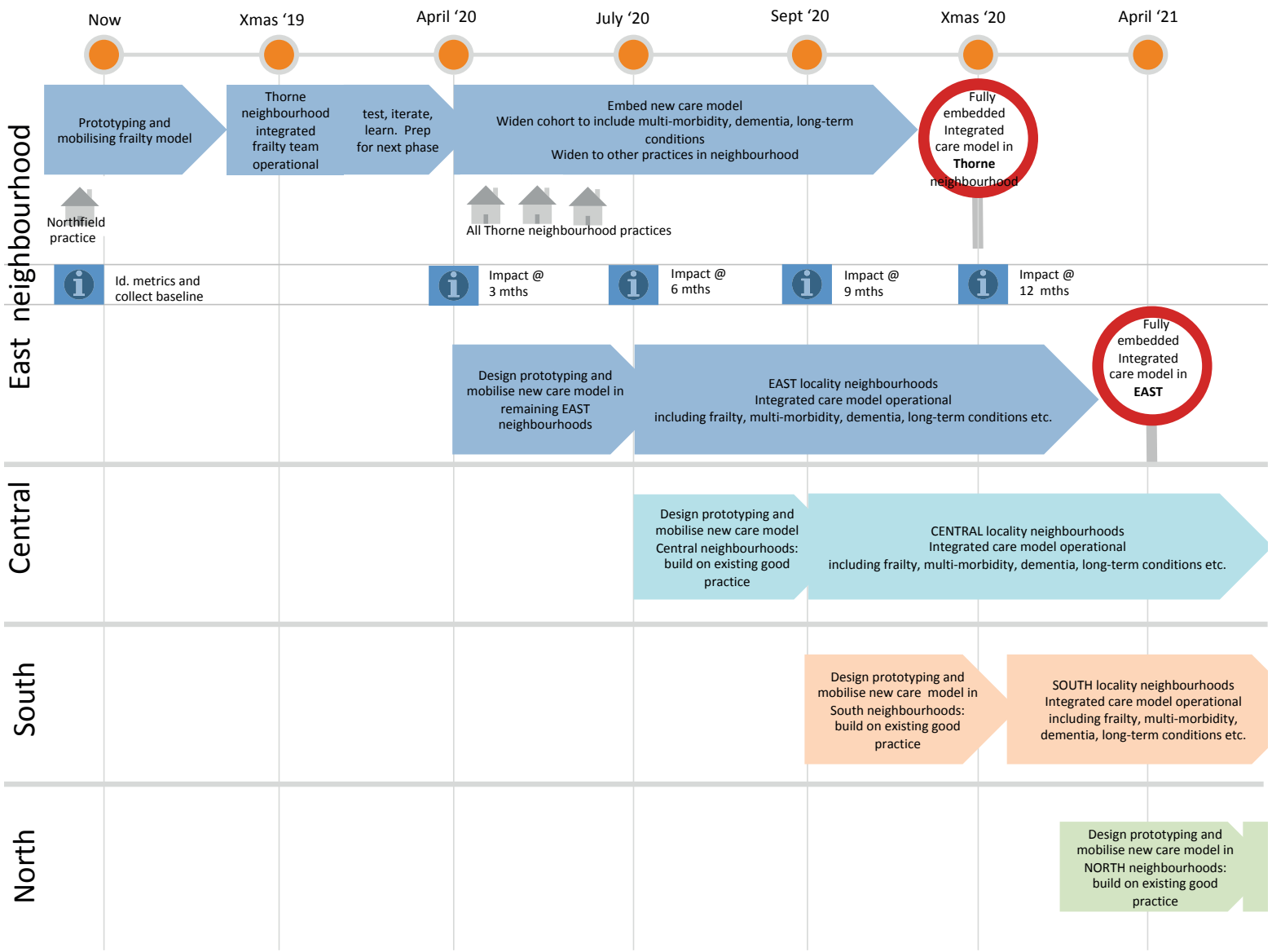
The team is supported by

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

The team feels

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

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



A note on roll-out:

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

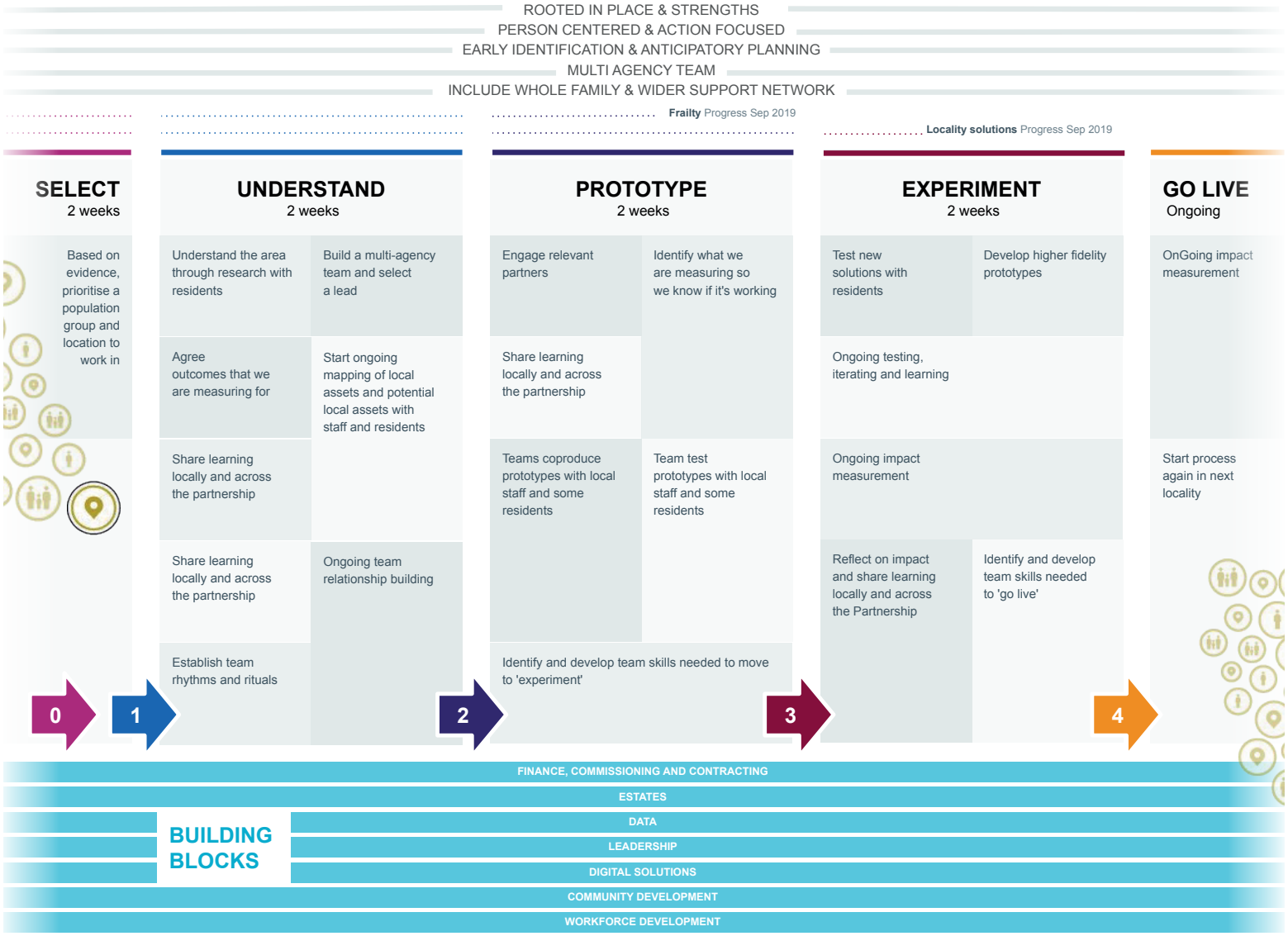
The next phase in terms of practices and neighbourhoods is not fixed and is flexible: some will be ready to go before others.

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

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

2. Delivery of neighbourhood-based integrated new care models

Our approach to prototyping



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

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

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

2. Delivery of neighbourhood-based integrated new care models

Theory into practice:

Doncaster Innovates supporting us to test and deliver integrated care teams

2. Delivery of neighbourhood-based integrated new care models

The Refresh commits the Doncaster Integrated Care Partnership to:

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

Children with long-term conditions including disabilities

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

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

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

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

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

The Integrated Care Partnership will

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

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

Mental health

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

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

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

The Integrated Care Partnership will

LAYER 1

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

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

LAYER 3

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

a. Integrated assessment and care management

b. Housing solutions

c. Acute liaison

Healthier Doncaster

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

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

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

The Integrated Care Partnership will

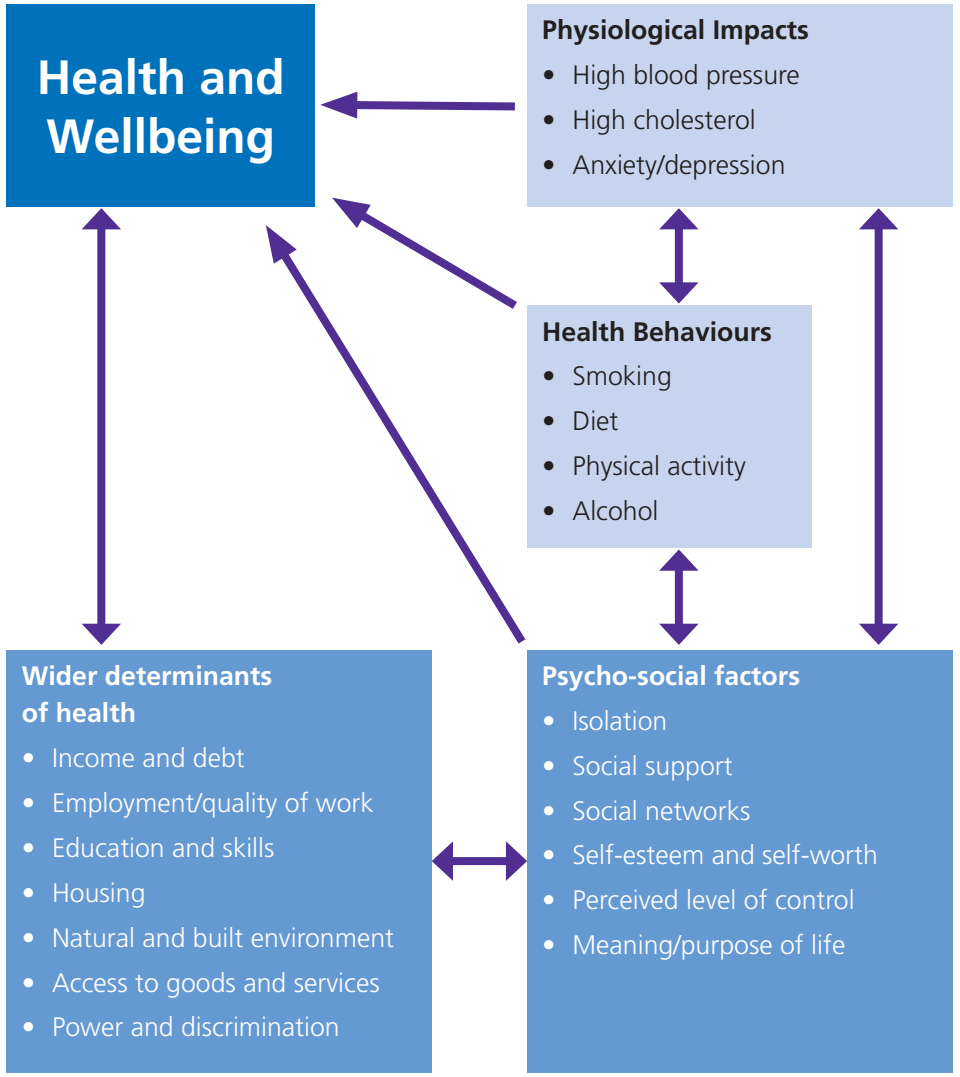
LAYER 1

LAYER 2

LAYER 3

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

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



Workforce

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

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

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

Digital Doncaster

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

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

Our digital vision

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

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

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

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

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

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

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

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

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

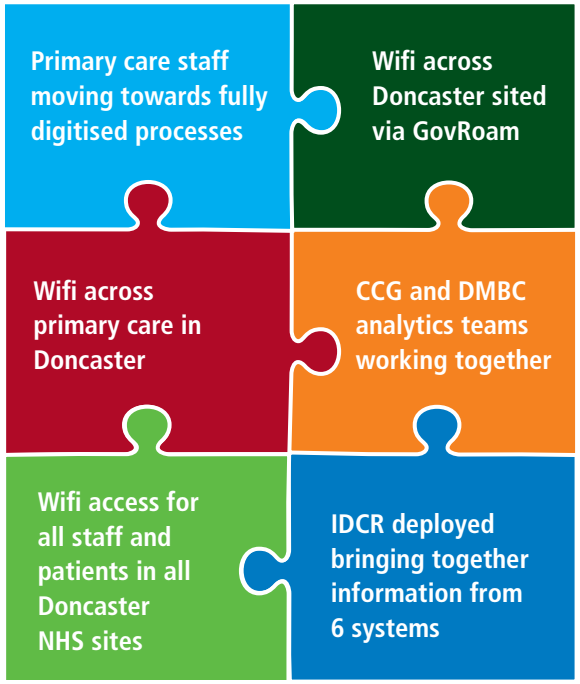
4. Strategic enablers

Using the Digital Work stream to address our system challenges

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

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

Wifi across primary care in Doncaster



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

4. Strategic enablers

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

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

Finance, payments and contracting

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

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

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

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

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

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

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

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

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

Estates

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

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

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

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

Priorities to support the delivery of the Place Plan are:

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

Joint Intelligence

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

Our Plan for Joint Intelligence

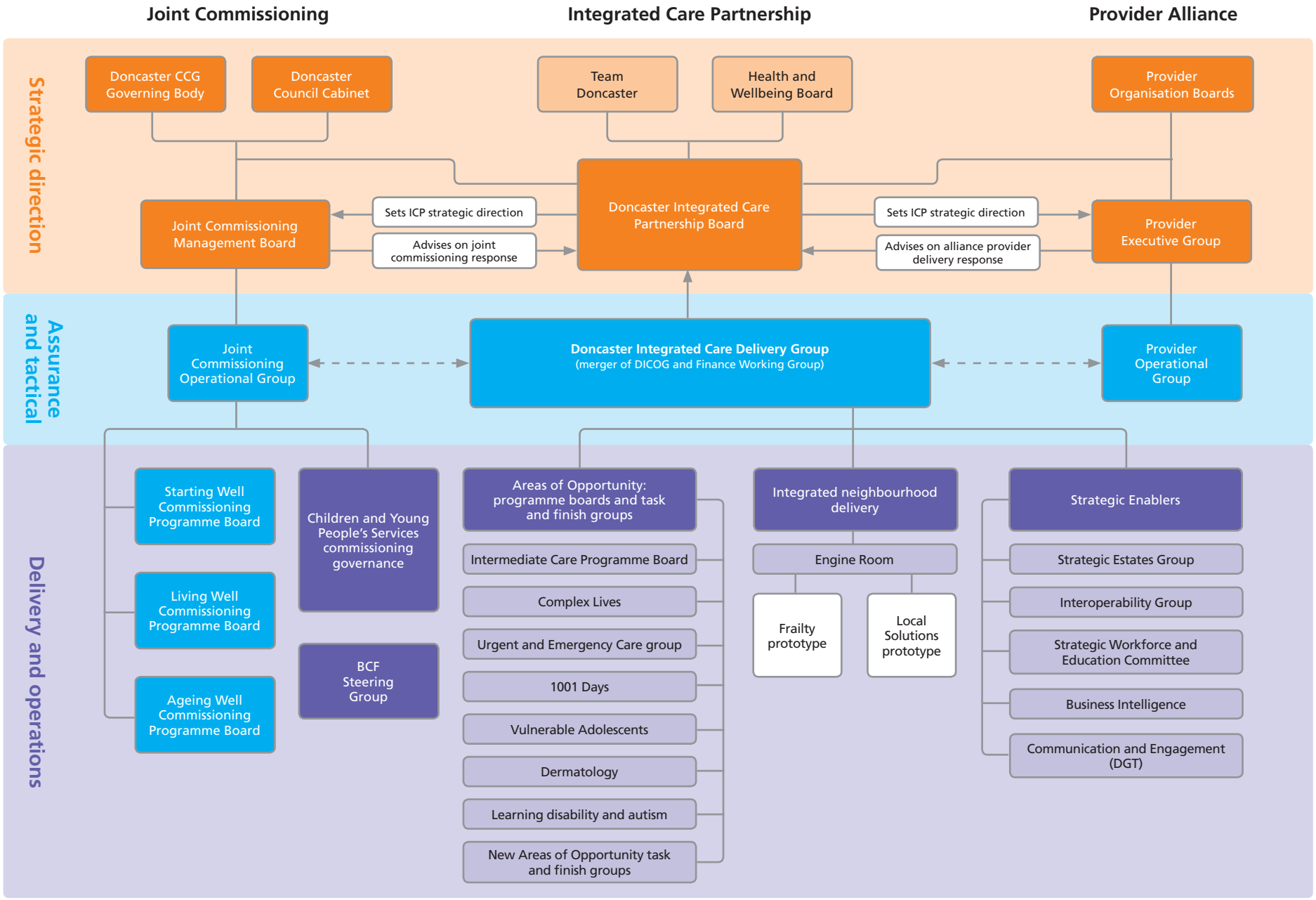
Our Joint Intelligence Working Plan includes:

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

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

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

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


Joint Commissioning
Integrated Care Partnership
Provider Alliance
Strategic direction
Doncaster CCG Governing Body
Doncaster Council Cabinet
Team Doncaster
Health and Wellbeing Board
Provider Organisation Boards
Joint Commissioning Management Board
Sets ICP strategic direction
Advises on joint commissioning response
Doncaster Integrated Care Partnership Board
Sets ICP strategic direction
Advises on alliance provider delivery response
Provider Executive Group
Assurance and tactical
Joint Commissioning Operational Group
Doncaster Integrated Care Delivery Group
(merger of DICOG and Finance Working Group)
Provider Operational Group
Delivery and operations
Starting Well Commissioning Programme Board
Living Well Commissioning Programme Board
Ageing Well Commissioning Programme Board
Children and Young People's Services commissioning governance
BCF Steering Group
Areas of Opportunity: programme boards and task and finish groups
Intermediate Care Programme Board
Complex Lives
Urgent and Emergency Care group
1001 Days
Vulnerable Adolescents
Dermatology
Learning disability and autism
New Areas of Opportunity task and finish groups
Integrated neighbourhood delivery
Engine Room
Frailty prototype
Local Solutions prototype
Strategic Enablers
Strategic Estates Group
Interoperability Group
Strategic Workforce and Education Committee
Business Intelligence
Communication and Engagement (DGT)

Appendix 1

Integrated neighbourhood delivery moving parts

Appendix 1 Integrated neighbourhood delivery moving parts

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

Appendix 1 Integrated neighbourhood delivery moving parts

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

Appendix 1 Integrated neighbourhood delivery moving parts

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

Appendix 2

Place Plan area of opportunity exit plans

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

Appendix 2 Place Plan area of opportunity exit plans

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

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

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

Appendix 2 Place Plan area of opportunity exit plans

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

This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:					June 2020	
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):					Laura Sherburn	
The Strategic Change Manager is:					Emma Challans	
The Commissioning lead is:					Karen Leivers	
The operational delivery lead is:					Rebecca Wright	
The following sets out what needs to happen by when to achieve this:		**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	Business case signed off	Community clinic mobilised	GPs commenced on accreditation framework with DBTHFT oversight	Community clinic and GP training underway	Community Clinic and GP training underway, early evaluation in place
	Anticipated significant decisions or stop-go gateway points	Approval of Business Case	Consultant job plans re-designed			
Commissioning	**Significant enabling commissioning activities and decisions**, including business case development, procurement, funding, identification of key personnel and any other key activities	Business case signed off				
	Anticipated significant decisions or stop-go gateway points	Approval of Business Case				

Appendix 2 Place Plan area of opportunity exit plans

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

This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:					December 2020	
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):					David Purdue	
The Strategic Change Manager is:					Ruth Bruce	
The Commissioning lead is:					Ailsa Leighton	
The operational delivery lead is:						
The following sets out what needs to happen by when to achieve this:		**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	Business case developed to include individual service costings Business Case approval by Provider Operational and Executive Groups (Sept 19) Service Specification and Case for Change developed Quality Impact Assessment completed Clear mobilisation plan developed	Phased mobilisation with partners: PHASE 1 – initial service change PHASE 2 – integration to teams Detailed future state model confirmed and UEC strategy written Testing in the following areas: Front door Doncaster Urgent Treatment Centre Doncaster Urgent Treatment Centre Mexborough (*may be Dec 19) Enabling work identified: • Workforce strategy • IT – interoperability	**Testing in the following areas:** Clinical Assessment Service (Doncaster CAS) Implementation of Doncaster UTC	By end of Sept 2020, all new services will have been mobilised PHASE 2 – further integration of services	All elements of the new service will have been implemented and embedded Evaluation of effectiveness – quality and performance Patient experience
	Anticipated significant decisions or stop-go gateway points	Sept 19 – agreement about the new UEC model and decision to from an alliance		Decision to cease local 0300 contact number		Further developments within service to be identified – part of 5 year plan

