Appendix A

Category	BCF Workstreams
Aids and Adaptations	DFG
	Telecare Strategy
	Community Aids and Adaptations

Narrative Update

The Disabled Facilities Grant (DFG) continues to be spent in line with DFG requirements, in 2016/17 expenditu
- Stair Lifts (20 Curved, 50 Straight)
- Extensions (3)
- Hoists (11)
- Level Access Showers (160)
- Over Bath Showers (8)
- Ramps (54)
- Step Lifts (2)

Appendix A

Category	BCF Workstreams
Building Community Capacity	Round 2 Innovation Fund (Having a Good Day) (Seed Fund)
	Community Capacity and Wellbeing Support Social Prescribing
	Well North Project
	Information and Advice Kiosks

	Disabled Go
	CLS Community Led Support

Narrative Update
Throughout the 2016 / 2017 financial period, there were 23 successful applications to SEED fund from across t and informal network activities ranging from Befriending, Breakfast and Laundry group, Dig It Denaby Allotmer and monitoring visits to date have indicated that these numbers have stayed the same for some groups and in The SEED fund has continued into 2017 / 2018 and from April 2017 to date the SEED fund has committed £457 outstanding applications.
This project is to develop the provision of personalised support to identify and address individuals' non–medic or community groups to improve their long-term health and wellbeing to; - Help people better understand and manage their condition(s) - Support carers to access the right support - Develop partnerships and joint working between primary care / district nursing staff, the diverse range of vol providers to ensure responsiveness and the quality of support - Build a pool of volunteers to support the delivery of the service and provide opportunities to enhance their e profile in the primary care setting The total number of referrals this contract year currently stands at 987 with 618 starts and currently 40% of re service and of the 987 referrals 757 have come through the GP route with a further 757 coming from commur
Well North is a collaboration between local areas, Public Health England and The University of Manchester. D Halton, Skelmesdale, Bradford, Newcastle and Cumbria. Everyone wants a comfortable home, a good job and a healthy life to enjoy with family and friends. But life isn happiness and hope. But people and places can change for the better and local people are the solution. Conversations with the community have identified local strengths and co-produced many solutions. Well Donc April 2015 and is financed until 2021. It acknowledges that some outcomes will need to be measured over five decades. To support this change Well Doncaster has reopened the library which is now run by volunteers and which is supporting an average of 100 people each week to build their confidence, access support and give bac active in the Denaby area serving a diverse range of ages and interests. A community micro grant scheme has l successful applicants. We successfully secured Building Better Opportunities, a programme from SYH which su support and commissioned a site management plan to develop a key green space asset in the community. The enterprise, celebrating culture and local talents, making the most of the physical environment, building on lea when they need them.
Information and advice kiosks have been installed in three community libraries, two of these kiosks are still act are well utilised in the community libraries this is supported by the performance information received from th five kiosks are funded from the Better Care Fund.

According to the latest National Census 2011 the Council provide services for around 297,200 people, of which 21% of the local population. Looking to the future, the UK's ageing population and its impact on the area's der population was recorded as being 65 years old or more. This is significant as we know that people over this ag address accessibility for disabled people and carers is only going to increase.

Disabled Go seeks to provide relevant access information which is specific to each venue and relevant to a wid choices about venues and services they would like to access. The provision of this information leads to people being in a position to improve their own health and well being.

By January 2018 this workstream aims to have created 1000 venue guides covering a selection of venues acro

Appendix A

Category	BCF Workstreams
Dementia	Dementia Mobile Day Services
	Dementia Friendly Communities Programme
	Enhancement of Dementia Support Services (Alzheimers Dementia Cafés)
	The Admiral Service (Making Space)
	Dementia Advisor (Peer Support Pilot)
	Dementia Advisor (Age UK)
	Dementia Befriending
	Dementia CCG Post (Fully Funded by BCF)

