Doncaster Council

NHS
Doncaster
Clinical Commissioning Group

Doncaster Health and Social Care

Commissioning Strategy

2019-2021

Contents

Foreword

Doncaster Council and NHS Doncaster Clinical Commissioning Group (CCG) are seeking to jointly commission services for the Doncaster borough to:

- Maintain health and wellbeing
- Improve individual experience
- Improve individual and community outcomes
- Avoid duplication
- Develop our workforce
- Make best use of the Doncaster pound

We have a long history of working together in Doncaster and a crucial step was taken in 2016 when health and social care commissioners and providers came together to jointly agree a plan for the future in Doncaster: The Doncaster Place Plan. This set out a vision for health and social care in Doncaster:

Our joint vision is:

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

We have made some significant strides towards that vision. We now have a joint forum between health and social care commissioners and providers in Doncaster which provides leadership on our journey to achieve our joint vision.

This strategy has been jointly produced by health and social care and sets out how our collective action can make the most impact, moving further towards the vision. It sets out our joint commissioning journey for the next two years to enable us to undertake the next steps to:

Work closely with local communities and neighbourhoods

- To aid and build communities, giving individuals hope and a positive vision for themselves and their families.

Ensure coordinated access

- To services when they are needed, ensuring they are accessible and matched to people's level of need.

Deliver a more holistic approach to care and support

- Ensuring all health, care and support needs of individuals and their families are considered.

Provide care and support for individuals when they are in crisis

- Making it easier to access health and care services when they need them the most.

Improve support for people with complex needs

- When it is identified that an individual has complex needs, social, physical or mental health issues, organisations will work together and wrap care and support around them.

Jackie Pederson,
Chief Officer,
NHS Doncaster CCG

Damian Allen,
Director of People
Doncaster Council

Executive Summary

Our Vision

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

Our Gaps	Health and wellbeing gap	Care and quality gap	Finance and efficiency gap
Our Challenges	**Health and wellbeing in Doncaster are improving, but still not as fast as the rest of the country, particularly for: Avoidable deaths; Emergency admissions; Proportion of children in need; Permanent admissions to care homes; Healthy life expectancy**	**Fragmentation and complexity of health & social care services** **Continued rising demand for health and care services** **Workforce shortages and the need to ensure the right skills mix to meet future needs**	**The cost of delivering health and social care continues to increase** **The collective commissioning gap will continue to grow if we do not deliver the changes we are looking to make**

Life course vision	**Starting Well:** To be the most child friendly borough in the country	**Living Well:** People feel supported within their community; where people do need health and care services they are coordinated and timely	**Ageing Well:** Doncaster ageing population will receive person-centred, flexible, integrated care and support in their own "home", that aims to maximise their health and independence

Making the change happen

Working with our neighbourhoods:

- Establish a community and voluntary sector infrastructure
- Build on what is already available within our communities and support them to develop
- Develop and integrated approach for the first 1001 days
- Adopt new ways of working that build resilience in Young People, their families and communities

Ensuring co-ordinated access to services:

- Digitally supported access points to enable signposting to services
- Explore options for co-ordination across access points
- Improve and simplify access to children's services
- Over time reduce the number of access points

Delivery of integrated health and social care through:

Taking a holistic approach to care and support:

- Commission services closer to home
- Develop locally based primary care networks
- Jointly commission dementia services from an alliance of providers
- Bring together physical and mental health services for older people to deliver a "frailty" approach

Person centred approach to support complex needs:

- Commission a person centred approach for people with substance misuse and mental health needs
- Commission services to meet the needs of vulnerable people
- Work to eliminate inappropriate out of area placements
- Develop the future placements approach to keep as many children and young people at home or close to home as possible

Rapid response for those in crisis:

- Commission further rapid response approaches, enabling more people to stay in their own home
- Commission alternatives to A&E for mental health crisis
- Further develop children's community nursing and therapy services

REDUCING INEQUALITIES

Enablers	Population Segmentation, supported by Population Health Management approaches	Integrated neighbourhood teams	Asset Based Community Development	Co-ordinated access to health and social care	A workforce fit for the future	Communication, IT and digital capacity across health and social care	A borough wide estates strategy for health and social care

Purpose

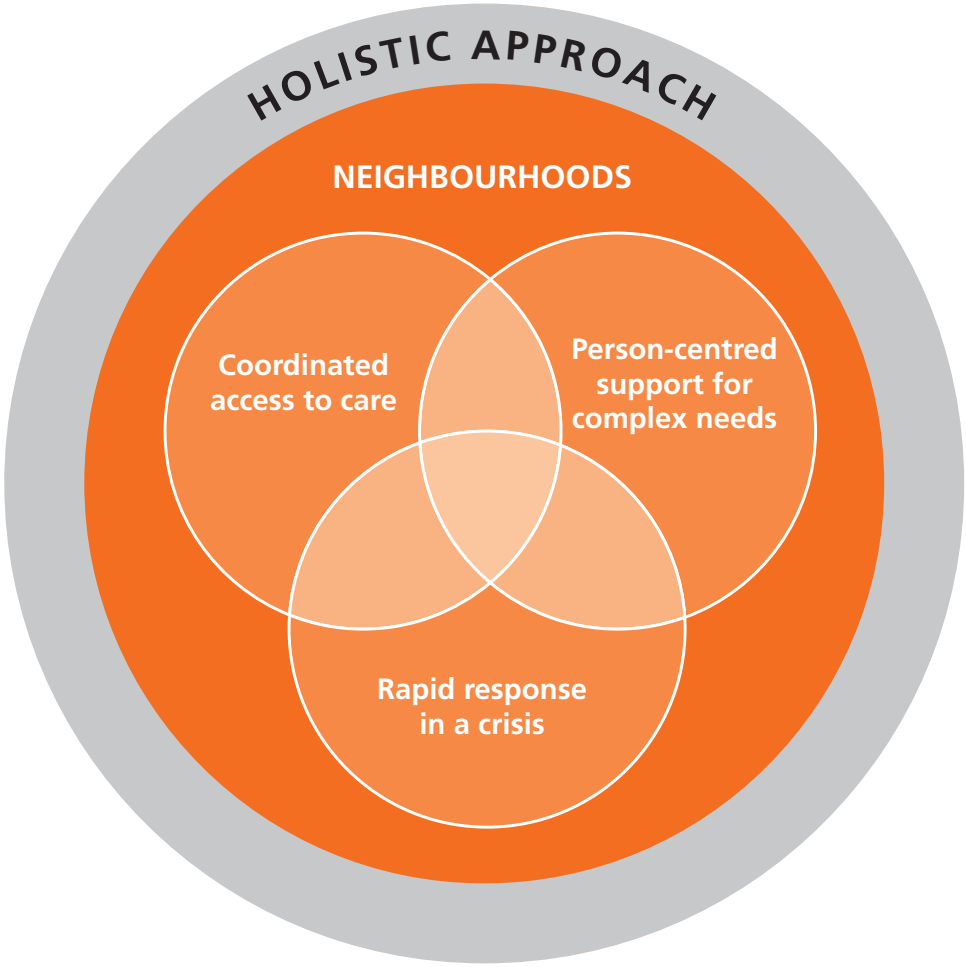
This document sets out the joint commissioning strategy for health and social care in Doncaster for the period April 2019 to March 2021.