Appendix 2 Place Plan area of opportunity exit plans

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

Appendix 2 Place Plan area of opportunity exit plans

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

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

Appendix 2 Place Plan area of opportunity exit plans

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

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

Appendix 2 Place Plan area of opportunity exit plans

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

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

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

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

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

Appendix 2 Place Plan area of opportunity exit plans

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

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

Appendix 2 Place Plan area of opportunity exit plans

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

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

Appendix 2 Place Plan area of opportunity exit plans

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

This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:					November 2021 -after the 2 years prototyping in the two areas.	
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):					Riana Nelson	
The Strategic Change Manager is:					Stephanie Douglas	
The Commissioning lead is:					Lee Golze and Carrie Wardle	
The operational delivery lead is:					Denise Beevers	
The following sets out what needs to happen by when to achieve this:		**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	**Business case complete Jan 19.** **Funding secured for 2-area pilot Jun 19.** **ODRs agreed& signed off Aug 19.** • Complete letter of intent, memorandum of understanding and agree staffing line management Aug 19 • Working groups to resolve fine details for Operational Services, Quality and Governance reporting frameworks, HR, Finance and communications plans Oct 19 • Recruitment to posts for Transformational Project Manager, 1001 Days Team Manager, Midwife, Health Visitor and 1001 days Support Workers Aug to end Oct 19 • The new First 1001 days team will be in posts and operating on the ground with families 1st Nov 19	• Whole 0 to 1001 days caseloads in pilot areas now delivered by the 1001 days team • Set of KPI's for continual monitoring of performance • Measures to monitor impact on outcomes as well as staff performance • Regular team meetings set with internal review on ways of working including community relationships, whole family focus, equal health, care and educational approach.	• Two year pilot running business as usual with performance monitoring and continual review • Issues improvements identified with team approach to solutions • Significant shift for super local professionals perception of cross partner working relationships and connectivity with local area	• Two year pilot running business as usual with performance monitoring and continual review	• Two year pilot running business as usual with performance monitoring and continual review
	Anticipated significant decisions or stop-go gateway points	• Complete letter of intent, memorandum of understanding and agree staffing line management – imminent • Recruitment to posts for Strategic Change Manager, 1001 Days Team Manager, Midwife, Health Visitor and 1001 days Support Workers by end Oct 19				

Appendix 2 Place Plan area of opportunity exit plans

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

Appendix 2 Place Plan area of opportunity exit plans

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

This Area of Opportunity will be handed over to business as usual, in commissioning and operational delivery by:					April 2021	
The Senior Responsible Officer taking responsibility for this plan is (this is an Executive Director):					Jackie Pederson	
The Strategic Change Manager is:					TBC	
The Commissioning lead is:					Joanne Forrestall	
The operational delivery lead is:					Joanne McDonough	
The following sets out what needs to happen by when to achieve this:		**By end of Q3 2019, the following will be in place** **Christmas 2019**	**By end of Q4 2020 the following will be in place** **March 2020**	**By end of Q1 2020 the following will be in place** **June 2020**	**By end of Q1 2020 the following will be in place** **September 2020**	**By end of Q2 2020 the following will be in place** **Christmas 2020**
Operational delivery	**Significant operational delivery activities** (including business case development, procurement, funding, identification of key personnel and any other key activities)	Doncaster Provider Alliance agreement to continue as collaboration. Live case audits evaluated to provide further assurance and identify any gaps within the new care model. Implementation plan and mobilisation Gateway process agreed with clear timelines & agreement of financial risk sharing	A single management structure to promote a multi-disciplinary approach and reduce duplication & improve efficiencies by realigning the provision Fully integrated Home First offer. Completion of first cohort of bed redistribution into community offer. Fully operational Community SPA to manage discharges (in the first instance). Final cohort of bed redistribution identified, agreed and implementation plan developed NHS Standard contract Alliance Agreement signed by all stakeholders.	Provider alliance will fulfil the actions outlined in the Implementation plan	Provider alliance will fulfil the actions outlined in the Implementation plan	Delivery plan in place for the delivery of a full integrated Intermediate Care New Care Model in line with Service specification
	Anticipated significant decisions or stop-go gateway points	Implementation plan and mobilisation Gateway process agreed with clear timelines & agreement of financial risk sharing	Financial envelope to be agreed			
Commissioning	**Significant enabling commissioning activities and decisions**	Outcome based service specification approved by Clinical reference Group Business Case agreed by DCCG Executive Committee. Joint performance framework agreed	NHS Standard contract Alliance Agreement signed by all stakeholders Financial envelope to be agreed (Financial Sustainability)	Potential changes to commissioning of short breaks		Embedded into the Gateway Agreement


DONCASTER PLACE PLAN REFRESH
2019 – 2022

Doncaster Council

Doncaster
Health and Wellbeing Board

Date: 7 November 2019

Subject: South Yorkshire & Bassetlaw Integrated Care System (ICS) response to the NHS Long Term Plan

Presented by: Rupert Suckling – Director of Public Health

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	Yes
	Obesity	Yes
	Children and Families	Yes
Joint Strategic Needs Assessment		
Finance		
Legal		
Equalities		x
Other Implications (please list)		

How will this contribute to improving health and wellbeing in Doncaster?
For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

Recommendations
The Board is asked to note the South Yorkshire & Bassetlaw ICS draft response to the Long Term Plan and support the direction of travel.

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Enclosure D

Update: South Yorkshire and Bassetlaw Response to the Long Term Plan

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM
COLLABORATIVE PARTNERSHIP BOARD

11 OCTOBER 2019

Author(s)	Will Cleary-Gray – Chief Operating Officer, South Yorkshire and Bassetlaw Integrated Care System on behalf of the Cross system task and finish group
Sponsor	Sir Andrew Cash, South Yorkshire and Bassetlaw Integrated care System Lead

Is your report for Approval / Consideration / Noting

For noting

Links to the STP (please tick)

☑ **Reduce inequalities**	☑ **Join up health and care**	☑ **Invest and grow primary and community care**	☑ **Treat the whole person, mental and physical**
☑ **Standardise acute hospital care**	☑ **Simplify urgent and emergency care**	☑ **Develop our workforce**	☑ **Use the best technology**
☑ **Create financial sustainability**	☑ **Work with patients and the public to do this**		

Are there any resource implications (including Financial, Staffing etc)?

Not at this stage.

Summary of key issues

- SYB shared its draft plan with the region on 27 September 2019.
- Work will continue to engage stakeholders including the guiding coalition planned for 8 October.
- Peer to peer process with the 4 systems in the Y&H and NE region took place on 2 October 2019
- Draft Plan available for Board, Governing Bodies, Councils and key stakeholders for discussion and input.
- An interim submission has been requested from all systems on 1 November 2019.
- Final draft due 15 November 2019

Recommendations

The Collaborative Partnership Board is recommended to:

- Received the draft plan shared with the region on 27 September
- Note the progress to date and the next steps/timeline.
- Share with local governance for discussion and input feeding back by 23 October 2019

Developing the SYB Long Term Plan

Progress Update: SYB System Strategic Plan

11 October 2019

1. Purpose

1.1 The aim of this paper is to provide an update on:

- Our cross-system and bottom up approach to developing the SYB ICS Strategic LTP narrative response;
- The progress made in developing our Strategic Plan response to the LTP and a the ambition, emerging themes and priorities ;
- Next steps.

1.2 The paper is intended to provide an update of progress and enable discussions on the SYB 1st draft strategic plan. The Plan includes key drivers for the strategic narrative, including the need to reduce health inequalities and unwarranted variation, improve population health and outcomes, access, quality of care and patient experience and how strategically we flex our resources across the balance of health and care to best meet the needs of all of our local populations.

2. National LTP Requirements

2.1 The SYB Strategic plan for 2019-24 has taken into account the LTP Implementation Framework (LTPIF) published 27th June.

2.2 It presents systems with a very challenging planning timetable with both strategic and operational planning for multiple years required simultaneously.

2.3 It sets out three core components of the LTP that ICS's must deliver:

- Strategic Delivery Plan – a system narrative that describes the ambition and five- year strategy of the ICS, how it will deliver the LTP requirements.
- Strategic Planning Tool – that sets out five-year plans at ICS/STP level for finance, activity and workforce in support of delivery of the Long Term Plan
- Strategic Planning LTP Collection template - that sets out five-year trajectories at ICS/STP level for the LTP metrics

2.4 The first draft LTP plan was shared with the NE&Y NHSE / I region on 27th September and final plans are expected to be signed off on 15th November 2019.

2.5 SYB will take part in a peer to peer process week commencing 2 October 2019 which is aimed at offering a supportive and development dimension to the NHS regional assurance of plans following which we will receive feedback.

2.6 The LTP plan must be developed following the core principles set out in the LTPIF and which will be used as part of the NHSE/I assurance process. Plans are expected to demonstrate they are:

- Clinically led
- Accessible to the public
- Based on local context

- Reflecting local system priorities
- Addressing health inequalities
- Closing the three gaps (set out in the FYFV and covered in the STP)
- Describe governance and relationships
- Give clarity of service models
- Be focused on delivery
- Have enabling strategies
- Align workforce, activity and finance
- Be clear on risks

3. Progress to date to develop SYB Long Term Plan

3.1 The SYB cross-system LTP Task and Finish Group is well established with place and sector representation to provide oversight and coordinate the work to develop our plan. An LTP Finance Group is also in place to oversee the development and population of the financial model. Existing regional infrastructure is coordinating the workforce aspect.

3.2 Engagement work is ongoing. A SYB ICS guiding coalition met in early July to influence the development of our plan and is due to convene again in early October. The key themes identified through the engagement work by Healthwatch, the ICS communications and engagement team and the feedback from the public survey have all been shared to inform the initial plan development. The staff survey and opportunity for local politicians to contribute will end in mid-September and together with all the information will be independently analysed with a final report due at the end of September. Interim reports with key themes have been used to inform the ongoing development of the plan.

3.3 In addition to developing the plan narrative work has been initiated on the other requirements to populate the Strategic Planning Tool. The Finance Group coordinated populating the strategic planning tool. This process has been challenging as it brings forward traditional operational planning for multiple years to align to the development of our strategic plan over the lifespan of the LTP. It was completed and shared alongside the draft narrative on 27th September.

3.4 We continue to await finance guidance which will set out trajectories for our system within a revised financial framework for 2020/21 onwards moving away from current financial regimes. Trust workforce leads completed a HEE led workforce submission in early September, similar to that in the tool.

3.5 Work has also been undertaken to populate trajectories for the LTP headline metrics. These were also shared on 27th September. Alongside this there has also been work to identify key areas where we can improve health outcomes and reduce inequalities.

3.6 The draft strategic Plan narrative was shared with the SYB Health Oversight Group on 26th September, the SYB Health and Wellbeing Board Leads on 27 September , the SYB Health Executive Group on 8th October and initial feedback was given in a number of areas.

3.7 We continue to liaise with the SYB DPHs and Public Health England to ensure that we have a common understanding of population health in SYB, our challenges and health inequalities and to harness their expertise in our developing approach to prevention and

reducing health inequalities. More broadly we acknowledge the importance of the wider determinants of health and have identified a number of areas where the NHS can take action to directly impact on wider determinants, to complement boarder joint working with the Local Authorities around these.

4. Building on our local context and a summary of the key emerging themes

4.1 Our first strategic plan was published in 2016 and we have just published our 3 year review of our achievements. Throughout 2019 we have been engaging with the public, patients, staff and partners on what they want to see happen next. We used the NHS Long Term Plan, published in January 2019, as the backdrop for our conversations and building on the work in our neighbourhoods and places and the work taking place across SYB and wider. Feedback from our conversations in 2017, on the back of our first plan, has also informed our thinking, approach and priorities which are set out in the draft strategy.

4.2 The feedback and our commitment following the guiding coalition in the summer were to reiterate and reinforce our commitment to tackling health inequalities. Healthy life expectancy is lower in South Yorkshire and Bassetlaw compared to the national average, which means that people are on average living fewer years in good health and many are living with multiple long term conditions.

4.3 The shape of our draft plan will begin with expressing our continued journey and our achievements to date which are captured in our 3 year review. It continues to build on the vision we have set out which is " we want everyone on South Yorkshire to have a great start in life, supporting them to stay healthy and live longer" with our ambitions set out in 4 strategic themes:

- Developing a population health system
- Strengthen our foundations
- Building a sustainable health and care system
- Broadening and strengthening our partnership to increase or potential

4.4 We have high levels of the common causes of disability and death, including high rates of smoking, obesity, physical inactivity and hospital admissions due to alcohol. Much of this burden of illness can be prevented or delayed.

4.5 Our reinforcing of our commitment will mean we will take a three-pronged approach to systemically tackle the inequalities in health and care, making it central to everything that we do. We will look at interventions at a civic level (with Health and Wellbeing Boards and local Integrated Care Partnerships), in the community (with local community, voluntary, social enterprises and faith originations and with the voluntary, community and social enterprise sector) and in the health service (across health and care services). Our focus will be on cutting smoking, reducing obesity, limiting alcohol-related A&E admissions and lowering air pollution.

4.6 We will build on the work we have started to give patients more options, better support and joined up care at the right time in the best care setting and we reinforce our commitment to this being as close to home as possible. In our 2016 plan we identified significant challenges to the sustainability of acute services in the region and as a result of a comprehensive and inclusive review of those services, we agreed to develop hosted networks.

4.7 There are now 30 Primary Care Networks (PCNs) in South Yorkshire and Bassetlaw, all preparing to extend the range of convenient local services and create integrated teams of GPs, community health and social care staff. This will strengthen the neighbourhood model to provide fast support to people in their own homes as an alternative to hospitalisation, as well as increase support for people living in care homes and develop social prescribing offers.

4.6 Since our 2016 plan, two of our 'Places' have launched urgent treatment centres to help people get the care they need fast and to relieve pressure on A&Es. The LTP plan asks systems to build on this progress with increasingly 'same day emergency care' as we balance our focus on hospital and out of hospital care with initiatives in the community and in our hospitals we improve processes and standardise practices. By redesigning hospital support, we will give patients the right to alternative modes of appointment such as online, telephone or video consultations. We will also carry out more planned operations and join up care better by increasing access to shared medical records.

4.7 We have started to make in-roads in our efforts to improve the quality of care and outcomes in cancer, children's services, stroke and mental health and learning disabilities and will now step these up at the same time as widening our focus to include diabetes, cardiovascular disease and respiratory conditions.

4.8 Workforce issues are a key driver for much of the work of the ICS. Our workforce challenge is in part because our workforce has not grown in line with the increasing demands on the NHS and also because the NHS hasn't been a sufficiently flexible and responsive employer. Our Plan aims to put this right by tackling nursing shortages and securing current and future supply, make the NHS in South Yorkshire and Bassetlaw the best place to work and improve our leadership culture while introducing new roles, rostering and programmes that enable flexibility for staff.

4.9 In 2016 we set out an ambitious journey to deliver digitally enabled care, but acknowledge that our progress has been limited. Some of our partners have made positive progress in delivering digital capabilities to integrate health and care teams around the person but the context of the LTP informs is that we need to do more. We are determined to ensure that patients and their carers can better manage their own health and clinicians can access and interact with patient records and care plans and decision support where they are. To achieve this, we will establish the basic digital capabilities across integrated health and care, ensure greater use of information and advancing capabilities and digitally enable citizens and professionals.

4.10 We also want to strengthen our approach to innovation and have partnered with the Yorkshire and Humber Academic Health Science Network to establish an Innovation Hub which will become the vehicle for system-wide innovation.

4.11 Bolstered by national transformation funding for some areas, such as cancer and mental health and primary care, we have been able to accelerate progress for patients in these areas. We need to ensure that achieving improved population health outcomes and optimal health and care delivery is not hindered by how we plan or pay for health and care services. We will deliver for tax payers, taking forward efficiency plans while we work with new payment systems and incentives across our NHS organisations to achieve financial balance.

4.12 The STP was underpinned by what we described as three gaps we needed to tackle, the health and wellbeing gap, the quality in care gap and the finance and efficiency gap. Whilst the financial settlement for the NHS is already set out there remain some significant unknowns for the financial context to the LTP and significant challenges remain which include the challenge in funding position in social care. This provides additional context to our strategic considerations and plans and will set the context for the level of ambition our system will need to consider as we develop our strategy and plans.

4.13 Our partnership and governance has evolved across the system and within each place. Each of our local places have developed strong partnerships in place across health and care. Across the SYB partnerships and collaborative working has continued to evolve with some adopting more formal arrangements where this make sense to do so. We have already started to broaden and strengthen our partnerships across SYB with Local Government and with the City regions on shared priorities. This is an area of our plan which will need further discussion and time to reflect how we broaden and strengthen out partnerships to achieve our ambitions over the next 4 years.

5. Key priorities to improve health outcomes and reduce health inequalities

5.1 A data pack has been developed using health outcome related data from the Public Health England (PHE) and global burden of disease websites. Using this we have identified 5 key areas where there is significant potential for health gain in SYB as follows:

- Best start in life
- Improve mental health and wellbeing
- Reduce smoking, harm from alcohol and obesity
- Improve cardio- respiratory health
- Early diagnosis and increased survival from cancer

5.2 For each area we are now in the process of identifying a headline ambition and metric, and a set of sub metrics, aligning to the LTP metrics where possible.

6. Next steps and timeline

6.1 Work will continue to engage stakeholders.

- The draft narrative was shared on 27th September with NHS England and Improvement and feedback is awaited.
- Peer to peer process with the 4 systems in the Y&H and NE region - 2 October 2019
- Draft Plan available for Board, Governing Bodies, Councils and key stakeholders
- Final draft due 15 November

7. Recommendations

7.1 Boards are invited to:

- Note the national requirements for NHS planning and SYB progress to date
- Receive the draft plan
- Note initial sharing of the draft plan on 27 September
- Provide feedback on key content including the level of ambition within the plan

Paper prepared by Will Cleary-Gray.
On behalf of the SYB Cross-system task and finish group

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South Yorkshire and Bassetlaw Integrated Care System

Strategic Plan 2019-2024 - 1st Draft

September 27 2019

Contents

Foreword

By Sir Andrew Cash
Chief Executive
System Lead

"We are starting to make real and lasting positive changes to people's lives across the region."

It is three years since we published the South Yorkshire and Bassetlaw Sustainability and Transformation Plan. In that time we have made significant progress in delivering our ambitions and we are starting to make real and lasting positive changes to people's lives across the region.

We have extended GP access at evenings and weekends, supported more than 3,000 people with long term physical and mental health conditions to find and stay in work as part of the Working Win programme led by the Sheffield City Region, invested more than £1 million into maternity services and care, introduced new nursing roles and freed up GP appointments with the introduction of 825 care navigators.

This snapshot of achievements is down to us working together in even better ways than we have before and we are rightly proud of our achievements. We have documented our work so far in a three-year ICS Review [link to the Review]

We have started to break down organisational barriers so that we can wrap support, care and services around people as individuals and improve people's lives. Each of our NHS partners has strengthened the way they work with other NHS organisations and with wider partners, such as local authorities and the voluntary sector.

As a System, we have joined forces where it makes sense to do so and where it makes a real difference to patients, staff and the public.

All this has put us in a strong position as we prepare to build on our successes and take forward our ambitions in our refreshed strategy for the next four years.

We have continued to talk with the public, our staff and our stakeholders about their hopes and vision for health and care services in South Yorkshire and Bassetlaw. Those conversations, which built on the ones we had in 2017, focused on the aims and aspirations set out in the NHS Long Term Plan, published in January 2019 [link].

The feedback [link to reports] from many months of conversations has informed our thinking which we have since tested with our Guiding Coalition and partners within the System.

The result is our refreshed Plan, which has been clinically led, builds on our work to date, is guided by the NHS Long Term Plan and shaped by our local constituents.

Foreword ...

Our pledges in 2016 were to give people more options for care while joining it up for them in their neighbourhood, help them to stay healthy, tackle health inequalities, improve quality, access and outcomes of care, meliorate workforce pressures and introduce new technologies. We paid particular attention to cancer, mental health and primary care, and the two key enablers of workforce and digital technology.

> "Our refreshed Plan has been clinically led, guided by the NHS Long Term Plan and shaped by our local constituents."

Our 2019 Plan builds on these but it also focuses on children's health, cardiovascular and respiratory conditions, diabetes, learning disabilities and autism. It also takes forward the work to strengthen primary and community based care and as a result of the review of hospital services across South Yorkshire and Bassetlaw, the development of Hospital Hosted Networks.

People have told us how proud they are of their local health and care services but they also shared their concerns about funding, staffing and the increasing inequalities from a growing and ageing population.

Our Plan tackles these issues as it sets out how we will make funding go as far as possible, alleviate the pressures faced by staff and redesign care and services so that we continue to offer and deliver some of the best health care services in the world.

By working as an ICS, we have benefitted greatly from more than £200 million in additional transformation funds over the last three years which has enabled us to progress so many schemes. Our refreshed strategy for the next five years includes an indicative £275 million of extra funding which means we can accelerate the progress in our priority areas while working with the new financial rules to drive efficiencies and deliver for taxpayers.

South Yorkshire and Bassetlaw Integrated Care System

Through our partnership working with Local Authorities and the Sheffield City Region we want to continue to influence and contribute to the development and implementation of a wide range of local 'Place' based strategies that are tackling the wider determinants of health, such as inclusive growth plans, housing, transport, employment and thriving communities. At the same time, we want to ensure that all our local communities have equitable access to a full range of health and care services.

Our 2019 Plan recommits our ambition for everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to be healthy and live longer while aiming to be the best delivery and transformation System in the country.

We have a very strong track record and our renewed drive puts us in an excellent position to deliver on our promises. I look forward to working with you on them to provide the best health and care for all our population.

Andrew Cash

Sir Andrew Cash
Chief Executive
South Yorkshire and Bassetlaw
Integrated Care System

Executive Summary

Our journey to becoming one of the first and most advanced Integrated Care Systems (ICS) in the country has been one of steady progress, solid performance and strong delivery. We have built on our excellent foundation of working together and are now delivering tangible improvements for our population.

We have been working as a partnership for three years and throughout this time, our vision has remained the same:

For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

We are in a transition year in 2019/20 as we start to have more responsibilities for our health system, including strategic planning and increasing collective accountability for health performance and finance. We will continue to evolve our governance in line with developments and you can read more about our approach on page 61.