Narrative Update
The Dementia Friendly Communities Programme contains a number of activities which help people to live well - Continued awareness campaign consisting of: - Focused events throughout Dementia Awareness Week in May 2017 - Focus on prevention of vascular disease and promoting healthy lifestyles - Production and display of awareness posters and dementia literature such as the Dementia Directory of Servi - Production and use of awareness material on Heath TV and other such as radio and press - Use of “health bus” throughout neighbourhoods - Expansion of intergenerational project work with local schools Continued roll out of Dementia Friends, Dementia Champions and the Dementia 'Pledge' and 'Commitment' Pr currently having over 16000 Dementia Friends, over 80 members of the Doncaster Dementia Action Alliance a further enhance this number but particularly with areas and groups that are regarded as "seldom heard". Celebration Event and Dementia Quality Improvement Awards - It is vital will feedback on progress to the com
The objectives of the service are to provide a high quality service to people with Dementia and their carers/far longer through enabling independent living. The Dementia Support Service has been commissioned by NHS Dc Society for several years. The service has 3 elements: - Information and Advice - Dementia Cafes - Carers Information and Support Programme (CrISP) The most recent year-to-date performance monitoring (April-July 2017) shows that the number of clients cont increased by 24% (867) and awareness raising/information and advice has increased by 21% (468) compared t
The Doncaster Admiral Service provides care for people diagnosed with Dementia (PWD) and their carers via a (AN) and Dementia Advisors (DA). A recent evaluation report in partnership with the University of Hallam shov carers said that a dementia advisor was helpful to meeting their practical needs as a carer. 72% of carers said t advice and guidance was provided in a timely and relevant way.

Appendix A

Category	BCF Workstreams
Discharges	Hospital Based Social Workers
	Home from Hospital
	Hospital Discharge Worker
	SPOC/One Point 1
	Stroke Early Supported Discharge

Narrative Update

Home From Hospital is a service providing a pre-discharge assessment of needs and post discharge support inc
for up to four weeks. This is followed up by Telephone support for a further four weeks, a three week review a

The objectives of the service are to:
- support appropriate planned discharge from hospital
- reduction of inappropriate readmission to hospital
- reduction in length of stay
- reduction of premature admission to residential care deliver a flexible person-centred service
- provide short term intervention packages
- support carers – reduced risk to carer breakdown
- free capacity within health systems elsewhere
- support the falls reduction agenda by the provision of a more formal level 1 falls assessment

94% of service users were still at home 91 days after discharge which is over 10% higher than the national targ
target of 1%).

Appendix A

Category	BCF Workstreams
Enablers	Procurement of a strategic partner to support DMBC and partners across the Doncaster Health and Social Care sector to deliver the Doncaster Place Plan.
	Dev & Enhancement of vibrant provider market
	Integrated health and social care information management systems - (Caretrak)
	Intermediate Care and support strategy
	PMO (Programme Management Office and Development)
	Integrated Digital Care Record Pilot – Consultancy Support

Narrative Update
To undertake a procurement exercise to select a provider who can deliver a ‘’bespoke ’work programme to th agreed at £15k).
This work programme aims to: enhance the sector’s ‘Business Acumen’ to help support the development and also further demonstrate the Local Authorities’ commitment to supporting the sector.
HealthTrak is a business intelligence, strategic commissioning and decision support tool that integrates and an Dashboards. The project proposes to align Dashboard and business intelligence development with the borough wide strate on Cohort B, Intermediate Health and Social Care. Work in this area is subject to establishing effective data sh ensure appropriate data sharing agreements; and compliance with information governance requirements is in In parallel to this, a key area of focus for Dashboard and intelligence development is to support the key objecti define and develop Dashboards that will bring insight into which cohorts of residents and which medical condi Dashboards have been designed, however stakeholder engagement will take place throughout quarter 2, later
Robust governance of the BCF and IBCF is essential. Current arrangements include the Transformation Co-ord and challenge techniques to these, recommendations are then made to the Joint Commissioning Co-ordinatio members. Governance will be strengthened through the developing risk management methodologies describ management framework which will be launched towards the end of the year.
DBTH have a number of disaggregated clinical systems holding patient related data. To provide a holistic acute record, it is necessary to develop the capability to integrate these systems and export data. The project deliver - Defining the available systems to be integrated within the portal - Mapping out how respective systems will interface and support the ICDR - Engagement with clinicians and other key stakeholders It is anticipated the first stage of development will include the ability to provide an internal patient portal, join DBTH. This should be ready to pilot in Q4 2017 and will include an expanded data set being available to the pa development will be completed to include more underlying Trust systems