It describes the next stage in an ambitious journey to ensure that Doncaster residents receive care, treatment and support that is person centred, designed around their own strengths and needs and that of their families and carers. Ultimately creating services that support Doncaster residents to access support and services at the **right place, in the right way at the right time.**

A key focus of the strategy is to support a managed shift towards health and care that is increasingly preventive and delivered at community level, rather than in acute settings.

If we get this right it will mean that for our population in Doncaster they will:

- Be able to access support developed within their community
- Have co-ordinated access to different health and care services across the borough
- Receive a holistic approach to care and support needs
- Be able to easily and quickly access support and services when in crisis
- Receive enhanced services where there are complex needs



Scope

This commissioning strategy sits across both health and social care, including Public Health, for adults and children. It captures the services commissioned by both Doncaster Council and NHS Doncaster CCG, with a particular focus on the areas where we will jointly commission together.

The joint commissioning strategy forms one of two key documents for 2019-20 that will drive how we continue to deliver our vision in Doncaster:

- **The Doncaster Place Plan Refresh**
- **The Joint Commissioning Strategy** (this document)

NHS Doncaster CCG is also part of a wider commissioning footprint, the South Yorkshire & Bassetlaw Integrated Care System (ICS). This strategy, however, only refers to commissioning at local place level.

	Doncaster Place Plan Re-fresh	Joint Health & Social Care Commissioning Strategy
Purpose	Sets out the vision for the Doncaster health and social care **system** over the next two years	Sets out the joint **commissioning** ambitions for health and social care in Doncaster over the next two years
Scope	Sits across all health and social care organisations, linking in to wider partners such as education. Set in the wider context of Doncaster Growing Together shared vision of Doncaster as a place to learn, work, live and care. Sets out the system drivers to deliver the new health and social care system.	Sits across the health and social care commissioners in the first instance; also recognises the work underway with a broader range of commissioners in Doncaster Focussed on the full range of priorities for NHS Doncaster CCG and Doncaster Council – setting out both joint priorities and those that remain for one organisation only e.g. medicines management
Timeframe	2019-22	2019-21
Governance	Doncaster Integrated Care Board	NHS Doncaster CCG - Governing Body Doncaster Council - Cabinet

For further detail on how these documents align please see **Appendix 2**

What is Commissioning?

This strategy considers both strategic and neighbourhood level commissioning, with a strong focus on joint commissioning.

There will also always be areas of health and social care commissioning that do not require a fully joint up approach. Both NHS Doncaster CCG and Doncaster Council have respective statutory duties and regulatory requirements that will continue to be independent.

This commissioning strategy remains the only commissioning strategy for NHS Doncaster CCG and therefore contains reference to the wider remit that will remain NHS Doncaster CCG only commissioning responsibilities within the appendices.

Commissioning

Commissioning is a process to determine how to best use available resources on the basis of needs analysis, evaluating existing services, past performance and notable practice elsewhere.

Strategic

Strategic Commissioning takes place over longer time frames. It is also expected that Strategic commissioning will set the framework and standards for commissioning activity at other levels.

Locality

Local place shaping and capacity building - move to a model where services are available for people to access without coming to the council, but the council does have a role in supporting these types of services to grow and evolve.

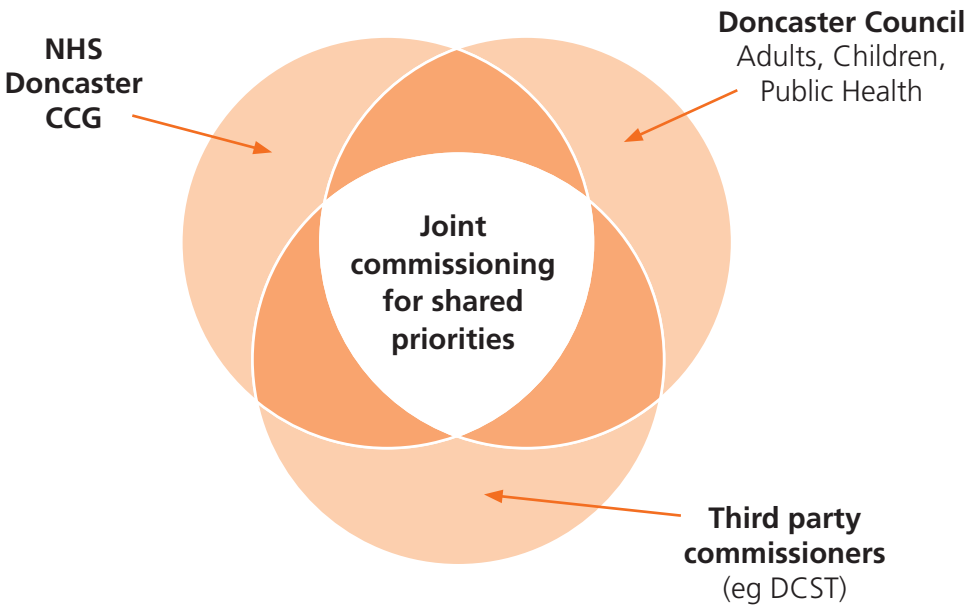
Use/community engagement - generating a richer picture of needs, desired outcomes, local quality and gaps. This could be directly or through community leaders, strengthening the role as an influencer and generating further connectivity across neighbourhoods, communities, wider services and partner footprints.