We published our first strategic plan in 2016 and have spent much of 2019 engaging with the public, patients, staff and partners on what they want to see happen next. We used the NHS Long Term Plan, published in January 2019, as the backdrop for our conversations but we are not starting from scratch. Feedback from our conversations in 2017 [ink], on the back of our first plan, has also informed our thinking, approach and priorities.

Our 2019 Plan builds on our work to date and focuses around four key ambitions:

1. Developing a population health system

Healthy life expectancy is lower in South Yorkshire and Bassetlaw compared to the national average. We have high levels of the common causes of disability and death, including high rates of smoking, obesity, physical inactivity and hospital admissions due to alcohol. Much of this burden of illness can be prevented or delayed. We will consider the wider determinants of health and tackle health inequalities with a whole population approach that is person-centred. Our focus will be a best start in life, reducing harm from smoking, alcohol and obesity, improving cardio-respiratory health, improving mental health and wellbeing and early diagnosis and increased survival from cancer.

We have started to make in-roads to improve the quality of care and outcomes in cancer, children's and maternity services and mental health and learning disabilities and we have launched the new South Yorkshire and Bassetlaw Hyper Acute Stroke Service and associated Hospital Network. We will now step up our work in these areas at the same time as widening our focus to include diabetes, cardiovascular disease and respiratory conditions.

Bolstered by national transformation funding for some of our work areas, such as cancer and mental health and primary care, we have been able to accelerate progress for patients in these areas. As we take on more responsibilities for our health system for finance, we will increasingly become the route through which System funds flow. We will deliver for tax payers, taking forward our efficiency plans while we work with new payment systems and incentives across our NHS organisations to achieve financial balance.

Executive Summary …

2. Building a sustainable health and care system

There are now 30 Primary Care Networks (PCNs) in South Yorkshire and Bassetlaw, all preparing to extend the range of convenient local services and create integrated teams of GPs, community health and social care staff. Already they have met as a Network of Clinical Directors, supported by the ICS, to discuss how they will start to shape the delivery of local services and provide fast support to people in their own homes.

Since our 2016 plan, two of our 'Places' have launched urgent treatment centres to help people get the care they need fast and to relieve pressure on A&Es. We are also trialling new pathways for urgent care and associated standards but we need to do more. We will increasingly start to treat people as 'same day emergency care' as we focus on out of hospital and in hospital emergency care.

We will build on the work we have started to give patients more options, control, better support and joined up care at the right time in the best care setting. In the next five years, we will accelerate the recently formed Hospital Hosted Networks to ensure everyone has the same high quality standards and equal access.

By redesigning hospital support, we will give patients the right to alternative modes of appointment such as online, telephone or video consultations. We will also carry out more planned operations and join up care better by increasing access to shared medical records.

3. Strengthening our foundations

Since 2016, we have had thousands of conversations with the public, staff and our stakeholders – all of which have shaped not just this Plan but our ongoing work in the ICS. We will build on this strong platform with support from our Guiding Coalition and Citizens' Panel to develop an online membership model and better understand how we can positively use the rich sources of patient experience data across the System.

Workforce issues are a key driver for much of the work of the ICS. Our staff provide services 24 hours a day, 365 days a year, and we must continue to support them to do the best possible job they can do.

Our Plan aims to tackle nursing shortages and secure current and future supply, make the NHS in South Yorkshire and Bassetlaw the best place to work and improve our leadership culture while introducing new roles, rostering and programmes that enable flexibility for staff.

In 2016 we set out an ambitious journey to deliver digitally enabled care. Some of our partners have made positive progress in delivering digital capabilities to integrate health and care teams around the person, such as the Rotherham Health App - but we need to do more.

We will establish the basic digital capabilities across integrated health and care, ensure greater use of information and advancing capabilities and digitally enable citizens and professionals.

We also want to strengthen our approach to innovation and have partnered with the Yorkshire and Humber Academic Health Science Network to establish an Innovation Hub which will become the vehicle for system-wide innovation.

4. Broadening and strengthening our partnerships to increase our opportunity

Our strategic plan takes account of the majority of the work across the ICS taking place locally, in neighbourhoods or in Places and the partnerships we have and continue to develop are built around these strong local relationships serving local populations.

In addition to strengthening the connections we have in Neighbourhoods and in Place with our local authorities and the voluntary sector, we want to build on the role we play in the local and regional economy. Serving the same population, we share a number of ambitions with the Sheffield City Region and we have agreed some key priority areas that will be developed across health and care with both the SCR and our local authorities.

We are extremely grateful to the public, staff and stakeholders who have taken the time to share their views on the future of health and care services in our region. In doing so they have helped to shape the thinking and contributed to the aims and objectives in this Plan.

Plan on a page

1 vision

For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

This is the **second** stage of our strategy

3 Life Stages

- Starting well
- Living well
- Ageing well

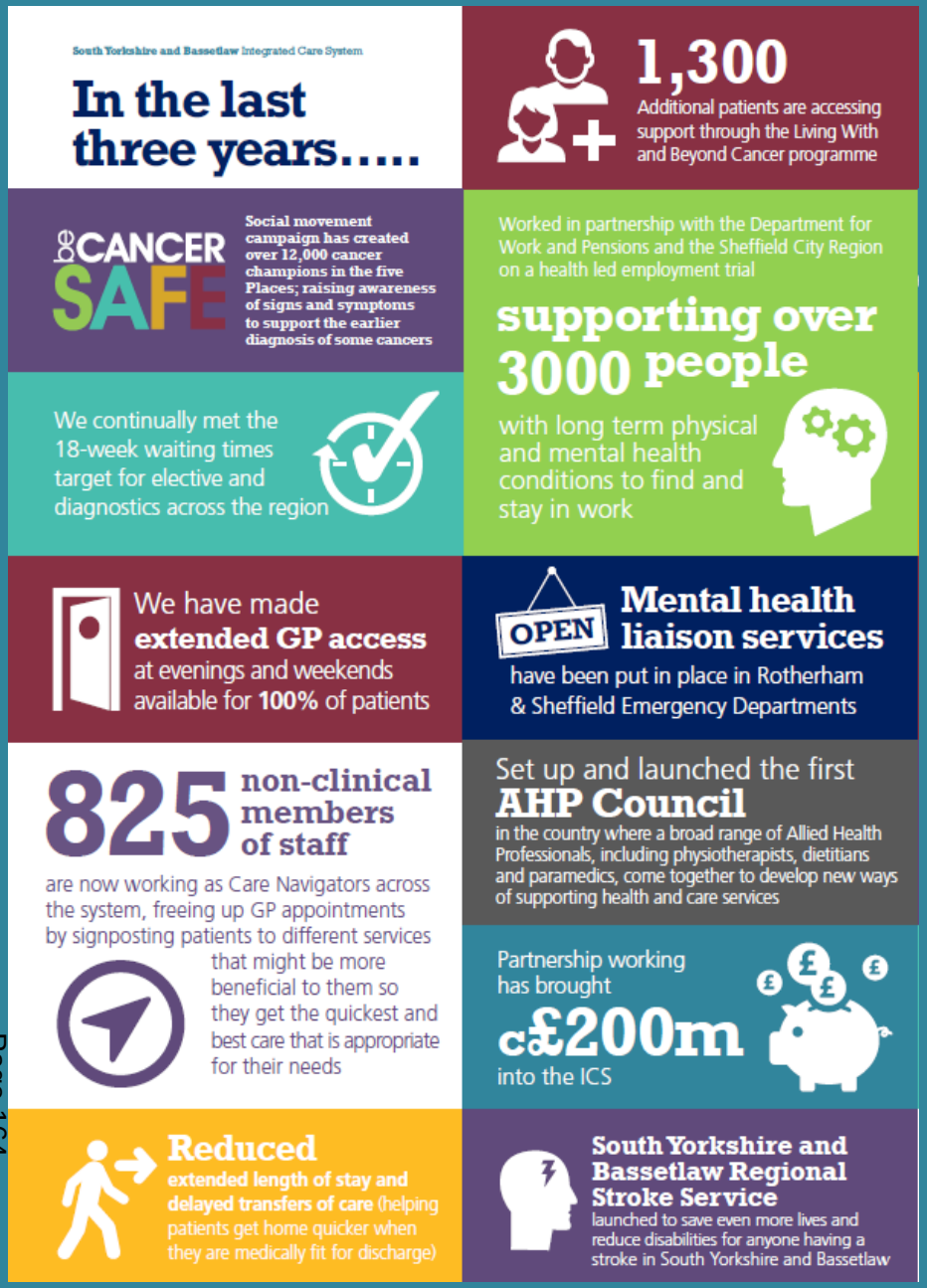
Four THEMES

1. Developing a population health system
2. Strengthening our foundations
3. Building a sustainable health and care system
4. Broadening and strengthening our partnerships to increase our opportunity

5 Focus Areas

- Best start in life
- Reduce harm from smoking, alcohol and obesity
- Improve cardio-respiratory health
- Improve mental health and wellbeing
- Early diagnosis and increased survival from cancer

Achievements and progress



Although we officially launched in October 2018 as an ICS, we have been working collaboratively at a System level since January 2016. Throughout this time we have built on our excellent foundations of working together and started to deliver real and tangible improvements for our population.

We have much to celebrate and the work we have undertaken over the last three years [LINK to the ICS Review] is transforming the way we do things at a system level.

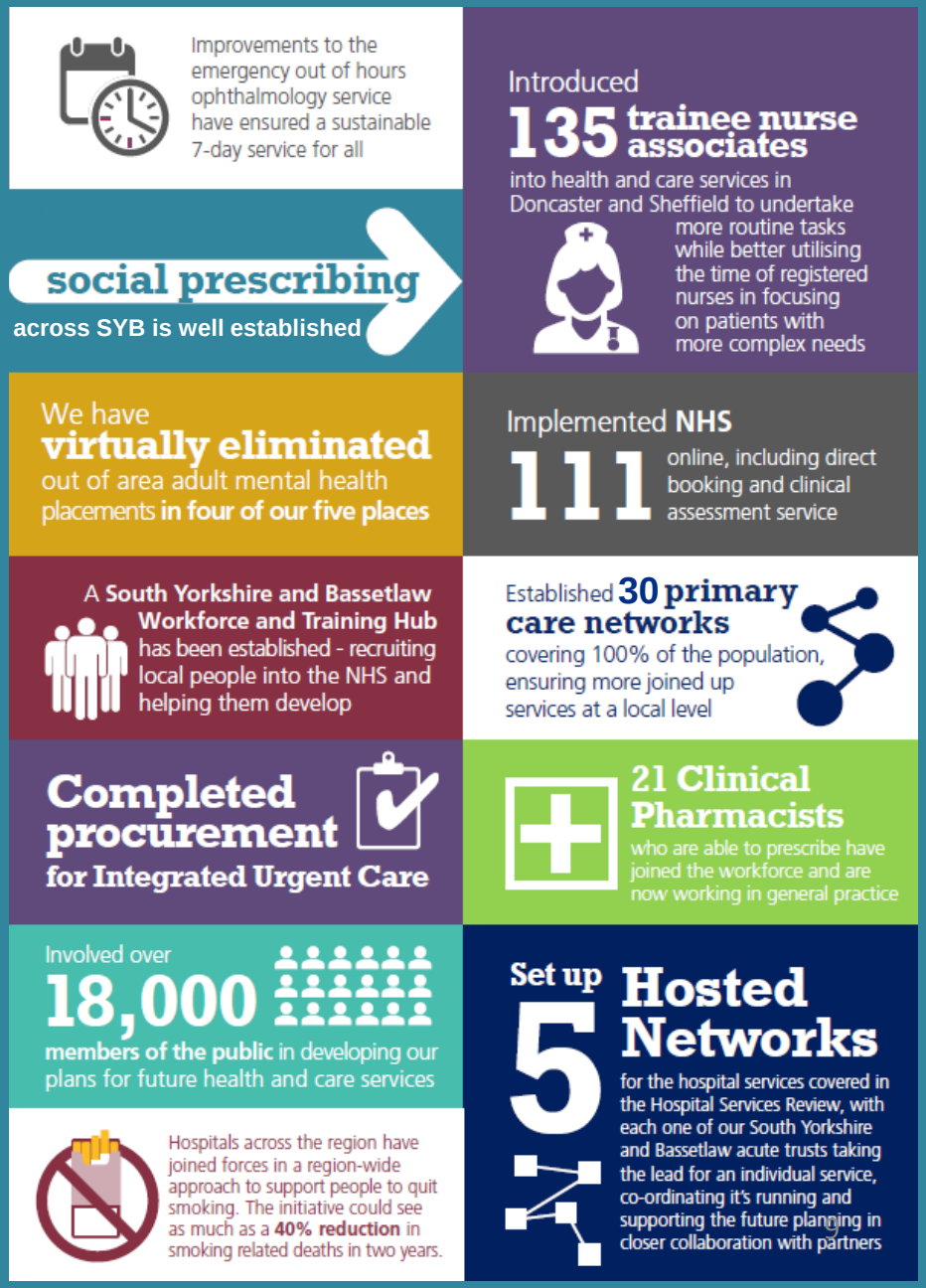
With support from staff, the public and stakeholders, we are making real inroads into transforming our approaches so that people continue to receive high quality services but in ways that are more convenient and with better outcomes.

Just some of our successes include:

- The launch of a new perinatal mental health service across Doncaster, Rotherham and Sheffield, adding to services already in place in Barnsley and Bassetlaw
- New pathways for lower GI, prostate and lung cancers – helping to diagnose and treat people earlier and improve overall outcomes
- Investing more than £1 million into our Local Maternity System to improve care for all mothers and babies. 85% of women now have a Personalised Care Plan
- Providing extended access GP appointments, at evening and weekends, for 100% of our population

Achievements and progress

- Over the last three years more than fifty per cent of practices have benefitted from funding to support them to become more sustainable and resilient, better placed to tackle the challenges they face and to secure continuing high quality care for patients
- We have developed a Primary Care Workforce and Training Hub
- We have put in place the South Yorkshire and Bassetlaw Regional Hyper Acute Stroke Service
- Made improvements in waiting times for diagnostic investigations
- Established the South Yorkshire and Bassetlaw Radiography Academy
- 1,300 extra patients are accessing support services through the Living With and Beyond Cancer programme
- Working in partnership with the Department for Work and Pensions and Sheffield City Region we have supported people with long term physical or mental ill health into the Working Win health led employment trial
- Set up five Hospital Hosted Networks for the services covered in the Hospital Services Review (which was commissioned to tackle sustainability of services following our 2016 Plan)
- Secured £200,000 from Health Education England to work with the Yorkshire and Humber Academic Health Science Network to support transformation in the mental health workforce



Our System

The South Yorkshire and Bassetlaw Integrated Care System formally launched as an 'ICS' in October 2018.

We have been working as a partnership for three years, first as a Sustainability and Transformation Partnership, then as a first wave Accountable Care System and now, as one of the leading ICS' in the country.

Throughout this time, our goal has remained the same:

For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

We are one NHS, working as a System. We work with other partners, such as Local Authorities and the voluntary sector, in Neighbourhoods, Place and across the System when we have a common purpose and where it makes a positive difference to people's lives. Our aim is to break down organisational barriers so that we can wrap support, care and services around people as individuals..

We agree to take shared responsibility (in ways that are consistent with individual legal obligations) for how we can use our collective resources to improve quality of care and health outcomes. As a first wave ICS, we are making faster progress than other health systems in transforming the way care is delivered, to the benefit of the population that we serve.

We are a system with a population of 1.5 million with five local Places with populations between 130,000 and 576,000

At a glance, we have:

- £3.9 billion total health and social care budget
- 1.5 million population
- 72,000 members of staff
- 208 GP practices
- 36 neighbourhoods
- 6 acute hospital and community trusts
- 5 local authorities
- 5 clinical commissioning groups
- 4 care/mental health trusts

Our System

5

Place partnerships

There are five Place Partnerships, covering populations between 130,000 and 576,000 . The Partnerships plan and deliver integrated health and care across the Place, and include:

- Primary Care Networks
- GP Federations
- Clinical Commissioning Groups
- Voluntary, community and social enterprise sector
- Local Authorities
- Healthwatches
- Acute hospital trusts
- Mental health hospital trusts

The **System** agrees shared objectives and outcomes

Hospitals are increasingly working in **Hosted Networks**

Partnerships plan and deliver integrated health and care across **Place**

Neighbourhoods integrate teams to deliver care where people live

36

Neighbourhoods

There are 36 neighbourhoods, served by 30 Primary Care Networks.
The Networks are GP practices working together to deliver as much care as possible close to where people live. Our Networks cover populations of 19,000 to 50,000, and include:

- GPs
- Pharmacists
- District Nurses
- Allied Healthcare Professionals, such as podiatrists and physiotherapists
- Community Geriatricians
- Dementia Workers
- Teams from social care
- Community Wellbeing Teams
- Teams from the voluntary sector

1

System

There is one System, covering a population of 1.5 million. The System plans and makes improvements for the NHS for the benefit of everyone across South Yorkshire and Bassetlaw. It also has an overview of System NHS finance and performance. It is a Partnership of NHS organisations working with others, such as Local Authorities and the voluntary sector.

5

Hospital Hosted Networks

There are five developing Hospital Hosted Networks covering gastroenterology, maternity, paediatrics, stroke and urgent and emergency care services. The Networks standardise clinical standards and reduce unwarranted variation.

Section 1: Developing a population health system

- Understanding health in SYB
- Developing a prevention driven NHS
- Taking a person centred approach
- Getting the best start in life
- Priority areas for improving outcomes from major health conditions
- Reshaping and rethinking resources and delivery to better meet need

Understanding health in

South Yorkshire and Bassetlaw

1.52 million population

Barnsley:	**39**
Bassetlaw:	**114**
Doncaster:	**42**
Rotherham:	**52**
Sheffield:	**60**

England Local Authority deprivation ranking (of 326, 1 most deprived)

8.9% population of Black and Minority Ethnic heritage and many people of Eastern European origin

57% increase in the 75s and overs by 2028

People's health is determined by a complex combination of genetics, behaviour, the health care that we receive and the physical, social and economic environment that we live in.

We know that we have a number of health issues that are not as good as they should be when comparing ourselves to similar regions and the national average. We also know that peoples health varies a lot within South Yorkshire and Bassetlaw.

In line with the national picture, life expectancy in South Yorkshire and Bassetlaw is no longer increasing.

The greatest contributors to our gap in life expectancy in SYB are cancer, cardiovascular disease (CVD) and respiratory disease.

9.6 years life expectancy difference for women between the most deprived and least deprived areas in SYB

12.4 years life expectancy difference for men between the most deprived and least deprived areas in SYB

In men, we have too many deaths in early adulthood from suicide, drug related death and violence.

While there has been an overall decrease in premature deaths from CVD and cancer over the last 15 years, this has not been seen for respiratory deaths and the mortality rate from liver disease is increasing.

Alzheimer's disease is now the commonest individual disease causing death in women and fourth commonest in men.

Not only do people in South Yorkshire and Bassetlaw die younger, but they also live fewer years in good health.

More people in SYB reported having a long term disability than the national average in the 2011 Census.

Many people are living with multiple long term conditions. People living in the most deprived areas experience onset of multi-morbidity 10 – 15 years earlier that those in the most affluent areas. The more physical illnesses you have the more likely you are to also have a mental health disorder.

The commonest conditions that lead to a disability are musculoskeletal disorders, mental ill health, neurological disorders and chronic respiratory disease.

Much of this burden of illness can be prevented or delayed. We have high levels of the common causes of disability and death, including high rates of smoking, obesity, physical inactivity and hospital admissions due to alcohol.

Many people are socially isolated and more people report have a mental illness in SYB than nationally. People with severe mental illness in SYB are 3.5 to 4 times more likely to die under the age of 75 than the general population.

People with a learning disability have worse physical and mental health. Women with a learning disability die on average 18 years younger and men 14 years younger .

Healthy Life Expectancy at Birth, 2015/17

	Male	Female
England	63.4	63.8
Barnsley	59.7	61
Doncaster	61.8	61.1
Rotherham	59.3	57.4
Sheffield	62.5	60.1
Nottinghamshire	65.2	62.7

Developing a population health system

Many people in South Yorkshire and Bassetlaw are living fewer years in good health compared to those living in similar regions or the English average.

The NHS has traditionally tended to focus mainly on treating people when they are unwell. However, we know that people's health is determined by a complex combination of genetics, behaviour and wider determinants of health – the physical, social and economic environments that people live in – as well as the health care they receive.

Many of the issues and illnesses leading to poor health and well being can be prevented. If we are to improve health and reduce health inequalities in South Yorkshire and Bassetlaw we need to broaden our approach.

Rather than focusing on just when someone is unwell, we will take a population health approach - working with our partners and local communities - to improve physical and mental health and wellbeing and reduce health inequalities across the entire population of South Yorkshire and Bassetlaw.

Our ambition is to help people early on and prevent future problems developing.

Our 2016 Plan focused on shifting our system to one that is focused on maintaining wellness and slowing or stopping the progression of disease by impacting on all the wider determinants of health. In our 2019 Plan, we set out our next stage ambitions to address health inequalities and improve our population's health over the next five years.

We have identified five areas that we will need to particularly focus on over the next five years to improve population health and reduce inequalities

- **Best start in life**
- **Reduce harm from smoking, alcohol and obesity**
- **Improve cardio-respiratory health**
- **Improve mental health and wellbeing**
- **Early diagnosis and increased survival from cancer**

We will

- Reduce the % of pregnant women in SYB who are smoking at time of delivery to 6% by March 24
- Reduce % of adults in SYB who smoke to below 10% by March 24, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness
- Reduce premature mortality from cardiovascular disease, improving fastest in the areas with highest deprivation
- Reduce the life expectancy gap between people with severe mental illness and learning disabilities and the general population
- Improve 1 and 5 year cancer survival rates
- Increase the % people with cancer who are diagnosed at stage 1 and 2
- Reduce suicide rates across SYB

Tackling health inequalities

We will take a three-pronged approach to tackle health inequalities, underpinned with strengthened partnerships and leadership in Place.