Appendix A

Category	BCF Workstreams
Intermediate Care	STEPs / OT Service
	RAPT
	(Positive Steps) Social care Assessment Unit
	Doncaster Intermediate Health & Social Care – Phase 3- testing the model
	CSI (MMH)

Intermediate Care	Occupational Therapists
	Bed Based Intermediate Care
	RDASH Falls Service
	RDASH Unplanned Nursing
	Social Care Assessment

Narrative Update

Doncaster Intermediate Care Redesign Update – August 2017

A comprehensive review of intermediate health and social care services in Doncaster was conducted between
- Analyse performance of the current intermediate care system.
- Clarify local need for intermediate care.
- Identify key elements required in the future service model for Doncaster.

It included a range of activities, for example;
- In depth, multi-disciplinary and multi-agency study of the needs of statistically significant sample (1027) of p
- Visits to current services and 51 interviews with key stakeholders
- Desktop analysis of data relating to current IHSC services (including benchmarking data from National Audit
- Interviews with 58 people using intermediate care services about their experiences.
- Findings from the hospital discharge pathway study. Qualitative study lead by Sheffield Hallam University fo

and home for 12 months.

The review found;
- Current services are too complicated and difficult to navigate.
- Lots of duplication- Similar services doing similar things to support people with similar needs.
- Not enough step up support to prevent admission and maintain people at home.
- More bed based services than in other areas.
- Most people who use intermediate care are over 80 and have complex, health and social care needs- need i
- Not all teams could work with Dementia and Cognitive impairment- despite growing need.
- Don't routinely address low level mental health, loneliness and social isolation.
- Commissioning and contracting arrangements contribute to complexity and disjointed provision.

The full case for change is available here;
http://www.doncasterccg.nhs.uk/wp-content/uploads/2016/05/DCCG-Case-for-Change-Final-HR.pdf

In phase 2 (mid 2016) the intermediate care team used the findings from the review and a set of design princip
care and design a more efficient model which will provide 4 integrated responses (rapid, short term, medium a
and social networks, preventing hospital admission and utilising community assets. Five working outcomes we
now being developed beneath these. Initial modelling also suggested that by utilising the intermediate care be
order to reduce activity in acute care. The project is currently in phase 3 (October 2016 onwards) and provider
future model and preparing staff for transition. This involves a number of test projects which have been scope
to encourage collaboration in delivering the outcomes above and test some of the aspiration in the Doncaster

The projects include;
1. Simplifying Access- Bringing together more access points in preparation for a place based Single Point of Acc
2. Rapid Response- Testing a multiagency rapid response.
3. Own Bed Instead - Developing and testing alternative community models of short term interventions in the
4. Integrated rehab and reablement- Developing and testing an integrated reablement and rehabilitation path

model.
5. Developing a shared competency framework, carrying out a workforce audit and a joint workforce developr
6. Integrated Digital Care Record Proof of Concept.
7. Developing an integrated health and social care dashboard.
8. Developing and testing a new integrated approach to commissioning and contracting.
These projects are all at different points in their implementation. A couple are highlighted in more detail belo
Simplifying Access;
Doncaster already had a Single Point of access (SPA) for some health services so the decision was made to buil
through this. We now have access to most services required to provide an urgent intermediate care response
in place to bring the more routine responses through SPA from October 2017. Although relatively small scale t
integrated access points and links closely with the redesign of the social care front door and community led su
Rapid Response:

The most noteable progress has been made with the development of the rapid response (number 2) with an ir
and social care providers to offer a single co-ordinated response to prevent need for conveyance to hospital ar
people accepted onto the pathway were supported at home. Feedback from those who have used the service
home.