Individual

Done by the individual, a carer, an independent broker, a staff member or a combination of these. The role of Adults Health and Wellbeing Board in this is to ensure individuals have the tools to identify and access the right services; to do so safely, cost effectively and sustainably and to monitor the effectiveness of services in meeting outcomes and managing demand (reviewing Management Information generated via the customer journey).

What does joint commissioning mean for Doncaster?

There are a number of health and social care commissioners in Doncaster and we already have a history of working together.



At the centre of our approach is an intention to jointly commission services where it makes sense to do so. This means that a range of functions will need to align across our organisations, to deliver the commissioning process noted on page 7.

We have already made good progress towards this in a number of areas, such as Starting Well (see opposite for more detail). Underpinning the continued progression is a joint agreement to move forwards from the Commissioning Agreement signed in 2018.

This will take us along the spectrum outlined on page 9 and will build on the developments seen during 2018, heralded by a number of joint commissioning workshops. The next steps to be taken will include:

- Refresh of the Joint Commissioning Agreement
- Expansion of joint governance mechanisms to include a broader a range of services broader than the seven Areas of Opportunity, commencing with Starting Well
- Development of joint reporting processes
- Consideration of lead commissioner roles across both organisations

With regards to joint commissioning for Starting Well, which includes services for children and maternity, there is an agreed intention to move to one integrated commissioning model, with a standardised approach across NHS Doncaster CCG and Doncaster Council. This will be done in a phased way beginning with co-location of staff across the existing NHS Doncaster CCG and Doncaster Council teams early in the life of the Strategy.

Both organisations recognise that this document is the start of a journey and the strategy will guide the conversations to understand where shared budgets and shared services can build and develop for the benefit of the population across Doncaster.

In addition to NHS Doncaster CCG and Doncaster Council, there are a wider set of commissioners for health and social care, for example the Doncaster Children's Services Trust (DCST). Work is underway to start to work more closely with our wider partners but we are at differing stages on these particular journeys.

What does joint commissioning mean for Doncaster?

The spectrum of joint commissioning

Key Aspect	Co-ordinated Commissioning	Lead Commissioner	Joint Commissioning	Integrated Commissioning
Description	Health and social care organisations work closely to align commissioning intentions and contract requirements but do not commission services together	One commissioner takes the lead responsibility to develop commissioning intentions and contract with a provider. Contract associates can work either to the main contract or require separate Key Performance Indicators	Commissioners across health and social care work together to define joint commissioning intentions, supported by shared values, objectives and a pooled budget. Ultimately one contract and one service specification for providers. Teams not necessarily located together but can be supported by an agreement to work together	Fully integrated commissioning team across health and social care. Located together, working as an independent commissioning unit

The principles that were developed and agreed by all partners during the journey to develop the Place Plan continue to underpin and influence this strategy. These are:

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

National Policy Context

In 2015, the Local Government Association published the **'Commissioning for Better Outcomes'** Framework. This framework was revised in 2017, in partnership with NHS Clinical Commissioners and published in 2018 as the **'Integrated Commissioning for Better Outcomes: a Commissioning Framework'** (ICBO). It sets out the standards to support local health and care systems to strengthen and progress their integrated commissioning arrangements.

The **NHS Long Term Plan**, published in December 2018, signalled the direction for health and care services over the next ten years. It aims to give everyone the best start in life, deliver world-class care for major health problems, such as cancer and heart disease, and help people age well.

The NHS Long Term Plan also sets out how the challenges that the NHS faces, such as staff shortages and growing demand for services, can be overcome by:

1. **Doing things differently:** giving people more control over their own health and the care they receive
2. **Preventing illness and tackling health inequalities: increasing the focus on** some of the most significant causes of ill health, such as smoking, drinking problems and avoid Type 2 diabetes
3. **Backing the workforce:** increasing the NHS workforce, training and recruiting more professionals
4. **Making better use of data and digital technology**
5. **Getting the most out of taxpayers' investment in the NHS:** through identifying ways to reduce duplication in how clinical services are delivered

The **Care Act 2014**, which came into effect in 2015, represents the most significant reform of care and support in more than sixty years, putting people and their carers in control of their care and support. Some of the main changes include:

1. A minimum national threshold for eligibility for care and support
2. A requirement for the council to arrange **care and support in the community** (not in care homes) for a person who pays for their own care, if requested
3. Increased rights and **help for carers**
4. People in need of support will be encouraged to think about **what outcomes they want to achieve** in their lives
5. Stronger arrangements to protect the most vulnerable people in our society from **abuse and neglect**
6. A greater emphasis on **prevention** - through encouraging and assisting people to lead healthy lives, reducing the chances of them needing more support in the future
7. A greater emphasis on existing **Personal Budgets**, enabling individuals to take control of their care and support delivery
8. Increased support for people who have difficulty in **understanding the care and support assessment** and have no family or friends to help with this