Civic

As partners in our five Health and Well Being Boards, Integrated Care Partnerships and Sheffield City Region we will support and advocate for public policies and strategies that improve the social determinants of health.

As anchor institutions we will maximise the impact that we can have on the wider social determinants of health in the way we run our organisations and support our staff. We will enhance social value in our commissioning, contracting and procurement processes. We will offer more apprenticeship and volunteering opportunities and be leaders in environmental sustainability.

Community

Recognising that most change happens in local communities we will continue to develop local neighbourhood partnerships and local community assets, help people to support each other and take control of their health.

We will:

- Involve local communities in priority setting, service design and evaluation.
- Strengthen local communities and social networks, including through investment in the voluntary, community and social enterprise sector.
- Build capacity for local people to be involved as volunteers, community champions and peer support workers.
- Make sure there is good access to local activities and support for people and groups at risk of poor health.

Health services

Through our core health services we will support people to manage their own health; support population health through the provision of high quality equitable primary care services; develop population health management capabilities and capacity to identify and address unwarranted variations in care. We will provide personalised care, focusing on what matters most to the person.

We will design services to meet the needs of communities with the greatest needs and prioritise services which have the biggest potential to decrease inequalities such as those for children and cardiac, diabetes, respiratory and cancer services . We will take measures to prevent or delay the onset of multi-morbidities and ensure good quality physical and mental health care for people with mental health conditions, learning disabilities and autism.

We will change the culture of the NHS to recognise prevention as a core responsibility of staff and services. We will ensure that prevention measures are commissioned, resourced and delivered at sufficient scale and in a sustainable way, ensuring those that are most disadvantaged benefit the most. We will undertake a range of actions, within the NHS's direct power to do, to support an improvement in the social determinants of health.

Wider determinants of health

Education
School readiness is similar to the national average. Fewer children in SYB achieve attainment 8 score. About 6% of 16-17 year olds are not in education, employment or training.

Employment
Fewer people in Barnsley and Sheffield aged 16-64 are in employment than the national average. Unemployment rates are higher in those with long term conditions.

Deprivation and income
SYB has high levels of deprivation. All Places, except Bassetlaw, have higher than average rates of children living in low income families.

Built and natural environment
Areas of poor private sector housing.
30% of adults who use mental health services and 20% of adults with learning disabilities do not live in stable or appropriate accommodation.
Air pollution is estimated to cause between 4.4% and 4.9% of all deaths in SYB.

Social capital and community safety
People using outdoor space for exercise is increasing but still only ranges from 14-19%. The percentage of those who have as much social contact as they would like is 40-49% for adult social care users and 28-43% for adult carers. Violent crime rates are higher than the national average, except in Sheffield.

Through our partnership working with the local authorities and Sheffield City Region we will influence and contribute to the development and implementation of a wide range of Place based strategies tackling wider determinants of health. There is also a range of practical actions that the NHS will undertake.

Education
We will support children to be ready for school and maximise their potential with improved provision of services such as perinatal mental health, early diagnosis and support for people with learning disabilities and autism and personalised health care for those with long term conditions and disabilities. Identification of children and families who need extra support early and provide tailored response.

Employment
As major employers in our local communities we will expand our work with local schools, colleges and universities to promote the wide range of NHS career opportunities, offer apprenticeship schemes, provide work experience and improve our staff welfare offer. We will also build on our Working Win pilot with the Sheffield City Region, set up Individual Placement and Support services for people with severe mental illness and enhance access to physiotherapists through Primary Care Networks for people with musculoskeletal problems and continue to improve mental health services.

Deprivation and income
Through social prescribing and working with local welfare advice services we will support people to access advice and support to claim welfare benefits and debt advice. We will be active partners in Sheffield City Region Inclusive Growth Plans.

Built and natural environment
We will collaborate with local authorities on planning for housing developments; engage with communities, public transport providers, Sheffield City Region and local authorities to improve links and walking and cycling routes and further develop active transport plans for hospitals; better integrate health services into local support for people who are or at risk of homelessness including providing specialist mental health services for rough sleepers.

Social capital and community safety
We will expand the provision of social prescribing; continue to invest in the voluntary sector; develop NHS volunteering opportunities for local residents and support our staff to volunteer; work with local communities to ensure NHS services are accessible and responding to local need. Health organisations will play their part in addressing the root causes of violence.

Developing a prevention led NHS

Cut smoking	Reduce obesity	Reduce alcohol related admissions	Lower air pollution	Tackle anti-microbial resistance

We will: Reduce % of adults in SYB who smoke to below 10% by March 24, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness.

Healthy Hospital Programme established. QUIT programme embedding the Systematic Treatment of Tobacco Dependency starting in all Acute and Mental Health Trusts early 2020

Wide range of activities across SYB on tobacco control, obesity, increasing physical activity, minimising harm from alcohol & improving air quality. High referral rates to Diabetes Prevention Program

Developing system level joint work with SYB Local Authorities:

- Enhancing social connectedness
- Increasing physical activity

Integrated approach to support people locked in a cycle of rough sleeping, addiction, poor physical health, mental health, and offending behaviour (Complex Lives)

We will work across the System to:

- Implement partnership place based plans for tobacco, alcohol, obesity, physical activity and air quality.
- Increase the provision of very brief advice within clinical practice. Provide SYB commissioned brief advice and behaviour change training for all new post holders in Primary Care Networks.
- Maximise the prevention opportunities afforded by the new Primary Care and Pharmacy Contracts.
- Further develop the scope of the SYB Healthy Hospitals Programme.
- Increase NHS health and wellbeing offer for staff.
- Implement the national antimicrobial resistance strategy.

Tobacco harm reduction:

- Roll out the QUIT programme so that from early 2020 all patients (except day case and maternity) admitted to acute and mental health trusts will be asked their smoking status and treated for tobacco dependency if a smoker.
- Further develop and implement plans to decrease smoking in pregnancy, supporting mother and family to quit.

Reducing obesity

- Work with Local Authorities and Sheffield City Region to promote physical activity. Embed physical activity as a treatment intervention in clinical care. Implement NHS healthy food standards.
- Increase referrals to the Diabetes Prevention Programme; Seek to be a pilot site for enhanced weight management support for people with a BMI of 30+ with Type 2 diabetes or hypertension and low calorie diets for diabetics.
- Review provision of tier three obesity services.

Reducing harm from alcohol

- Ensure all SYB acute Trusts have an alcohol care team, with a standard SYB service specification in line with national guidance, commencing during 20/21.

Improving air quality

- Complete clean air consultations in Sheffield and Rotherham and put recommendations in place
- Develop alternatives to face to face NHS appointments
- Encourage staff to travel sustainably and actively
- Install more electric charging points on NHS sites, green the NHS fleet and review energy use and supply

Population health management

- We will take a broad approach to population health so that we create the conditions for good health through our role as NHS anchor institutions, using our assets and developing approaches that help build on the strengths of local communities and increase social value.
- We will develop integrated and compassionate care offers in response to population health and care needs across our local neighbourhoods. We will reduce variation across population groups ensuring we improve health fastest in those with the greatest need. We will look at the whole population needs and not just those accessing services.
- We will improve the population health management capability across SYB using digital technology that will help to better understand the needs of the population. SYB is part of the Yorkshire and Humber shared care record programme which when will enable patient information to be shared across hospitals, primary and community care and social care enabling seamless integrated care regardless of where people are treated.

We will focus on:

Outcomes
Health and wellbeing outcomes are often measured as averages, which can hide large variations in outcomes between population groups. We will delve deeper to identify the differences using population segmentation techniques and set realistic expectations for improvement at Neighbourhood, Place and System.

Expectations
Expectations will be underpinned by a set of interventions and service or practice models that may need to be different from those that improve the health of all population groups.

Urgency
We will approach this with a new level of urgency, curiosity and vigour.

Ownership
We will have collective system ownership of the challenges and address them through mutually reinforcing actions.

Empowering people
We will empower local people and communities with support and tools to help improve health and wellbeing across SYB.

Interventions
The approach will inform the redesign of services to ensure they meet the needs of those with the most to gain. We will use evidence based risk stratification and segmentation tools to understand and meet our populations needs. We will use Patient Activation Measures to personalise wellbeing support and digital technology to support people to make healthy lifestyle choices.

Place progress: Sheffield has whole population linked data analytics capability and population health management intelligence dashboard. A pseudonymised linked data warehouse covers the entire GP population and can link all care services datasets at person level, including social care and modelled predictive risk values. Bassetlaw's Primary Care Networks are pioneering PHM approaches, working to undertake root cause analysis for key population segments

Reducing unwarranted variation

Our priorities

SYB has areas of unwarranted variation in access, quality, health outcomes and cost of health care services in primary care, secondary and tertiary care.

Differences between the quality of care and the clinical practice followed mean that, in some instances, patients across SYB receive different standards of care and potentially have different clinical and health outcomes. These variations can have significant financial implications.

We know from NHS RightCare that we have more people being admitted to hospital as emergencies with respiratory and cardiovascular disease and that we have marked inequalities in health. We also know from Getting it Right First Time that we have variations in the way services are provided and outcomes. Our challenge is to reduce unwarranted variations in care whilst improving care and outcomes overall and making cost efficiencies that can be reinvested in improving health across SYB.

We've made good progress in recent years, including the consolidation of provision of hyper acute stroke services, standardising commissioning across SYB for some procedures, supporting quality improvement in primary care, standardising a number of secondary care elective pathways and using RightCare and GIRFT data to inform planning, service reviews and Quality Innovation and Prevention Programmes.

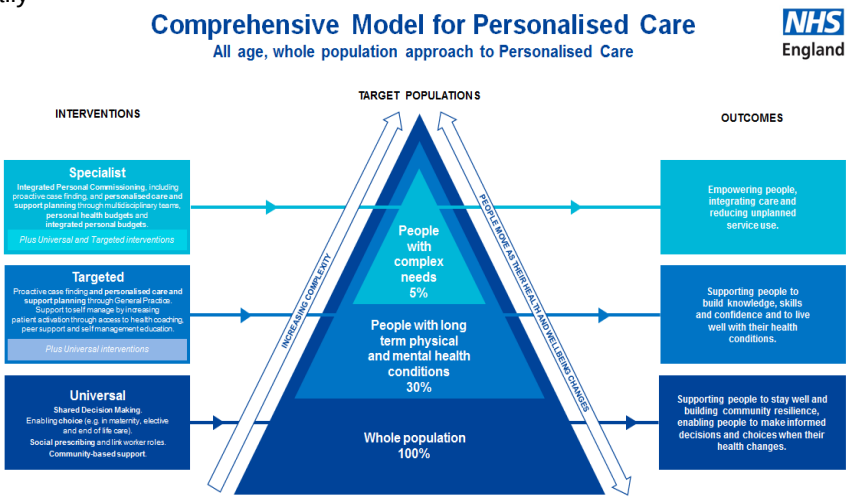
We will work across the System to:

- Work with the combined improvement offer from NHS England and Improvement eg RightCare, GIRFT
- Carry out an annual review of variation against peers on all our main programmes
- Strengthen our population health management analytical capabilities and review the support that's needed for Primary Care Networks
- Support Primary Care Networks to use the Network RightCare packs, national audits and other tools that support a reduction in variation
- Offer targeted support to primary care providers
- Systematically embed NICE and other national guidelines and standards
- Standardise clinical standards and reduce unwarranted variation with the Hospital Hosted Networks
- Continue work on the standardisation of outpatient pathways and the use of medicines
- Focus on cardiorespiratory and mental health
- Increase focus on prevention, with particular focus on reducing harm from tobacco, alcohol and obesity
- Put in place actions that will help to deliver consistent high quality care and access to care for vulnerable communities, such as physical health checks for people with severe mental illness or learning disabilities and continuity of care during pregnancy

Taking a person centred approach

Our progress

- Personalised care is a system wide priority and SYB places are providing personalised care approaches using the national personalised care comprehensive model. It is a key element of Primary Care Network development and supports out of hospital care and the Long Term Plan deliverables - prevention and early intervention, integrated community care and social prescribing
- SYB is one of 20 ICS' nationally to have committed through an MOU with NHSE to fully implement Personalised Care collaboratively across the system footprint by 2024
- Sheffield CCG is a exemplar site for Personalised Care supporting other systems nationally



We will offer personalised care through:

- **Choice**
- **Shared decision making**
- **Social prescribing and community based support**
- **Patient Activation Measurement and support for self-management**
- **Personalised care and support planning**
- **Personal health budgets**

Personalised care means people have a say in how their care is planned and delivered, based on 'what matters' to them, their individual needs and preferences

We will work across the System to:

- Systematically implement the Comprehensive Model for Personalised Care by 2023/24, working with primary care networks, wider NHS services, people with lived experience and partners in local government and the voluntary and community sector.
- Enable people to take more control of their health and care, providing more options, coordinated support and care at the right time and right place
- Make the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences
- Supporting people with long-term physical and mental health conditions to build knowledge, skills and confidence to live well. Also taking whole-population approaches to supporting people to manage their physical and mental health and wellbeing
- Develop our relationships with, and commissioning of, the local voluntary and community sector.
- Develop our Workforce, Learning and Development strategies to support health and care professionals to further develop their skills and competencies in promoting personalised approaches, choice and shared decision making.
- Further expansion of link workers in Primary Care Networks
- Ensure personalised care approaches are embedded in service redesign

Place progress: South Yorkshire and Bassetlaw are national leaders for Social Prescribing, with well established services in all five Places

Getting the best start in life

Children's services

Our progress

- We have established innovative out of hospital approaches and are looking to translate these across SYB.
- We have strong, mature networks including for children's surgery and anaesthesia and care of the acutely unwell child, through which we have developed new models and standardised pathways for common and urgent conditions.
- The Hospital Services Review recommended accelerating shared transformation for children's services

Our challenges

- 4/5 Places exceed the England average for the rate of children in low income families
- High neonatal/infant and child mortality
- High child obesity
- Insufficient uptake of some immunisations in some communities
- High under 18 conception rate
- Specialist workforce challenges with particular shortfalls in hospital children's services.
- Agency and locum use is high
- Integrated out of hospital care models exist but application is inconsistent
- Inconsistency in waiting times for some specialist services, such as ADHD, ASD and SEND

We are developing a Children's Hospital Hosted Network

We will:
Reach 95% of children having had 2 doses of MMR by age 5 by March 2022

We are learning from **great examples of integrated care in our Places**, such as the Rotherham team bridging acute and community paediatrics; Recruiting paediatric endocrine, respiratory and tissue viability nurse specialists in Bassetlaw; Integrated service for children with long-term conditions and disabilities in Doncaster and the early intervention and prevention models Healthy Minds and Sleep Project in Sheffield.

In mental health services, we are learning from Rotherham's approach to CAMHS/ASD/ADHD; Barnsley's eating disorder pathway and Bassetlaw's innovative use of the voluntary sector.

We will work across the System to:

- Leverage the power of the ICS, combining a public health approach and integrated service models, with pathways across primary, community and acute healthcare. We've already done this in our Places and will work to apply this learning consistently and equitably.
- Yorkshire and Humber regional MMR delivery plan is under development and will include great focus on health equity audit
- Create a Children's Hospital Hosted Network, bringing together existing networks, with shared aims and senior ownership. Two of our Trusts (Sheffield Children's and Doncaster and Bassetlaw) will explore closer working
- Continue the work of our networks, including embedding the children's surgery and anaesthesia model.
- Ensure a focus on workforce. The networks, along with our Deanery, Health Education England and academia will deliver an initial series of strategic options for an integrated, sustainable workforce.
- Take a systemic view of mental health services for children and young people to understand gaps in service and capacity across SYB
- Implement the Long Term Plan ambitions. We await and will participate fully in the children and young people transformation programme. Given the opportunity, because of our Royal College links, our mature networks, our specialist Trust and established ICS, we intend to apply to be one of the 5-10 systems chosen to develop an evidence-based approach to integrated care models.
- We will build in work on transitions, taking a 0-25 approach. This is already being evidenced by Sheffield's all-age mental health pathway and work in Doncaster for ADHD.

Getting the best start in life

Maternity services

Our progress

- Our Local Maternity System (LMS) has strong clinical leadership
- We have public health and prevention and perinatal mental health work streams
- The Hospital Services Review recommended accelerating shared transformation as the next step for maternity services

Our challenges

- High rates of teenage mothers and mothers over 35
- High rates of low birth weight and neonatal and post neonatal deaths
- High obesity and smoking rates during pregnancy and substantial numbers of mothers are classed as intermediate or high risk
- Workforce challenges with shortfalls in maternity and difficulty recruiting midwives and middle grade doctors. This has led to substantial spend on locums.
- Increasing continuity carer will be challenging with existing workforce pressure.

We will:

Reduce the % of women in SYB who are smoking at time of delivery to 6% by March 24

We exceeded the Continuity of Care standard as at March 2019 – 22.3% vs 20% target

4/5 Places have very low breastfeeding rates at 6-8 weeks

We will work across the System to:

- Develop a comprehensive strategic approach from pre-conception to transition into children's services
- Create a Maternity Hosted Network (MHN) to work in parallel with our Local Maternity System (LMS) with shared aims and senior ownership
- Undertake a comprehensive review of smoking in pregnancy and implement a range of measures to reduce the percentage of women who are smoking at time of delivery and post natally
- The MHN will focus first on workforce and reducing clinical variance
- The MHN and LMS will continue Better Births implementation, ensuring all plans are fully integrated with wider system plans, such as children's and neonates
- Develop shared approaches to delivering increased Continuity of Care standards and improvements in breast feeding rates
- Ensure that the needs of disadvantaged and vulnerable communities are embedded within our plans to reduce inequalities
- Build on good practice in our Places such as Sheffield's plans to support people in high risk groups (eg diabetes and maternal obesity) to access services
- Develop plans to deliver strong and equitable midwifery led, community and home birth choices in each of our Places. We will build on the good practice in Rotherham where three community midwifery hubs have been introduced
- Work across all our providers to develop a consistent midwifery led approach

In Place:

- We are investing transformation funding to deliver *Better Births*
- We have specialist perinatal mental health services in some of our Places
- Each of our Places has a developing and maturing Maternity Voice Partnership

We are developing a Maternity Hospital Hosted Network

Major health conditions

Mental health

We Will:
Reduce the life expectancy gap between people with severe mental illness and learning disabilities and the general population

We will:
Reduce suicide rates across SYB

Our progress

- On track to deliver majority of Five Year Forward View ambitions
- Funding secured for 2018/19 and 2019/20 with plans in place to deliver enhanced suicide prevention programme
- SYB wide IPS employment service commissioned for people with severe mental illness
- Enhanced perinatal mental health service launched in Doncaster, Rotherham and Sheffield
- 24/7 liaison mental health services established in Sheffield and Rotherham and funding secured for Barnsley and Doncaster
- Approval gained to establish New Care Models for three specialised services through NHS-led provider collaboratives
- Dementia diagnosis rates remain high across the ICS
- All CAMHS LTPs received fully assured status from NHSE and successful Green Paper Trailblazers in Doncaster, Rotherham and Sheffield and waiting list initiatives in Barnsley and Sheffield
- Workforce transformation project targeting high risk areas

Our challenges

- Increasing demand on mental health services and addressing existing inequalities in health outcomes and life expectancy.
- Maintaining stable and resilient services whilst transforming to meet the Mental Health Investment Standard, Five Year Forward View for Mental Health and LTP commitments
- Enabling more children and young people to access community mental health services and expanding core community teams for adults and older adults through NHS led provider collaboratives for those with severe mental health illnesses (SMI).
- Growing the mental health workforce to deliver quality timely care
- Variation in access and uptake of physical health checks
- Working across boundaries that reside in other ICS footprints
- Suicide rate has reduced, but remains high for some groups.

An integrated approach to support those with complex lives in Doncaster is already demonstrating improvements in outcomes.

We will work across the System to:

- Work with partners to develop an all age service and investment strategy, digitally enable care and support and develop the mental health workforce.

Children and Young People Mental Health

- Continue to deliver on our commitment to invest in and expand access to mental health services for children and young people, expanding community provision.
- Continue to develop specialist community perinatal mental health provision
- Continue to prioritise eating disorders with collaborative commissioning
- Expand timely age appropriate crisis services (24/7) including implementation of Intensive Home Treatment services
- Implement mental health support teams in schools to enable early intervention and offer ongoing support
- Develop a strategic approach to service provision 0-25, including those 18-25 to support transition into adulthood as part of an all age strategy.

Adult Mental Health

- Work with partners to delivery the suicide prevention programme including further development of real time surveillance and bereavement support
- Adult Common Mental Illness – Continue to expand IAPT for adults/older adults with a focus on those with long term conditions.
- Severe Mental Health Problems – As a pioneer, trial new and integrated models of primary and community mental health care to support adults/older adults with severe mental illness. Work to increase uptake of physical health checks. Improve physical health with a particular focus on reducing harm from tobacco, obesity & improving cardiorespiratory health.
- Emergency Mental Health Support – Expand services for people experiencing a mental health crisis to include 24/7 age appropriate access to crisis resolution, home treatments and alternative provision. Work with the ambulance service to improve crisis response options, including staff training, response vehicles and expanding the use of 111.
- Therapeutic Mental Health Inpatient – Provide therapeutic environments and work to reduce longer lengths of stay and reduce out of areas placements.
- Problem gambling – Understand the problem in SYB and collaborate regionally on development of specialist clinics.
- Rough sleeping mental health support –Further understand the problem and work collaboratively with Local Authorities to develop approaches to improve outcomes.