Integrated Digital Care Record (IDCR) Proof of Concept

The Intermediate Care Project team worked with the interoperability group to develop a specification for a pr
procurement process has been completed and a contract awarded to Orion Health who we are now working w
across 4 organisations including social care. This is due to be ready for testing from Nov 2017.

Commissioning and Contracting

As part of the place plan work there is an aspiration to move towards an accountable care model for commissi
the areas of opportunity (or initial cohorts) to test this work. An initial memorandum of understanding was agr
testing a different approach to developing services in setting up and running the test projects. Alongside this fi
to jointly confirm funding and cost of current services and to start to model some of the proposed changes to
initial steps towards formal pooled budgets for intermediate care, integrated commissioning and aligned outc

Next Steps;

We will shortly move into phase 4 and full implementation of the new model. It will build on the test projects l
commissioning and contracting model.

Debbie Aitchison
Intermediate Care Project Manager/ Head of Strategy & Delivery
17th August 2017

Appendix A

Category	BCF Workstreams
Mental Health	Mental Health - Doncaster Mind
	Mental Health - Changing Lives
	Adults Health and Wellbeing – Creative Options for Learning Disability service users
	MH Care Home Liaison & Treatment
	OP MH Liaison
	Mental Health Crisis Services
	Dementia Services
	Mental Health Social Care Input
	MH WSR

Narrative Update
Changing Lives provides support for vulnerable people and their families through intervention sessions such as providing signposting to information advice and guidance.
Using the Warwick Scale, 84% of clients who attended interventions provided by Changing Lives reported impr onto service and were approached by 506 people for information advice and guidance.

Appendix A

Category	BCF Workstreams
Neighbourhood Delivery	Community mobile day service / borough wide
	Winter Warmth
	Phase 1 Review officers
	Direct Payment Support Unit and Business Support Unit temporary staffing
	RDaSH EoL Domicillary Care

Narrative Update
The Community Day Service is provided for: - Older People who are physically frail and need more care and attention than a more informal community ser - Carers who need respite - Older people who are socially isolated or lonely and need emotional or practical support - Older people diagnosed with Demetia and their carers Service users often attend the day service to get respite from carers and to allow carers to have some time to and reduces the occurrence of carer hospital admissions through stress and burn out. Others attend to meet f Age UK Doncaster's Community Day Service first began with a service in Warmsworth in the early 1980s. With funding of eight centres. This basic funding principle has remained largely unaltered since then. The service ho aspirations of older people. The Service has grown from strength to strength with an increased number of Centres and range of activities a operates to co-production principles with service users shaping their 'day' and activities each having a persona Services currently provide 11 community day service opportunities with a total of 220 clients each centre offer equates to around 920 places a month or 11,960 per year.
Using BCF Funding, the Warm Homes, Healthy People in Doncaster (Winter Warmth) workstream has provided available winter warmth services within Doncaster covering Energy advice, top tips for keeping warm and eme Improved health and wellbeing of those directly involved and their families; Increased confidence within the c partner agencies; Effective and efficient use of limited resources; and Enhanced awareness of vulnerable peop
Excellent progress has been made against direct payments, as at Dec 2016 there were 530 direct payments in with a further 9 waiting to be set up on CareFirst. All team managers are now aware of the need to promote d trend will continue and there is a renewed focus on ensuring that managers thoroughly check the documentat are minimised. The DP steering group met weekly and then fortnightly to look at issues, the improvements identified by this g paperwork, processes and the information available. There continues to be a DP Champions Group which mee subject matter experts within each team in relation to DP and to undertake regular quality audits of paperwor aware of the DP option

Appendix A

Category	BCF Workstreams
Prevention	Falls Development Programme (Age UK)
	Healthy homes healthy people
	Carers Breaks
	Alcohol Safe Haven

Narrative Update
The Move More programme offers accessible exercise classes each week aimed at improving health in people
During the period April 16 – March 17 the Move More falls development programme was accessed by 282 Dor of 250) through the provision of 4 exercise classes per week. 74% of residents who participated in the Move M