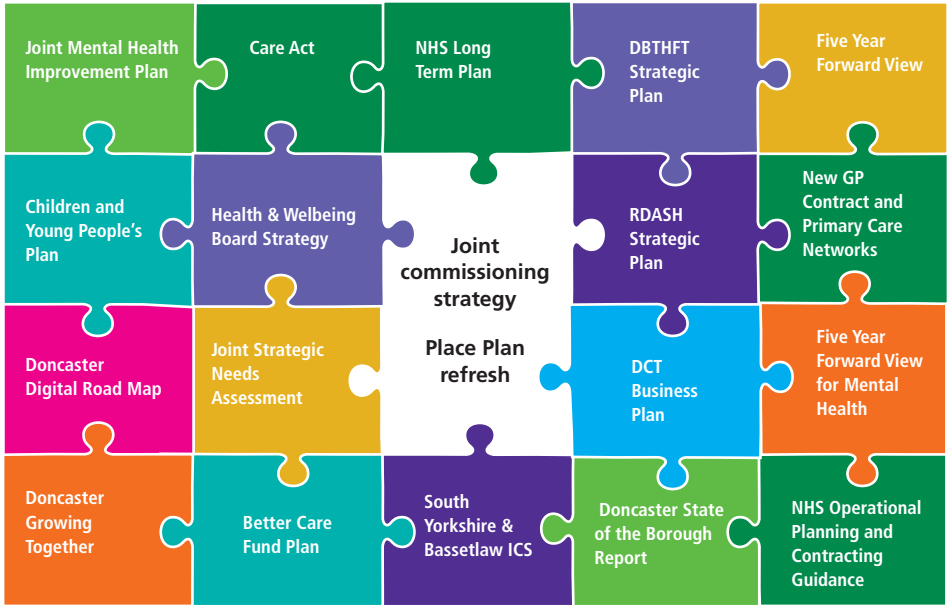
These changes lie at the heart of what we are doing locally.

The Local Context

The challenges posed by the national context are clearly recognisable in Doncaster, heightened by the three gaps as originally recognised in our Place Plan:

- **The Health & Wellbeing Gap**: health is improving in Doncaster but life expectancy is significantly lower in the most deprived areas of Doncaster
- **The Care & Quality Gap**: although we have made some excellent improvements in the ways that services are delivered, we still continue to have some services that are fragmented and difficult to navigate
- **The Finance & Efficiency Gap**: whilst our services are becoming more efficient, and we are delivering more for the Doncaster pound, demand continues to rise

It is important to note that the strategy also sits within a local policy context:



What needs to be in place to make this strategy a success?

Across the Doncaster health and social care system there are a number of fundamental changes underway, which are enablers to achieving our vision. They take forward the developments started within the Doncaster Place Plan and include:

- **Population health management and population segmentation**
- **Asset based community development**
- **Integrated neighbourhood teams**
- **Development of co-ordinated access across health and social care**
- **Workforce development to meet future needs**
- **Borough wide estates strategy**
- **Communication, IT and digital capacity across health and social care**

Community feedback: Why we need to change

During the development of this overarching strategy, we made a commitment to communicate and engage with members of the public, including existing service users and patients.

On 7 January 2019, we launched a six week engagement period, providing a range of online and face-to-face opportunities so people could have their say on our vision to jointly commission health and care services. We asked five key question and the feedback received is summarised below.

Over the next two years, we will continue to work with and for Doncaster people and local communities to shape, deliver and evaluate health and social care services. We expect this approach to become a normal way of working and details of the next steps can be found in **Appendix 2**

Do you think working across the three life stages will help ensure that local people will get the appropriate health and care services to meet their needs?

Is there anything you think that is missing from the vision?

What one thing could we do better to ensure you are able to take control over your own care?

How could we work better with you to plan, deliver and evaluate health and care services in Doncaster?

Would you like to be involved in future work to develop the strategy?

The Journey so far…..

2016

The Place Plan signalled a step change...

All age, person centred

Strengthened commitment to joint commissioning and provision

2017

We started to make our plans a reality...

The **7 Areas of Opportunity**

Commissioners and providers agreed to plan and deliver services in a more joined up way for: Starting well, Vulnerable Adolescents, Urgent Care, Dermatology, Learning Disability, Intermediate Care, Complex Lives

2018

We took this a step further…

The **Joint Commissioning Agreement** was agreed, which detailed the commitment to join together commissioning resources that support the seven Areas of Opportunity

What have we delivered to date?

The Doncaster Place Plan and subsequent work introduced seven Areas of Opportunity for joint work across commissioners and providers for health and social care. Good progress has been made across the Areas of Opportunity, as highlighted below:

Seven Areas of Opportunity	So far	Where next?
Complex lives	Concept proved Team in place Good impact	Commissioning model development including funding model
First 1001 days	Comprehensive business case	Securing funding to prove concept and test model
Vulnerable Adolescents	Comprehensive business case	Securing funding to prove concept and test model
Learning disability and autism strategy	Strategy developed	Presentation to Cabinet/ Governing body in April
Dermatology	Care model developed Implementation plan clear	Commissioning and funding model to be agreed
Intermediate care	Rapid in place and concept proved Good impact	Securing funding to prove concept and test rest of model
Urgent and emergency care	System perfect Intelligence mapping Patient flow	UEC strategy, discharge, integrated urgent care

The Place Plan is now being refreshed to consider a broader agenda, balanced across the health and social care system. The refresh will drive the next steps in moving towards our vision from a whole system perspective. This is very much linked to the developments outlined in our plans in the following pages.

As commissioning organisations, NHS Doncaster CCG and Doncaster Council also held a series of joint workshops for commissioners over the course of summer 2018, in order to:

- Get to know one another and establish how we do business
- To begin to develop joint commissioning intentions and delivery plans around three life stages: Starting, Living and Ageing Well
- Share how far we have come on our journey already and start to identify our next steps

Our Catalysts for Change

In order to address these challenges we face in Doncaster we have recognised a number of catalysts to make the change:

Working with our neighbourhoods

Delivery of integrated health and social care through:

- Taking a holistic approach to delivering care and support
- Rapid response for those in crisis
- Person centred approach to support complex needs

Ensuring co-ordinated access to services

These catalysts run throughout our plans as they are important to our population as a whole. The catalysts have been developed through reviewing the needs of our population, and tested out during our engagement on this strategy.