Major health conditions

Learning disabilities and autism

Our progress

- Highest reduction of inpatients nationally, significant reduction of admissions and reduced length of stay in line with learning disabilities (LD) senate guidelines.
- Implemented intensive support teams – now running extended hours, demonstrable success with preventing admissions
- Implemented forensic outreach liaison services and a forensic step up/step down service on transforming care footprint
- Developed key partnerships with experts by experience who are involved in all aspects of the transforming care programme in line with the ladder of participation methodology
- Proactively rolling out LD/Autism awareness training to GPs acute trusts and other mainstream services, delivered by experts by experience
- Developed an exemplar Dynamic Support Protocol for children and young people which is being rolled out in other areas
- Led on the development and implementation of the Yorkshire and Humber enhanced community framework, leading the way with referrals and new ways of working to improve the community offer.
- Embedded learning disabilities and autism into the ICS mental health and learning disabilities programme, to ensure alignment with all age mental health

Our challenges

- Reducing health inequalities for people with learning disabilities due to low uptake of screening and variations in numbers and quality of annual health checks
- Waiting times vary for children and young people and adults for diagnosis of autistic spectrum disorders (ASD)
- Addressing gaps in provision of post-diagnostic support for autistic children and young people, autistic adults and their families
- Ensuring services work in an integrated way and pathways are seamless across all ages regardless of geography.
- Workforce, both lack of workforce and workforce with the right skills
- Housing, lack of appropriate housing for people with learning disabilities and autism including general and specialist

We will work across the System to:

- Ensure people who are still living in hospitals are discharged in a timely manner, supporting the local markets and systems to facilitate discharge
- Further invest in intensive community support provision including children and young people, increasing extended hours and crisis response to meet the needs locally and to focus on preventing admission into hospital
- Promote health and wellbeing through My Health Day events targeting people and families with LD and/or autism, raising awareness of annual health checks, STOMP/STAMP, Hospital Passports, Screening programmes
- Continue to roll out the coproduced and co-delivered LD/Autism awareness training until the mandatory training is in place
- Roll out a programme of training around the LeDeR learning priorities utilising the ECHO platform to embed the learning across the system
- Increase the number people receiving AHC's, by working as a system to ensure the right support and reasonable adjustments are in place to deliver the 75% target
- Increase number of children receiving Care, Education and Treatment Reviews (CETR) prior to hospital admission by looking at developing a CETR hub to provide additional capacity to meet the increasing demand and provide a sustainable system for delivery and assurance
- Work with families and people with lived experience to improve pathways and experiences for ASC/ADHD, utilising transformation monies to fund pre and post diagnostic support working with the voluntary sector
- Bring to life the Autism Friendly Charter (under development)
- Work to secure funding to develop a strategic housing needs assessment for people with learning disabilities and autism
- Develop a joint workforce delivery plan to identify gaps and review new roles and new ways of working to address some of the gaps
- Develop the concept of providing neuro disability services on a 'holistic whole family – life span' approach
- Support vulnerable groups from becoming involved in crime
- Work with digital work stream to ensure digital flagging of patients with learning disabilities and autism and ensure QOF registers are up to date and information about AHCs logged appropriately and self-management apps

Major health conditions

Cancer

Our progress

- Our Cancer Alliance is a key partner in driving the radical upgrade in prevention. The Alliance is supporting the QUIT programme to reduce preventable deaths from tobacco use
- Established a clearer understanding of our inequalities and the communities more likely to be diagnosed later
- Launched Be Cancer SAFE social movement to help address inequalities
- Promoted earlier diagnosis by enabling primary care to implement new tests and care pathways
- Invested in our hospitals to deliver RAPID pathways to coordinate tests to provide faster diagnosis
- Our specialist cancer centre, Weston Park, has improved facilities, their research profile and are testing new models providing chemotherapy closer to home
- Enabled a thousand more people to access information and support in their local communities through meaningful conversations.

Our challenges

- The number of people being treated for cancer is expected to rise from 14,000 to more than 18,000 by 2030. Over 5000 cancers could be prevented through behaviour changes.
- SYB has a significant gap from the national ambition to have three in four people diagnosed at stage one or two.
- This burden on demand is creating additional pressure on diagnostic and treatment capacity and ability to deliver national operational standards.
- Variation in access, care pathways and outcomes.

We Will:
Increase the percentage of people with cancer who are diagnosed at stages 1 and 2

We will:
Improve 1 and 5 year cancer survival rates

1 in 2 people are currently diagnosed at a late stage, with many through the emergency route

1 year survival is improving and narrowing the gap from the England average

5 year survival remains significantly worse than the England average

45,000 people living with and beyond cancer expected to rise to as many as 78,000 by 2030

The Cancer Alliance will work across the System to:

- Drive prevention priorities around alcohol, obesity and physical activity in addition to smoking
- Utilise Primary Care Networks to further engage communities to reach optimal uptake of vaccination and cancer screening with the biggest increase in those living in most deprived areas
- Introduce lung health checks and rapid diagnostic centres to enable earlier and faster diagnosis
- Embrace innovation and research to bridge the gap on early diagnosis with the SYB Innovation Hub.
- Build and network diagnostics to enable our workforce to operate as a single cancer service to meet demand and deliver national operational standards
- Ensure equitable access to optimal and personalised treatment including access to national and international clinical trials
- Support capital investment plans to ensure specialist cancer services are developed at Weston Park and care in communities closer to home
- Continue to adopt personalised care and support through a ‘What Matters To Me’ approach

Place progress: Doncaster is leading our participation in the national lung health checks programme

Major health conditions

Stroke care

Our progress

- Following consultation, hyper acute stroke services are now centralised in Doncaster, Sheffield and Wakefield to enable equitable access to high quality care, improve outcomes and provide sustainable provision.
- Sheffield Teaching Hospitals are delivering mechanical thrombectomy with plans to expand access over more hours per week.
- Direct to scan pathways have been implemented in Doncaster and access routes redesigned in Sheffield.
- All SYB stroke units contributed to the Hospital Services Review and work to review the wider pathway.

We are developing a Stroke Hosted Network

Our challenges

- Stroke can be prevented and a leading cause of death and disability. Mortality has decreased, but survivors with a disability has increased
- Most SYB stroke units are improving their performance on the Sentinel Stroke National Audit Programme (SSNAP) but there is still significant variation in care
- SYB thrombolysis rates are below the national average.
- Specialist workforce challenges and shortfalls
- There is significant variation in the commissioning and care delivery of the post HASU pathway, particularly for stroke rehabilitation

Place progress: There are existing models of good practice in our Places – eg In patient rehabilitation in Sheffield and early supported discharge in Rotherham

We will work across the System to:

- Develop a Stroke Hospital Hosted Network (HN), with clinical and managerial leadership hosted by Sheffield Teaching Hospitals, and bring together all partners across the stroke pathway, including ambulance services and the Stroke Association to act as the SYB Integrated Stroke Delivery Network
- Work through the Network to reduce stroke incidence by making links with CVD prevention work, increase public awareness of TIA symptoms, need for urgent care and tackle variation in delivery.
- Develop networked provision to deliver the NHS seven-day standards for stroke care and the National Clinical Guidelines for Stroke.
- Embed the centralised hyper acute service and realise the benefits, including equitable access to high quality specialist care and increased access to thrombolysis for eligible patients.
- Work with Health Education England to modernise the stroke workforce, focussing on cross speciality and cross profession accreditation and exploring the use of new roles, including Advance Care Practitioners and new ways of working.
- Enable more consistent access and delivery of stroke rehabilitation. Focus on integrated out of hospital higher intensity rehabilitation models working with the voluntary sector.
- Ensure that early supported discharge is routinely commissioned as an integrated part of community stroke services
- Work with Sheffield Teaching Hospitals to increase availability and equitable access to mechanical thrombectomy, by supporting workforce planning, collaborative working with other neuroscience centres and the use of technology.

Major health conditions

Diabetes

There are **137,000** people at high risk of developing Type 2 Diabetes in SYB

Our progress

- Expanded provision of nationally accredited structured education programmes and set up a digital pilot in Barnsley.
- Targeted upskilling of primary care to improve achievement of treatment targets and prevent complications.
- Achieved full coverage of the NHS Diabetes Prevention Programme hosted by Bassetlaw in September 2017 and over 9600 referrals to the programme have been made.
- Implemented a 7 day diabetes nursing service at Doncaster and Bassetlaw Teaching Hospitals.

Our challenges.

The estimated prevalence of diabetes (16+) is **8.6%** of SYB population, similar to the England average

- Type 1 diabetes cannot be prevented and is not linked to lifestyle, but Type 2 diabetes is largely preventable through lifestyle changes.
- The cost of diabetes to the NHS is high and the majority of this is currently on treating complications.
- One in every six people in hospital has diabetes. Although diabetes is often not the reason for admission, they often have a longer stay in hospital, are more likely to be re admitted and their risk of dying is higher. More than 500 people with diabetes die prematurely every week.
- There is significant variation in the management of diabetes across SYB and variable achievement of the NICE treatment targets.

Place progress: Sheffield has reduced the average length of stay for people with diabetes and achieved a measurable reduction in severe foot ulcerations.

We will work across the System to:

- Establish a Diabetes Programme Steering Group (DPG), that will oversee the implementation and delivery of the national diabetes programme and all the diabetes LTP commitments in SYB.
- Expand access to the 'Healthier You' NHS Diabetes Prevention Programme to deliver the required (6044) places by 2023.
- Work to ensure that the recently expanded structured education, multi-disciplinary footcare team and diabetes specialist nursing capacity is sustained.
- Work with Primary Care Networks to support them to target support to reduce health inequalities and the decline in treatment target achievement.
- Lead the implementation of the national online education platform for Type 2 diabetes in line with national timeframes.
- Pilot and evaluate 'low calorie diet' programmes aimed at achieving remission for obese people with Type 2 diabetes.
- Ensure that pregnant women with Type 1 diabetes are offered continuous glucose monitoring from April 2020.
- Work with the relevant clinical network to improve the quality of care for children living with diabetes and improve transition to adult services.
- Work with clinical services to ensure equity of access to high quality services for all, including making reasonable adjustments for people with learning disabilities and severe mental illness.
- Evaluate and share learning from the digital pilots.

Major health conditions

Respiratory

Our progress

- Supported the development of the SYB QUIT Tobacco dependency Programme.
- Completed a baseline assessment in each SYB place against the North Respiratory Programme for 2018/19 and developed plans to improve respiratory care pathways
- Our places have over the last 3 years prioritised respiratory disease as a key focus to support more people in the community
- Initiated a review through our ICS Urgent and Emergency Care workstream to reduce respiratory related admissions to hospital

Our challenges

- Respiratory disease is a leading cause of death, Barnsley, Rotherham and Doncaster have significantly higher under 75 mortality rates from respiratory disease.
- We know from NHS data and intelligence there is unwarranted variation in respiratory outcomes and care in SYB such as detection rates of COPD, provision of spirometry, uptake of pulmonary rehabilitation and the prescribing and use of medicine.
- Emergency admissions for respiratory place significant pressure on the urgent & emergency care system, particularly during the winter period.
- High smoking rates

We will:

Reduce % of adults in SYB who smoke to below 10% by March 24, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness

Respiratory disease is a leading cause of death in SYB

Barnsley, Rotherham and Doncaster have significantly higher under 75 mortality rates from respiratory disease

We will work across the System to:

- Establish a clinically led respiratory network to reduce variation, accelerate improvements through the sharing of best practice and standardise respiratory care pathways to improve quality and outcomes
- Participate in the North STP Leaders Programme to ensure that the SYB ICS benefits from collaborative working across the North of England.
- Work with our primary care networks to provide more care closer to home including improving the diagnosis and management of respiratory disease, supporting clinicians and professionals to use systematic tools to identify those at risk.
- We will utilise new roles and approaches in case management in a way that benefits those with respiratory conditions, including clinical pharmacists to optimise medicine use, physician associates and more specialist nurse roles in the community.
- Improve uptake of pulmonary rehabilitation, working with partners such as the British Heart Foundation, British Lung Foundation and Universities to improve access to and completion of rehabilitation.
- We will work with patients and families to develop new models of pulmonary rehabilitation that are more tailored to peoples needs for rehab
- Improve the response for people with pneumonia by reviewing existing pathways and working with public health to maximise the update of flu and pneumococcal vaccination for at risk groups and health care staff.

Place progress: Rotherham has developed a new breathing space facility for outpatients which is delivering excellent results

Major health conditions

Cardiovascular Disease

Our progress

- Member of North ICS CVD group and SYB CVD Prevention Task Group and Clinical Lead in place
- SYB is close to the national ambitions for Atrial Fibrillation detection and anticoagulation. Primary care development schemes are supporting quality improvement
- Sheffield is piloting a community pharmacy and GP hypertension shared care arrangement
- All Places have BNP pathway. Consistent referral guidelines in place for secondary care echo referrals
- Barnsley is redesigning its heart failure pathways

We will: Reduce premature mortality from cardiovascular disease, improving fastest in the areas with highest deprivation

Our challenges

- CVD is a major contributor to our health inequalities. Deaths from CVD are the second biggest contributor to the gap in life expectancy between SYB and England
- Although premature mortality from CVD has decreased in SYB over the last two decades, all Places in SYB (except Bassetlaw) still have significantly higher under 75 mortality rates than the English average
- High rates of the key risk factors for CVD.
- Barnsley has next to highest non-elective spend on CVD in the country and Doncaster and Sheffield have higher non-elective spends than their RightCare peer group average
- Significant unwarranted variations between GP practices in diagnosis/management of patients with or at risk of CVD and uptake of cardiac rehab is low
- Suboptimal proportion of patients post NSTEMI are receiving their angiography +/- percutaneous coronary intervention within NICE recommended timelines.

More than 1,000 people under 75 die every year from CVD in SYB

Under 75 CVD mortality rates are 4 times higher in the most deprived areas of SYB, compared to the least deprived

We will work across the System to:

- Prevent CVD – see the section on developing a prevention driven NHS
- Detect early and improve treatment of CVD and its risk factors. We will:
  - Move towards the national ambitions for Atrial Fibrillation, blood pressure and CVD risk
  - Decrease unwarranted variations by providing targeted support to GP practices; support use of CVD Prevent audit; develop quality improvement and population health management capacity and support for primary care
  - Maximise the opportunities of the additional roles in Primary Care Networks and the new community pharmacy contract. SYB CVD training course to be commissioned. Learn from national Atrial Fibrillation pilots
  - Expand the Sheffield community pharmacy shared care hypertension pathway across SYB, if pilot evaluation positive
  - Identify patients who may have Familial Hypercholesterolaemia
  - Link with the Mental Health and Learning Disability work to ensure a focus on CVD within severe mental illness and learning disability Health Checks
  - Continue to work with Local Authorities, to support the delivery of Health Checks
  - Work with Yorkshire Ambulance Service (YAS) and our community and voluntary sector partners to develop CVD prevention champions
  - Support the public with opportunities to check on their health
  - Support practices to enhance their support for patients with or at risk of CVD to self manage eg develop peer educators
- Develop agreed messages for the public, patients and professionals to ensure consistent approach on CVD prevention
- Work with YAS on their restart a heart campaign and support schools in SYB implement CPR training
- Work with partners (British Heart Foundation, British Lung Foundation, universities) and patients to redesign cardiac rehabilitation (including digital options) to increase uptake
- Review GP direct access to echo across SYB & share learning from Barnsley on Heart Failure pathways
- Through the Specialised Cardiac Improvement Programme (SCIP) improve acute care and decrease variations in access to angiography

Reshaping and rethinking

how we flex resources

System finance

As a high performing ICS, we have had access to offsets and used this effectively in delivering the 18/19 financial position.

The System delivered strong financial performance despite significant local and national challenges. Each of our Places delivered a performance better than that planned at the start of the year and only one organisation did not meet its individual control total and was supported by the System to ensure that they received their full share of PSF.

The ICS financial performance at the end of the year was better than planned at £19.6m (excluding PSF). This was a very positive performance and forms a foundation for continued investment in services or infrastructure for the coming years.

The strength of the financial performance is a testament to our collaborative approach. However, much of the surplus has been generated through non-recurrent measures. Next year remains a challenging financial year and requires the continued robust management of finances.

Transformation funding

We have had access to transformation funding over the last three years and been able to invest significantly in primary care (including access funding, digital funding and cancer), secondary care (including mental health, urgent and emergency care, pathology and maternity) and prevention (including suicide prevention, care homes and social prescribing)

Indicative additional transformation funding of £129 million the next five years will enable us to deliver our plan.

Commissioning development

Across South Yorkshire and Bassetlaw, commissioning has already started to evolve and adapt to meet the needs of people and patients. This is in line with the NHS Long Term Plan and ensures a stronger focus on population health, the impact on the wider determinants of health and reducing health inequalities. This builds on the work of the Joint Committee of Clinical Commissioning Groups.

In each of our Places, NHS commissioners continue to develop closer working with local authorities; enabling joint working, joint teams and supporting and enabling the development of neighbourhood working, integrated primary and community care and the development of Primary Care Networks.

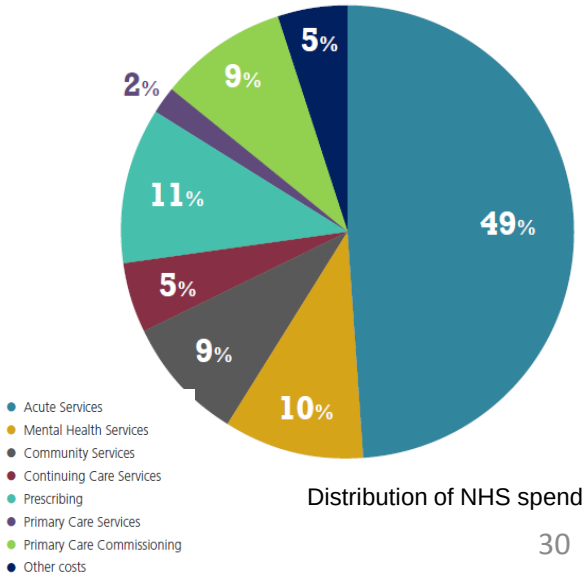
Across the System, commissioners are working jointly with providers to agree joint ambitions and outcomes for the health of their shared population together and will continue to plan together where it makes sense to do so – especially where we can reduce variation in standards, quality or access to services.

We are committed to building on this work and strengthening our ability to deliver our ambitions by having further developed arrangements in place for April 2021.

NHS and social care spend within South Yorkshire and Bassetlaw

The expenditure of the five clinical commissioning groups totals £2.5bn in 19/20 and the spend is as shown. In addition, there is further £0.5bn on specialised commissioning and the Local Authorities spend £1.4 billion on social care.

To deliver our ambitions, we will need to flex our resources. A population health approach and a focus on prevention will mean a shift in our investment thinking and planning, which will result in a different share of the overall spend.



Distribution of NHS spend

Reshaping and rethinking

Estates

We will move from a functional approach to Estate Management …

Hospitals

- £1bn of hospital assets
- 44 separate acute and mental health sites
- £160m of backlog maintenance categorised as critical and high

Primary Care

- 316 separate GP, third party, NHSPS and CHP assets
- £44m of estate running costs

Disposals

- 17 different Disposal sites identified
- £28m opportunity
- (£24m fair share disposal target from Naylor Review)

Finances

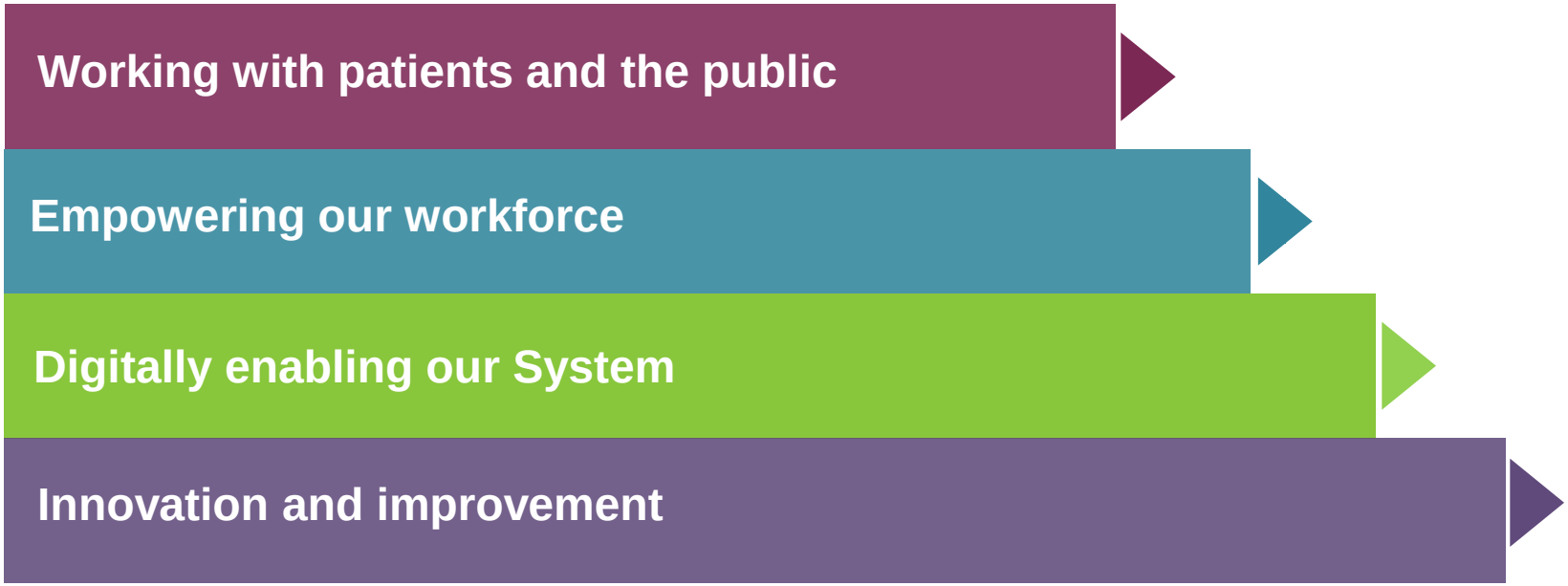
- £20m of Wave 1 and Wave 2 schemes (Yorkshire Ambulance Service, Barnsley Hospital, Doncaster and Bassetlaw Teaching Hospitals, Sheffield Teaching Hospitals)
- £118m planned investment in 19/20 (incl £7m information management and technology and £19m equipment)
- Over £400m planned investment through to 2023/24
- £60m annual depreciation
- £150m working capital balances

… to a System approach

Acute and mental health	Primary care	Digital and IT
High quality and fit for purpose, sustainable estate which reflects modern patient needs and experience	New facilities reflecting new models of care	Full connectivity
Improved resilience through reduced backlog maintenance	Support a left-shift in provision	Systems which support data sharing and collaboration
New facilities reflecting service developments	Reconfigured existing estate to enable changes in ways of working	Modern IT infrastructure
No redundant estate	No redundant estate	
	Asset Optimisation	
	£57.5m Wave 4 capital	

Section 2: Strengthening

our foundations



Working with patients and the public

Our progress

- We have built on the strong communication and engagement networks in SYB enabling us to deliver consistent messages through trusted sources
- Strengthened our relationship with the SYB Healthwatches and organisations that work with seldom heard communities which have undertaken engagement on our behalf
- Undertaken extensive involvement work with public and patients to inform the work of the Hospital Services Review
- Worked with community, patient and voluntary groups as well as staff to inform work across a range of areas, including NHS 111 procurement, over the counter medicines, hip and knee pathways, ophthalmology services, autism, emergency admissions from care homes and stoma care
- Carried out comprehensive involvement with staff, patients, public and stakeholders on the NHS Long Term Plan to inform our Five Year Plan
- Established the SYB ICS Guiding Coalition – a strategic advisory forum which includes voices from primary and secondary care clinicians, local authorities, voluntary sector and the public
- Established the SYB ICS Citizens' Panel, bringing together people from across the region to provide an independent view on matters relating to work at System level
- Established a Transport and Travel Panel with patients and the public, also from across the region, to look at the potential impact changes to services would have
- Developed a System involvement duty assurance process

Our challenges

- Shifting people's view from organisation to Neighbourhood, Place and System
- Articulating the benefits of working across a System to patients, communities and staff
- Working in a matrix style across partners' communications and engagement functions

We will work across the System to:

- Meet as a Guiding Coalition twice a year to discuss and agree our strategic direction
- Strengthen our links across partner communications and engagement teams to carry out System involvement and meet duties
- Build on our work with the Citizens' Panel and develop an online membership model to support our involvement work on transformation
- Explore how we can triangulate patient experience data from all partner sources to develop a System profile approach to involvement

Long Term Plan involvement

We worked with our Healthwatches and together we connected with over 1500 people who shared their views through completing the survey online and face-to-face. We also connected with staff and the public through our partner organisations, our ICS Staff Side Forum, other forums and at events. We also asked our MPs and Health and Wellbeing Boards what they thought. Both the Healthwatch report and other key theme findings have all been shared to inform the development of our Plan.

Key themes from our involvement:

- Seamless pathway of care / true patient-centred care
- Focus on prevention
- Integrated working across teams and organisations
- Integration and improvement of IT systems/digital technology
- Equality within the System
- Improved staffing conditions
- More care provided in homes/in communities
- Social care reform
- Better leadership/senior management

Our involvement work routinely connects with people from seldom heard communities such as asylum seekers, the deaf community, prisoners, young people, people with visual impairment, older people, black and minority ethnic communities, pregnant women and new mothers, Chinese community, people with mental health issues, people with drug and alcohol issues and veterans. We also connect with the 'working well' through our links with South Yorkshire and Bassetlaw employers

Empowering our workforce

We employ over 48,000 members of NHS staff - 72,000 if we include all health and care workers - who work to meet the needs of 1.5 million people across South Yorkshire and Bassetlaw

Our progress

- Established an ICS Workforce Hub to support co-ordination of activities across Place and System level
- Commenced core programmes, including: Primary Care Workforce Training Hub, South Yorkshire Regional Excellence Centre and Faculty of Advanced Clinical Practice
- The Barnsley Partnership is delivering a Workforce Transformation plan for out of hospital workforce based on population health. This is supported by a Barnsley wide OD plan, workforce strategy and talent management strategy.
- Launched collaborative staff banks and implemented agency procurement
- Increased portability of staff between organisations
- Supported increase in Advanced Care Practitioners across primary, community and mental health care
- Supported partners to work collaboratively on national initiatives including NHSI Retention Programme
- Delivered eRostering “Masterclass” Programme
- Developed an Allied Health Professions Council

SYB trusts report more than 800 nursing and midwifery vacancies

Our challenges

- Tackling vacancy gaps in supply and demand impacting our workforce, particularly across nursing
- Aligning workforce planning with service, activity and finance.
- Strengthening the primary and community care workforce to enable care closer to home
- Developing the mental health workforce
- Making the NHS the best place to work, improving retention and engagement
- Work with our schools to promote the NHS and social care to promote health and social care as a career of choice
- Making prevention a core element of every staff member role.
- Equipping existing and future senior leaders to operate successfully system wide in our evolving ICS
- Developing a co-ordinated approach to talent management, with focus on diversity and inclusion

Strengthening primary care workforce is a priority for the ICS

To support sustainable services and enable care closer to home, we have introduced a Primary Care Workforce Hub supporting:

- Growth in number of GPs
- Development of Primary Care Network Additional Roles such as 1sk Contact MSK practitioners
- Delivery of a Primary Care Nurse Vocational Training Scheme
- Coordination of Undergraduate Nurse Placements Across SYB
- Delivery of targeted apprenticeship scheme for healthcare assistants
- Recruitment of GP Fellows to support transformation projects
- Delivery of a SYB wide Practice Manager Conference
- The roll out of a data collection/workforce tool
- The introduction of physician’s associate role across general practice

Empowering our workforce

We will work across the System to:

Make the NHS the best place to work:

- Take a System approach and implement the new national core offer for staff
- Build on NHSI/NHSE programmes to improve retention
- Support Places, align systems around national Health and Wellbeing Framework
- Improve our health and wellbeing offer to staff
- Monitor sickness, violence and bullying and harassment and target support linking to regional and national programmes

Improving leadership culture

- Promote an agreed systems leadership framework
- Optimise use of external provision and commission system leadership at ICS level only
- Ensure current and future senior leaders access and use leadership development
- Address the cultural barriers in and between organisations and build trust
- Co-ordinate Talent Management Boards, workstreams and colleagues to ensure integral part of senior Boards, Committees and key forums
- Develop a system wide approach to retain and fully use our talent
- Build HR capability

Tackling urgent nursing shortages and securing current and future supply

- Develop system level approach to strategic workforce planning
- Accelerate new roles across key professional groups
- Work together to attract staff to SYB as a place to live and work
- Support values based recruitment to attract and retain staff
- Engage partners on collaboration of international recruitment
- Set up a Placement Pilot Scheme to increase and improve placements
- Implement the Future Workforce Programme including schools engagement and employability
- Scale up apprenticeships and access to training to upskill our workforce.
- Develop the voluntary sector as a partner within the system, with VCS staff, volunteers and unpaid carers provided with the same access to support as staff within the statutory organisations

Releasing time for care

- Deliver e-workforce strategy building on ICS eRostering "Masterclass" programme
- Collaborative bank and agency management

Delivering 21st century care workforce redesign

- Develop Healthy Hospitals Programme
- Enable flexible/streamlined movement of staff between trusts
- Regional Excellence Centre and Faculty for Advanced Clinical Practice
- Implement of collaborative staff banks across medical and nursing
- Embed System level approach to new roles across primary and secondary care eg Trainee Nurse Associates, Advanced Care Practitioners, Physician Associates
- Engage with AHSN on workforce innovation
- Develop primary care workforce training hub

Developing a new operating model for workforce

- Build on existing framework and agree system level workforce responsibilities
- Develop ICS "Workforce Hub" offer
- Develop system wide strategy for education, training and development
- Implement improved governance including a Strategic Workforce Group and strengthen links between strands
- Support hosted clinical network development and co-ordination of professional councils eg AHPs
- Further develop our partnerships across unions, education and local authorities

Analysis, insight and affordability

- Oversee workforce planning at System level
- Work collaboratively to develop intelligence systems

Digitally enabling our system

Our context

Digital remains a key enabler for us and there is significant ambition to deliver digitally enabled care.

There is a mixed economy across SYB that needs to be resolved through implementing the basic digital capabilities for integrated care, whilst providing a framework to allow for innovation and more mature Places to go further faster but in an aligned manner.

Technical standards are critical to enable integration and standardisation in the delivery of digital services (includes online and offline e.g. phone), which SYB needs to adopt in line with published national standards.

Digital themes

A set of digital themes have been developed based on the needs, priorities and objectives of our transformation workstreams, such as prevention, as well as the relevant digital delivery challenges and capability/category types.

Draft priorities, roadmap, framework

The digital themes and phases have been merged to create a draft roadmap/ framework.
Phases have been developed to structure and prioritise the delivery of digital enablers. They support aligned delivery, which can be done in a more agile and incremental approach, where organisations and places can learn from, support and collaborate with one another.

Phase 1 - Establishing the basic digital capabilities for integrated health and care

Phase 2 - Greater use of information and advancing capabilities to improve health and care delivery

Phase 3 - Digitally enabled citizens, professionals and system

Impacts and Implications

There are many implications of this proposed strategy, which include 1) significant increase in funding required, 2) additional capacity within clinical/service leads, operational teams to take on the business change and digital delivery, 3) increased risk appetite, 4) more 'digital/agile' delivery culture to prototype changes, deliver incrementally, 5) greater focus on system requirements from organisations, e.g. consider use of existing systems, consider system requirements within procurements.

Digitally enabling our system

Across the System we will:

- Deliver stable, performant, secure (including cyber security) and cost effective infrastructure across SYB, resolving backlog IT maintenance that is a corporate risk
- Achieve 100% compliance with mandated cyber security standards across all NHS organisations by summer 2021
- Deliver unified/integrated health and care records across SYB for professionals and citizens which integrate with the Yorkshire and Humber Care Record
- Provide all citizens with an online/digital service to manage their health and care needs, with provision for those digitally excluded
- Develop basic capabilities to fully digitise Primary Care and Primary Care Networks delivered by 2022, including shared record, citizen access, a Population Health Management capability and support infrastructure services
- Ensure all secondary care providers – acute, community and mental health are fully digitised by 2024
- Deliver a Population Health Management capability across SYB, which integrates with the Yorkshire and Humber Care Record PHM capability
- Establish a consistent maturity of Electronic Patient Record services in NHS Providers and Social Care [GP / Primary Care has this already]
- Establish a hub for digital innovation across SYB, which integrates with the Yorkshire and Humber Academic Health Science Network
- Establish a set of Digital Principles and Standards, which all organisations and Places will commit to and will support more effective system working to deliver digital enablers
- Ensure all service/clinical transformation is underpinned by user centred service design approaches to ensure digital enablers support whole person pathways and wider transformation activity

Principles and Standards

Seven principles and standards have been developed to support more effective system working across SYB by organisation leaders, digital leaders and their teams, wider users and stakeholders, and to guide digital delivery and investment decisions. The draft standards are available in the Annex

Innovation and improvement

Our progress

- The SYB ICS has partnered with the Yorkshire and Humber Academic Health Science Network (AHSN) to establish an Innovation Hub which will become the vehicle for system-wide innovation
- The Innovation Hub began operations in June 2019 and is staffed by individuals knowledgeable in innovation who are embedded into the SYB ICS
- To help establish the processes of engagement with the Hub, a number of Innovation exemplar projects have been developed that target major system wide unmet needs

Our challenges

- Knowledge and awareness of innovations that can help improve practice and address unmet needs is patchy across the sector
- Uptake of innovative technologies, service delivery models and policies has traditionally been slow in the health service
- The process of sharing knowledge and innovative practices from one part of the health service to another is disjointed
- Collaborative efforts to test out new models of working need improvement
- Despite examples of healthcare innovations incubated in the NHS, a culture of innovative thinking does not pervade across all of the services and staff

Led by the AHSN through initiatives such as the Local Health and Care Record Exemplar (LHCRE) programme, the AHSN's Innovation Exchange and the Accelerated Access Collaborative, we will continue the system wide adoption of nationally and locally identified innovation that fit with our priorities.

Our patients can fully benefit from breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery

The Innovation Hub will enable SYB ICS to:

Match innovation to unmet need

- Establishing and managing a unified approach to capturing, validating and prioritising the unmet needs (problems) of SYB ICS
- Matching and supporting the identification and validation of market ready innovations to help drive improved health outcomes, operational and clinical processes, and patient experience across the ICS health economy

Target single point of contact

- The Hub will act as a single point of contact for all ICS system wide innovation enquiries and requests for guidance, advice and support
- The Hub will lead on the liaison between key stakeholders across the region including the NIHR Clinical Research Network and Healthcare Technology Cooperatives, academia, the AHSN and others

Signpost

- Signposting and connecting internal organisations (NHS providers / Commissioners etc.) and those external to the system (Industry partners) This will be aided by partners including the AHSN and others such as Devices for Dignity and Academic institutions

Build a culture of innovation

- Developing a programme of activities and a platform that will support and encourage staff across the system to continually identify unmet needs and consider better ways of addressing them

In creating a managed and prioritised repository of 'problems' that can be solved through innovation, the Innovation Hub will ensure the ICS is at the cutting edge of identifying, evaluating and embedding innovative and transformational approaches. This will be achieved through effective interactions with the YHAHSN innovation exchange, academia, industry, research funders and providers of health and care.

Section 3: Building a

sustainable health and care system

- **Delivering a new service model – Neighbourhood, Place, System**
- **Transforming care with new service models**
- **Making the best use of resources**

Delivering a new service model

In our 2016 Plan we said we needed to rethink how we invest in, plan for and deliver our services – and how we ourselves are arranged and set up to do so.

We have made significant progress in better organising and thinking about how we work and have strengthened our approach so that our entire population has access to high quality local services while addressing health inequalities.

We now work in Neighbourhoods, Places and at a System level. Complementing these are Hospital Hosted Networks for some of our most challenged services and a joint commissioning approach for services and areas of work that apply across the region.

Each of our partner organisations continue to exist as they always have, but their thinking and approaches are now based on collaborations around their local populations; whether those populations are Neighbourhoods, Places or the System.

Of course, the majority of work takes place locally in Neighbourhoods. We have 36 Neighbourhoods with populations of 30-50,000.

Barnsley brings together its six neighbourhoods into one 'super-neighbourhood', bringing our total of Primary Care Networks to 30. At this level, primary care is strengthened by working together in Networks.

In our five Places, health and care works together more closely at town or city level. Each of our Places has a plan which sets out what the partners want to achieve together to improve health and wellbeing and other factors that affect health, such as employment, housing and education.

At the System level, our health system is really joining up to ensure we are delivering health services across our population where it makes sense to do so.

As we mature even further, we will agree an ICS strategic commissioning function, thinking carefully about how this complements the commissioning operations in Place.

We will also expand and develop our collaborations across both acute and mental health providers where appropriate.

The **System** agrees shared objectives and outcomes

Hospitals are increasingly working in **Hosted Networks**

Partnerships plan and deliver integrated health and care across **Place**

Neighbourhoods integrate teams to deliver care where people live

Transforming care

Primary Care, working in Networks

Our vision

To transform Primary Care through the establishment of 'at scale' primary care organisations capable of taking on population health responsibilities, which provide high quality integrated care services accessible seven days a week through collaborative working in neighbourhoods at Place.

Our guiding principles

- Promote the continuous improvement of primary care and excellent access to services
- Maintain the right balance between operating in a consistent fashion and maintaining appropriate local flexibility
- Demonstrate clear alignment between Primary Care Networks, CCG and ICS strategies and delivery plans
- Deliver the funding guarantee for Primary and Community Care
- Where appropriate 'do once' across SYB

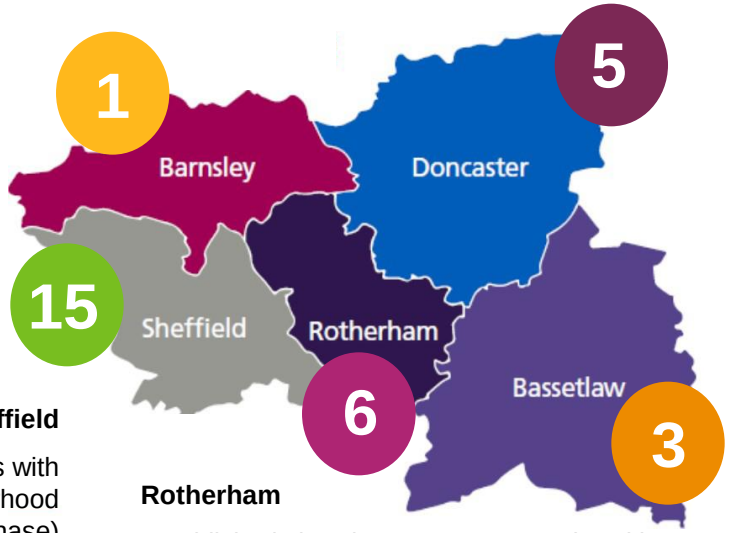
Our Primary Care Networks

Barnsley

Established a single Primary Care Network, with clinical leadership and six sub networks. Integrated neighbourhood teams are aligned to Local Authority area councils. Local PCN development programme to be implemented. Neighbourhoods to agree local health and wellbeing priorities and engaging local communities

Sheffield

Established 15 Primary Care Networks with clinical leadership. Neighbourhood transformation programme (1st phase) established across 6 PCNs - integrated care and support targeting needs of specific populations, with plans to roll out across the city.



Rotherham

Established six Primary Care Networks with clinical leadership in place. Strengthening the primary care workforce through provision of primary care nurse preceptorships, health care assistant apprenticeships and nurse development roles.

Doncaster

Established five Primary Care Networks, with clinical leadership. Neighbourhood project coordinators in place linked to GP practices with social care, community nursing, local authority community and wellbeing teams. Early intervention, local solutions and joined up teams working with common operating models.

Bassetlaw

Established three Primary Care Networks, with clinical leadership and co located integrated neighbourhood teams. Agreed link workers to be employed by the voluntary sector. Extended access to primary care is available through PCN hubs as well as through individual practices. Increased support for practice pharmacists to undertake clinical reviews. New arrangements developed for PCNs with care homes.

Transforming care

Primary Care, working in Networks

Our progress

- Full population coverage with 30 PCNs established across SYB each with a Clinical Director
- The Clinical Directors have formed a 'guiding coalition' of clinical leadership across the developing PCNs
- Agreements between CCGs and practices to target and focus on variation and data analysis used by PCNs to improve Population health ie risk stratification and segmentation
- Emphasis on developing primary and community based care and support
- Local OD approaches to support sectors to work together and engage with communities
- SYB workforce training and development hub well established and delivering schemes to promote new roles and recruitment into primary care
- PCNs appointing paramedics and pharmacists to their multi disciplinary teams
- Neighbourhood teams within PCNs delivering joined up care supporting people to remain or recover at home.
- Integrated neighbourhood teams aligned to Local Authority areas and PCNs. Some co-location achieved with community clinical and social care services. Wider representation from voluntary sector and schools.
- Testing service redesign within community based new care models eg Neighbourhood project coordinators and link workers supporting practices to engage with partner services (social care, community nursing, LA community and wellbeing teams; housing, welfare and employment).

We have full population coverage with 30 Primary Care Networks. The Network approach enables a focus on population health, prevention, early intervention, and anticipatory care to reduce inequalities.