Understanding the needs of our population

We already have a wealth of health and care data at the Doncaster level, as set out in the Joint Strategic Needs Assessment, which identifies our key health and wellbeing issues in Doncaster.

However, in taking this forwards we have recognised that we need to tailor our approach for our population and we are using Population Health Management as a tool to guide this work.

Population Health Management (PHM)

What is population health?

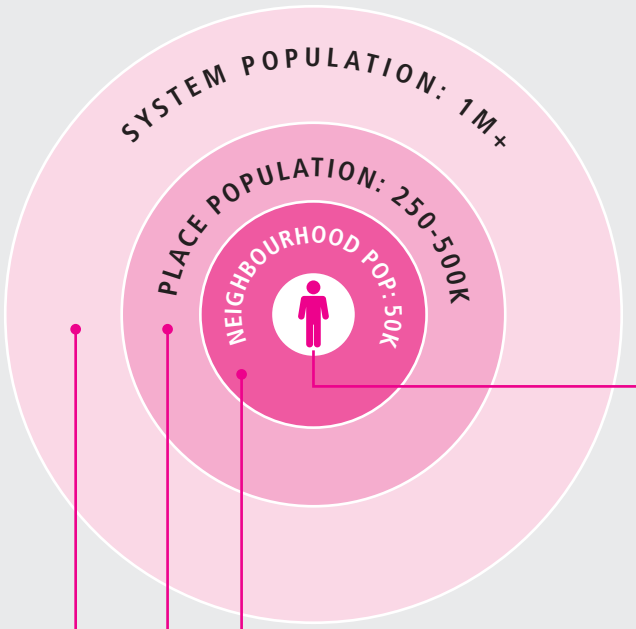
Population Health is an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing the wider determinants of health, and requires working with communities and partner agencies.

Principles of population health management

PHM improves population health by data driven planning and delivery of care to achieve maximum impact.

It includes segmentation, stratification and impact modelling to identify local "at risk" cohorts. This is turn enables the design of targeted interventions to prevent ill-health and improve care and support for people, resulting in reduced variations in outcomes.

In taking forwards the PHM management approach we are now starting to be able to identify how we need to target our commissioning across the life stages and within our neighbourhoods. The intention is to build on a standard offer for all our population, by identifying specific challenges at neighbourhood level, using new combinations of data and lived experience, to identify and deliver targeted interventions. This could include developing specific approaches for population segments as opposed to using any pre-existing disease based categories.



We have identified three key life stages and these form the framework for our plans:

Starting Well: focussed on our children, adolescents and maternity

Living Well: focussed on working age people

Ageing Well: focussed on our older population

Approach to prevention

Embedding prevention in all our services is critical in order to ensure that our services are sustainable and that they achieve the desired outcomes for the people of Doncaster. Whilst prevention means different things to different people, we have used a model of prevention (see opposite) that is holistic and captures the different levels of prevention, within each of the life stages:

- **Wider determinants** or strengthening the resilience of individuals and communities e.g. housing, transport, healthy food, green spaces, asset based community development, etc. These also are described as "Wellbeing" theme in Doncaster Health and Wellbeing Board outcome framework.
- **Primary prevention** such as reducing risk factors of diseases e.g. stopping smoking, and weight management – (relevant to Starting Well, Living Well, and Ageing Well programmes)
- **Secondary prevention** (early detection of diseases e.g. screening programmes) - (relevant to Starting Well, Living Well, and Ageing Well programmes);
- **Tertiary prevention:** This includes the management of long-term conditions such as self-management; complex lives, end of life care, etc. While this type of prevention is considered to be most relevant for Ageing Well, it is also relevant for Starting Well and Living Well programmes.

Model for prevention

Supporting people living with chronic conditions to manage their health. With the aim of preventing further disease and reducing the impact on health care services e.g. medications, care planning,

Tertiary Prevention
Long Term Conditions Management

Finding people living with undiagnosed disease. Early detection can lead to better disease outcomes. e.g. cancer screening programmes, NHS Health Checks.

Secondary Prevention
Early Detection

Reducing risk factors that cause disease, before disease is prevalent. E.g. smoking cessation, weight management.

Primary Prevention
Risk Factors

Wider determinants

Population wide interventions available to everyone. Ensuring the environment people live in is conducive to a healthy lifestyle. E.g. green space, active transport, healthy food policy.

What is a Delivery Plan?

To achieve our ambitions, we need a number of delivery plans that will ensure key priorities are addressed and delivered by health and social care organisations in Doncaster, working with and for patients and members of the public