Our Challenges

- Addressing variation while also valuing the differences between practices and Primary Care Networks (PCNs)
- Mobilising the resource and support to develop PCN models at scale
- Culture and behaviour change
- Improving access to and consistency of general practice
- Providing information and intelligence to support Population Health Management
- Facilitating PCNs working differently to reach seldom heard groups.
- Collaboration with acute sector to develop new models of care/delivery out of hospital.
- PCN maturity enabling them to represent primary care in the ICS
- Meeting the funding guarantee for primary and community care

We will work across the System to:

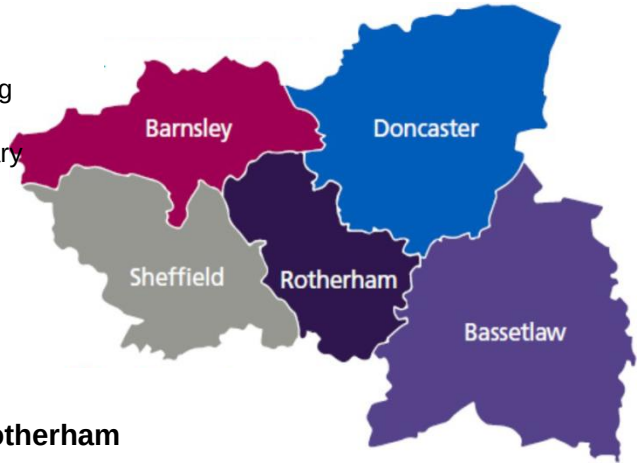
- Enable PCN progression against maturity matrix, support development plans, including new models of integrated community services as part of PCNs phased over next three years.
- Have GP Federations supporting development of PCNs through lead employer and other arrangements
- Extend access to General Practice via PCN hubs.
- Offer an ICS Support Offer to Clinical Directors to promote system wide leadership and PCNs incorporating national framework & compliment CCG arrangements.
- Recruit into Social Prescribing and Clinical Pharmacy positions during 2019/20 under the GP Contract DES 'new roles' scheme. In some cases voluntary sector recruitment.
- Support practice manager development
- Support practices to increase telephone consultations.
- Invest in Local Enhanced Services, delivering care closer to home and improving management of patients to avoid admission.
- Develop new PCN led arrangements with Care Homes

Transforming care

Out of Hospital Care

Our progress

Each Place has established an out of hospital care approach through its Integrated Care Partnerships and delivered through Primary Care Networks working collaboratively with health and care partners to provide care closer to home



Barnsley

- Partnership of Barnsley MBC, Barnsley CCG, Barnsley Hospital, South West Yorkshire Partnership Foundation Trust, Barnsley Healthcare Federation, Barnsley Hospice, Healthwatch Barnsley and Barnsley Community and Voluntary Services developing the out of Hospital strategy
- One Primary Care Network and six Neighbourhood Networks with 'one team , no boundaries' philosophy to integrate services providing care closer to home
- Integrated model for intermediate care including rapid response Intermediate Care Services
- Integrated community respiratory and pulmonary rehabilitation pathways
- Improved nurse led support to care homes including introduction of digital technology to enable video link up to Rightcare Barnsley to reduce care home hospital attendances

Bassetlaw

- Introduced community ophthalmology, audiology and pain management services and extended the scope of dermatology services
- Call for Care rapid response providing two hour urgent community response
- Well established Integrated Neighbourhood Teams (INTs) in all three PCNs, with community clinical and social care services co-located with primary care
- PCNs have paramedics and pharmacists in their INTs, a Memorandum of Understanding was put in place for GP led review of care homes

Rotherham

- Aligned community services to work around GP practices in the PCN networks
- Integrated rapid response service, therapies and care co-ordination centre now co-located to support integrated working
- GP practices aligned to care homes, for care continuity
- Rotherham Health Record live across all services enabling services to have the same information for patient care
- Improved hospital discharge, leading to some of the lowest lengths of stay and delayed transfers in the country

Doncaster

- Integrated intermediate care service introduced with rapid response provided within two hours
- Complex lives service providing proactive care and support to people rough sleeping reducing the risk of admission through better support for addiction, mental health and wellbeing needs
- PCNs established and developing integrated care approaches across health and social care
- Improving care for people with delirium and dementia in the community

Sheffield

- Mature neighbourhood working established over last four years with a development programme to support leadership across PCNs
- Significant investment to support neighbourhood collaboration across schools, mental health, voluntary and community sector, social care, community nurses and police, including a keeping people well programme
- Enhanced care homes support programme well established
- Joint re-ablement services and provision of care home beds to facilitate assessments and care needs outside of hospital, reducing length of stay markedly over the last 12 month period

Out of Hospital Care

We will work across the System to expand out of hospital care for our local populations to help them care for themselves where they can and receive the right treatment, in the right place, when they need It.

Our plans

System architecture

- One Primary Care Network with six neighbourhood networks in Barnsley with a shared care record to be deployed in 2020/21
- Established Barnsley Population Health Management Unit (PHMU),
- Community based hubs in Sheffield to be developed offering access to health, social and voluntary services
- Development of a model in the community to escalate and de-escalate patient needs, which will include consideration of the improved crisis response within two hours and re-ablement care in two days.
- Ongoing development of current population health need tools for PCNs such as risk stratification and population segmentation that profiles cohorts people in terms of health and care needs supporting future planning of service needs

Pathway change

- New intermediate care service with flexible beds usage and more home based care with a dedicated geriatric nurse led frailty service across Bassetlaw
- Improve care pathways in respiratory, dementia, CVD, diabetes and gastrointestinal across SYB
- Continue to work across primary care and community nursing to improve the interface between the two services and integrated models of care
- Mental health services will be enhanced to ensure timely high quality access for people in crisis.
- Improve flow through the hospital and enhance step up provision to facilitate quicker discharge
- Continued implementation of Enhanced Health Care In Care Homes across SYB

Service Transformation

- New care home support to reduce avoidable hospital attendances across all SYB places
- Community health services led by neighbourhood teams of nurses and allied health professionals offering care to keep people at home, supporting timely discharge from hospital and ongoing case management for people with complex needs and at end of life in Barnsley
- Re-configuring intermediate care and re-ablement in Rotherham , reducing the bed base and providing improved care in the community
- Home care provision re-procured in Rotherham to improve quality and support individuals to stay within their preferred place of care
- Continued development of PCNs across Sheffield incorporating risk stratification, multi-disciplinary working, enhanced case management and person centred care planning
- Active support and recovery programme across Sheffield PCNs will build capability and capacity in the community to support people to live well in their own homes and will promote independence.
- Implementing a single point of access (SPA) covering the full range of services available outside of hospital
- Developing a Barnsley proactive care model in primary and community care

Transforming care

Out of Hospital Care

As part of their out of hospital approach, each Place is developing and implementing plans to support people to age well

Supporting people to age well:

- People are increasingly more likely to live with multiple long tern conditions, or live into old age with frailty or dementia.
- It is recognised in SYB that extending independence as we age requires a targeted and personalised approach
- Work is well underway in each Place as part of their out of hospital approach and development of primary care networks to support people to age well. This includes:
  - GPs using the frailty index to routinely identify people with severe frailty
  - Proactive population health management approaches focused on the moderately frail
  - Integrated primary and community teams continuing to gather pace to work together to support people to maintain their independence and age well
  - Established falls prevention schemes
- Home based and wearable technology has been tested out to support different cohorts of people across SYB
- The pivotal role undertaken by carers is recognised in each place, and there are strategies and action plans to ensure we identify carers and offer appropriate information and support
- Dementia diagnosis rates remain high across the ICS and there is ongoing work in each Place to provide better support in the community for those living with dementia as we practically translate the NHS comprehensive Model of Personalised Care.

We will work as a System to:

- Continue to develop and implement plans in each Place to support those living with multiple long term conditions or living into old age with frailty or dementia
- Work with Primary Care Networks and integrated primary and community teams to maximise the use of a population health management approaches to inform a targeted and personalised approach
- Support the deployment of home based and bed based elements of the community response model, community teams and enhanced health in care homes
- Consider the use of home based and wearable technology in our planning and digitally enable community services in preparation for future advances in these care models
- Continue to implement action plans in each to improve how we identify unpaid carers and strengthen support for them to address their individual health needs
- Ensure out of hospital approaches continue to consider the needs of those living with dementia and their carers so we can strengthen community support

Sheffield: Active support and recovery programme in Sheffield is supporting people to live and age well in their own homes
Bassetlaw: The home first model in Bassetlaw includes community based rapid response in two hours

Partnerships in Place

Integrated care partnerships at place

Over the last three years all five places in SYB have established mature integrated care partnerships (ICPs) with their local authorities and other place partners. These partnerships have become the bedrock of SYB place development and relationships in each ICP continue to evolve and flourish through ambitious joint strategic plans to integrate health and care locally.

ICPs have implemented a range of joint working arrangements and mechanisms to drive forward joint working with local authorities and providers including the following:

Joint Commissioning:
Joint strategies with local authorities in place, based on life course; Starting Well, Living Well and Ageing Well. Delivery in some Places is supported and facilitated through shared commissioning posts in areas such as children's services, mental health and learning disability. Joint arrangements will continue to develop in line with each ICP's strategic direction, priorities and the requirements of the LTP to integrate care and improve population health outcomes for local people.

Provider alliances and provision:
ICPs have developed approaches with local providers to align, integrate and incentivise care to improve, quality and access and population health outcomes - for example in services such as mental health liaison, social prescribing, acute services, urgent care and intermediate care.

Population health management :
Development of strategic partnership work on the wider determinants of health, such as housing, employment, education, homelessness, transport and population health initiatives that incorporate lifestyle change support aligned to PCNs.

Digitally enabled care:
Shared health and care records have been implemented across most of SYB to enable NHS and social care clinicians and professionals to access patient information to enable seamless care. These databases of information are also being used in the ongoing development of population health management tools for PCNs.

"Our ICP vision for integrated care is to develop a local system where the people don't see organisational boundaries. Instead, they experience continuity of care; regardless of where they are seen, be that in hospital, in the community or at home. Patients and their families are supported and empowered by 'one team'.

"Our goal is to dismantle boundaries at the point of delivery of care to create a simpler, integrated health and care system that supports a shift in focus on treating patients with health problems to supporting the community to remain healthy."

Barnsley Integrated Care Partnership

Transforming care

Reforming emergency care

Our progress

- Procured and mobilised a new model of Integrated Urgent Care, with a regional and local Clinical Advice Service (CAS) Supported by full population coverage of NHS 111 online
- Introduced an Urgent Treatment Centre (UTC) in Doncaster
- Engaged patients and public through the ICS Citizen Panel and Transport Group on plans to reduce avoidable ambulance conveyance
- Rotherham Hospital is a field test site for the new national clinical emergency and urgent care access standard
- Embedded clinical primary care streaming in all SYB A&E departments
- Reviewed and improved system intelligence by piloting an escalation management system for urgent care data and implemented the care home bed capacity tracker
- Strengthened relationships with Yorkshire Ambulance Service and piloted HALO+ to support system escalation pressures
- Mapping to explore digital opportunities to support patient pathways
- Local progress to commission rapid community response services.
- Frailty services in place across SYB

Our challenges

- Growth in A&E attendances and emergency admissions, exceeding planned activity levels
- Increasing complexity and acuity of patients
- Workforce capacity and resource limitations
- Public expectations, culture and behaviour
- Some places have challenges with delayed transfers of care

We will work across the System to:

Work collaboratively to continue to improve performance

- **Pre hospital urgent care**
- Simplify patient/public access by further developing a fully integrated urgent care model, developing the virtual clinical advisory service through improved clinical pathways accessible via 111 or 999 and other service access points
- Further designation of additional Urgent Treatment Centres (UTCs) to simplify access for patients where this model fits with the locally commissioned services
- Continue to work with ambulance services to eliminate handover delays
- Develop improved clinical pathways, initially in respiratory and mental health, to avoid conveyance to hospital via 999 services
- Strengthened alignment and work with Primary Care Networks
- Ensure patient flow and demand is clinically managed and supported through transparent comprehensive system intelligence
- Further develop high intensity user programme
- Support care homes to deliver improved patient care by providing better access to clinical advice, access to services and direct support from the ambulance service
- Expansion of NHS 111 direct booking via roll out of GP Connect, initially expanding direct booking into GP services, urgent treatment centres, GP out of hours services and considering further expansion and developments into other community based services
- **Reform hospital emergency care – Same Day Emergency Care**
- Ensure Same Day Emergency Care is in place to complement type 1 A&E departments
- As part of the NHS Clinical Standards Review develop new ways to look after patients with the most serious illness and injury
- **Reduce delays in patients being able to go home**
- Improve system intelligence to support patient flow and demand
- Continue to improve performance to support people home and reduce delayed discharges

Insight from conversations led by the partners in Doncaster to better understand the use of A&E by 18-30 year olds has shaped plans for a streaming model at the 'front door'

Transforming care

Transforming planned care

Our progress

We have developed a range of new care models:

- South Yorkshire and Bassetlaw hip and knee follow up pathway including virtual follow up clinics
- The use of virtual appointment in a range of specialties eg fracture clinic, dermatology, ophthalmology and 'good news calls' to reduce delays in receiving results unnecessarily
- MSK first contact practitioner pilots have been trialled in readiness for roll out across the system
- Teledermatology has been rolled out to primary care in some areas evidencing a reduction in referral levels to secondary care
- Community services in a range of specialties including; heart failure, dermatology, integrated sexual health and gynaecology, ophthalmology, audiology and pain management
- Outpatient reform in a number of specialties including introduction of outpatient follow up protocols
- South Yorkshire and Bassetlaw Commissioning for Outcomes policy

Our challenges

- Across the system there is increased demand in both elective and diagnostic care across clinical pathways
- A need to maintain and reduce referral to treatment times by growing the amount of planned surgery year on year, to reduce long waits and cut the waiting list
- Redesign services so that patients can avoid up to a third of face to face outpatient visits by reducing unnecessary follow up and offering alternative modes of appointment eg virtual, telephone or video consultations
- Enable increased access to shared medical records for patients and healthcare professionals to support new service delivery models and more joined up co-ordinated care planning.

We will work as a System to:

- Design and implement a digitally enabled outpatient transformation programme to include:
  - Roll out of clinically agreed outpatient follow up pathways
  - Increased uptake of advice and guidance
  - Increased use of technology and virtual appointments to reduce face to face outpatient appointments as per the Long Term Plan commitment
  - Development of community services/alternative planned provision
- Increase the rollout of first contact practitioners for MSK (or equivalent)
- Implement *Urolift* as part of the range of treatment options for benign prostatic hyperplasia
- Specialty level reviews to agree and implement recommended pathways of care using Rightcare, GIRFT, elective handbooks and other best practice
- To implement technological solutions to support patient information sharing
- Development of the shared care record including the ability to move relevant clinical information across the region to access specialist opinions
- Delivering shorter waits for elective care through more effective use of capacity and choice at 26 weeks

Partners in Sheffield are supporting primary and secondary care to help make sure patients get the right treatment at the right time in the right place with a new elective care model

Transforming care

Providers working together

Our progress

The providers in SYB have a long history of shared working. The mental health providers have formed a provider Alliance, which has identified lead providers for three priority pathways and is looking to establish three provider collaboratives. Mental Health providers are putting into place the governance to support this, with a draft Partnership Agreement in development.

The acute trusts first came together as the Working Together vanguard programme in 2014, which created a collaboration between the five SYB Trusts, Mid Yorkshire and Chesterfield. This has evolved into a wide programme of shared work, which is now formally supported by a Committees in Common model, and overseen by an Acute Federation.

Our challenges

- Shared working can bring clear benefits for patients and staff. But as shared working has matured we have come to understand better which programmes are best addressed at system level, and which are better done at Place or individual organisation level
- To be done well, shared working needs significant focus and time, streamlined governance and supporting behaviours from all the partners
- In the next phase of shared working, both the acute trusts and the mental health trusts will put the building blocks into place to enable shared working
- Following the review of sustainability of services in the Hospital Services Review we will need to look at developing a clinical strategy which is underpinned by capital resources

The acute providers will strengthen their ability to work together:

The acute providers are working together to develop an infrastructure of agreements that will make shared working more streamlined and effective:

- Building the underlying infrastructure: shared action, with the rest of the ICS, on digital and workforce
- Greater transparency about risks and challenges, so that trusts are better placed to support each other and to prioritise areas for shared work
- Agreements around how the trusts will work together

The mental health providers will strengthen their ability to work together:

Phase 1

- Develop provider collaborative arrangements for Low/Medium secure inpatient services, eating disorders and CAMHS Tier 4 service
- Form and mature the Collaborative Alliance Board
- Agree partnership agreement which sets out ways of working
- Agree membership for Alliance governance
- Strategic discussions and establish priorities for new care models and other mental health services
- Establish governance and delivery arrangement;
    - Alliance operational delivery group and new care models delivery infrastructure – joint with independent sector and commissioners
    - Align with ICS mental health transformation programme

Phase 2

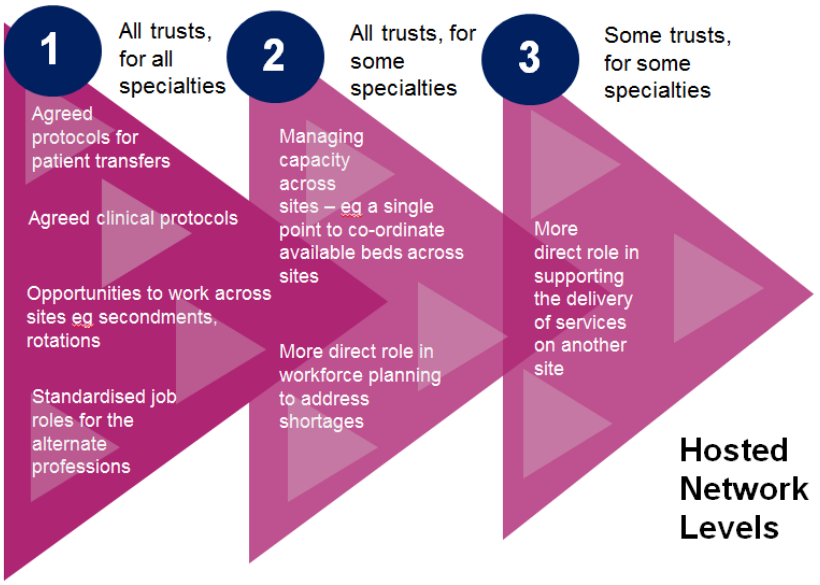
- Embed provider collaborative ways of working in three priority pathways
- Establish formal governance - Committees in Common
- Agree areas for formal delegated decisions making
- Agree additional new care model priorities

Transforming care

Hospitals, working in Networks

Using shared working to improve care

- The shared working that the acute trusts are developing has the aim of improving outcomes for patients. The programmes of work which Trusts are taking forward aim to: improve clinical standards, make better use of our workforce and make the SYB acute providers a great place to work, reduce inequalities and make efficiencies.
- The guiding principle for the acute providers is that the trusts should work together to make sure that all patients can access the best care. The majority of hospital care will be provided in the patient's local hospital, but trusts will work together to give access to more specialist services.
- The SYB acute providers already work in networks eg consolidation of Hyper Acute Stroke Units (HASU) onto three HASU sites to ensure all patients have access to the best life saving treatment; the head and neck cancer multi disciplinary team which has representation from every trust, with major surgery centralised at Sheffield Teaching Hospitals and clinics and diagnostics at every district general hospital; and bilateral arrangements such as Doncaster providing nephrostomy interventional radiology at Rotherham, or Barnsley and Rotherham recruiting joint gastroenterologist posts.
- The SYB acute providers have also developed shared strategic and efficiency work:
  - Shared working on procurement and back office functions, which has saved £5.2 million so far;
  - A review of hospital services, focused on five challenged services, (urgent and emergency care, maternity, paediatrics, stroke and gastroenterology) which looked at the configuration of services and how trusts could work together better. This resulted in the setting up of Hosted Networks which are a structured approach to strengthening shared working.



We will work as a System to:

- **Develop a new approach to shared working**, called Hosted Networks. We are setting up level 1 Hosted Networks in five specialties. These put a stronger governance framework and support around collaboration to develop workforce planning, clinical standardisation, and innovation across the trusts, while retaining equal status of all partners
- **Make the best use of specialist clinical expertise** to support other Trusts: Developing a level 3 Hosted Network between Sheffield Children's Hospital and Doncaster and Bassetlaw Teaching Hospitals (DBTH): SCH will support the delivery of services on the DBTH sites
- **Develop shared infrastructure** through building our shared capacity e.g. through creating SYB pathology and networking imaging and diagnostics
- **Deliver the national standards for all of our patients**: the acute trusts will work together to deliver the targets in the NHS Constitution. For example, for elective care we will work as a system to match capacity to demand, so that we make better use of the beds and workforce we have, so that we can reduce waiting times for patients

Making the best use of resources

System efficiency

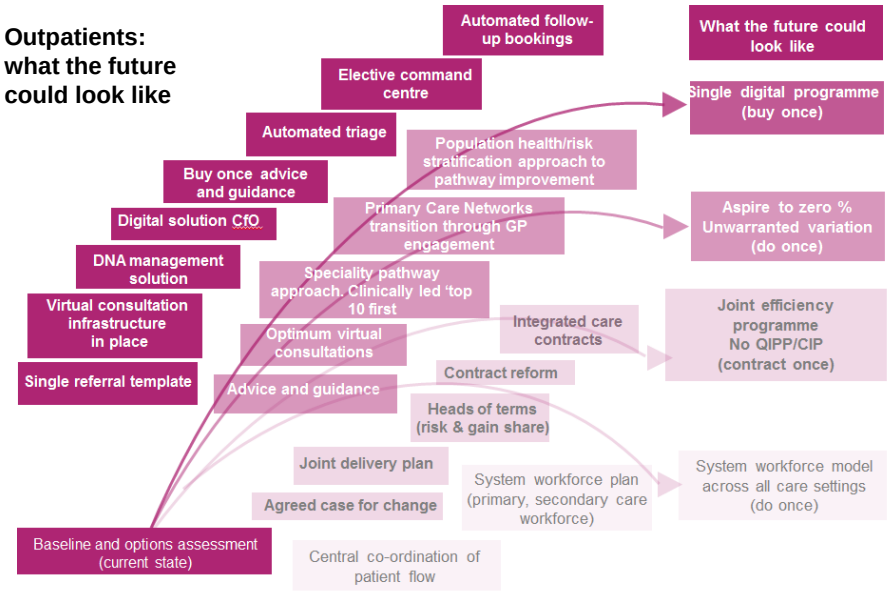
Our System Efficiency Board was set up to:

- Prioritise a small number of efficiency opportunities and ensure the pipeline is developed for creating future efficiencies
- Recommend the schemes that can be best done at scale by building on existing ICS and place schemes avoiding duplication
- Make faster progress on transformation as an ICS than can be done individually

Our progress:

- As part of a rigorous process with partners, we mapped a range of possible projects against value for money, deliverability and quality and strategic fit benefits.
- Four priorities emerged which the System has adopted

Outpatients: what the future could look like



E-rostering

Aim: to reduce the £92m spend on temporary staffing.
Scale of opportunity: £9m-£18m

Suggestions being explored: Centralised and coordinated frontline training, implementing medical rostering (non consultant, System level job planning, System level nurse erostering policy, System level eroster contract 2021 renegotiated by the Allocate Regional User Group on behalf of the ICS, Hub and Spoke model – centralised eroster helpdesk with satellite local helpdesk officers.

Outpatients

Aim: to redesign outpatients and reduce unwarranted variation - 2.2 million attendances in 2018/19 – with estimated spend of £330-£340m
Scale of opportunity: £9m - £10m

Suggestions being explored: Reduction in unwarranted pathway variation (specialty basis), rolling out advice and guidance – roll out, virtual consultations, DNA management solutions, joint efficiency programme and delivery framework, single referral template, automated triage and a System workforce plan.