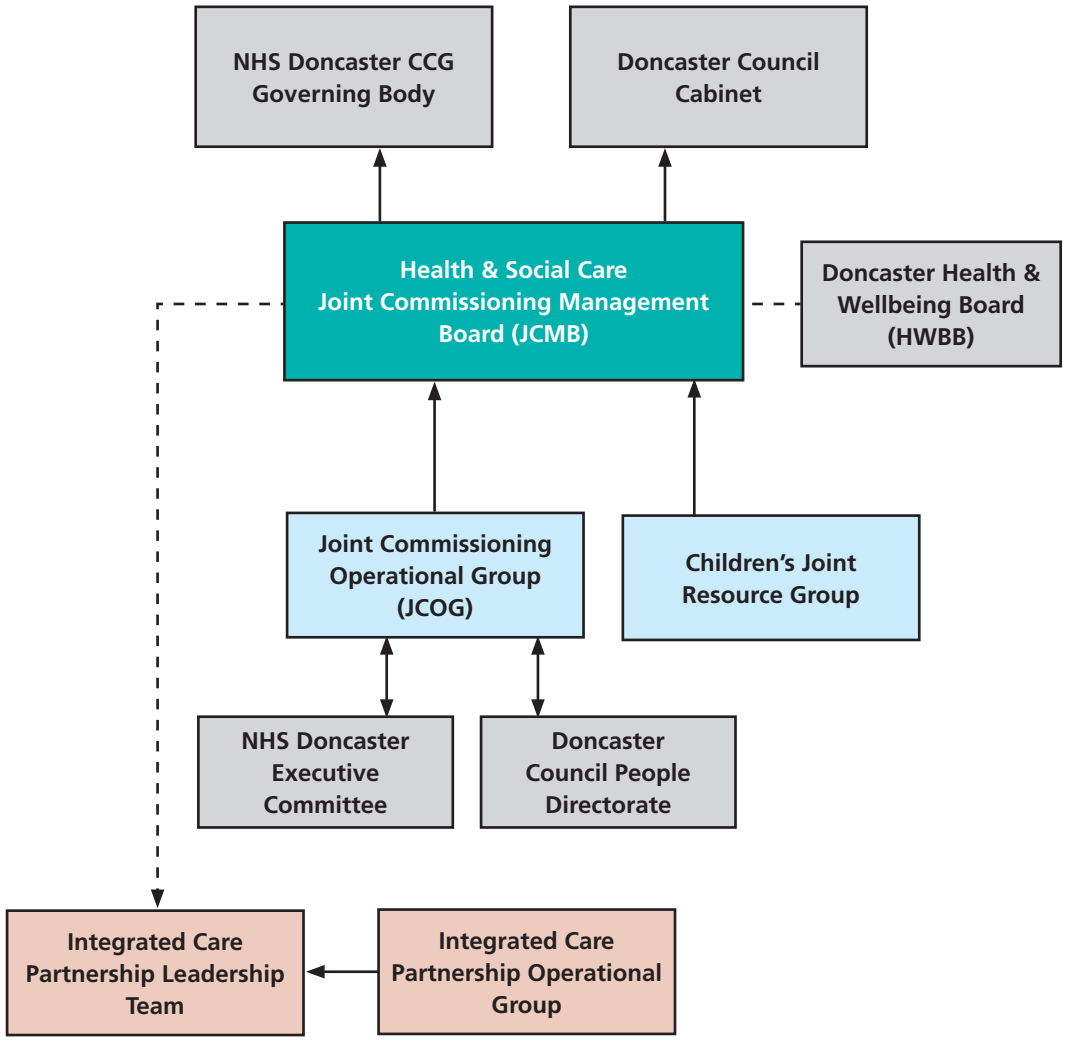
Delivery plans have been agreed at both at strategic and operational level and the full plans can be found in **Appendix 1**. The following pages within this document capture the essence of each of those plans:

- What we want to achieve
- How we will know if we are making a difference
- Actions to make the change happen

The specific plans are aligned to the three life stages and these will be used in year to drive the commissioning activities of our organisations and to hold ourselves to account.

Accountability

The Delivery Plans form a key driver for holding ourselves to account in year, against the actions we plan to take. In order to do this we will be developing joint reporting mechanisms, using the governance framework shown opposite. The refresh of the Commissioning Agreement will set out the underpinning detail to enable this to happen.



STARTING WELL - Summary Plan 2019-21					
Scope	Starting well is the local term to define all aspects of the children and maternity agendas and sits within the strategic framework of the Doncaster Children and Young People's Plan (2017 -20). This plan marks a significant step forward in our collective efforts driven by the vision to be the most child friendly Borough in the country.				
Starting well vision	***To be the most child friendly borough in the country***				
What do we want to achieve for the children and young people of Doncaster?	**Low level interventions based in our neighbourhoods**	**Co-ordinated access to services when needed**	**Holistic delivery of care and support**	**Responsive and accessible care in a crisis**	**Person centred support for people with complex needs**
	• Children have the best start in life • Teenagers and Young People are Safe • Children and Young People are healthy and have a sense of wellbeing • Children and Young People's development is underpinned through a healthy lifestyle	• Children have access to the right services at the earliest opportunity • Young People are equipped to access education, employment or training	• All Children are school ready • All Children attend a good or better setting educational setting and aspirations are raised to ensure that they reach their potential • No child suffers significant harm from neglect • Fewer Children living in poverty	• Domestic abuse practice is transformed across Doncaster	• Diminish the difference between disadvantaged and non-disadvantaged Children and Young People

STARTING WELL - Summary Plan 2019-21					
Making the change happen	**Low level interventions based in our neighbourhoods**	**Co-ordinated access to services when needed**	**Holistic delivery of care and support**	**Responsive and accessible care in a crisis**	**Person centred support for people with complex needs**
	• Listen to what Children and Young People have told us is important to them, and improve outcomes in these areas. • Adopt new ways of working that builds resilience in Young People, their families and communities. • Develop an integrated commissioning approach for the first 1001 days	• Improve access to autism and ADHD services, ensuring a smooth pathway • Improve access to children's mental health support services	• Place a renewed focus on social mobility and how services enable Children and Young People to get on • Deliver the Better Births Programme to ensure woman have access to information to make decisions about their own care centred around their individual needs • Further develop children's community nursing and therapy services	• Develop an integrated commissioning approach for Vulnerable Adolescents • Develop the local dynamic risk register for identified children and young people	• Develop a future placements strategy • Develop joint commissioning arrangements across health and social care for special educational needs
How will we know we are making a difference?	• There will be a reduction in Stillbirths, Maternal mortality, neonatal mortality and serious brain injury • There will be 0 suicides for Children and Young People in Doncaster • Any child or young person referred into a consultant paediatrician-led rapid-access service can be seen within 24 hours of the referral being made • Children and young people have a positive experience of care • Sustainable improvements in emotional wellbeing and mental health • Improving Waiting Times for Urgent and Routine Referrals for Children and Young People's Eating Disorder Services • Reducing and preventing Children with a learning disability, autism or both being admitted to a Tier IV inpatient service • A reduction in the achievement gap between disadvantaged pupils and their peers • Reduction in the Rate of Children in Need and in Care				

The respective actions to commission services to deliver this along with the full set of expected outcomes are set out in the Starting Well Strategic Delivery Plan; please see ***Appendix 1***

LIVING WELL - Summary Plan 2019-21					
Scope	Living Well covers a very broad segment of our population. The focus for this population segment is around helping working age people to keep healthy and active where possible, receiving timely treatment where needed.				
Living well vision	***People feel supported within their community; where people do need health and care services they are coordinated and timely***				
What do we want to achieve for the people of Doncaster?	**Low level interventions based in our neighbourhoods**	**Co-ordinated access to services when needed**	**Holistic delivery of care and support**	**Responsive and accessible care in a crisis**	**Person centred support for people with complex needs**
	• People are engaging with community neighbourhood support to manage aspects of their health and wellbeing, including physical and mental health • Where low level interventions are required these are delivered within communities, through an integrated voluntary and statutory offer	• Where services are required they are readily accessible and responsively matched to people's level of need • Access points are co-ordinated across the health and social care system to enable people to be proactively signposted	• Pathways consider the holistic "whole" needs of the individual in the context of their family and community • This includes access to and integration of a broader informal support network in addition to any formally commissioned health and social care provision • Local markets are shaped to ensure that delivery meets the needs of our population in a holistic manner	• Where people are in crisis care and support services are simple to access and community based where appropriate	• Agencies work together to deliver effective, person centred care for people with complex health and or social need • Agencies also work together and identify missed opportunities to engage with people who may have needs that would otherwise be unmet

LIVING WELL - Summary Plan 2019-21					
Making the change happen	**Low level interventions based in our neighbourhoods**	**Co-ordinated access to services when needed**	**Holistic delivery of care and support**	**Responsive and accessible care in a crisis**	**Person centred support for people with complex needs**
	• Work with our Learning Disability population to ensure that the recommendations from the LD Strategy are implemented • Commission a Social Isolation Alliance, to tackle all age loneliness and social isolation • Commission dispersed housing and outreach support for victims of domestic violence • Develop four neighbourhood based social cafes to provide person centred support and champion mental wellbeing within communities	• Increase the use of Your Life Doncaster, the Integrated Doncaster Care Record and other technologies across health and social care to enable a coordinated response at any point of access • Building on care navigation, explore the scope for Primary Care Extended Access hubs to become the co-ordinating centre for a number of services, alongside the development of Primary Care networks	• Deliver the local Living With and Beyond cancer strategy, to support people that have undergone cancer treatment to manage the next steps on their journey • Develop a community based health single point of access to ensure that people are able to access the right service in the community, only being admitted when there is no other alternative and enhance discharge support. • Maximise use of Assistive Technology • Continue to redesign health services to ensure community based delivery where appropriate, such as fibromyalgia, ophthalmology and spinal	• Develop and implement proposals for the front end modernization of Mental Health Access Services, providing genuine alternatives to A&E and hospital admission • Review the Doncaster Urgent Care model, to ensure that people are able to get to the right service quickly and in the right place	• Develop a joint agency agreement for homelessness and rough sleeping, including intensive wrap around support models and a Doncaster Housing first offer • Review the panels that oversee management and support for complex and high intensity users, working with the police to ensure one coordinated approach across the local system • Agencies to develop a person centred approach for people with substance misuse and mental health needs currently within supported accommodation

LIVING WELL - Summary Plan 2019-2021	
How will we know we are making a difference?	• There will be a 10% reduction in suicides • Fewer people in Doncaster will be overweight or obese • 100% of all adults with a learning disability will receive a timely Care and Treatment Review pre and post admission • Fewer people in Doncaster will smoke • Doncaster residents' quality of life will be improved and inequalities reduced • People will be more often managed in the appropriate setting • Fewer people under age 75 will die from Cancer, Cardiovascular disease and Respiratory disease • People of all ages will be able to access a range of urgent care in different settings, dependent on clinical need • Urgent care services will work smoothly and effectively across all parts of the system, at both points of access and discharge • Patient-reported outcomes from Physical healthchecks will improve for patients with a Serious Mental Illness • At least 50% of people who complete IAPT treatment should move towards recovery • Improved satisfaction of Doncaster residents with the health and care services they receive • The number of people with a Delayed Transfer of Care will be at least maintained in line with the nationally required trajectory, and reduced as far as possible • Improvement in the proportion of people who use services and carers, who report that they have as much social contact as they would like. • The rate of domestic abuse incidents reported to the police, per 1,000 population will be reduced

The respective actions to commission services to deliver this along with the full set of expected outcomes are set out in the Living Well Strategic Delivery Plan and Supporting Operational Plans; please see ***Appendix 1***

AGEING WELL - Summary Plan 2019-21					
Scope	Healthy ageing will be supported across Doncaster, recognising preventative approaches that reduce loneliness and social isolation, promote self-care and independence.				
Ageing well vision	***Doncaster ageing population will receive person-centred, flexible, integrated care and support in their own "home", that aims to maximise their health and independence***				
What do we want to achieve for the older people of Doncaster?	**Low level interventions based in our neighbourhoods**	**Co-ordinated access to services when needed**	**Holistic delivery of care and support**	**Responsive and accessible care in a crisis**	**Person centred support for people with complex needs**
	• Healthy ageing is supported across Doncaster through preventative approaches that reduce loneliness and social isolation, promote self care and independence • People will be supported to live in their homes for longer by services that are able to respond to their increasing complexity of need	• Care and support is co-ordinated and seamless • Individuals, their families and carers will be engaged in their care and support	• Individuals are supported and in control of their condition, care and support, optimising their independence to enable them to live better quality of lives • Person centred approaches are taken that ensure more involvement and control, through direct payments and greater choice • The health and social care workforce have the skills to safely care and support individuals within their neighbourhood • Individuals have choice in their place of death	• No individual is admitted to or will remain in hospital or residential care unnecessarily	• People are supported to live in their homes for longer by services that are able to respond to their increasing complexity of need