Theatres

Aim: to increase theatre utilization from 82% currently
Scale of opportunity: £4m-£7m

Suggestions being explored: Standardisation of scheduling process so demand and capacity can be managed across the patch, System wide demand and capacity to maximize use of NHS, standardised protocols and processes to enable movement across sites, ECCU – to support demand and capacity review, theatres performance dashboard and maximizing the use of NHS theatres (less activity flowing to IS for additional capacity).

Independent Sector

Aim: to reduce spend which is currently for additional capacity (not patient choice). IS Spend £46m.
Scale of opportunity: <£1m

Suggestions being explored: IS framework for managing the market for contracting capacity, ICS standardized contract with KPIs, contracting best practice pathways NHS and IS to free up capacity, ICS Elective Care Coordination Unit (ECCU) to coordinate capacity and demand, System based approach to contract all elective activity (NHS and IS), lead NHS provider model for high volume pathways

Making best use of resources

Improving Productivity

Improving clinical productivity to release more time for patient care	**Deliver efficiencies in administration costs**	**Reducing growth in demand through integration and prevention**
Maximising the buying power of the NHS	**Make better use of capital investment and system assets**	**Reducing unjustified variation**
Supporting the development of pathology networks and of diagnostic imaging networks	**Utilising the Evidence Based Interventions Programme**	**Making better use of capital investments and existing assets**
Support pharmacy staff to take on patient facing clinical roles and optimise medicine usage	**Utilising the national Patient Safety Strategy**	**Delivering System wide efficiency**

We will work across the System to:

- Optimise System level collaboration to improve clinical productivity and release more time for patient care. We will take a network approach to develop more efficient rosters and deliver opportunities to manage support contracts
- Maximise the buying power of the NHS through benchmarking and comparing our spend and review opportunities for individual and collaborative savings
- Leverage economies of scale through partnership across SYB and with neighbours
- Continue to work with clinical specialties and the Get It Right First Time programme to adopt recommendations around unwarranted variation and standardisation
- Identify opportunities for efficiencies in our corporate services to reduce running administrative running costs
- Enable the development of an SYB pathology network to enable efficient use of our workforce and capacity to meet demand
- Progress the development of a diagnostic imaging network to improve capacity planning. Continue to develop the imaging academy and workforce plan/strategy
- Optimise medicines management in care homes through clinical pharmacists and pharmacy technicians as part of NHSE Enhanced Health in Care Homes framework
- Redesign pathways to improve medicines management
- Review medicine related resources to ensure they are optimised and identify areas suitable for guidance
- Optimise the management of the interface between primary and secondary care initiatives and innovations
- Generate direct savings linked specifically to medicine costs through rebates and standardisation
- Optimising estate and investment through a System wide strategy
- Working through national programmes at organisation level, Place level and System level to deliver best practice e.g. Right Care, maternity and neonatal

Making the best use of resources

System Planning 19/20

- The financial planning approach has been to agree a framework and timetable across the systems and allow Places to work together to agree fully aligned finance and activity plans
- Key planning assumptions have been agreed including:
    - Systems should develop and agree realistic assumptions based on local trends. This should take account of:
    - How funding growth will deal with improving the volume of elective procedures, cut long waits and reduce the size of waiting lists
    - How outpatients will be reformed to remove a third of face to face outpatient visits
- All organisations are required to return to recurrent financial balance over the life of the five year plan or earlier
- For emergency care assumptions for demand growth need to be agreed between providers and commissioners to ensure they reflect recent local trends adjusted for agreed demand management initiatives and national priorities including improving performance on cancer and A&E
- Commitments for increased spend in mental health and primary medical and community services
- All organisations to return to recurrent financial balance over the life of the five year plan or earlier
- Regional teams agreeing a realistic and stretching bottom line each year where providers in balance requiring to deliver 1.1% cash releasing productivity growth and those in deficit delivering at least an additional 0.5% of cash releasing productivity growth

Place	Planned £m	Variance £m	Actual £m
Sheffield System	(20.9)	9.4	(11.5)
Doncaster & Bassetlaw System	(18.1)	0.3	(17.8)
Barnsley System	(15.7)	0.2	(15.5)
Rotherham System	(18.3)	0.2	(18.1)
Sub-total	**(73.0)**	**10.1**	**(62.9)**
Technical Adjustments (including in-year adjustments & CCG drawdown)	(9.5)	9.5	-
Total	**(82.5)**	**19.6**	**(62.9)**

Capital

- We will prioritise capital plans to inform how the funds will be deployed once we know what system capital is available
- We have agreed a process to evaluate and score business cases
- In anticipation of Wave 4 capital, the ICS identified £445m of capital investment requirements covering all aspects of primary, acute and mental health services
- This included material investment in the digital agenda, clinical strategy, removal of critical infrastructure risk and joined-up system wide investment in cancer services
- Business as usual capital is focussed on maintaining current estate; particularly noting the high and increasing value of critical infrastructure risk backlog maintenance
- The ICS investment requirements are currently being updated in the context of national constraints of capital availability, as well as dealing with critical investment in the intervening period

Making best use of resources

Draft STP Planning Tool – Indicative Financial Analysis
Key issues emerging from the first draft

High levels of engagement:

- The ICS has made significant progress in a short space of time to produce a draft strategic financial plan.
- Organisational Boards and Governing Bodies are activity engaged in the process to iterate further submissions reflecting updated intelligence

Risk management:

- The 19/20 System Control Total is routinely managed through system governance reflecting the emergent and ongoing risks including demand and performance pressures. Plans have been based on current forecasts

Ambition:

- The SYB ambition to return the system to balance by 2023/24 has not yet been realised with a mixed approach to deliverability based on a number of key variables

Financial framework:

- The system is awaiting publication of control totals at organisation and system level; and a full understanding of available support monies

Cash and support:

- Although organisations have modelled their draft position excluding support monies, there is an urgent need to address support monies associated with the withdrawal of Provider Sustainability Funding (PSF)
- There will be a significant reliance on FRF at a level consistent with the support monies provided into the system this year

Efficiency:

- The pace of improvement is different amongst providers and a process of peer review will enable a full and transparent system-wide understanding of the pressures and efficiencies included in plans to deliver a consistent system approach to supporting transformation

Drawdown:

- CCGs have significant levels of banked drawdown which they are looking to drawdown and invest in local transformation across the planning period

Wave 4 capital:

- Commissioners have reflected the Wave 4+ capital for Primary and Community Care in their draft plans. The timely release of resources will provide much needed investment in the sector

Transformation of capital:

- Constraints on capital nationally provides a potential barrier to transformation.
- Providers have sought to cover immediate capital needed through internal sources but major investment in required in the system to deliver service change and resilience to manage critical infrastructure risk. The strategic approach to capital investment will be linked to the ICS Estates Plan

Alignment:

- Financial alignment is strong across SYB partners and a process has been developed to improve activity alignment

Making best use of resources

Draft STP Planning Tool - Indicative Financial Analysis
High level outputs

The initial outputs reflect a first draft of the STP Planning Tool
The agreed process for developing the system-financial-strategy is provided below

	19/20	20/21	21/22	22/23	23/24
Annual System Deficit	£(52.1)m	£(67.2)m	£(53.8)m	£(44.6)m	£(28.7)m
Avg Efficiency – Provider Trust	2.90%	2.20%	2.10%	2.00%	2.20%
Avg Efficiency – Commissioner	2.30%	2.20%	1.80%	1.60%	1.60%
Total Efficiency – Value	£118m	£105m	£98m	£95m	£103m
Total Capital Investment	£100m	£165m	£128m	£292m	£642m
Financial Alignment	0.90%	1.20%	1.80%	2.40%	3.00%
Activity Alignment					
Outpatient – First	n/a	0.92%	0.91%	0.90%	0.88%
Outpatient – FUP	n/a	5.25%	5.25%	5.25%	5.24%
Elective - Day Cases	n/a	1.90%	1.92%	1.90%	1.88%
Elective – Inpatients	n/a	1.25%	1.24%	1.26%	1.28%
Non-Elective – Inpatients	n/a	3.07%	3.09%	3.10%	3.12%
Non-Elective – A&E	n/a	0.67%	0.78%	0.82%	0.86%

Making best use of resources

Draft STP Planning Tool - Indicative Financial Analysis
Next steps

Item	Current State	Action	Future State
1	There has been a differential approach to delivery of financial balance - with one provider maintaining a deficit in every year; and there are differing levels of efficiency across organisations	ICS DOFs have agreed to jointly understand relative investment and efficiency challenges through development of shared bridge analyses to provide full transparency	A single approach to delivering control totals taking into account the deliverability of efficiencies, level of investment and availability of cash and revenue support.
2	There has been a differential approach to recognition of CCG draw down for future investment	ICS DOFs have agreed to understand place-based investment needs to inform drawdown phasing across the period	A single approach to accessing drawdown taking into account the need to investment in the system to enable transformation
3	There has been a differential approach to capital planning with some providers including additional PDC	ICS DOFs have agreed to review the ICS Estates Strategy and reflect updated assessments of required PDC over and above self-financed capital	A single approach to strategic capital priorities linked to the ICS Estates Strategy recognising the need for additional capital in SYB
4	Activity alignment is not as robust as financial alignment	A detailed process is underway to improve activity alignment at a more granular level	Alignment differences reconciled to at least the level of assurance as financial alignment

Making the best use of resources

Our progress

- Effective use of ICS flexibilities (offsets) to secure organisation positions and maximise inward investment
- Strong financial performance in a time of ongoing challenges of activity increases and pressure in the system
- Transparent approach to the utilisation of transformation resources for system investment
- Development of a System Efficiency Board to identify where the system can add value by working differently together to provide more effective implementation or faster progress than can be done individually
- Deliver of a capital and estates investment strategy including £57.5m of capital to improve primary and community facilities

The NHS financial settlement

- In September 2019, the Chancellor announced an NHS spending increase of 3.1% in real terms (£6bn) including investment in increased training places (HEE), investment in public health, capital investment (of which SYB received £57.5m for primary and community schemes) and investment in artificial intelligence. This was alongside an additional £1bn for social care and a process to review the social care precept
- This built on the budget announcement (October 2018), providing real terms growth of 3.4% (£20.5bn) by 2023/24 taking the overall NHS budget to £148bn
- There is also the commitment to ensure mental health investment grows at the same rate as the overall NHS budget for five years
- The budget announcement reflected the Prime Ministers spending announcement in June 2018 promising real terms growth of £20.5bn (nominal £33bn and £1.25bn pension funding)

Our challenges

- Maintaining strong financial performance linked to strong operational performance in a time of increasing activity and workforce challenges
- Inflationary pressures on providers and continued recurrent delivery of stretching cost improvement programmes and challenging control totals
- Upward pressure in all aspects of CCG investment both inside and outside the acute sector
- The complexity of the financial framework (including tariffs) providing uncertainty for the future
- Lack of a strategic capital framework nationally acting as barrier to transformation
- High levels of backlog maintenance across the system requiring urgent injections of capital to ensure resilience

This financial settlement is part of the Long Term Plan which includes five key financial tests for delivery

Test 1
How organisations will return to or maintain financial balance through providers in balance delivering cash releasing productivity growth of 1.1% per annum

Test 2
Providers in deficit will require delivering additional cash releasing productivity benefits of at least 0.5% per annum. Regional teams will agree a realistic and stretching bottom line position in each year

Test 3
Plans to incorporate system actions to maximise efficiencies and support appropriate reductions in demand for care

Test 4
Reduce variation across the health system

Test 5
Better use of capital investment and existing assets to drive transformation

Section 4: Broadening and strengthening our partnerships

Partnership with the City Region

The Sheffield City Region (SCR) works across the Region and brings together public and private sector leaders to make decisions that drive economic growth and create new jobs.

Our Plan recognises that economic prosperity and health and wellbeing are interdependent. A healthy population means less people out of work or retiring early due to ill health, but equally it means that having a good job supports and protects health.

Our progress

We have been working with the SCR on the Health-led Employment Trial, Working Win. The Trial has been testing individualised employment support delivered by healthcare professionals. It has received over 6,000 referrals demonstrating the demand for labour market interventions delivered with the health sector.

We are committed to exploring further opportunities to work collaboratively to locally design and commission programmes.

Sheffield City Region

- We are committed to strengthening the anchor institution role of our NHS organisations. We recognise that the health and care sector is the biggest employer in the City Region and that NHS organisations have huge economic power both as an employer and through commissioning and procurement processes. We will explore the potential of the Public Services Social Value Act across SYB ICS so that we can have a significant impact on health and health inequalities, and also support the local economy
- We will team up with the SCR to explore the significant research strengths and technologies that are being developed locally that could futureproof health services and transform the way care is delivered. We will explore the research strengths in health and wellbeing innovation and technology, children's health, digital, and orthopaedic products and medicines and translate them into health interventions and efficiencies
- As part of our ongoing work and through the SYB Innovation Hub, we will work collaboratively with locally based research and technology, as well as invest in institutions like the Advanced Wellbeing Research Centre and the Olympic Legacy Park
- Our support to the local authority led work on active travel connects directly with the SCR programme of activity to promote healthy and active lifestyles. Through both routes, we will back Active Travel within the region to improve the commute of residents and drive improvements in the health and wellbeing of our population
- A commitment to move to sustainable transportation across the SYB ICS, including enabling active travel for staff, visitors and even for some patients, would have wide reaching benefits for health whilst also helping to reduce air pollution and meet carbon targets
- Through our partnership work to tackle health inequalities, we will also lend our support to prevent ill health amongst the most vulnerable people as part of the Mayor's campaign to end Excess Winter Deaths

Anchor institutions and wider contributions

An anchor institution is one that in addition to its main function, plays a key role in making a strategic contribution to the health and wellbeing of the local population and the local economy.

This includes non-profit organisations like hospitals, local councils, and universities whose long-term sustainability is linked to the wellbeing of the local population.

The NHS has significant influence over population health and is able to enhance its impact by choosing to invest in and work responsibly with other anchor institutes and local communities to collectively harness resources.

Alongside being a system partner there are a number of key areas where the NHS can contribute further as an anchor institute:

The NHS as an employer - Given that employment is important for good health increasing the amount of recruitment an NHS organisation does locally is an opportunity to increase the impact that it has on the wellbeing of the local community.

The NHS as a purchaser and commissioner for social value - As major procurers and purchasers of services, NHS organisations have an indirect impact on the conditions of workers more widely not formally NHS employed.

The NHS as a land and capital asset holder – As a significant land and asset holder the NHS has the potential to manage and develop its land and estates to support broader social, economic and environmental aims.

The NHS as a leader for environmental sustainability – Given the significant environmental impact and large carbon footprint the NHS is well placed to take action to support responsible consumption and reduce waste that can have a positive impact on the environment.

We will work as a System to:

- Maximise the potential role of all anchor institutes in SYB to harness their collective influence on the health and wellbeing of our population
- Maximise the benefits of the NHS and other anchor institutes as employers in SYB to promote local recruitment and widen access to quality work
- As a purchaser promote spend in communities to support local businesses, employ local people and stimulate local economic development
- Promote the consideration of social value into purchasing decisions
- Manage and develop land and estates in a way that benefits local communities
- Take action to support responsible consumption to reduce waste and our environmental impact

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust provides staff with a comprehensive Health and Wellbeing offer which includes support in the following areas; physical health, mental health, financial health, weight management & healthy lifestyle promotion. In January 2019 the offer was recognised by Nottinghamshire County Council and accredited their Platinum Wellbeing @ Work Award."

Partnership with the voluntary sector (VCSE)

Our progress

- SYB is home to a large and diverse voluntary, community and social enterprise (VCSE) sector that undertakes wide ranging activities and services that impact positively on the health of our residents
- VCSE representatives sit on the ICS Collaborative Partnership Board, Health and Wellbeing Boards and Integrated Care Partnerships
- VCSE/ICP Chair in Bassetlaw positively impacting on 'parity of esteem' with the public sector
- VCSE organisations influencing ICS workstream priorities
- Expansion of social prescribing an existing ICS priority, building on our well established and highly regarded VCSE led social prescribing services in all five places
- Examples of NHS funded micro commissioning of VCSE via our VCSE infrastructure organisations
- Examples of Primary Care Networks forging relationships with VCSE partners
- Range of VCSE organisations commissioned to provide services wrapping around primary care in Bassetlaw
- Sheffield Accountable Care Partnership investing in additional VCSE infrastructure to strengthen linkage between health services and the VCSE

Our challenges

- Fragile VCSE but increasing national and local expectations of the VCSE eg due to expansion of social prescribing
- Increasing need of the types of support that the sector can offer people who have complex social, psychological and physical needs, compounded by deprivation
- New approach to commissioning and funding the VCSE needed
- Capacity, on both sides, to engage with such a broad and diverse sector of over 10,000 organisations

We will work across the System to:

- Develop a strong vision for embedding VCSE participation at every level of the ICS as an equal partner in strategy and delivery
- Co-design a new framework for engagement and development of relationships between the ICS and VCSE, strengthening existing relationships and developing new ones
- Support VCSE organisations and the NHS to better understand each others values and expertise
- Invest in the VCSE sector and infrastructure support, developing new models of funding and commissioning, enabling greater sustainability
- Harness local VCSE expertise and knowledge of local communities to support identification of need and co-design of services to enhance population health
- Embed within care pathway development consideration of the potential role of VCSE services
- Support the development of community assets and services for vulnerable and at risk groups, in collaboration with the VCSE and wider partners
- Further expand social prescribing
- Develop peer support and health champions to support prevention awareness and LTC personalised care
- Maximise the potential benefits for our communities from further developing volunteering opportunities within NHS organisations and the broader health and wellbeing system
- Further develop the potential role of VCSE within secondary care
- Explore the linkages between Trusts as anchor institutions and the VCSE
- Consider VCSE colleagues as core part of multidisciplinary teams

Our commitment to work together

Shared Principles

We operate within an agreed set of guiding principles which cover the ICS groups and ways of working and shape how we work together:

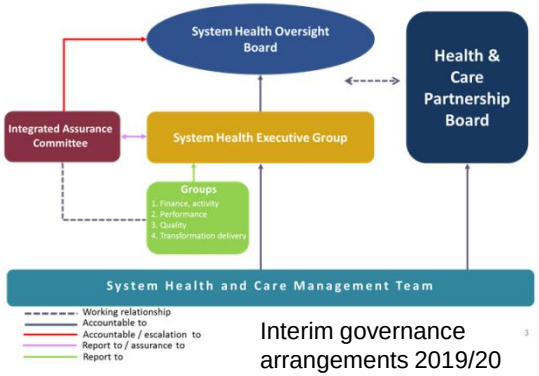
- We are ambitious for the people and patients we serve and the staff we employ
- We will build constructive relationships with partner organisations, groups and communities to tackle the wise range of issues which have an impact on people's health and wellbeing
- We will do the work once and avoid duplication of systems and processes; ensuring we make the best use of our available resources
- We will apply a subsidiarity principle in all that we do with work and action taking place at the most appropriate level for our System and as local as possible
- We will apply a 'no worse off' principle whereby no place will be worse off as a result of our shared action

We are one NHS, working as a System. We work with other partners, such as Local Authorities and the voluntary sector, in Neighbourhoods, Place and across the System when we have a common purpose and where it makes a positive difference to people's lives.

Clinical leaders, chief executives, chief officers and very senior and experienced leaders from NHS Trusts and CCGs support the work of the ICS alongside a team of people seconded or aligned from organisations across the region. It is led by Sir Andrew Cash, the ICS Chief Executive.

There is a range of groups where partners come together to collaborate at a System level. It gives both space and focus for NHS partnership working and NHS partnership working with Local Authority colleague and key stakeholders. Our governance works alongside the governance of our statutory organisations.

System Health Oversight Board - provides a joint forum between health providers, health commissioner, NHS England, NHS Improvement and other national arms' length bodies, to respond to the national policy direction for health and implementation of the NHS Long Term Plan.



Interim governance arrangements 2019/20

It builds on the SYB partnership working on strategic health priorities requiring closer working across systems. It facilitates a maturing of relationships and System working, building on collaborative working locally in Places and across SYB collaborative health groups of Joint Committee of CCGs (JCCCG), Committees in Common (CsiC), Mental Health Alliance (MHA) and Primary Care Federations.

System Health Executive Group - facilitates a maturing of relationships and integrated working between health partners, building on the work locally in each Place and collaborative health groups across the system, including: JCCCG, CsiC, MHA and Primary Care Federations.

Health and Care Partnership Board - we continue to work with our Local Authority partners to inform and shape how our system health and care partnership works.

Integrated Assurance Committee - provides assurance to the partners and to regulators on the performance, quality and financial delivery of health and care services within the five places and across the system in South Yorkshire and Bassetlaw.

Links to Annexes:

(Right click on links to open)

SUPPORTING VIDEOS:

- Developing our LTP Response: first guiding coalition event 9th July :
- Our second LTP guiding coalition event 8th Oct :

SUPPORTING INFORMATION:

- Engagement:
  Healthwatch Report and Independent Report

- Understanding the SYB Population our Challenges and Inequalities: - LW slides/Rob data

PROGRAMME PLANS: *Work in progress*

- Cancer Alliance:
- Mental Health:
- Primary Care:
- Digital:
- Workforce:
- Local Maternity System:

FINANCE:

- Finance narrative:

OTHER:

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Doncaster Council

Doncaster Health and Wellbeing Board
Date: 07.11.19

Subject: Health and Wellbeing Board Outcomes Framework Update - November 2019

Presented by: Laurie Mott

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

How will this contribute to improving health and wellbeing in Doncaster?
The paper gives an update on the outcomes framework for the Health and Wellbeing board which allows the board to drive delivery and be sighted on the key outcomes and indicators identified as important for the Board.

Recommendations
a) Note and comment on the updated information contained within the Health and Wellbeing Board Outcomes Framework particularly the Well Being and Prevention areas b) Consider any specific items that should be added as part of the board's forward plan that arise from the information presented. c) Note the new format for the report. This includes long-term indicator flags.

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