AGEING WELL - Summary Plan 2019-21					
Making the change happen	**Low level interventions based in our neighbourhoods**	**Co-ordinated access to services when needed**	**Holistic delivery of care and support**	**Responsive and accessible care in a crisis**	**Person centred support for people with complex needs**
	• Improve recognition of and support for carers • Continue to raise awareness and reduce stigma regarding dementia, across Doncaster • Raise public awareness of the importance of the last year of life across Doncaster • Develop commissioning intentions for day opportunities , ensuring links into emerging neighbourhood developments • Commission a Social Isolation Alliance, to tackle all age loneliness and social isolation	• Ensure admission and discharge processes into Acute Hospitals are seamless, ensuring a "home first" approach supported by robust direct pathways and signposting to alternatives where appropriate	• Jointly design and commission an integrated frailty model, including people in care homes • Explore the opportunities for a joint community therapies offer to improve outcomes associated with rehabilitation and re-ablement • Jointly commission post-diagnostic dementia support services, contracting with an accountable care partnership • Continue to work with wider stakeholders on the development of a neighbourhood model for community based multi-professional teams	• Continue to work with providers to implement the Intermediate Care service model, building on the Rapid Response model, avoiding hospital admission where possible	• Increase system-wide adoption of advanced care planning as part of the Doncaster approach for managing frailty and end of life care • Ensure the urgent and emergency pathway for people with dementia aligns with the intermediate care program, to develop out of hospital care that responds to increasing complexity of need

AGEING WELL - Summary Plan 2019-2021	
How will we know we are making a difference?	• There will be an increase in people with Dementia whose care plan has been reviewed in primary care in the last 12 months • At least 67% of people with Dementia will be diagnosed in line with the national standard in 2019-20 • People aged 65 and over will report an improvement in their functioning and quality of life following the episode of care • More people aged 65 and over will report that they would be likely to recommend community services to friends and family • There will be an Increase in people aged 65 and over being discharged to their usual place of residence in 2019-20 • There will be an increase in the percentage of people aged 65 and over still at home 91 days after discharge from hospital into reablement/rehabilitation services • There will be a reduction in the percentage of people who died and had 3 or more emergency admissions in the 90 days prior to death • The percentage of people recorded on the end of life pathway as dying in their preferred place of death will increase • There will be a reduction in people aged 65 and over attending A&E, including those from care homes

The more detailed actions to commission services to deliver this, along with the full set of expected outcomes are set out in the Ageing Well Strategic Delivery Plan and supporting Operational Plan; please see ***Appendix 1***

Finance

The financial environment for all health and social care organisations is challenging. The Doncaster Place Plan recognised the scale of this challenge in 2016, and despite significant efficiencies being delivered by both commissioners and providers since then, the challenge remains:

- **Demand is increasing**
- **Complexity of need is increasing**
- **Costs are increasing**
- **Resources are restricted**

As a result, our plans to reduce duplication, work with existing strengths within communities and promote prevention/keep people as well for as long as possible, are essential.

Both NHS Doncaster CCG and Doncaster Council face the continued challenge of closing the financial gap whilst continuing to invest in services. The CCG has an overall allocation of £530m which includes ring-fenced allocations for Primary Care (£46m) and running costs (£7m). The remainder of the allocation is to deliver Acute, Mental Health, Community, Prescribing and Individual Placement activity. NHS Doncaster CCG has significant investment to make in Primary Care and Mental Health in order to deliver the Five Year Forward View and expectations contained within the NHS Long Term Plan. The CCG has identified an overall gap of approximately £10.3m for 2019-20 and has detailed plans to close this gap, working alongside Doncaster Council wherever possible to jointly commission services and individual care for patients

Doncaster Council has an estimated £21m budget gap in 2019-20 on a gross budget of £495m across all services. Following the use of £3m one-off reserves, the gap for 2020-21 is estimated at £13m. The 2019-20 budget plan includes £19.6m additional funding for Adults & Children's Services to meet demand, cost pressures and undelivered savings from previous years. It also includes £7.0m savings for Adults Services covering all areas of the care ladder; Residential Care Working Age, Home Care & Direct Payments and the impact of the Front Door and Community Offer. In addition savings are targeted for staffing restructuring & functional review to manage our workforce to deliver effective and efficient services.

Next steps: How will the strategy be used

This joint commissioning strategy sets a number of challenges:

- **To work in different ways with our communities**
- **To work together, in a much more joined-up way as commissioning organisations**
- **To encourage our providers to work differently with regards to the services delivered – both how and where they are delivered**

In order to achieve this, the commissioning strategy must be used as a live document:

- We have a number of prerequisites which we must continue to develop across our system and then adopt as business as usual.
- We have broad ranging strategic delivery plans, supported by operational delivery plans to deliver (see **Appendix 1**)
- We have a challenging financial environment to deliver.

The table below sets out the next steps and indicative timeframes for our joint commissioning journey.

Commissioning Agreement Key Milestones and timeframes		2019-20	2020-21
Delivery of Strategic and Operational Plans			
Commissioning Agreement Refresh	Develop joint reporting for the Delivery Plans		
	Amend governance arrangements to reflect three life stages		
	Further develop joint commissioning levels of ambition		
	Consider lead commissioner roles		
	Consideration of shared savings plans approach, commencing with Starting Well		
Place Plan Refresh			
Implementation of enablers *Note: The enablers are closely aligned to the Place Plan, and as such cannot be delivered by commissioners alone*	Population health management and population segmentation		
	Asset based community development		
	Integrated neighbourhood teams		
	Health and social care co-ordinated access		
	Co-productive workforce		
	Borough wide estates strategy		
	Communication, IT and digital capacity